From ages 18-24, I skateboarded competitively. This took me on adventures from my home in Phoenix to contests across the country. In my travels on the skateboarding circuit, I saw firsthand the devastating effects that substance use and unmet mental health needs can have on the lives of people I met. Meanwhile, at home, I witnessed many of my peers find themselves involved in criminal activity and substance use. I realized that individuals respond to psychosocial stressors such as gang violence in many ways, sometimes helpful, but many times not. These experiences were the impetus for my transition from skateboarding to a profession that would create opportunities to enhance the lives of those in my community experiencing distress and the hardships of substance use.

This motivated me to volunteer at a local halfway-house where I sought to learn more about how to help my community. There I saw the harsh realities of the criminal justice system, military deployment, and the paradoxical nature of substance use disorders. Individuals I worked with often felt compelled to use substances despite wanting to stop. It became clear to me that substance use and affective experiences are intertwined. This sparked my interests in what drives substance use behavior. These experiences inspired me to pursue a career in addiction psychology and to begin my undergraduate studies.

As a first-year college student at age 25, I discovered a deep passion for scientific inquiry and began to appreciate that gaps can exist between the science and treatment of substance use disorders. Moreover, I realized that my life experiences give me a unique vantage point by which to approach clinical work and develop novel research questions. These revelations coupled with mentored research training confirmed that a clinical research career was an ideal path to bring about change. Strong grades coupled with excellent research and clinical experience ensured my admittance to a graduate program in clinical psychology. During graduate school, I have grown as a clinician and scientist. Given the breadth of my advisor's work, I was afforded the opportunity to craft a research program that has the potential to impact the lives of those from communities like mine. Additionally, I have become committed to advancing drug and treatment policy through my work as the student representative to the executive committee of the Society of Addiction Psychology.

Despite all of these personal and professional experiences, I still have a lot to learn. I seek to compliment my generalist training with focused training in the delivery of evidenced-based treatments for substance use disorders and comorbid conditions, which will in turn inform future research. I look forward to advancing my emerging specialization in substance use disorders, while continuing to refine my research acumen. As such, I am eager to pursue internship. My long-term goal is to pursue an academic position at a university or teaching hospital where I can actively engage in research informed by practice and make a difference in communities like mine.

My theoretical orientation is cognitive-behavioral. I believe my role as a therapist is to respond genuinely and empathically to my clients' distress, to help them identify and harness their strengths, and to provide empirically supported treatments that equip them with the necessary skills to effect and sustain the changes they desire. I find the cognitive model to be an elegant tool to understand the psychogenesis of psychopathology and to illustrate how treatment can work for clients. Both my practice and research operate from this theoretical model, where the interconnections between emotion, cognition, and behavior explain human behavior and human behavior change.

In therapy, I explain that how we feel and act are not necessarily products of what happens to us, but how we *perceive* what happens to us. That is, it is the meaning we assign to the events or actions. By changing the relationship we have with our thoughts, we can change our emotions and behavior. I place great importance on the fact that negative emotions are adaptive. They tell us important information about our environment. It is when negative affective experiences are too intense or persist for too long that they can become maladaptive. Over time, people develop characteristic ways of relating to their experience that were usually functional at one point, but now keep them feeling stuck.

As a scientist-practitioner, I am dedicated to using efficacious treatments supported by empirical evidence and rooted in theory. At the same time, I recognize that common factors, such as genuineness, empathy, and collaboration, transcend modality and are strong predictors of treatment outcomes. I always work hard to facilitate a strong working alliance and monitor its strength throughout treatment. I also believe that case conceptualization is essential to an effective therapeutic experience. I take a linchpin approach to case conceptualization (Bergner, 1998), whereby the features of the client's experience are organized in relation to explanatory mechanisms that link distal antecedents to the proximal symptoms the client is experiencing. Collaborating with the client to identify their own linchpins is central to this process, which allows for the most potent and efficient, empirically grounded, client-centered treatment goals to be established.

As a therapist, I view clients as inherently resilient and the expert in themselves, and my goal is to help them become their own therapist. Hence, I do not believe that therapy necessarily requires a major overhaul of their coping strategies. Instead, a few well targeted modifications can bring people lasting and meaningful change. I have been fortunate to receive strong training in cognitive-behavioral therapy and mindfulness-based cognitive therapy for individuals experiencing mood and anxiety disorders and cognitive processing therapy for posttraumatic stress disorder. Additionally, I have experience working with substance use disorders. However, I lack focused training in the delivery of evidenced-based treatments for co-occurring substance use and psychiatric disorders (e.g. depression, PTSD, anxiety). I look forward to the opportunity to build on what I have learned and continue to grow by working with individuals from these populations on internship.

Growing up a biracial child of Irish/Italian and Native American (Costanoan-Rumsen-Carmel Tribe) heritage whose parents were products of California's Bay Area in the 1960's, I deeply value compassion, social justice, and equality. I developed an appreciation for the fact that power exists, whether we realize it or not. My values expanded as my father and I moved around while I was young. By age twelve, I had lived in San Jose, Stockton, Los Angeles, and Honolulu before settling in the multicultural urban sprawl that is Phoenix, Arizona. As a result, I have continuously strived to understand and share in the breadth and depth of diversity in all of my experiences. Before graduate school, I explored culturally responsive care through my work at a multicultural bilingual residential substance use treatment center and criminal justice settings in Phoenix. My understanding of diversity was furthered again when I moved from Phoenix to rural South Dakota. Here, I have come to appreciate the nuances of diversity within groups as I engaged with the rural values of farmers and ranchers.

As a function of these experiences, I learned two important lessons about culture and diversity. First, to be culturally responsive one must regularly examine their own cultural identity and biases. In this regard, I continuously take part in diversity-related didactics and have become a mentor in the Students of Color in Psychology Program at my university to help me and my colleagues explore our professional identities. This is an important resource considering the underrepresentation of people of color within the field of clinical psychology. Second, I discovered individuals' understanding of themselves, the world, and the future are viewed through a unique lens comprised of the multiple intersecting dimensions of their identity and the relationship they have developed with these factors. With this in mind, I have used the ADDRESSING model (Hays, 2008) as a conduit to understand clients as they understand themselves. This has helped me conceptualize clients' strengths and problems with respect to how unhelpful thinking patterns are organized around their individual relationship with the aspects of their identity, such as their racial/cultural heritage, social class, sexual orientation, gender, and spirituality/religion. Using this framework thoughtfully, I am able to more accurately determine whether problems stem from bias in others or unhelpful coping and creatively apply interventions to meet clients' needs.

In sum, even with knowledge of different populations, it is critical to approach every client as an individual. Therefore, regardless of whom I serve, I aim to approach all clients with an open mind and collaborative stance. I continue to see how supervision, consultation, and didactic training can inform my treatment delivery, and enhance my cultural responsiveness. I always strive to do work informed by cultural considerations and I am aware that my client's unique experience may differ from the presumptive cultural norm. As such, I seek to understand which aspects of a client's culture and identity are most meaningful to them, in order to identify personal strengths and tailor treatments accordingly.

Substance use disorders (SUDs) are the fourth most common mental disorder and are a leading cause of health care costs nationally. My program of research focuses on the mechanisms that underlie substance use and associated problems with an emphasis on the role that affect dysregulation and implicit cognitive processes play in the development, progression, and maintenance of SUDs. A highlight of my work is the use of advanced mobile technology to examine how fluctuations in state and trait level variables lead to systematic changes in substance use over time. For example, I recently published findings using ecological momentary assessment (EMA) demonstrating that women, but not men, exhibit reductions in negative affect after drinking alcohol and this reduction was attenuated by rumination (Simons, Emery, Wills, & Webb, 2016).

EMA is a data collection method that uses repeated assessments to capture emotional, cognitive, and behavioral experiences as well as contextual information, in real time, while participants are in their natural environment via smart phones (i.e., *in vivo*). This allows researchers to establish temporal precedence between variables of interest and decrease recall bias. Importantly, EMA maximizes generalizability given the nature of collecting data on dynamic processes in the "real world," which helps bridge gaps between science and practice.

During graduate school, I managed a longitudinal EMA study of risk/resilience factors of comorbid PTSD and substance use among returning veterans. I also managed projects examining the role of self-control, mood, and cognitive biases in alcohol involvement and sexual behaviors using daily diaries. My thesis examined how mood and drinking motives interact to activate alcohol-related attentional biases. I published results that highlighted the poor reliability of alcohol-related attentional bias measures and provided suggestions for improved assessment of attentional biases (Emery & Simons, 2015). My dissertation, funded by the Center for Brain and Behavior Research, extends this by assessing how within-person variability in emotion regulation difficulties activates alcohol-related attentional biases *in vivo* that, in turn, promote increases in alcohol consumption.

While the majority of my research focuses on etiological factors, I am also interested in how these mechanisms can inform the design of personalized treatments for SUDs in line with the Precision-Medicine Initiative (National Institutes of Health [NIH], 2015). The precision-medicine approach offers important opportunities to improve SUD treatment outcomes by optimizing treatments tailored around individual differences factors and environmental health-determinants.

I have received great mentorship during graduate school. My course of study involved training in several research methodologies (e.g., mood induction, EMA, implicit biases) and advanced statistics (e.g., multilevel modeling, structural equation modeling, and modeling with zero-inflated count variables; Bayesian analysis) that translated to a number of professional presentations and manuscripts. These experiences have prepared me to design and implement these protocols independently. The opportunity to continue my scientific training during internship is an exciting next step in my development. I am eager to extend my work with new mentors and build my program of research through exposure to new ideas, methodologies, and populations. Long-term, I plan to develop a strong program of NIH-funded research.