**PSYC 862-002: COGNITIVE BEHAVIORAL THERAPY WITH ADULTS II**

**Didactic Practicum**

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Phone:

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Office Hours: Friday 11:40-12:30 (clinic), by appt

Course Description:

This course is designed to build on your initial instruction in cognitive-behavioral theory and therapy by furthering your understanding of and ability to apply this theory in therapy settings. The overall purpose is to develop your ability to integrate theory, principles, and applications of cognitive therapy and behavioral therapy for a variety of psychological problems. In addition, the literature regarding treatment of specific anxiety disorders and couples distress will be covered, and you will receive training in specific cognitive-behavioral techniques for these issues.

This course will utilize several modes of learning, including readings, lecture, discussion, example video/audiotapes, homework, role plays, and supervision of actual clinical cases. We will not use tests or other methods to grade you, and the grades will simply be “Satisfactory” or “No Credit.” This should not, however, give you the impression that you can “slide by” on readings or assignments. Each aspect of the coursework is **essential** to the development of your ability to apply cognitive-behavioral therapy. Class time will be split between didactic instruction and active group supervision of cases. Active participation in supervision of all cases (not just your own) is integral to the learning that will occur in this course.

As before, the course is not intended to convey that cognitive-behavioral therapy is the only acceptable therapy to practice. Rather, it is intended to further inform you of (a) the problems for which cognitive-behavioral therapy has been shown to be efficacious and/or effective, (b) the steps and techniques involved in conducting cognitive-behavioral therapy, particularly for anxiety disorders and couples’ distress, and (c) the flexibility of this therapy when it is based on a coherent case conceptualization.

Course Goals:

1. To further the development of your professional identity as a therapist.
2. To further your understanding of the principles and tenets of cognitive and behavioral theories with regard to mental health problems.
3. To further your ability to apply cognitive-behavioral therapy techniques in therapy settings.
4. To learn more cognitive-behavioral techniques for treating specific anxiety disorders and couples’ distress and to practice applying these techniques.
5. To further develop your ability to develop a comprehensive, cohesive cognitive-behavioral case conceptualization and to derive a treatment plan from that conceptualization.
6. To further your ability to implement a cognitive-behavioral treatment plan throughout the course of therapy, understanding how the case conceptualization drives all therapeutic activity.
7. To further your appreciation of how issues of diversity (e.g., age, race, ethnicity, culture, sexual orientation, etc.) can be incorporated into a cognitive-behavioral conceptualization.
8. To further your appreciation of the importance of the therapeutic relationship to cognitive-behavioral therapy.

**Individual Case Presentations:**

When we discuss your case, please come prepared with the following questions/points of discussion.

1. Brief presentation of case – this should not be a step by step review, but rather a summary of the client’s presenting problem, recent stressors, and what you did in the last session.
2. Summary of process in the session. How do you think the session went? Were there moments that you felt like you clicked really well with the client? Were there moments that you felt like you were not connecting with the client? What was happening when you felt something change in the session?
3. Question for supervision – please think about what question would be most helpful for you to discuss with the class for supervision. Your supervisors will also give you feedback about the session, but we would like to start with what you view as the most important question about the session.

Technology Usage:

Important announcements and study questions may be distributed by email, and you are required to check your Mason email account to receive these [and to keep your mailbox maintained so that messages will not be rejected for over quota]. ***Please note that email cannot be considered confidential, so no identifying information regarding clinical cases should be included in email.***

Disabilities:

If you are a student with disability and you need academic accommodations, please see me and contact the Disability Resource Center (DRC) at 709-993-2474.  All academic accommodations must be arranged through that office. Please note that accommodations MUST BE MADE BEFORE grades are assigned. I cannot adjust your grade after the fact.

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| Week | Topic | **Readings** |
| 1 Jan 24 | Distress Tolerance Skills \*\* Alternate Class day | DBT workbook DT module  |
| 2 Jan 31 | Social Anxiety Disorder CB Conceptualization CB Treatment | Barlow (2014): Ch. 3Golden (2011) |
| 3 Feb 7 | Eating Disorders \*\*Alternate Class Day | Linardon, J., Brennan, L., & De la Piedad Garcia, X. (2016). Rapid response to eating disorder treatment: A systematic review and meta‐analysis. *International Journal of Eating Disorders*, *49*(10), 905-919.Sonneville, K. R., & Lipson, S. K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders*, *51*(6), 518-526. |
| 4 Feb 14 | Interpersonal Effectiveness Skills\*\* Alternate Class Day | DBT workbook IE module  |
| 5 Feb 21 | Exposure Therapy Theory Techniques | Abramowitz (2013)Craske et al. (2014) – reviewAbramowitz et al. (2019): Ch. 5-6 |
| 6 Feb 28 | Emotion Regulation Skills \*\*Alternate Class Day  | DBT workbook ER module  |
| 7 March 6 | Panic Disorder Conceptualization, Treatment, and Interoceptive Exposure | Barlow (2014) Chapter 1Craske & Barlow (2007) |
| 8 March 13 | GMU Spring Break – supervision TBD |  |
| 9 March 20 | Substance Use Disorders *Guest Lecturer: Patty Ferssizidis* CBT for Substance Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) | McHugh et al. (2010)Videos to watch prior to class:* <http://www2.jbsinternational.com/imc/sbirt/bt/story.html>

<https://www.dropbox.com/sh/pgb66bkk07bopmd/AABC0Cmtxp9GJaWsX6KTwg3ca?dl=0> (watch final video: “Urge Surfing”) |
| 10 March 27 | GAD |

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| Behar et al. (2009)Newman et al. (2013) |
| Intolerance of Uncertainty handoutBarlow (2014): Ch. 5 Zinbarg et al. (2006) - *review* |

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| 11 April 3 | Obsessive Compulsive Disorder Behavioral Conceptualization Exposure/Response Prevention Imaginal Exposure | Barlow (2014): Ch. 4Steketee (1993): Ch. 9 |
| 12 April 10 | Obsessive Compulsive Disorder (cont) | Clark (2004): Ch. 2Grayson (2010) |
| 13 April 17 | Posttraumatic Stress Disorder CB Conceptualizations Empirical Status of Treatments | Hembree & Feeny (2006)Gillihan et al. (2014)Watkins et al. (2018) |
| 14 April 24 | Posttraumatic Stress Disorder Prolonged Exposure Therapy Written Exposure Therapy | Foa et al. (2019)Sloan & Marx (2019) |
| 15 May 2 | Gender Identity  | Balsam, K. F., Martell, C. R., Jones, K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (p. 287–314). American Psychological Association. [https://doi.org/10.1037/0000119-012](https://psycnet.apa.org/doi/10.1037/0000119-012)Daley, T., Grossoehme, D., McGuire, J. K., Corathers, S., Conard, L. A., & Lipstein, E. A. (2019). “I Couldn’t See a Downside”: Decision-Making About Gender-Affirming Hormone Therapy. *Journal of Adolescent Health*, *65*(2), 274-279.WPATH Standards of Care <https://www.wpath.org/publications/soc> |

**Practicum Supervision Contract**

This is an agreement between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Supervisee), and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Supervisor) for clinical work associated with child practicum at George Mason University’s Center for Psychological Services.

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(start date) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(end date).

Regular supervision days/times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(day of week) at \_\_\_\_\_\_\_\_\_\_\_(time).

This contact should facilitate conversation between practicum students and their supervisors about the legal, ethical, and clinical issues of the supervisory relationship. It is also intended to set expectations related to dates and frequency of supervision, as well as training expectations.

The purpose of supervision is to monitor and ensure the welfare of clients, facilitate the supervisee’s personal and professional development in preparation for careers as psychologists, ensure services are provided within the supervisee’s level of competence, promote accountability, and fulfill the requirements of the supervisee’s graduate training program and Virginia State laws governing the practice of psychology. The supervisory relationship is a two-way process through which growth is enhanced and mentoring is accomplished. Across the supervisor-supervisee-client triad, attention and respect will be accorded to developing competence related to culture and diversity.

1. **Context of Services**
	1. Unless otherwise specified and approved by the supervisor (e.g., for purposes of exposure), all services will be provided at George Mason University Center for Psychological Services at 10340 Democracy Lane Suite 202 in Fairfax, Virginia.
	2. Practicum students will provide evidence-based assessment and therapy services to adults. The evidence-based treatments provided to adults will depend on the needs of the clients, focus of the course associated with practicum experience, and the experience and training of both the supervisor and supervisee.
2. **Goals and Objectives of the Training Experience**

By the conclusion of the training experience, the supervisee will demonstrate:

* 1. Knowledge of research related to the treatment and development of mental disorders in adults. Understanding of the rationale and empirical evidence base for mental health treatments.
	2. Competency in assessment and diagnosis of mood and behavioral difficulties in adults.
	3. Competency delivering therapeutic techniques (e.g., exposure, cognitive restructuring, behavioral activation) to adults.
	4. Effective communication with third parties, (such as psychiatrists or office of disability resources) regarding client care.
	5. Demonstrate clinical judgement commensurate with developmental level.
	6. Accurately assess risk related to child abuse, elder abuse, suicidal ideation/behavior and homicidal ideation/behavior and report to supervisors and protective agencies appropriately
	7. Manage any potential ethical, legal, or interdisciplinary difficulties competently, with supervisory support
	8. Respectful and professional behavior that adheres to program rules and regulations.
	9. Respectful of individual and cultural differences.
1. **Nature of Supervision and Training Experience**
	1. For a practicum student, time each week will be allotted approximately as follows:
		1. 2 hours delivering outpatient therapy to adults (each student is expected to carry 2 cases)
		2. 2-3 hours of indirect time (preparing for sessions, treatment planning, clinical documentation, preparing receipts, scheduling sessions, case management)
		3. 2 hours of regularly scheduled, face-to-face group supervision during child practicum course meeting time (individual supervision is available upon request, and supervisors are available during office hours for additional support)
	2. Each supervisee’s developmental clinical level, training goals, and professional goals will be considered when assigning clients and providing feedback and suggestions within supervision.
	3. If a student has an interest in adding additional responsibilities into his or her training program (e.g., taking on an additional weekly outpatient therapy case), his or her current caseload, competencies, and professional goals will also be taken into account and discussed with the primary supervisor(s), his or her academic advisor, and the director of the center in making the decision to take-on additional work.
2. **Method of Evaluation**
	1. Supervisor will review supervisee’s work during every session via audio or video tape
	2. Informal feedback will be provided to the supervisee during each supervisory session.
	3. Formal feedback will be provided in form of a student evaluation at the end of the training experience.
		1. Specific feedback will focus on the supervisee’s demonstrated clinical skills, documentation, ethics, and professionalism.
	4. The supervisee will also complete an evaluation of the supervisor at the end of the training experience.
3. **Responsibilities of the Graduate Training Program**
	1. Provide current ongoing malpractice insurance for each student’s clinical work.
	2. Respond to concerns raised by practicum supervisors in a timely manner.
	3. Communicate any misconduct of student to supervisors if it may impact clinical work.
4. **Responsibilities of the Supervisor**
	1. Attend scheduled supervision and be available on an as-needed basis. Arrange back-up supervisory coverage if out of office.
	2. Commensurate with supervisee’s developmental level, ensure that the supervisee understands and delivers the diagnostic assessments and treatments outlined in the client’s treatment plan.
	3. Provide feedback and sign all documentation in a timely manner.
	4. Review each session via video or audio recording. At least once per semester, review a video recording or provide live observation of a session \*\*\*
	5. Maintain weekly supervision notes.
	6. Facilitate a positive learning relationship that encompasses respect, encourages autonomy, and enhances the training experience.
	7. Help the supervisee explore and clarify thoughts and feelings which underlie his/her practice. Identify and bring to the supervisee’s attention any personal and/or professional difficulties that may directly affect the supervisee’s ability to provide competent clinical care and recommend a course of action to address them. This information will be shared with the co-supervisor of the course to allow for: (a) provision of any needed support by both supervisors; and (b) ethical and competent supervision and resultant client care.
	8. Intervene if client welfare is at risk.
	9. Consult with co-supervisor and/or director of the center around any immediate concerns about supervisee’s ability to conduct clinical work competently.
	10. Discuss disagreements or conflicts in the supervisory relationship as soon as possible with the supervisee. If the situation cannot be resolved in the context of these discussions, let the supervisee know that the supervisor will be seeking consultation with the supervisee’s advisor and/or the Director of Clinical Training.
	11. If a supervisee is not meeting practicum expectations, the supervisor will discuss concerns with the supervisee. The supervisor may inform the supervisee’s advisor within the program if the supervisee is not meeting practicum expectations and notify supervisee of contact with advisor. With the supervisee and the advisor, develop a plan to support the supervisee in completing the practicum successfully. The Director of Clinical Training may also be consulted as needed.
	12. Ensure that ethical guidelines are upheld during provision of clinical services.
	13. Conduct activities in accordance with George Mason University Center for Psychological Services policy and procedures, APA guidelines, and applicable state and federal law.
5. **Responsibilities of the Supervisee**
	1. Maintain a caseload of two individual clients throughout the year.
	2. Complete clinical documentation of service directly after provision of service.
		1. Forward note to supervisor for review and signature within **24 hours** of delivering a clinical service.
		2. Complete clinical intake summary within one week of intake session, unless instructed by supervisor to enter a note and complete intake the following week.
		3. Complete termination summary within one week of discharge.
		4. Close clinical file within two weeks of discharge.
	3. Contact your supervisor **immediately (before the client leaves the building) if a client or family member presents with the *potential* for: suicidal ideation or behavior, homicidal ideation or behavior, psychosis, any other concern for the immediate welfare of the child (risk for child abuse, neglect).** This includes if a client endorses risk via any assessment measures, such as weekly OWL measures. This means that all OWL measures must be reviewed BEFORE the client/family leaves the session, and preferably at the start of session to allow for management of any risk issues without having to extend the session. If your supervisor cannot be reached in person or via phone, contact the other practicum supervisor for the course. If that individual cannot be reached, contact the clinical supervisor on call. Supervisees are not permitted to allow a client/family to leave building without having reviewed case/risk with a clinical supervisor. \*\*
		1. If a client presents with risk, clinical documentation of that risk and steps taken to address risk must be completed and note must be forwarded to supervisor for expedient review directly after the appointment, before the supervisee leaves the building.
	4. Receive supervision from supervisor between every session.
	5. Assign and review OWL measures for each client weekly. As noted above, scores on OWL measures should be reviewed before the client leaves the session.
	6. Be punctual at sessions with clients, class, and supervision. If supervisee is delayed for or unable to attend a class or supervision session, it is the supervisee’s responsibility to notify the supervisor ahead of time and make alternate arrangements for supervision prior to the next scheduled session with a client/family.
	7. Be prepared, both for sessions with clients and at supervision. You are expected to (a) have reviewed cases prior to supervision, (b) have followed any specific instructions from your supervisor, (c) have a plan to review the cases and/or issues that you need addressed, and (d) bring client files and receipts to session as needed for review or supervisor signature.
	8. Be receptive to feedback and guidance from your supervisor and follow through on suggestions or instructions.
	9. Inform your supervisor of any difficulties you are having in the areas of delivering services to clients, completing paperwork, or coordinating with other agencies or providers. Share any personal or professional issues or concerns that have the potential to impact your clinical work, consistent with professional ethics. If shared with one supervisor, this information will be shared with the co-supervisor of the course to allow for: (1) provision of needed support by both supervisors; and (2) ethical and competent supervision and resultant client care.
	10. Discuss disagreements or conflicts in the supervisory relationship as soon as possible with the supervisor. If the situation cannot be resolved in the context of these discussions, seek consultation with one’s advisor and Director of Clinical Training (or Department Chair if the Director of Clinical Training is a source of conflict). Manage these situations in a professional manner by limiting conversations around such issues to those involved.
	11. Deliver evidence-based treatment models with fidelity, unless deviations have been specifically discussed and approved by your supervisor.
	12. Ensure that all clients are informed of the supervised nature of your work as a supervisee, and of the ultimate professional responsibility of the supervisor. At intake, provide client with supervisor’s name and credentials (e.g., Licensed Psychologist), and explain how to contact him/her if needed.
	13. Advise your supervisor of all important information and/or changes in a case (e.g., mandated reports, status of case, custody dispute). Any changes in the treatment plan (including termination) must be reviewed with and approved by your supervisor before presented to a client.
	14. Notify your supervisor immediately if you are contacted by an attorney, receive a summons to testify, or you are told that you will be subpoenaed. **Do not*,* under any circumstances, speak about or release any portion of a client’s record to an attorney or anyone else (including the client) without first discussing with the supervisor.**
	15. Seek supervision whenever you are uncertain about a situation. You may consult informally with other supervisors or trainees after the fact, but your primary supervisor must be kept aware of any and all emergencies.
	16. Demonstrate respect for others’ thoughts and opinions during class, including group supervision.
	17. Complete professional tasks within time frames specified by supervisor. For example, if asked to call a psychiatrist for collateral information within a week, be sure to make the phone call within that time frame.
	18. Conduct activities in accordance with George Mason University Center for Psychological Services policy and procedures, APA guidelines, and applicable state and federal law (e.g., privacy, confidentiality and its limits, mandated reporting)
	19. In the event that someone you know from another context is being seen at the Center, you are expected to remove yourself from situations in which that client’s case is being reviewed.
	20. Remember that the supervisor bears liability in supervision, and thus it is essential that the supervisee share complete information regarding clients and files and abide by the supervisor’s final decisions, as the welfare of the client is critical.
6. Grading and Communication of Performance Outside of This Course
	1. Lack of completion of all clinical documentation by the last day of classes will result in an INCOMPLETE (IN) grade which appears as an F on the supervisee’s transcript until the work is turned in. Please be aware that an F on a transcript can jeopardize student funding. If work is not turned in by the college deadline for incompletes, an F remains on the transcript and funding may be revoked.
	2. Repeated lack of compliance with supervisee responsibilities will result in a NO CREDIT (NC) grade and the need to repeat this course. It will also likely result in placement on probation in the Clinical program.
	3. Communication regarding student performance in the course (ability to meet supervisee responsibilities, remediation plans, and grades) will be communicated with the student’s advisor as well as the clinical faculty. It is the faculty’s responsibility to review student progress in all graduate courses to ensure that all students are successfully meeting requirements of graduate program. This information is shared during faculty end-of-semester student review meetings and earlier as needed.

This contract serves as verification and a description of the clinical supervision outlined above, between the parties listed on Page 1 of this Supervision Contract. Additional goals may be jointly developed and specified below.

Supervisee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Reading List**

Required Texts

Barlow, D. H. (2014). *Clinical handbook of psychological disorders: A step-by-step treatment manual (5th ed.).* New York: Guilford.

Optional Text

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2019). *Exposure therapy for anxiety: Principles and practice (2nd ed.).* New York, NY: Guilford.

Articles/Chapters/Workbooks

Abramowitz, J. S. (2013). The practice of exposure therapy: Relevance of cognitive-behavioral theory and extinction theory. *Behavior Therapy, 44,* 548-558.

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2011). *Exposure therapy for anxiety: Principles and practice.* New York, NY: Guilford.

Behar, E., DiMarco, I. D., Hekler, E. B., Mohlman, J., & Staples, A. M. (2009). Current theoretical models of generalized anxiety disorder (GAD): Conceptual review and treatment implications. *Journal of Anxiety Disorders, 23,* 1011-1023.

Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 78,* 225-235.

Clark, D. A. (2019). *Cognitive-behavioral therapy for OCD and its subtypes (2nd ed.).* New York: Guilford.

Craske, M. G., & Barlow, D. H. (2007). *Mastery of your anxiety and panic: Therapist guide (4th ed.).* New York: Oxford University Press.

Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58,* 10-23.

Foa, E. B., Hembree, E. A., Rothbaum, B. O., & Rauch, S. A. M. (2019). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences – Therapist guide (2nd ed.).* New York: Oxford University Press.

Gillihan, S. J., Cahill, S. P., & Foa, E. B. (2014). Psychological theories of PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 166-184). New York: Guilford.

Golden, A. (2011). Wrestling with the beaver: Embracing absurd exposure in the treatment of social anxiety disorder. *the Behavior Therapist, 34,* 87-90.

Goldstein, A. J., & Chambless, D. L. (1980). Comprehensive treatment of agoraphobia. In A. J. Goldstein & E. B. Foa (Eds.), *Handbook of behavioural interventions: A clinical guide.* New York: Wiley.

Grayson, J. B. (2010). OCD and intolerance of uncertainty: Treatment issues. *Journal of Cognitive Psychotherapy: An International Quarterly, 24,* 3-15.

Hembree, E. A., & Feeny, N. C. (2006). Cognitive-behavioral perspectives on theory and treatment of posttraumatic stress disorder. In B. O. Rothbaum (Ed.), *Pathological anxiety: Emotional processing in etiology and treatment* (pp. 197-211). New York: Guilford.

Hinton, D. E., Rivera, E. I., Hofman, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry, 49,* 340-365.

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive-behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33,* 511-525.

Newman, M. G., Llera, S. J., Erickson, T. M., Przeworksi, A., & Castonguay, L. G. (2013). Worry and generalized anxiety disorder: A review and theoretical synthesis on nature, etiology, mechanisms, and treatment. *Annual Review of Clinical Psychology, 9,* 275-297.

Sloan, D. M., & Marx, B. P. (2019). *Written exposure therapy for PTSD: A brief treatment approach for mental health professionals.* Washington, DC: American Psychological Association.

Steketee, G. S. (1993). *Treatment of obsessive-compulsive disorder.* New York: Guilford.

Watkins, L. E., Sprang, K. R., & Rothbaum, B. O. (2018). Treating PTSD: A review of evidence-based psychotherapy interventions. *Frontiers in Behavioral Neuroscience, 12,* 258.

Zinbarg, R. E., Craske, M. G., & Barlow, D. H. (2006). *Master of your anxiety and worry: Therapist guide (2nd ed.)* New York: Oxford University Press.