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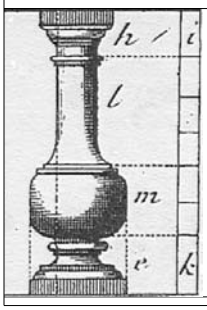

Letter to the Editor

One Practitioner's Reflection on the 40th Annual ABCT Convention: Are You a Cognitive Behavior Therapist?

Tommy Kot, *Private Practice*
Morristown, NJ

After attending ABCT's 40th Annual Convention in Chicago, I realized that the convention's theme (Translational Research: Bridging Basic Science and Clinical Practice) had many implications for the practitioner. For me, the symposia, panel discussions, and addresses I attended helped clarify what I had been observing and struggling with since venturing from academia into private practice: The farther the practitioner deviates from or is ignorant of basic behavioral science, the more likely it is that a *folie à deux* will develp within the context of therapy. By this, I mean an otherwise unknowing patient can be led to believe he or she is receiving cognitive or behavior therapy, and the practitioner can believe that he or she is conducting it.

Though there are a number of reasons why this unfortunate circumstance may occur, one reason could reflect the growing demand for evidence-based practice. In effect, behavioral and cognitive therapies could well be victims of their own successes. The dominance of behavioral and cognitive therapy in evidence-based practice is not a bad thing. On the contrary, it rightly asserts that the evidence provided by appropriately applied cognitive and behavioral therapy by properly trained clinicians meets the needs of the patient by reducing suffering and enhancing functioning in a more meaningful way than other forms of therapy. The problem that I have seen is

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INSTRUCTIONS FOR AUTHORS

The Association for Behavioral and Cognitive Therapy (formerly known as Association for Advancement of Behavior Therapy) publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
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David Reitman, Ph.D., Center for Psychological Studies, 3301 College Avenue, Nova Southeastern University, Fort Lauderdale, FL 33314-7796

that, increasingly, practitioners who profess to be cognitive or behavioral therapists do not have training within the fundamental behavioral sciences (e.g., predoctoral training or postdoctoral supervision). When pressed, some practitioners may offer, "No, I am not a cognitive or behavioral therapist, but I use cognitive or behavioral techniques." In most cases, such a response would likely satisfy an inquiry from otherwise naive patients or professionals.

Unethical at the very least, and fraudulent at the very worst, this kind of misrepresentation may well be normative in clinical practice. Behavioral and cognitive therapies are being promoted in the media and by professional organizations as superior forms of treatment for an increasing number of disorders; therefore, there are now real benefits, in terms of both prestige and financial gain, associated with representing oneself as a behavioral or cognitive therapist. Research suggests, however, that therapy provided under the guise of behavioral or cognitive therapy by improperly trained practitioners does little but mimic control conditions (Persons & Weersing, 2006). A disservice occurs in two major ways. First, patients do not receive the treatment they need. Second, cognitive behavior therapy is misrepresented to the public.

Particularly for those practitioners trained outside of behavioral or cognitive models, the techniques developed by behavioral and cognitive therapists may be perceived as a "bag of tricks"—that is, skills that can be learned by reading a book or attending a workshop. A commonly held belief might be that a doctorate and/or licensure equates with competence in delivering CBT, or that "experience" is equivalent to appropriate training and education in a given model. One discussant at a recent ABCT panel related an amusing (in a tragic sense) anecdote about an individual seeking a junior faculty position at a doctoral program with a strong cognitive-behavioral orientation. It became apparent that while the applicant identified himself as a cognitive-behaviorist, the only reason he identified himself as such was because he had read a treatment manual (Berger et al., 2006).

Perhaps the dissemination of manuals, numbering over 200 by last count (Chambless et al., 2006), has conveyed the impression that reading a manual fully equips one to perform therapy; if therapy is unsuccessful, the manual is to blame, not the clinician. Further, if the manual does not work, then the behavioral or cognitive theory from which it derives is fundamentally flawed. The mediating factor, namely, an untrained or unskilled practitioner, appears blameless.

I suspect (hope) that our field is beginning to address these issues, though it may not happen overnight. There was a potent exchange during one panel discussion that addressed the fundamental differences between the second and third generation of behavior therapies (Herbert et al., 2006). At the panel, discussants addressed the merits of a shift of clinical emphasis from content- to function-based case conceptualization. Perhaps even the recent changes in the American Psychological Association's policy on evidence-based practice (APA, 2005) could help, though this appears doubtful (Kot, 2005). Whatever the impact of APA policy, it is my opinion that practitioners should be held more accountable for what they do (and what they say to the public about what they are doing) than they are at present. When interacting with the lay public (i.e., informally, or formally in media outlets), cognitive behavior therapists should underscore their unique skills and services, as well as other features of their clinical training that distinguish them from the vast majority of non–empirically oriented practitioners.

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ERRATUM

In the article "Internship Opportunities for ABCT Student Members" (Volume 29, issue 8, p. 216), the Massachusetts Mental Health Center Partial Hospital program was described as a training site for psychology interns. It is in fact a training site both for the Massachusetts Mental Health Center Psychology Internship Program and also for the Harvard Longwood Psychiatry Residency Training Program.

Introducing the Men's Mental and Physical Health Special Interest Group at ABCT

Michael E. Addis, SIG Leader, *Clark University*
Esteban Cardemil and James V. Cordova, *Clark University*
Lynn S. Dowd, *University of Massachusetts Memorial Medical Center*
Thomas Hildebrandt, *Mount Sinai School of Medicine*
Matthew Jakupcak, *VA Puget Sound Health Care System–Seattle*
Abigail K. Mansfield, *Clark University*
Todd M. Moore, *University of Houston*
Gregory L. Stuart, *Butler Hospital and Brown Medical School*

In November 2005, as ABCT was enjoying its first annual meeting under its new name, 22 of its members gathered for the inaugural meeting of a new Special Interest Group (SIG), "Men's Mental and Physical Health." This article introduces the SIG by describing the purpose of its formation, its mission, and its relevance to existing areas of interest and expertise within ABCT. After providing a brief background on the formation of the SIG, several different authors describe the relevance of research and clinical work on men, masculinity, and health to their interests in other areas that are well-represented in ABCT.

Why a Men's Mental and Physical Health SIG Per Se?

Until very recently, research and clinical work focused on men's well-being has been nearly invisible. There are many reasons why this is the case (see Addis & Cohane, 2005; Courtenay, 2000), but one major factor has been our culture's historical inability or unwillingness to recognize (a) that men as a group often struggle with their mental and physical health, and (b) that our difficulty acknowledging this and doing something about it is partly a function of the way we construct what it means to be a man. Put simply, men are expected to be physically strong, stoic, mentally tough, and self-reliant. Thus, to acknowledge men's problems directly, and particularly as men, is to violate several cultural taboos regarding masculinity.

For several reasons, there is a need to question the traditional rules of masculinity in the service of bettering men's, women's, and children's lives. First, although women are twice as likely to be diagnosed with major depression, a significant number of men suffer from the disorder. There also is evidence that this gender gap may be narrowing (Kessler et al., 1994; Kessler et al., 2005; Stoolmiller, Kim, & Capaldi, 2005). Second, men are four times more likely to commit suicide; many of these men are likely to be suffering from major depression and associated disorders (Moscicki, 1997; Oquendo et al., 2001). Third, across virtually the entire spectrum of mental and physical health problems, men are less likely than women to use professional helping services (Addis & Mahalik, 2003). Finally, a growing body of research links traditional notions of masculinity to variations in the way men and women experience, express, and respond to problems in living (e.g., Addis & Cohane, 2005; Levant & Pollack, 1995).

Common Concepts and Concerns

The contributions below represent a diverse array of research and clinical interests. Yet they also reflect a common set of assumptions about what we need to understand regarding men's mental and physical health and, to varying degrees, how we should go about understanding it. First, each author makes a distinction between sex (i.e., being biologically male or female) and gender (i.e., the cultural, social, and personal meanings we attach to being female or male). Second, each author is interested in various aspects of masculinity and the roles it plays in men's and women's well-being. Masculinity can be understood as the set of norms, practices, ideologies, and beliefs that shape and reflect our ideas about how men should feel, think, and behave. Finally, each author sees great potential for the study of men's mental and physical health to inform other areas of interest in ABCT. We hope that you will come to the same conclusion and will consider joining our new SIG!

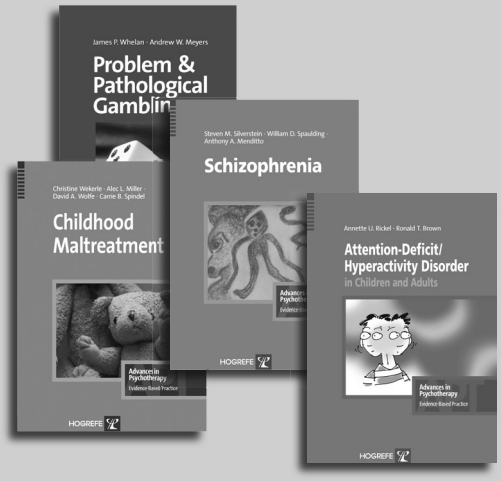
■ Men's Experience of Trauma

Matthew Jakupcak, *VA Puget Sound Health Care System-Seattle*

The rate of posttraumatic stress disorder (PTSD) among women is more than twice that found among men in the general population, yet men are more likely to experience traumatic events (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). This disparity may result from men underreporting symptoms of PTSD (Bryant & Harvey, 2003), although men's response biases may vary for different types of trauma. Male victims of childhood and adult maltreatment are markedly underrepresented in the trauma literature (Haskett, Marziano, & Dover, 1996), whereas male combat veterans with PTSD are overrepresented (Brewin, Andrews, & Valentine, 2000). Indeed, the types of trauma most studied give the impression that combat exposure is a "male trauma" while rape incidents or childhood sexual abuse represent "female traumas" (Pimlott-Kubiak & Cortina, 2003). Cultural definitions of masculinity may inform men's reactions to many (if not all) types of trauma; however, combat and childhood sexual abuse are salient examples of the relevance of male gender norms.

Military training may foster an extreme adherence to traditional male gender norms and contribute to a hypermasculine subculture that can shape men's emotional and interpersonal behaviors long after they have left military service (Brooks, 1990, 2001). Stress associated with violations of traditional masculine gender norms, or *masculine gender role stress* (Eisler & Skidmore, 1987), is associated with male veterans' abuse of alcohol (Isenhart, 1993) and is positively associated with alexithymia (i.e., the inability to talk about feelings due to a lack of emotional awareness) and negatively related to social support of male veterans, even after accounting for PTSD symptom severity (Jakupcak, Osborne, Cook, Michael, & McFall, 2006). Relationship violence, substance abuse, and impulsive risk-taking in veterans are often correlates of PTSD (e.g., Chemtob, Hamada, Roitblat, & Muraoka, 1994), problem behaviors that are likely informed by male gender norms.

Cultural definitions of masculinity also are relevant for understanding men's experience of childhood sexual abuse. Men with a



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history of childhood sexual victimization may be reluctant to disclose these traumas because cultural norms suggest that men should not be victims and are to always remain in control of their thoughts, emotions, and behaviors (Butler, Qualheim, Turkal, & Wissing, 1993). Evidence suggests men are more likely than women to minimize childhood histories of sexual abuse (Varia, Abidin, & Dass, 1996). Nonetheless, compared to nonvictims, male victims of childhood sexual abuse report higher rates of risky sexual behaviors (Homes, Foa, & Sammel, 2005) and substance abuse (Coxell, King, Mezey, & Gordon, 1999). Men with a history of sexual abuse report life-long difficulties in occupational/academic and relational domains (Lisak & Luster, 1994) and often endorse reactivity, confusion, and distress related to issues of sexual orientation and personal masculine identity (Lisak, 1994).

More research is needed to better understand the ways cultural definitions of masculinity inform men's experience of traumatic events. These efforts should include examinations of male gender norms in relationship to less "gendered" events such as natural disasters and motor vehicle accidents. Such research also should investigate men's expressions of posttraumatic distress, including substance abuse, emotional and interpersonal skill deficits, and the perpetration of aggressive or antisocial behavior.

■ Men in Relationships

James V. Cordova, *Clark University*

Couples researchers often statistically analyze sex differences on the way to examining other, more central hypotheses. Although couples research has not necessarily ignored gender, we have yet to develop compelling theories and a sound body of evidence concerning the psychology of men in relationships. What are the varieties of ways-of-being that men construct within their intimate relationships? How are conceptions of masculinity developed, understood, and lived out in the context of adult attachment? What do we know about marital satisfaction in men? What role do men see for themselves and what roles do men take on to actively maintain the health and stability of their long-term intimate relationships?

What little we know about the psychology of men in relationships comes to us as the reflection of what we can say about women in relationships. It has become conventional wisdom in couples research that women are "the barometers" of the relationship in that they are the better source of measurement and prediction of marital health and stability. By implication, therefore, we understand men in relationships as less accurate sources of data and less "tuned in" to their relationships. Consider the common finding that women are better predictors of their partners' feelings than are men (Heller & Wood, 1998). The authors note that "these findings suggest that women may be more attuned to intimacy or that definitions and assessment of intimacy are gender biased or both." In both interpretations, we have a vague sense that men are somehow either not measuring up well in their relationships or that our measures are somehow not accurately representing men (or enacting masculinity) in long-term intimate relationships.

Bradbury, Campbell, and Fincham (1995) looked explicitly at masculinity and femininity in marriage: They found some evidence that measures of masculinity are associated with *wives*' reports of marital satisfaction, but found little evidence of similar associations with husbands' marital satisfaction. This study highlights several points of interest. First, it represents one of the relatively few studies explicitly examining masculinity in marriage and providing data suggesting an important role for the study of masculinity as a predictor of marital health. Second, it falls squarely within our dominant paradigm for conceptualizing and measuring masculinity (i.e., masculinity as a personality trait), which inadvertently fails to fully explore the various ways there are of "doing masculinity" in intimate relationships. Third, as with many of our studies in which we examine wives and husbands, (a) we tend to find that their patterns of results differ, (b) the results often are stronger or more numerous for wives than for husbands, and (c) our theoretical models for explaining and predicting men's patterns of results and their status as poorer measures of marital health remain less than satisfying to us. As Bradbury et al. suggest, we will possibly stumble upon some other aggregation of variables that will better predict men's marital outcomes, but what remains is "the more general point that fundamentally different mechanisms may operate to produce change in husbands' and wives' satisfaction" (Bradbury et al., 1995, p. 340).

To further the point, Cordova, Gee, and Warren (2005) found that, although ability to identify emotions was associated with the spouses' marital satisfaction for both wives and husbands, only *husbands*' ability to *communicate* emotions was associated with wives' marital satisfaction, whereas *wives*' ability to communicate emotions was *not* associated with husbands' marital satisfaction. These results were predicted and interpretable but do not even begin to address most of our questions about the experience of men in relationships.

The area of couples research and therapy has a great deal yet to learn from dedicated and deliberate study of men in relationships—and there is a virtually untapped goldmine of important research in this direction. For example, there is likely a great deal more to be discovered about the dimensions and parameters of men's relationship satisfaction, beginning with how men approach, understand, and come to answer even the most basic questions on our standard measures. Take a basic question from the Dyadic Adjustment Scale (Spanier & Thompson, 1982): "In general, how often do you think that things between you and your partner are going well?" What do men tend to think about before they answer this question? How have men come to understand what "going well" means in this context? How often do men actually even think about how things are going between them and their partners? In sum, although we have learned a great deal about gender differences in the couple literature, we are only beginning to adequately study and understand the experiences of men in intimate relationships.

■ Intimate Partner Violence

Todd M. Moore, *University of Houston*
Gregory L. Stuart, *Butler Hospital* and *Brown Medical School*

Intimate partner violence (IPV) is a prevalent national problem. Schafer, Caetano, and Clark (1998) surveyed U.S. couples and found that more than 20% reported experiencing one or more episodes of IPV within the past year. Given its detrimental effects (e.g., depression, injury, substance abuse), much effort has been directed at identifying predictors of partner violence. While these efforts have explored a range of biological, social, and psychological correlates (see Holtzworth-Munroe, Bates, Smutzler, & Sandin, 1997), increasing attention has focused on the psychology of men and masculinity as being informative in the study of IPV.

Moore and Stuart (2005) recently conducted a critical review of the empirical literature on the relationship between masculinity and IPV. One interesting finding was that direct measures of masculinity

as a personality trait (e.g., "I am . . . assertive, tough, etc."; Bem, 1984) generally were not associated with IPV. Studies that examined men's beliefs about appropriate male behavior (e.g., male role norms), the degree of power differential in intimate relationships, and the extent to which men experience stress in situations perceived to be violating traditional norms (e.g., gender role stress) were moderately to strongly associated with IPV. In a study of a large sample of men arrested for violence perpetration, masculine gender role stress was significantly correlated with perpetration of psychological aggression, physical abuse, sexual coercion, and injury to partner (Moore, Stuart, Addis, & Cordova, in preparation).

The Moore and Stuart (2005) findings are important for determining how the psychology of men and masculinity can inform the study of partner violence. It makes intuitive sense that being highly masculine, regardless of how it is defined, could and would be associated with IPV. Yet the empirical literature suggests that men at greater risk for IPV may be the ones who believe that it is important to uphold traditional masculine norms, who experience discomfort in situations that threaten their ability to uphold these norms, and who try to maintain or obtain power in their intimate relationships. Thus, the current research on masculinity and IPV is best understood when masculinity is conceptualized as a multidimensional construct.

The study of masculinity and partner violence is in its infancy compared to other well-known and often researched correlates of partner violence (e.g., alcohol use). It could be argued that masculinity often serves as a proxy for variables traditionally studied in relation to partner violence (e.g., anger). However, contemporary theories about men's gender role socialization in regard to violence and the growing body of theory-based research supporting the relationship between these constructs have clearly demonstrated that masculinity should be viewed as an independent correlate of partner violence.

We believe that there are several important directions for future research and clinical efforts. First, most research in this area is cross-sectional and uses convenience samples. Longitudinal research with clinical samples is needed to understand the role of masculine socialization processes in predicting violent behavior in order to develop strategies to reduce and prevent partner violence. Second, it will be important to test the relationship between various dimensions of masculinity in relation to IPV as part of a multidimensional view of masculinity. We are in the process of conducting a study examining the unique and combined effects of men's gender role orientation, gender role norms, and gender role stress on their use of violence in intimate relationships. Third, IPV is a prevalent problem that crosses racial and ethnic boundaries, and it will be important to conduct research examining this relationship among various groups. Fourth, it is important to recognize that masculinity may be a predictor of partner violence for some men and not others. Thus, future research might explore the interaction of intrapersonal and situational/contextual factors that could explain the association between masculinity and IPV. Finally, given the questionable efficacy of violence intervention programs (see Babcock, Green, & Robie, 2004), future research could test the degree to which assisting men in accepting less traditional masculine norms and learning to improve their coping strategies in the face of challenges to their masculinity can reduce violence recidivism.

■ Women's Issues

Abigail K. Mansfield, *Clark University*

At first glance, an application of the psychology of men and masculinity to women seems paradoxical. Doesn't the psychology of men and masculinity pertain largely, if not entirely, to men? Fostering research about men's experiences *as men* is an important, timely application of the psychology of men and masculinity, but there are other important applications as well.

We live in a culture in which men's experiences and expectations are seen as normative. Put another way, in American culture, that which is deemed masculine is usually considered either healthy, or desirable, or both. This means that the same pressures that bear down on men to succeed, to dominate, to compete, to win, to be autonomous, to be in control, to be stoic, to be strong, and to avoid vulnerability also bear down on women. As such, women are subject to masculine pressures or norms. Conforming to these pressures, or norms, can be adaptive; there is survival value for both men and women in enacting the above mandates. But there also are contexts in which enacting such norms causes problems in women's (and men's) lives, and it is in these contexts that an analysis of the psychology of men and masculinity can be especially helpful.

Research on "women's issues" involves a number of areas, from an inquiry into how a particular diagnostic category affects women to how certain social stressors are particularly salient for women. Typically, researchers who address "women's issues" do so as part of a specific area of research, such as eating disorders, sexuality, transgender issues, body image, trauma and PTSD, or partner aggression. A "men and masculinity" lens can help generate questions and testable hypotheses. For example, such a perspective might lead a researcher interested in developing treatment protocols for anorexia to wonder how masculine norms of toughness and discipline are enacted in anorexic patients and whether addressing such norms in treatment improves outcomes. Alternatively, a researcher interested in partner-aggressive women might generate questions about how such women avoid vulnerability and about the costs and benefits of such avoidance. These questions might then inform treatment protocols or psychoeducational interventions aimed at helping partner-aggressive women to be deliberate about the contexts in which they avoid vulnerability and cognizant of the ways such avoidance can be either relationship enhancing or toxic.

Although there are many potential applications for bringing men and masculinity research into women's issues, two areas are especially urgent: combat-related PTSD and partner violence perpetrated by women. Combat-related PTSD among women is currently relevant because the U.S. is at war, and for the first time women are coming home with combat-related PTSD. Many of these women may have prior histories of sexual abuse, child abuse, or sexual assault that combine with their combat exposure to make their experience of PTSD especially complicated. In addition, a military environment demands strict adherence to certain masculine norms that can make it difficult to ask for help or show vulnerability. As such, bringing a masculinity lens to bear on the treatment of such women seems especially important. In a related vein, awareness of the prevalence of partner violence perpetrated by women is on the rise, and research on PTSD suggests that men with combat-related PTSD are more likely to be partner aggressive than the general population (Castillo, Fallon, C'de Baca, Conforti, & Qualls, 2002; Chemtob et al., 1994). Thus, it is possible that women with combat-related PTSD may be at risk for both perpetrating partner aggression and being a victim of it.

■ Body Image

Thomas Hildebrandt, *Mount Sinai School of Medicine*

The study of men and masculinity is vital to body image research. Until recently, body image research primarily focused on the sociocultural factors that relate to body image disturbance (e.g., Cafri, Yamamiya, Brannick, & Thompson, 2005; Stice, 2002). Most of this research focused on female populations and was designed to better understand the development and maintenance of eating disorders. However, the field is currently in the midst of theoretical revitalization. Research on the negative consequences associated with the pursuit of muscular and lean body types (Pope, Gruber, Choi, Olivardia, & Phillips, 1997; Pope, Katz, & Hudson, 1993) has improved the understanding of how males experience their appearance. This theoretical shift has led to the study of phenomena associated with appearance control among males, such as exercise and appearance- and performance-enhancing drug (APED) use (Hildebrandt, Langenbucher, Carr, Sanjuan, & Taung, 2005; Kanayama, Gruber, Pope, Borowiecki, & Hudson, 2001).

Despite these theoretical advancements, there are still several challenges to research on male body image. Perhaps most important is the development of reliable and valid measurement tools that assess cognitive, behavioral, and emotional constructs important to males' experiences with their appearance. Much of this work has already begun, including the development of measures such as the Drive for Muscularity (McCreary & Sasse, 2000), Muscle Dysmorphic Disorder Inventory (MDDI), Bodybuilder Image Grid (BIG; Hildebrandt, Langenbucher, & Schlundt, 2004), Muscle Appearance Satisfaction Scale (MASS; Mayville, Williamson, White, Netemeyer, & Drab, 2002), and Swansea Muscle Attitudes Questionnaire (SMAQ; Edwards & Launder, 2000). However, these measures need to be validated against psychopathology (e.g., muscle dysmorphia), a task complicated by the fact that relatively few men seek treatment for body image problems. Identifying the difference between normative and pathological expressions of appearance control is closely related to these challenges. For instance, what level of exercise is pathological? How much does APED use impair functioning? No clear answers have emerged.

Little is known about how to treat clinically significant body image disturbance and its psychiatric, psychological, and physical consequences in males. There are obstacles to developing appropriate treatment approaches, most notably the reluctance of males to seek help for body image distress. While there are certainly cultural reasons for this reluctance (e.g., social stigma), it is possible that mental health professionals do not have the expertise to adequately address males' concerns. Several authors have found that anabolic steroid users generally believe that health professionals know little about the physical and psychological effects of steroids (Monaghan, 2002; Pope, Kanayama, Ionescu-Pioggia, & Hudson, 2004). Both addressing these attitudes and disseminating information about the consequences of male body image disturbance to health professionals are equally important.

In summary, future research on male body image will benefit greatly from a better understanding of men's experiences with their appearance. Applications may include improving basic assessment strategies, creating treatment strategies for male body image disturbance and related consequences, and more ambitious cultural applications such as reducing stigma against men seeking help for body-image-related problems.

■ Race, Ethnicity, and Culture

Esteban Cardemil, *Clark University*

Research on gender in racial and ethnic minority groups presents many exciting opportunities for those interested in men's mental and physical health. First, research with individuals from diverse backgrounds allows for the exploration of different cultural conceptions of gender and masculinity. There are likely to be cases in which the concepts of masculinity are quite similar, as researchers have found that many racial/ethnic minorities who come from more collectivistic cultures endorse traditional patriarchal and hierarchical gender roles (Falicov, 1998). There also may be conceptions of masculinity that differ in degree or emphasis from those characterized as traditional. For instance, the concept of *machismo* among Latinos has been used to explain the traditionally rigid patriarchal family structure, in which the male is responsible for the protection and welfare of the family (Rodriguez, Bauer, & Flores-Ortiz, 2001), but it can also include behavior that is controlling, abusive, and disrespectful of women (Gloria, Ruiz, & Castillo, 2004).

Second, research with racial/ethnic minorities—and particularly immigrants—offers an exploration of the developmental processes underpinning the acquisition of gender and masculinity concepts. Most research with immigrant families has found that children and adolescents tend to acculturate more rapidly to U.S. culture than their parents (Szapocznik & Kurtines, 1993). What, then, might be the relationship between the acculturation process and the acquisition of U.S. conceptions of gender and masculinity? Moreover, some researchers have found that large acculturation differences within a family system may be associated with increased family conflict and problems (e.g., Baptiste, 1993). Might the acquisition of U.S. values related to gender roles and conceptions of masculinity also be related to family conflict?

Third, considerable research has documented the fact that racial/ethnic minorities experience pervasive disparities in access to both physical and mental health care (e.g., Alegría et al., 2002; Kung, 2003; USDHHS, 2001, 2004). Various explanations have been offered regarding mental health service utilization, including increased prevalence of logistical and financial barriers, language barriers between consumers and providers, and mistrust of health care providers (Snowden, 2001). Also, some researchers have suggested that culture-specific beliefs may interfere with seeking help from traditional mental health services, including beliefs about mental illness, the utility of alternative sources of treatment (e.g., religious and faith healers), and the use of family and friends as support mechanisms (Snowden & Yamada, 2005). Could culture-specific conceptions of gender and masculinity also play a role in preventing treatment seeking, similar to that suggested by research with Caucasians? Emerging research suggests that this might in fact prove to be the case (Snowden, 2001), although it may better predict underutilization of treatment than sex differences in absolute rates of treatment use (Albizu-Garcia, Alegría, Freeman, & Vera, 2001).

In sum, there exist compelling reasons for researchers interested in men's mental and physical health to extend their work to consider issues of race, ethnicity, and culture. It is likely that this work will help us better understand conceptions of masculinity and better inform our work with individuals from different racial, ethnic, and cultural groups. Ultimately, this program of culturally informed research should aid us

in addressing the serious public health needs of men in the U.S.

■ Emotional Development

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Emotional development is a crucial factor in human functioning. It is the acquisition of capacities to be aware of subjective emotional experience, to identify (usually with the assistance of language) emotions and the meaning of events that generate them, and to express emotion in ways that are healthy and adaptive. Effective emotional regulation enables an individual to cope with high stress-induced arousal by maintaining a relatively stable internal state. Recent advances in theory and research in the area of neurobiological development in the early years of life have opened a window into the relationships among genetic predisposition, the building of emotion-related structures and processes in the brain, and environmental factors (e.g., Shore, 2003; Siegel, 1999).

While this applies to all individuals, the question arises of how sex and gender affect the process of emotional development. How are males and females emotionally different, and how do genetics and environmental forces interact to produce these variations? We know that cultural norms guide both verbal and nonverbal expression of emotion (Thoits, 1989) and that embedded in these same cultural norms are rules for gendered behavior. These rules likely extend to styles of parenting, which may vary depending on the genders within the parent-child dyad. Hyde (2005) warns that overinflated stereotypes of gender differences may affect our expectations and undermine our ability to respond adequately to the needs of children. If we think that boys are less verbal than girls, we may talk with them less, and thus limit their opportunities to develop their verbal abilities. Likewise, if we think boys are (or should be) less emotional, we may fail to attend to their expressions of distress, and may shortchange them in their emotional education. Shore (2003) suggests that males may be particularly vulnerable to pathological development of emotion-regulating structures and processes in the brain, due to slower rates of central and autonomic nervous system maturation. He posits that early deprivation and abuse may have a greater impact on male infants, leaving them more vulnerable to the development of externalizing disorders and aggression, in particular. Gender differences appear early in a variety of complex affect-related behaviors and are often moderated by age (Denham, 1998), but the underlying factors for the gender divergence are unclear. While Hyde (2005) cautions that most gender differences are small or extremely context-dependent, she notes that meta-analyses of aggression studies show a moderate effect size indicating greater aggression in males. Men are overrepresented in prison populations (a gross indication of developmental derailment), but are less likely than women to seek psychological help voluntarily (Addis & Mahalik, 2003). This may reflect attachment-related discomfort with closeness and lack of support seeking in times of distress (Feeney, 2004).

Attempts to address emotional self-regulation problems can be seen in treatments for addictions, domestic violence, anger management, stress management, anxiety disorders, and depression. Dialectical behavior therapy (Linehan, 1993) and various sensory and attachment-centered treatments for trauma sequelae (e.g., Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; Omaha, 2004) are expressly designed to stabilize dysregulated affective processes. Future work will investigate the biology of interpersonal experience and brain development, trauma and attachment issues, and treatment design and efficacy evaluation. Particularly important is early intervention with at-risk infants and caregivers, and the provision of home, school, and treatment environments that are responsive to the needs of boys and men.

■ Substance Use

Gregory L. Stuart, *Butler Hospital* and *Brown University*

Todd M. Moore, *University of Houston*

Substance use and abuse is a major public health problem affecting millions of Americans (SAMHSA, 2001; USDHHS, 2000). Substance use disorders are among the most common of the psychiatric disorders in the U.S., affecting approximately 20% of the population (Kessler et al., 1994). Negative consequences of substance use can include interpersonal violence, risky sexual behavior, injuries, depressive symptomatology, health problems, neurological damage, and employment problems (see Martin & Bates, 1998; Moore & Stuart, 2005). Moreover, substance use affects a disproportionate number of men compared to women. For example, in nationally representative samples, men appear to be 2 to 3 times more likely than women to have an alcohol abuse or alcohol dependence diagnosis (USDHHS, 1997, 1998).

Yet there remains a dearth of evidence regarding the influence of psychosocial factors in the onset of substance use and the development of problems. The psychology of men and masculinity may help provide a context for understanding the gender differences in the initiation of substance use and the development of substance use disorders.

Masculine gender role socialization may be an important factor in explaining men's relatively greater use and abuse of alcohol and other drugs. Men may be socialized to possess stereotypically masculine attitudes and to adhere to cultural norms for masculine behavior (Eisler, 1995; Eisler & Blalock, 1991). The onset of drinking may be the outcome of cultural norms that prescribe alcohol as an expected behavior of the traditional male role (McCreary, Newcomb, & Sadava, 1999; Monk & Ricciardelli, 2003). Thus, men may drink, in part, because they may believe it is "masculine" to do so. Male gender norms concerning alcohol use could partially explain the data showing that men have more opportunities to engage in alcohol use than women.

Monk and Ricciardelli (2003) relate hazardous drinking and illicit substance use to the development of generalized gender role expectations that include risk taking. Men may drink hazardously and use drugs because they believe that their masculinity "rides" on risk-taking. Available evidence suggests that various aspects of masculinity and gender role socialization are related to substance use. For instance, McCreary et al. (1999) found that alcohol consumption mediated the relationship between traditional attitudes about men and alcohol problems. Although gender role stress was not related to alcohol consumption in this study, it did predict alcohol problems.

In a large sample of men arrested for violence perpetration, we found that masculine gender role stress was significantly correlated with a form of risk-taking, impulsivity, and a variety of indices of substance use and abuse. It was associated with men's hazardous alcohol use, drug use, and whether the man was likely to have a substance use disorder (Moore et al., in preparation). Monk and Ricciardelli (2003) found that one component of gender role conflict, difficulty expressing feelings or coping with others' feelings, was significantly associated with alcohol and cannabis use in an Australian sample, although few other posi-

tive relationships emerged. Other investigations have shown that traditional male attitudes, gender role conflict, and gender role stress are related to alcohol and illicit drug use (e.g., Blazina & Watkins, 1996; Moore et al., in preparation; Pleck, Sonenstein, & Ku, 1993) and Monk and Ricciardelli used measures that were normed with American men. Thus, we agree with these authors that the lack of relationship between male role variables and substance use may be explained by cultural differences.

Overall, there appears to be convincing evidence that alcohol and drug use and abuse may be partly explained by gender role socialization. This means that the pathways by which men initiate and abuse substances may be qualitatively different from women. However, this contention has yet to be tested and past research has been cross-sectional. Future work must focus on conducting longitudinal research to assess the extent to which gender role socialization differentially influences the onset of substance use as well as the progression from use to abuse for men and women. It also will be important to further test the relationship between various dimensions of masculinity in relation to substance use and abuse as part of a multidimensional view of masculinity. Substance use is a prevalent problem that crosses racial and ethnic boundaries, and it will be important to conduct research examining this relationship among various groups. As substance use and abuse stem from multiple factors, male gender role socialization may be a predictor of substance use for some men and not others.

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Lighter Side

Elizabeth Moore, *Mayo Clinic*

With only one managed-care-approved session left, Dr. Smith had to speed up the exposure schedule for her arachnophobic panicker with public speaking anxiety.

Lighter Side

On My Mind

Robert L. Leahy, *American Institute for Cognitive Therapy, New York*

I was sitting in my office, worrying about my taxes, when I heard yelling coming from the waiting room. This surprised me, because no one had an appointment. I opened the door and there was a very short man, with a wrinkled torn suit, his hair rising wildly in the air.

"I've got to see you. Right now. It's an emergency."

"But you don't have an appointment and . . ."

"I don't need an appointment, do I? If I'm here, why can't I see you right now?"

Filled with doubt and without any ready-made answers to this plausible question—and even more curious than I was disturbed—I said, "What's on your mind?"

"That's exactly it. Exactly. I knew you were the right person for me. I knew you'd understand."

"Understand what?"

"Whatever absolutely needs to be done—and done *soon*. I can't wait anymore."

"Done about what?"

"What's on my mind."

I thought, *Is one of my friends playing a joke on me? Is this "Who's on First?"*

"Who are you?" I gently and cautiously inquired.

"Why? Don't you recognize me? No—how could you? I'm in deep trouble."

"Have I met you before?"

"Perhaps yes, perhaps no. Maybe a thousand times or a thousand, thousand times."

"I don't recognize you."

"Ah. That's exactly the problem. OK—I may as well tell you. I'm an intrusive thought. Yes, I know it sounds incredible. You're probably thinking, 'I must be crazy to be talking with him.' But yes, I'm REAL. And I'M HERE!" For a moment he seemed happier, but then looked down forlornly.

"You 'think' you're an intrusive thought. But you look like someone I might see walking outside."

"Think? Of course I think. I think, *therefore I am*." He began laughing. And then he began to cough. Louder, gasping for air. "I don't have much time left." "Look," he went on, wheezing. He sat down on the

chair, his short legs dangling over the sides. "I used to be someone *important*. People would pay attention to me. They would analyze me. If I went off on a wild tirade, people would *interpret* me. Like I was the Sphinx. I love it. 'What does it really *mean?*' Hours lying on the couch trying to understand me. Writing me down, tracing my history. 'Do you remember the first time you had this thought?' Ah, those were the days. Real class. Real sophistication. *Interpretations*. 'What does this remind you of?' I loved it."

"It sounds like those were wonderful times for you." I tried to empathize.

"Yes, people took me *seriously*. I was always busy. No one could get an appointment. I mean I could be *anywhere*—New York, Vienna, Beverly Hills—and I would pop up and people—I mean *educated people*—people with *real* medical degrees—would stand up and say, 'There he is! Again!'"

"Did it go to your head?" I gritted my teeth after saying this. So insensitive.

"What do you think?" he said, somewhat contemptuously, but sadly. Like he was lost in a reverie of a better time—one gone forever.

"I traveled in the best of circles. I didn't get any sleep—which, when you come to think about it, is the point. Yes, always on. Twenty-four seven."

"Then what happened?"

"Well, at first—back in the old days when I was cooking—at first someone thought, 'Let's get rid of him *completely*.' I loved that. What an *invitation*. To try to get rid of me completely." He began laughing and his cough got worse. There were tears in his eyes as he recalled those days. "Get rid of me. Hah! They began shouting at me. STOP. STOP THINKING! It never worked—so they shouted more. All day shouting at me. It's the most attention I ever got."

"Then what happened?"

"Well, after a long time people began realizing that the shouting was making things worse. After all, you had to pay attention to me—and take me seriously—to shout at me. I never went away. I kept popping up. Then one day someone approached me—totally cool, level-headed. And said, 'Why should I take you seriously?' This guy with a bowtie—he took out a pad of paper and said, 'Let's test you out.' All day—every day—it seemed I was being tested. They barraged me with logic, asking me, 'What's the evidence?' They told me to go out and test out my predictions. It was exhausting."

"Then what happened?"

"Well, it was like being humiliated every day. None of my predictions held up. And, can you imagine, telling me, an intrusive thought, 'You're not really rational.' Well, you can imagine how the *other thoughts* felt about me."

"How did they feel?"

He looked down, a bit ashamed. "They wouldn't have anything to do with me."

And he looked at me, almost looking for reassurance that I wouldn't judge him. "That's when I began drinking."

"I imagine this must have been hard for you. At one time people were interpreting you, writing books about your *secret message*. And now you were feeling humiliated. How terrible."

"Oh, it gets worse."

"How?"

"Well, one day someone just said. 'OK. Let him hang out. But we'll get on anyway.' That's the day I saw this psychologist *just walk past me*. He said, 'If you want to go along, that's cool. But I'm getting on with things with or without you.'"

"I can't imagine anything more humiliating for you."

"Oh no. It gets even worse. Then one guy said, 'So you think you're so powerful. Let's see you do this. Stand in front of the mirror and just keep repeating yourself.'"

"What happened when you did that?"

"I began to disappear. I was simply an empty voice. I finally checked myself into a rehab center for intrusive thoughts."

"Wow. What an experience."

"But can you help me?"

I wasn't sure what he wanted. In fact the longer I spent with him the more I doubted that this was real. But I thought, *It's a nice sunny day in New York. He's a tourist—I don't know how long he's going to be in town.* "Let's take a cab to the Empire State Building."

He brightened up. His feet began kicking. "I've never seen it. OK."

We went downstairs and caught a cab downtown. He began fidgeting, "Watch the traffic. It's dangerous. I'm scared." A smile came over his face when he saw I was getting nervous, clutching the door in the cab. When we got to the Empire State I took him inside, paid the fee to go to the observation tower, and we got in the elevator. There was a family from Pittsburgh in the elevator. He looked at them and said loudly, "Are you sure this elevator is safe?" His energy was growing. This is what he needed. We got to the roof and I walked out to the deck with him.

We were standing there and I looked at him and said, "Close your eyes." He closed them. I could see this made him nervous. Must be his lack of control. I looked out over the sky over Manhattan. The clouds were drifting in the sunlight. "Open your eyes." I pointed toward the western sky. "Isn't this magnificent?" I said.

I heard him groan and then he gave a deep sigh that grew more faint. He coughed. "I can't take it any . . . longer." His voice became softer. I looked around but the deck was empty. I thought I saw a shadow, very small, creeping away. In the smallest voice, below even a whisper, I heard him sadly say, "Thanks for everything."

He was gone. I felt sad. He was simply a prankster. And no one cared anymore. I looked over the buildings and saw the clouds reflected in the windows. I felt lost in the sky and the reflections. And for a moment, I felt, I was at peace.

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Obituary

Billy A. Barrios, Ph.D. (1952–2006)

Anne Marie Albano, *Columbia University*

On August 11, 2006, Billy A. Barrios of Oxford, Mississippi, suddenly and unexpectedly died from a heart attack. Family, friends, and former students are mourning the death of a most beloved man who touched the lives of many during his 53 years. Billy was born on September 28, 1952, and raised in Larose, Louisiana. He received a B.S. in psychology from LSU, an M.S. in clinical psychology from Mississippi State, and a Ph.D. in clinical psychology from the University of Utah in 1980, where he was a student of Don Hartmann's.

Billy joined the clinical psychology faculty at the University of Mississippi in 1981, and in 2001, he moved to the University Counseling Center. Billy was a member of AABT, APA, and the Mississippi Psychological Association. He served on numerous editorial boards including *Behavioral Assessment* (as associate editor, 1984-1985), *Psychological Assessment* (as contributing editor, 1993-1995), *Behavior Therapy, Behaviour Research and Therapy*, and *JCCP*. Billy was very well known for his seminal chapters on childhood fears and anxieties in Mash and Terdal's *Assessment of Childhood Disorders* and Mash and Barkley's *Treatment of Childhood Disorders*.

A staunch empiricist and behaviorist, Billy also became a devoted Buddhist well before these traditions became integrated into cognitive and behavioral therapies. He was described by others as a bodhisattva, which is a person who has the compassionate determination to aid all beings on their quest for the highest state of development. Among his efforts, Billy was a founder of "The Way of the Heart," a racial reconciliation program. Billy's selfless and tireless caring for others, coupled with his impishly humorous notes, endeared him to a wide spectrum of Oxford, Mississippi's, inhabitants—including top university administrators, local attorneys and the mayor, faculty from all disciplines, wild-born cats that roamed campus, and students.

Billy was a mentor, supervisor, teacher, healer, and friend to dozens of clinical and counseling psychology graduate students—whether he was their major advisor or not. He was always there at the right time, with the right words, encouraging when students were discouraged with soothing or humorous words, notes in calligraphy, homemade cookies, and thoughtful gift books.

In 1995 Billy was honored with the coveted Elsie M. Hood outstanding teacher award from the University of Mississippi, and in 1996 he received the Mississippi State Legislature HEADWAE Professor award. He was also the inaugural recipient of the Mississippi Psychological Association's Training Award. These awards came as no surprise to his former graduate and undergraduate students—his course in tests and measures and his therapy supervision groups were memorable for their content, unique delivery style, and demonstrations. Billy contributed his expertise in assessment and research design to probably half of the research produced by the department, either by consulting or sitting on students' committees.

Most sadly, Billy leaves behind his greatest joys, his wife Tricia and their 2 ½-year-old daughter, Emory. Billy touched the lives of many hundreds of people, and he will be sorely missed by all.

Friends wishing to do so may make contributions toward Emory's education in Billy's memory. Checks should be made out to Mississippi Affordable College Savings Program with "for Emory Barrios" written on the comment line, and sent to Emory Barrios c/o Tricia Barrios, P.O. Box 1913, Oxford, MS 38655. ✍

Book Review

Robert J. McMahon & Rex L. Forehand (2003) *Helping the Noncompliant Child: Family-Based Treatment for Oppositional Behavior* (2nd ed.)

The Guilford Press

• HARDCOVER (2003) ISBN: 1-57230-612-2; $45.00
• PAPER (2005) ISBN: 1-59395-241-X; 313 pp., $25.00

Reviewed by David Reitman, *Nova Southeastern University*

Long before the call for manualized treatment protocols became a rallying cry for science-based practice advocates, Rex Forehand and Bob McMahon (1981) introduced their now classic guide to behavioral parent training, *Helping the Noncompliant Child* (HNC), to an appreciative audience of young behavior therapists. A tribute to its utility, as aptly noted in the foreword by Sharon Foster, is that HNC is among the most frequently "borrowed" texts from faculty bookshelves. Users of the second edition will find it no less challenging to keep on the shelf. Although not the only choice for faculty in clinical training programs, or mental health professionals not exposed to behavioral parent training while in graduate school, the text remains an excellent "how-to" for any professional hoping to facilitate family-based efforts to diminish oppositional behavior with 3- to 8-year-old children.

Structure of the Book

HNC is comprised of 10 chapters and 4 appendices. The first 3 chapters contain introductory material detailing important conceptual and empirical work on compliance and noncompliance (Chapter 1), the history of parent training (Chapter 2), and an overview of the HNC program itself (Chapter 3). Chapter 4 introduces the reader to assessment techniques developed for measuring noncompliance, with a focus on the direct observation of parent-child interactions and multimethod assessment techniques. Chapters 5 through 7 provide exceptional detail concerning the delivery of the HNC program, from the provision of feedback following assessment (Chapter 5) to the two core chapters describing Hanf's "two-stage" parent training model.

Chapter 6 describes the therapist behaviors needed to teach the parent the "skills of differential attention" and "active ignoring." Chapter 7 seeks to enable the therapist-in-training to facilitate improvements in the parent's use of effective commands, contingent labeled praise, and time-out techniques that form the core of compliance training efforts. Chapters 8 through 10 contain an extended discussion of contextual factors that may directly influence the success of the HNC protocol. Chapter 8 explores how marital stress, depression, and substance use problems may interfere with therapeutic gains and offers some advice about how to address these challenges. Chapter 9 (authored by Dr. Karen Wells) describes adaptations of the HNC program for noncompliant 3- to 8-year-olds with additional challenges, such as ADHD, child abuse exposure, and developmental disabilities. Of special note is Dr. Wells's informed discussion of applications of HNC in institutional settings and hospitals. Finally, Chapter 10 explores the impressive research output of the authors and their colleagues concerning a variety of practical issues related to the delivery of the HNC program. The appendices contain a variety of intervention and evaluation aids such as a consumer satisfaction questionnaire (Appendix A), excellent handouts to accompany each treatment session (Appendix B), social learning criterion tests and scoring (Appendix C), and a mealtime behavior protocol (Appendix D).

What's New?

The second edition of HNC is fundamentally unchanged, despite a very thorough revision to incorporate research conducted since 1981. Some relatively minor changes are apparent. For example, HNC-2 places greater emphasis on the complexity of family relations and contains an extended discussion of sibling and father influences on child development. The chapter sequence has been altered slightly and the manual for the behavioral coding system is now available at www.guilford.com. Modest changes have also been made to the assessment of noncompliance and some measures have been dropped in favor of those with better psychometric properties (e.g., the Child Behavior Checklist and Eyberg Child Behavior Inventory replace the Parent Attitude Test).

Although HNC can be described as a "how-to" manual, readers interested in the theoretical aspects of parent training will appreciate the expanded coverage of diagnostic and developmental issues in Chapter 1. For example, there is little if any mention of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in the first edition of HNC. In contrasting the first and second editions, it is striking how much contemporary thinking about noncompliance is framed by the *DSM*. (Yes, young ABCT members, there was a time when behavior therapists questioned the utility of the *DSM*! See Follette & Hayes, 1992; and there may still be rumblings of discontent—see Pelham, Fabiano, & Massetti, 2005). Nevertheless, the authors effectively utilize the *DSM* taxonomy to highlight the long-term risks associated with ongoing non-compliance through early childhood and adolescence.

The authors also present a brief, but informative, contrast of the HNC approach with other variants of the "Hanf-model" family of parent training programs developed by Eyberg (Parent-Child Interaction Therapy), Barkley (Defiant Children), and Webster-Stratton (Incredible Years). Considering the influence of the aforementioned parent training programs on the field, one is most struck by the impact of Dr. Hanf and her teaching. Her insistence on both specification of operational terms and repeated, measurable outcomes laid the foundation for data-based revisions and enhancements to the behavioral parent training approach, while providing a blueprint for the development of manualized treatments for many other populations. True to their roots as behavioral scientists, McMahon and Forehand are also candid about the limitations of the HNC approach. Notably, they point out that additional work is needed to explore how cultural factors might influence treatment outcomes in behavioral parent training.

An unusual but welcome feature of the second edition is the full chapter devoted to the delivery of feedback after behavioral assessment (Chapter 5). Following an exceptionally strong chapter on the assessment of noncompliance (Chapter 4), Chapter 5 allows the reader to gain insight into how the developers of HNC build rapport with families while gaining information vital for treatment formulation. The chapter also conveys much about the authors' approach to shaping clinical skills. Chapters 3 through 5 are essential reading for any beginning child behavior therapist or young faculty member. Especially compelling are discussions about Webster-Stratton and Hebert's (1994) qualitative analysis of client perspectives upon entering treatment and Patterson and Chamberlain's (1994) "struggle hypothesis." In general, these chapters effectively communicate that while the existing parent training literature is populated by a number of effective methods of conveying various parenting skills (including HNC), we still lack a well-developed literature on client engagement. As noted by the authors, "The steps necessary to *persuade* one parent to *try* a particular procedure with a child may be quite different from those required to *persuade* a second parent" (italics added). The inclusion of this material is a tacit recognition of the need for behavior therapists to hone their persuasive abilities to better facilitate client change efforts. Although not new (see Kanfer & Schefft, 1988), discussions about client motivation and engagement are critical at this stage in the development (and dissemination) of parent training models.

Critique

There is little to critique in a text so well considered and researched, but a few observations seem warranted. First, while there is ample consideration given to developmental perspectives on compliance, there is relatively little discussion about the analysis of compliance offered by behavior analysts. As might be expected, the analysis of compliance offered by developmental psychology is fundamentally descriptive and topographical. Thus, various forms of compliance presented in HNC are distinguished based upon structural considerations such as whether or not the act was accompanied by angry, hostile, or oppositional behavior (direct defiance), the child ignored a parental command (passive noncompliance), the child acknowledged the command but refused (simple noncompliance), or the child attempted to renegotiate conditions of the command (negotiation). By contrast, behavior analysts interested in noncompliant behavior have utilized a functional approach derived from an experimental assessment methodology (e.g., Kodak, Miltenberger, & Romaniuk, 2003). Of primary interest is whether assessment information gleaned from a functional analysis of noncompliance might lead to better intervention design and better outcomes (see Nelson-Gray, 2003, or Reitman, 2006, for extended discussions of the treatment utility of assessment). Specifically, would it be possible to identify distinct functions of noncompliance (e.g., escape-motivated, attention-seeking, tangible, etc.) using functional assessment or functional analysis methodologies and to improve treatment outcome based upon the results of such an

assessment? For example, time-out can be exceedingly difficult to implement for some children, and perhaps especially so for children whose noncompliance is primarily a function of parent or teacher attention. Teaching parents about functional assessment might enhance the effectiveness of HNC. Perhaps parents of attention-seeking noncompliant children should be advised to "place themselves" in time-out to avoid reinforcing inappropriate behavior (e.g., arguing) during disciplinary action (see Reitman & Drabman, 1996, 1999)?

As previously noted by the authors, explicit training in general social learning concepts (related to, but not isometric with, functional assessment) appears to enhance HNC outcomes (McMahon, Forehand, & Griest, 1981), so more explicit incorporation of functional assessment principles into behavioral parent training might produce comparable benefits. Importantly, greater emphasis on a behavior analytic perspective need not diminish the value of the developmental analysis. For example, the identification of age-related differences in the appearance of the various forms of topographically defined noncompliance may have important implications for intervention selection and outcome as suggested above.

Perhaps a more significant concern relates to the portability of the HNC model to private practice and mental health settings where most psychotherapy is still delivered. In this respect, the scientific rigor and structured protocols associated with the HNC model could be a liability. As one example of the high level of demand that may be placed on both therapist and client, consider the parent self-control program[1] described in Chapter 8 as an enhancement to HNC. Regrettably, this adjunctive program seems more likely to promote dropout than skill acquisition (at least in community mental health settings where parents and third-party payees are contracting for services). In their defense, the authors seem to acknowledge the potential drawbacks of this aspect of HNC and note that the program "obviously involves a number of procedures." Nevertheless, to successfully complete this adjunctive intervention the parent must (a) learn to count his or her own parenting behaviors in session (e.g., attends, praise, alpha commands), (b) follow instructions for regular practice and count their behaviors in the home, (c) set up and maintain a home rewards system, and (d) call in data to a telephone answering system.

Importantly, the authors note that "which of these components, individually or in combination, are effective ingredients is unknown." While the portability (i.e., generalization) issue is more problematic here than in other sections of the text, it seems that we will need to seriously consider simplification of HNC and programs like it if they are to be more widely disseminated. For example, even in core sessions of the HNC program, therapists are trained to expect parents to meet explicit behavioral criteria for in-session performance of discipline skills (e.g., praise of appropriate behavior), participate in extensive in-session role-plays, and dedicate themselves to daily home practice to promote mastery of the skills.

Put another way, can HNC be altered and streamlined and retain its effectiveness? Can it be delivered in "good enough" form (see Budd, 2001, for an analogous discussion of "good enough" parenting)? Answers to this question may be at hand, as modularized parent training programs such as Triple P (Turner & Sanders, 2006) appear to be effective even when "full strength" treatment is not utilized. On the other hand, what distinguishes HNC from most other parent training approaches is its heavy emphasis on modeling, practice, and performance feedback with all family members present (at minimum, mother and child). Consistent with the maxim of "no pain, no gain," it simply may not be possible to ensure lasting change without the extensive modeling, practice, and feedback characteristic of HNC—at least in cases where the family-child interactions deviate significantly from the norm. Nevertheless, in its present form, HNC remains far more demanding than commonplace parenting programs that do not require modeling, practice, and feedback on skill acquisition. In the end, I found myself wishing that we had a simplified, scaled-down version of HNC, readily exportable to private practice and community mental health settings. So I am torn between great respect for the scientific accomplishment that this second edition of HNC represents, and nagging concern that we need to make an even stronger effort to reach out beyond the clinical science community. Could we do a better job of appealing to practitioners that might be intimidated by the demands associated with the HNC approach? Recent efforts by other Hanf-model parent training programs to present information in a video format (e.g., Incredible Years; Webster-Stratton, 2000) and other "modularized" behavioral parent training approaches (Triple P; Turner & Sanders, 2006) may signal that more sophisticated marketing efforts are under way. On the other hand, third-party payers may be more comfortable with clinic-delivered parent training models (with "child present," of course) than video-based formats. Community-based prevention programs may also face serious sustainability challenges. Applied research is sorely needed to determine whether efforts to improve the marketing and acceptability of behavioral parenting training programs will result in widespread changes (and improvements?) in clinical practice.

[1]The maternal self-control program is an optional adjunctive procedure, not a core element of the HNC program.

Summary

Readers will find that the second edition of HNC enhances their understanding of child development and increases their awareness of contemporary theories about noncompliance. Readers will also be exposed to a very thorough and helpful presentation of a multimethod assessment protocol for child noncompliance. Clinicians unfamiliar with behavioral parent training will be exposed to the critical conceptual tools needed to communicate effectively with prospective clients about the HNC treatment program. Although the authors acknowledge uncertainty about the extent to which the text can facilitate effective behavioral parent training in the absence of the many supplemental training techniques they use in their clinical training and research efforts, the evaluation of this question is at the heart of our efforts to promote widespread improvements in clinical practice. Indeed, McMahon (1985) has previously argued strongly that the merits of self-help manuals must be demonstrated rather than asserted. Although his comments were directed toward consumers of self-help materials, extension of this logic to training manuals such as those employed in behavioral parent training programs seems highly relevant. In the interim, I'll be keeping my copy of *Helping the Noncompliant Child* under close watch, pending the next graduate student's visit to my bookshelf.

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THE JOHNS HOPKINS SCHOOL OF MEDICINE, Department of Psychiatry and Behavioral Sciences announces a faculty position for a clinical psychologist. Applicants should be licensed or license eligible clinical psychologist with expertise in CBT We seek an outstanding clinician with a particular interest and expertise in the treatment of OCD/anxiety disorders, resident education and supervision. This position can be either part time or full time. The position provides the opportunity for both clinical and research activity. There are many additional activities in this academic environment, including various departmental and campus wide didactics and seminars and ongoing projects. The goal is to promote early career individuals who are interested in working in an advanced academic and clinical setting but individuals at other stages of career or who are on different career paths will be considered. We are most interested in applicants who have completed an APA accredited program and internship. Applications should include a letter requesting consideration and stating long term career goals, curriculum vitae, and three letters of reference. Send letter of interest and CV to the attention of Dr. Gerald Nestadt: Meyer 4-181, Johns Hopkins Hospital, 600 N Wolfe St, Baltimore MD 21287-7481 (phone: 410-955-4838) or e-mail gnestadt @jhmi.edu.

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ED BLANCHARD, LIFETIME ACHIEVEMENT RECIPIENT, 2006

President's New Researcher

ABCT's President, Ray DiGiuseppe, Ph.D., invites submissions for the 29th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. Submissions will be accepted on any topic relevant to behavior therapy, but submissions consistent with the conference theme emphasizing basis research are particularly encouraged. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Ray DiGiuseppe, Ph.D.; Michael Otto, Ph.D., ABCT's Immediate Past-President; and Anne Marie Albano, the ABCT President-Elect. Submissions must be received by Monday, August 13, 2007, and must include four copies of both the paper and the author's vita. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

Virginia A. Roswell Student Dissertation Award

This award will be given to a student based on his or her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a $1,000 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. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should complete the nomination. Please complete an on-line nomination by visiting www.abct.org, and completing the appropriate application forms. Then, e-mail the completed forms to **ABCTAwards@gmail.com**. Also, mail a hard copy of your submission to ABCT, Virginia A. Roswell Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Elsie Ramos Memorial Student Poster Awards

These awards will be given to three student poster presenters (student first authors only), member or nonmember, at ABCT's 41st Annual Convention in Philadelphia. The winners will each receive a 2008 ABCT Student Membership, a 1-year subscription to an ABCT journal of their choice, and a complimentary general registration at ABCT's 2008 Annual Convention. To be eligible, students must complete the submission for this year's ABCT convention by **March 1, 2007.** The proposal must then pass ABCT's peer review process. ABCT's Awards and Recognition Committee will judge all student posters.

2007 STUDENT AWARDS

NOMINATE ON-LINE: www.abct.org | Questions? email Joann Wright at ABCTAwards@gmail.com

Call for Web Editor

ABCT is seeking a Web editor to assist in updating material in and developing policies for its Web site. The position is funded with both an honorarium and editorial support. The role principally involves helping to develop content for the Web site. Technological knowledge is less essential. The following mission statement and strategy statement detail information on the proposed aims, activities, and audiences of this new Web site effort.

Web Page Mission Statement

The Web page serves a central function as the public face of ABCT. As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT. Informational and resource activities are directed toward three conceptual groups:

- **Members**—with emphasis on providing an interface for many of the administrative functions of the organization, including conference information, dues, public listing of therapists, etc.
- **Nonmember Professionals**—to advertise the comparative efficacy, diversity of styles, and methods of cognitive-behavior therapy, with additional information on training opportunities and new findings in the scientific literature.
- **Consumers**—to provide information and treatment resources on disorders and their treatment, with emphasis on the style, "feel," and efficacy of cognitive-behavior therapy, as well as information on additional issues that consumers confront in treatment (e.g., combined treatments, relapse prevention, etc.).

Web Page Strategy Statement

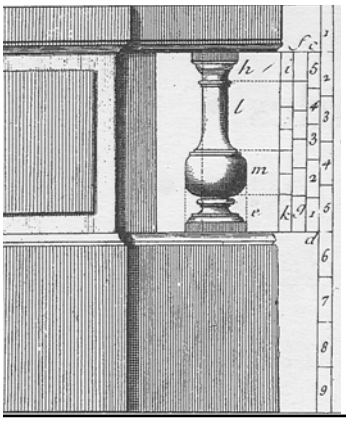
One of the broader changes in the architecture of the Web page is that our content will now come up on searches. Accordingly, we need to plan content that will bring professionals and consumers to our site. The Web editor will need to liaise with associate editors (new), committees, and SIGs for content. Such content includes:

- Diagnosis-specific information pages (e.g., information on depression and its treatment)
- Efficacy information (comparative, combination treatment issues)
- The "feel" of cognitive-behavioral treatment
- CBT, BT, DBT, RET . . . what is in a name?
- Research finding of the month
- Position statements—regarding issues in the field (to clarify what our organization stands for)
- Speakers bureau
- Links to publications
- Helping media find the right person to discuss a topic
- CBT curricula
- Featured therapist of the month

ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org.

The deadline for applications is March 1, 2007.

CALL for PAPERS



THE FOUNDERS OF OUR ORGANIZATION originally defined behavior therapy as the application of scientific-based laws of learning to clinical problems. Since that time our organization has matured and changed its name to include cognitive interventions. However, the focus on science as the foundation for clinical practice has remained.

Our primary stated purpose is "the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the utilization of these interventions."

The theme of the 41st Annual ABCT Convention returns to this concept of building our therapeutic interventions on sound psychological science. Researchers and practitioners in our field rarely have the time to reflect upon developments in basic research of human behavior.

What new developments have occurred in our understanding of human learning, information processing, social cognition, memory, psychopathology, linguistics, neural bases of behavior, and emotions? How can these new findings in psychological science inform our mission of reducing human suffering?

Because even our most efficacious treatments fail for some people, we need to explore new areas of scientific inquiry that can enlighten the process concerning human problems and lead to more effective interventions. The applications of basic psychological science to clinical problems cast a wide net. Research and interventions not strictly behavioral or cognitive may provide new insights. However, the expansion of our knowledge is important if our organization is to achieve its goals.

Return to Basic Research: Developing Clinical Interventions on Recent Scientific Findings

Submissions may be in the form of symposia, round tables, panel discussions, and posters.

www.abct.org

DEADLINE: MARCH 1

ABCT's 41st Annual Convention

November 15–18, 2007

Philadelphia Marriott Hotel

We seek studies that focus on the use of interventions built upon new scientific discoveries or content areas considered nontraditional by this group. Sessions that address new discoveries in learning and cognition or other areas of psychological science and their implications for psychological treatments are welcome.

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