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ISSN 0278-8403
VOLUME 28, NO. 6 • SEPTEMBER 2005

the Behavior Therapist

Contents

Clinical Forum

special series

Treating Outside the Box: The Top-10 Lists for Treating Comorbid Addictive Behaviors in Indigenous, African, Hispanic, and Asian American Groups

Introduction

Karen K. Chan, *University of Washington*

The U.S. Census Bureau (Bergman, 2004) predicts that ethnic minorities will rise from 32% of the population to 51% in 2050. More specifically, this would almost triple the size of Hispanic and Asian American groups, and decrease the proportion of White non-Hispanics to half the population. With the rise in ethnic minorities comes an increased demand for services and programs to serve and treat these individuals effectively. While mental illness has been declared disabling to all individuals, the Surgeon General (U.S. Department of Health and Human Services, 2001) reported that most ethnic minorities have less access and availability to services, are less likely to receive needed services, and often receive poorer quality of mental health care. Taken together, the Surgeon General concluded that many ethnic minorities may experience more disability burden from a mental illness compared to their White counterparts. In fact, the barriers to seeking treatment are also greater among minorities when factors such as culture, class, and language are considered (Sue & Sue, 2003). While disparities in mental health care have been noted, it is important to keep in mind that these findings are not universal. Many ethnic minority cultures are collectivist and seek support from their community and family members. Alternative help-seeking behaviors like these are less

the Behavior Therapist

Published by the Association for
Advancement of Behavior Therapy
305 Seventh Avenue - 16th Floor
New York, NY 10001-6008
(212) 647-1890/Fax: (212) 647-1865
www.aabt.org

Subscription information: *the Behavior Therapist* is published in 8 issues per year. It is provided free to AABT members. Nonmember subscriptions are available at $40.00 per year (+$32.00 airmail postage outside North America).

Change of address: 6 to 8 weeks are required for address changes. Send both old and new addresses to the AABT office.

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detectable in large-scale mental health care surveys.

As the demand for ethnic-specific service delivery rises, more graduate and continuing education programs have been emphasizing cultural competency and diversity training. Cultural competency has been defined as the "belief that people should not only appreciate and recognize other cultural groups, but also be able to effectively work with them" (Sue, 1998). This process involves a greater self-awareness of one's own ethnic identity (his or her own assumptions about human behavior, biases, etc.), knowledge of other cultures' worldviews or backgrounds, and the development of appropriate and sensitive intervention strategies (Sue & Sue, 2003). Developing and honing skills to work with ethnic minorities has been described as an ongoing process that strengthens over time and experience.

The research in cultural competency first began examining ethnic match. Researchers matched therapists and clients by ethnic background, language, and level of acculturation, and found that ethnic match led to lower dropout rates and more attended sessions among Asian Americans, Hispanics, and Whites (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Further, Whites and African Americans were found to attend more sessions when an ethnic match was present. Similarly, gender match has been found to lead to fewer dropouts in Asian Americans and Whites (Maramba & Hall, 2002). These findings suggested something intrinsic to the matching process that improved client retention. Since ethnic and gender matching is not always allowable or feasible, researchers began examining whether the intrinsic matching process was related to a cognitive match where therapists and clients shared congruent views. Researchers found that when therapists and clients were congruent about mental health etiology and treatment approaches, stronger therapeutic alliances were fostered (Sue, 1999; Sue & Zane, 1989). Research has also found that when therapists were rated high on multicultural counseling competence by ethnic minority college student clients, this variable alone mattered most when compared to general competence ratings (Constantine, 2002). This suggests that multicultural counseling is most effective when therapists are trained to be culturally competent.

With the shift toward therapists gaining cultural competency, the American Psychological Association (APA) and National Institutes of Health (NIH) have published guidelines for working with minorities in clinical and research settings (APA, 1993, 2003; NIH, 1994). These include an increased awareness and knowledge of self and others, culturally specific research and practice issues, our clients' worldviews, and culturally specific techniques.

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David Reitman, Ph.D., Center for Psychological Studies, 3301 College Avenue, Nova Southeastern University, Fort Lauderdale, FL 33314-7796

This clinical panel was presented at last year's AABT conference in New Orleans. The following articles were written by clinical experts, summarizing the literature available on the prevalence of comorbid addictive behaviors within their own ethnic group and providing a "top-10 list" of recommendations for working clinically with each population. Dr. Arthur Blume of University of Texas at El Paso makes recommendations for American Indian and Alaska Native populations. Dr. Blume has conducted research examining factors associated with changing alcohol use among participants with comorbid disorders and has substantial clinical experience with urban and reservation American Indians and Alaska Natives of all ages. Dr. Lily McNair of Spelman College presents special considerations for working with African Americans. Her research experience focuses on how alcohol use and expectancies influence the decision-making process involved in risky behaviors, with a special emphasis on the influence of gender, race, and ethnicity. Dr. Felipe González Castro of Arizona State University offers insights from his work with Hispanic/Latino populations. His work examining the factors motivating drug abuse, treatment, and relapse is noteworthy, as well as his contribution to Hispanic health issues. Dr. Gordon Hall from the University of Oregon considers important issues in working with Asian Americans. His research interests are devoted to the cultural context of psychopathology, particularly in the area of sexual aggression. Finally, Dr. Alan Marlatt, director of the Addictive Behaviors Research Center and professor at the University of Washington, adds a thoughtful discussion about the integration of comorbid addictions treatment with ethnic minorities. This special series should provide readers with practical tools for working with persons with dual diagnoses in ethnic minority populations. While this compendium of articles focuses on the treatment for ethnic minorities, it should be remembered that diversity is represented in many facets, including class, gender, and sexual orientation, and that therapists should continue to develop a greater competency to work with all types of individuals.

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ACKNOWLEDGMENTS: The author would like to thank Drs. Stanley Sue, Gordon Nagayama Hall, and William George for their support and guidance in organizing this esteemed clinical panel and editing the content of this article. Correspondence regarding this article can be sent to kkchan@u.washington.edu.

Top 10 Recommendations for Treating Comorbid Addictive Behaviors for American Indians and Alaska Natives

Arthur Blume, *University of Texas, El Paso*

1. One size will not fit all.
2. Traditional medicine practices may be preferred.
3. Respectful noncompliance.
4. Language.
5. Fatalism.
6. Sickness: a symptom of something else.
7. The cultural meaning of the behavior.
8. Spirit world and dreams.
9. Soul wounds.
10. Walking in beauty and peace.

The exact statistics for comorbidity among indigenous groups in the United States is difficult to determine. The largest studies on comorbidity, the Epidemiological Catchment Study (e.g., Regier et al., 1990) and the National Comorbidity Study (e.g., Kessler et al., 1994) had very sparse representation of indigenous Americans, and indeed American Indians and Alaska Natives were collapsed into an "other" ethnicity category in those studies. Because of the lack of data, little is known about true comorbidity rates for indigenous Americans. However, evidence exists that various disorders co-occur with substance abuse at alarming rates in some but not all communities. These disorders include depression and suicidality (Dinges & Duong-Tran, 1992; May et al., 2002; Rhoades, 2003); problems with attention and concentration, including concerns about fetal alcohol syndrome and fetal alcohol effects (May, 1993); and traumatic stress, including concerns that it may have a cumulative effect and be transmitted intergenerationally (e.g., Gray & Nye, 2001).

Treating comorbidity in American Indian and Alaska Native communities depends upon sensitivity to community culture and tradition, respect for social structures and values, and an understanding and respect for the history of the com-

munity being served. It is with these basic principles that the top-10 list is developed. The first item, *one size will not fit all*, is so obvious as to be taken trivially. However, professionals forget that population groups, like Native Americans, are not homogeneous, and tend to be treated similarly. There are over 500 distinct indigenous communities in America, with a vast array of cultures, languages, and traditions. Large between-group cultural and language differences make it unlikely that one "native" treatment for comorbidity can be developed.

With "one size will not fit all" in mind, the next few items can be important cultural considerations to remember when treating comorbidity, but do not assume that all American Indian and Alaska Native clients will share these views. The second item involves understanding that traditional medicine practices may be preferred by your indigenous client. A savvy professional will ask the client if such services are being utilized in addition to CBT.

The third item is to understand that American Indians and Alaska Natives may not comply with therapeutic recommendations, but the professional may never know it. Native clients may respectfully disagree with those recommendations in a way that feigns compliance. Many indigenous people have learned how to express dissent in silence because of a long cultural history of betrayals and abuses. Language issues (#4) also are of concern. Some American Indians and Alaska Natives speak English as a second language, or may have low education levels, which can cause miscommunication in therapy. In addition, research suggests that ethnic minority clients may talk about symptoms differently than Whites (e.g., Hardie, Janson, Gold, Carrieri-Kohlman, & Boushey, 2000), so an indigenous client's description of problems in session has the potential to be misinterpreted. Furthermore, some indigenous people (but not all!) may have fatalistic worldviews (#5) that in fact may be oppositional to some of the basic tenets of CBT. The difference in worldview may increase communication difficulties and could prove challenging when attempting to orient and gain commitment of clients to engage in therapeutic recommendations. In addition, the sickness (comorbidity) may be experienced by the client as a symptom (#6) of a more systemic or universal problem caused by possession by spirits or ghosts, spiritual imbalance, or even the result of a broken taboo or misdeed. A savvy therapist will try to determine (and respect) the larger context of meaning that clients have for comorbid disorders. Similarly, professionals will be aided by understanding any cultural meaning attached to the behavior (#7). For example, in some communities, abusive drinking has assumed the function of expressing defiance toward the majority society, and this defiance may be reinforced by the community as a patriotic act. Another example may be that psychotic symptoms are interpreted as a sign of strong spiritual connections and may be revered by communities as well.

Spirituality, as may be evident in the previous items on the list, is very important to most indigenous people. The spirit world is real and present, and dreams are to be taken seriously as vehicles for healing and lessons about life (#8). Many feel that spirituality will be the source of healing for the soul wound that the communities have experienced (#9). This phrase is used to describe the tremendous intergeneration injury caused by the conquest. Many indigenous people feel that destructive behavior and mental health problems (like comorbidity) began with the conquest and have multiplied with each subsequent episode of betrayal or abuse. Professionals working with American Indians and Alaska Natives with comorbid substance abuse and other disorders should be aware of the unspeakable wound. Finally, walking in beauty and peace (#10) is the way that many indigenous people describe finding balance in life. The idea is to be in harmony with all things, to seek balance in your behavior while finding your rightful place in the web of creation. Effective therapy to treat comorbidity among indigenous clients will need to include ways to walk in beauty and peace.

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Top 10 Recommendations for Treating Comorbid Addictive Behaviors in African Americans

Lily D. McNair, *Spelman College*

1. Actively integrate the client's experiences of race, ethnicity, and culture into therapy.
2. Directly address racism and discrimination in the client's life.
3. Conceptualize racism and discrimination as "triggers" for addictive behaviors as well as relapse.
4. Evaluate the role of racism as a mediator between the client's comorbid disorder and substance use.
5. Address culturally relevant factors related to initiation of substance use.
6. Assess the cultural context of substance use.
7. Assess the cultural context of the comorbid disorder.
8. Examine the client's engagement in therapy in order to enhance completion of therapy.
9. Consider the role of gender and race interactions, e.g., women with PTSD related to sexual trauma who also engage in addictive behaviors.
10. Address potential HIV risk, particularly in women who use cocaine and alcohol.

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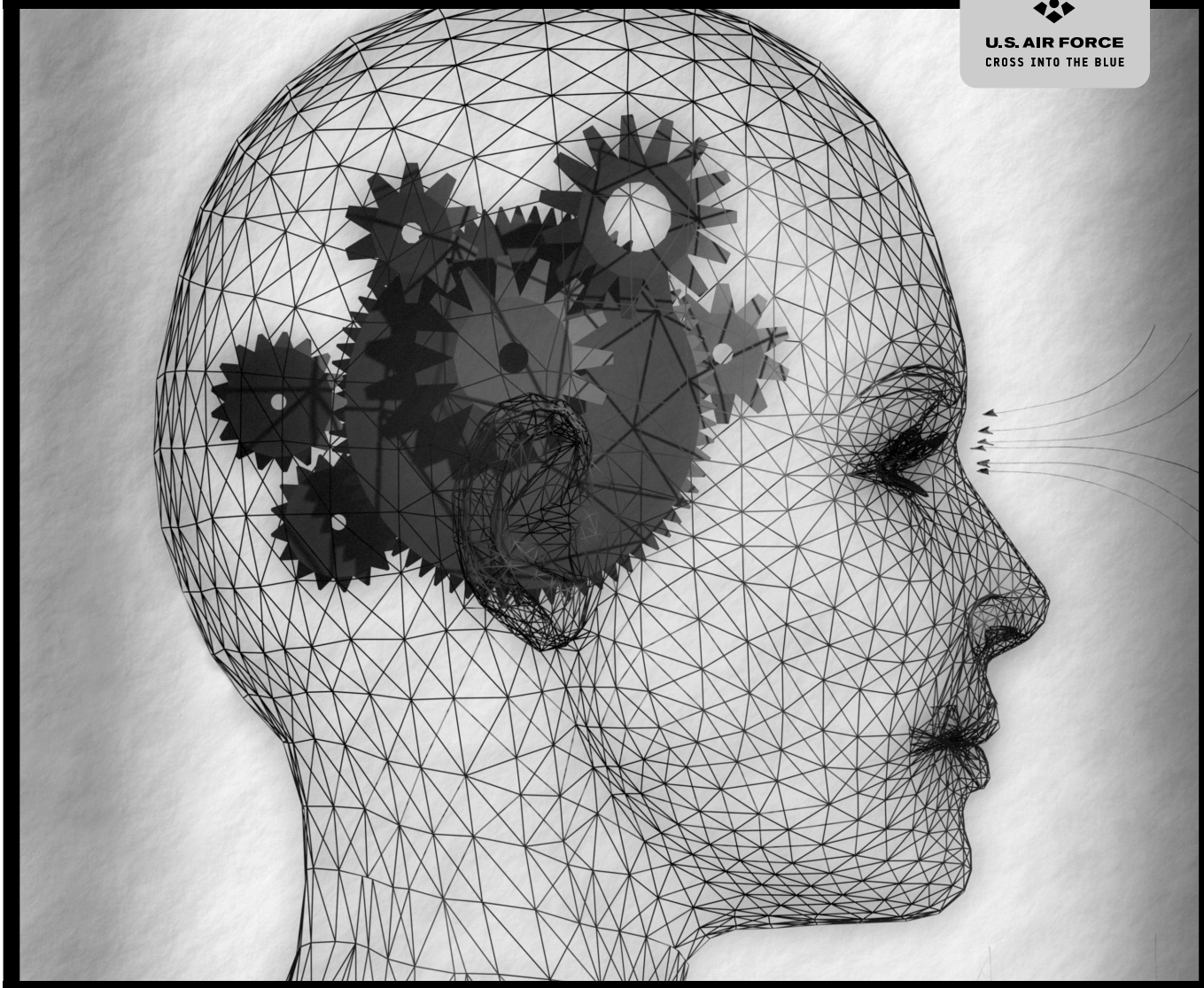

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as psychological disorders. For example, women experience higher rates of depression, dysthymia, phobia, panic, and anxiety disorders than men, while men have higher rates of substance use disorders and antisocial personality disorder (American Psychiatric Association, 1994). Racial and ethnic differences in alcohol use and dependence have also been noted. For example, Caucasian men between the ages of 18 and 29 years have higher rates of alcohol use and dependence than African Americans (18% vs. 8%), while African American men have higher rates of alcohol use later in life than do Caucasian men aged 45 to 69 years (15% vs. 8%; Robins & Regier, 1991).

Among African Americans with drug dependence, high rates of comorbid disorders exist. Although the overall comorbidity among African Americans is lower than for Caucasians, these rates are still high, particularly among men. For example, 73% of African American men with any drug dependence diagnosis also have one of the following comorbid conditions: antisocial personality, phobia, major depressive disorder, dysthymia, and generalized anxiety. Among African American women with a drug dependence disorder, 61% also have a comorbid condition, such as phobia, antisocial disorder, major depressive disorder, dysthymia, and generalized anxiety (Compton et al., 2000).

The high rates of comorbid conditions among African Americans with addiction problems underscore the importance of assessing for these common comorbid disorders. As Compton and colleagues (2000) state, ". . . comorbidity is the rule rather than the exception among treatment-seeking substance abusers." For African American clients, it is necessary for the therapist to explore how race, ethnicity, and culture influence the initiation of substance use as well as the etiology of comorbid conditions. A significant first step in this direction is developing a positive therapeutic relationship in which issues related to race, ethnicity, and culture are openly discussed. This sets the foundation for an accurate assessment of the cultural context of both the addictive behavior(s) and comorbid condition(s). By conceptualizing the client's experiences of racism and discrimination as "triggers" for high-risk situations (Williams & Gorski, 1997), the therapist can more comprehensively address relevant stressors that impact African Americans' vulnerability to relapse. In an investigation of African American clients' experiences of relapse, Williams and Gorski found that 45% cited issues related to race as significant in their relapse, and 48% indicated that they experience more triggers because they are African American. Thus, it is particularly important for therapists to address African American clients' experiences of racism and discrimination to enhance relapse prevention. It is possible that such direct discussions of racism and discrimination will increase the likelihood that African American clients will become more engaged in, and complete, therapy.

For African American women, comorbid conditions related to depression and trauma history, combined with alcohol and cocaine use, predict HIV risk (Zule, Flannery, & Lam, 2002). In general, sexual risk increases as alcohol and cocaine use increases (Rasch et al., 2000), thus increasing the possibility of high-risk behaviors related to the transmission of HIV. Therefore, therapists should be aware of this association and assess for exposure to risky behaviors related to HIV transmission. While the relationship between substance use and sexual risk also exists for men, it is much more prominent in women given the "web of risk" (depression, trauma history, and substance use) that increases HIV risk for African American women (Johnson, Cunningham-Williams, & Cottler, 2003).

In summary, cognitive behavioral therapists working with African Americans who have comorbid addictive behaviors need to actively integrate issues related to race, ethnicity, and culture as they relate to the client's history of substance use and their comorbid psychological disorder. These considerations are salient and relevant during all phases of therapy, and can be especially useful during relapse prevention, when triggers related to racism and discrimination frequently pose unique, high-stress situations for African Americans. By addressing these issues consistently and effectively with African American clients, therapists can increase the likelihood that clients will continue in therapy and experience positive outcomes.

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Top 10 Recommendations for Treating Comorbid Addictive Behaviors in Asian Americans

Gordon C. Nagayama Hall, *University of Oregon*

1. One size doesn't fit all.
2. Only penguins look alike.
3. Some Asian Americans believe in a genetic etiology of problems.
4. Some Asian Americans believe in a psychosocial etiology of problems.
5. There are limited data on comorbidity among Asian Americans.
6. Treatment is a form of acculturation.
7. Acculturation in treatment can be coercive.
8. Matching treatments with client etiological beliefs may be effective.
9. Clients having genetic etiological beliefs may benefit from a medical solution.
10. Clients having psychosocial etiological beliefs may benefit from a psychosocial solution.

Asian Americans proportionally are one of the fastest growing ethnic groups in the United States. Yet, the rates of comorbid addictive behaviors in this group are unknown. Whereas addictive disorders are comorbid with mood and anxiety disorders at rates of 18% to 20% in the U.S. (Grant et al., 2004), similar rates of comorbidity in Japan have been lower, ranging from 11%

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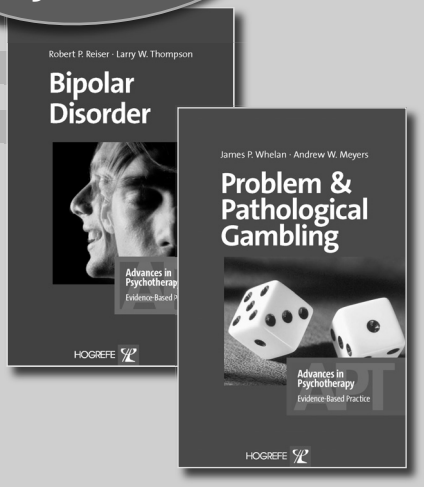

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to 12% (Kawakami, Shimizu, Haratani, Iwata, & Kitamura, 2004). Nevertheless, epidemiological data from Asia are not necessarily applicable to Asian Americans.

Although empirically supported treatments for addictive behaviors have been developed for European Americans, there is limited evidence of their effectiveness among Asian Americans. It cannot simply be assumed that treatments that work for one group work for others without actual evaluation. Moreover, Asian Americans are an extremely diverse group, although some group members may appear phenotypically similar.

Part of this diversity involves beliefs about the etiology of psychological disorders. Many Asian Americans believe that psychological disorders have a genetic basis. Somatization is common among Asian Americans and may be an expression of distress (Lin & Cheung, 1999). For those who believe in a genetic etiology and somatize, a medical solution, such as drugs, may be most relevant for psychological disorders. In the case of comorbid substance abuse disorders, Naltrexone might be useful in that it regulates mood states associated with problem drinking (Kranzler et al., 2004).

Other Asian Americans believe that the basis of psychological disorders involves a failure to fit into the social environment. The most relevant solution to such psychosocially based problems may be guidance from experts, analogous to the process of psychotherapy (Lin & Cheung, 1999). There is evidence that Asian Americans view cognitive therapy as a credible form of treatment. Cognitive therapy has been demonstrated to be efficacious in treating addictive, mood, and anxiety disorders.

Psychological treatment has Western origins and is an acculturative process. Such acculturation in psychotherapy can become coercive when the therapist and client do not share the same goals (Hall & Malony, 1983). Rather than attempting to change a client's etiological beliefs to conform to a particular treatment approach, it may be more effective to offer the client multiple treatment approaches and attempt to match clients with efficacious treatments that address their etiological concerns.

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Top 10 Recommendations for Treating Comorbid Addictive Behaviors in Hispanics

Felipe González Castro, *Arizona State University*

1. Examine early-life migration, acculturative change, and other developmental experiences.
2. Assess the duration, severity, and type of psychiatric and substance abuse disorders.
3. Consider within-group heterogeneity as related to levels of acculturation.
4. Examine cultural orientations, personal identities, and ethnic pride.
5. Consider traditionalism in cultural life views.
6. Examine cultural and other forms of personal identity.
7. Assess feelings of discrimination and victimization.
8. Consider motivations for recovery and risks of relapse.
9. Examine family connectedness and social support or its absence.
10. Assess spirituality and a quest for giving back to the family and the community.

For many Hispanics, migration is an important element of early life history, and for those who are immigrants, the process of immigration influences many life experiences. The process of migration to a new environment prompts acculturative change, which for some is stressful but for others is stress reducing. A variety of developmental experiences in more than one culture prompts the development of a bicultural identity, but may also induce stress, cultural conflict, and substance abuse. The duration, severity, and type of psychiatric disorder and of substance abuse constitute important features of a client's illness. Beyond ethnicity, significant differences exist between Hispanics who have mild forms of mental disorder comorbid with a minor use of drugs or alcohol, in comparison to other Hispanics who exhibit severe psychiatric disorder comorbid with severe substance abuse. Making this distinction is important for sound treatment.

Level of acculturation is one of the foremost dimensions that describes the within-group variability among Hispanics (Cuellar, Arnold, & Gonzalez, 1995). Understanding distinctions between low acculturated, bicultural, and high acculturated Hispanics is a useful heuristic for understanding variability by level of acculturation observed among Hispanics (Castro, Cota, & Vega, 1999). Moreover, it has been observed that comorbidity may increase with acculturation (Vega, Sribney, & Achara-Abrahams, 2003). Many Hispanics who espouse a bicultural orientation express an equal sense of attachment to their native Latino culture (e.g., Mexican nationality), as well as to the mainstream White American culture. Others vary in their preferences and identification toward each of these two cultures; some are highly assimilated and identify primarily with White American culture, while others are more separatist and identify almost exclusively with their Latino culture (Castro & Garfinkle, 2003). These differences in cultural identification should be considered in understanding Hispanic clients within their total cultural context.

Hispanic clients also differ in their level of traditionalism, that is, their adherence to old-world lifeways that include strong gender role identities such as endorsement of *machismo* (domineering male attitudes) and *marianismo* (a nurturing motherly persona). Consistent with these gender role identifi-

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cations, alcohol and psychiatric disorder may be the most prevalent form of comorbidity for Hispanic men (7.5% lifetime prevalence), whereas Hispanic women may exhibit depression and substance use as a more prevalent form of comorbidity (Vega et al., 2003). Issues of personal cultural identity and identification with one's culture or nationality, or efforts to avoid such identification, constitute important psychological aspects of personality and identity among many Hispanics (Phinney, 2003). As clients recover from drug abuse and develop new personal identities, it is important to revisit their own identity and discover whether ethnic or cultural pride may serve as factors that aid in the avoidance of the use of alcohol and other drugs.

While overt racism and discrimination against Hispanics has diminished since the 1940s and 1950s, some Hispanics still complain of racial discrimination, racial profiling, and of treatment as people who are uneducated and inferior. These concerns appear more prevalent among darker-skinned Hispanics and among those having indigenous features. This self-consciousness about discrimination and victimization may influence how these Hispanics cope with stressors, including their use of drugs and alcohol as ways of coping with distress. In relation to the experience of victimization, youth with a history of violence may be more likely to engage in violence after release from drug treatment if they encounter victimization (Zilberman, Tavares, Blume, & el-Guebaly, 2003).

Currently, little is known about the empirically identified determinants of relapse as they may be similar or different for Hispanics, relative to members of the mainstream population. Nonetheless, close family relations may serve as sources of protection against relapse or, conversely, as sources of risk for relapse. Generally, therapists should consider the role that families and close interpersonal relations may play among Hispanics in promoting motivation for their recovery and for avoiding relapse. While *familism*—strong family bonds—is considered a core feature of Hispanic cultures, many heavy drug users alienate family and often find themselves disconnected from family and significant others. This lack of psychosocial support may be particularly distressing for Hispanic drug users, and strategies for reintegration into the family system by becoming a more responsible provider or caretaker should be considered in helping recovering Hispanic drug users to develop a family support system to avoid relapse and recidivism.

Finally, religious faith, especially Catholicism, has been an important element of the Hispanic cultures. Additionally, a sense of community and a value of service to the community are important cultural values. The therapist should consider ways in which personal growth toward greater spirituality and a "giving back to the community" may serve as therapeutic approaches that can help recovering Hispanic drug addicts to avoid relapse and to foster resistance against a recurrence of psychiatric disorder. More research is needed to understand how these important sources of cultural strength may help Hispanic clients recover from psychiatric disorders coupled with substance abuse.

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Treating Outside the Box: Discussion

G. Alan Marlatt, *University of Washington*

In reviewing the top-10 lists for treating comorbid addictive behaviors across diverse ethnic populations (Native American, African American, Asian American, and American Hispanics), four major common themes emerge. Although these themes have unique relevance for each population, there are also some important commonalities.

The first major theme reflects a common preference across diverse groups to develop a "welcome message" for new clients that embraces cultural and traditional values of that particular culture. By presenting clients with a worldview of a treatment philosophy that matches their own cultural identity, the door is open to acceptance of and commitment to a treatment plan that is based on a partnership of values shared between therapists and their clientele. Depending on the cultural match between client and therapist, the focus is on cultural bicompetence and sensitivity to acculturation issues, including migration or recent immigration to a mainstream culture.

A second theme is that in addition to major differences between diverse ethnic groups, there are also important differences within each culture that need to be considered, including degree of assimilation into both minority and mainstream cultures, gender differences, and differences in belief about the etiology of certain disorders (e.g., biological, psychological, or cultural) and how they should be treated. Clients with diverse backgrounds within the same culture should be offered a choice of multiple treatment approaches that match their own individual beliefs. This point is captured by slogans such as ONE SIZE DOES NOT FIT ALL and ONLY PENGUINS LOOK ALIKE.

The third major theme that emerges is that partnership and cooperation are the hallmarks of an integrated approach to our training, prevention, and treatment programs in cultures of diversity. Integration can occur in terms of forming a partnership between clients with a particular ethnic identity with therapists who share their values, whether or not they are both from the same minority population. For clients with co-occurring problems with addictive behavior and mental health disorders (e.g., alcohol dependence and depression), an

integrative approach is recommended so that the client is not faced with barriers based on cultural beliefs about which disorder should be treated first. For clients of diverse backgrounds, there should be "no wrong door" to integrated access to treatment.

A fourth and final theme described by most authors is the need to directly address the possibility that clients of diverse cultures have experienced racism and discrimination by others from mainstream or other ethnic minority populations. Therapists who are able to put such "taboo" topics on the table for open discussion with their clients are more likely to facilitate acceptance, open discussion, and a capacity to share the impact of these difficult experiences. The potential impact of racist discrimination on both the initiation of problem alcohol or other drug use and as a risk factor for treatment relapse needs to be taken into consideration by both therapists and clients. A history of trauma based on racism and discrimination may promote a need for "self-medication" that is linked to the "web of risk" (trauma, depression, and substance use) that increases risk for HIV infection and continued drug use.

In conclusion, one recommendation that emerges from this review is that when treatment first begins, both the therapist and client should take note of their own individual "top-10 lists" so that common values and differences can be identified and discussed right from the beginning of the therapeutic relationship. ✍

Training Program Update

Master's Programs in Behavior Therapy

(Training Program Editor's Note: I would like to acknowledge Steve Evans for his suggestion to develop this special issue. This issue highlights the contribution of master-level training programs within the context of doctoral training and includes detailed descriptions of seven noteworthy MA/MS training programs. —C.F.)

Finding Their Niche: The Role of Master's Programs in Scientist/Practitioner Model Graduate Training

Steven W. Evans and Bebhinn Timmins, *James Madison University*

We appreciate the opportunity to address issues pertaining to master's-level training in the science and practice of applied (clinical, counseling, school) psychology for students interested in obtaining a doctoral degree in these disciplines. Earning a terminal master's degree is a popular choice for many students who eventually complete doctoral training, yet the value of these programs is rarely recognized and they remain unsupported by many of the funding mechanisms that support doctoral training programs. For example, many of the awards granted by professional organizations to graduate students and most student research funding opportunities are intended for individuals in doctoral programs. Furthermore, many graduate program directories for students interested in doctoral training do not include descriptions of these programs. This is an unfortunate omission since students applying to doctoral programs frequently also apply to master's programs that could facilitate their eventual acceptance into a doctoral program. While the master's degree is not the terminal degree for those interested in careers as scientist/practitioners, it is an important stepping stone for many and an unrecognized opportunity for many others. This is especially true for those whose long-term goals include achieving a Ph.D. in clinical psychology since the admission process for these programs is so competitive.

There are three main categories of students for whom this option is ideal. The first includes students whose undergraduate degree is not in psychology. These students may have excellent GRE scores and solid grades but lack the depth of training in psychology necessary to be competitive applicants for a doctoral program. Many times these students gain postbaccalaureate expe-

rience in a setting that convinces them to change their career path. A terminal master's program may serve as an ideal bridge for these students to enter a competitive doctoral program.

These programs are also ideal for psychology students with borderline credentials. Competitive doctoral programs have the opportunity to be selective: excellent grades, high GRE scores, and other notable accomplishments are important credentials to gain admission. An advisor's letter indicating that low GRE scores are not representative of the student's ability is frequently insufficient to overcome this blemish. Isolated compromises in an otherwise stellar record may be due to many factors, including immaturity as an underclassman, test anxiety, poor preparation, or insufficient advising as an undergraduate student. These problems may be overcome through success in a reputable master's program and may allow students in this category to accomplish their goal of admission into a competitive doctoral program.

Finally, students uncertain of their eventual career path may establish clarity and focus while completing a master's program. A program with multiple research teams led by faculty focused on a variety of areas of study provides students with an opportunity to experience topics in psychology that they may have never known existed. While shifting between research teams may slow one's progress in a master's program, it also may provide the uncertain student with the opportunity to gain valuable experience and resonate with a career-shaping field of study.

In addition, it should be noted that many students whose credentials are competitive experience pressure to apply to reputable doctoral programs immediately following their undergraduate training. In spite of solid credentials, many undergraduate students do not have sufficient experience to determine the path they wish to pursue as a graduate student. As a result, some students enter doctoral programs without a full understanding of what they entail. This can lead to frustration if the student realizes 2 months after beginning a doctoral program that they have no interest in the research specialty of their chosen advisor. A master's program can give students the opportunity to narrow their research interests so that they are more likely to find a doctoral program with which they are suitably matched. Thus, for many students, master's programs should be viewed as a chosen opportunity rather than a second alternative to a Ph.D. program.

While completing a master's program with the goal of pursuing a scientist/practitioner-oriented doctorate program, students should consider a variety of activities. First, it is critically important to establish a strong academic record. Faculty who take students into doctoral programs want to be confident that problems with course work will not derail students. As a result, signs of problems with courses in master's programs are likely to be viewed quite negatively when applying to a doctoral program. Given a solid academic record, students in master's programs have the opportunity to distinguish themselves from most other applicants to competitive doctoral programs. Although students usually only attend these programs for 2 years, if they participate on an active research team they have the opportunity to experience the intellectually challenging dialogue of faculty, staff, and students critiquing projects, brainstorming theories, and debating points of view. In addition, they may contribute to book reviews, grant proposals, and articles for professional newsletters. Of course, manuscripts for peer-reviewed journals are an excellent credential and students should pursue opportunities to contribute to these whenever possible. Presenting scientific posters, coleading training workshops, and participating in symposia at professional conferences are also valuable learning experiences. These experiences not only provide valuable training in areas that are the currency of the scientific field, but also help students distinguish themselves from other applicants to doctoral programs.

Finally, students should take advantage of the opportunity to develop a professional network. Faculty can facilitate introductions to other scientist/practitioners in their field, and attendance at national conferences affords opportunities to meet other researchers. While making these personal connections can be intimidating to many students, the relationships can be quite valuable. Professional colleagues may offer suggestions on projects or manuscripts, provide leads to other training and research opportunities, and share ideas that may develop into theses and dissertations. In addition, students may meet faculty with whom they may apply to work with in a doctoral program. For others, these relationships may help them find employment as a part of a research team after completing their master's degree.

To summarize, rich training opportunities exist in master's programs for students interested in applying to scientist/practitioner-oriented doctoral programs. They represent an important niche in the training opportunities for professionals in the field of psychology. The seven programs appearing below responded to a call for master's program descriptions, but are limited here to those programs with an applied or basic science orientation. Other programs were nominated by members of the editorial board of *tBT*. Most of these programs place a substantial number of their graduates in doctoral programs. Directors of programs not appearing below are encouraged to describe their training in future issues of *tBT*. Please join us in sharing information about these opportunities with students seeking advanced training in behavior therapy.

MIDDLE TENNESSEE STATE UNIVERSITY

Graduate Training in Clinical Psychology

Kimberly J. Ujcich Ward

• *Program Mission and Overview*

The Psychology Department at Middle Tennessee State University (MTSU) offers graduate study leading to the master of arts with an emphasis in clinical psychology. Operating from a broadly based scientific professional approach, the goals of the clinical program are to train students comprehensively in the core of clinical psychology, and for students to develop a specialization/competency area consistent with their professional goals. Specific program requirements include 46 semester hours: 22 hours of required core clinical courses (e.g., psychopathology, theories of personality, cognitive assessment), 3 hours of off-campus practica, 6 hours of statistics, 3 hours of thesis, and 12 hours of approved electives in a specialization. All students also must pass a comprehensive exam. Upon completion of the program, graduates are prepared to pursue doctoral training and/or employment in psychological assessment and diagnosis or in the application of behavior analysis principles. The skills training does not prepare students to practice psychotherapy at the terminal master's level; we instead focus on training practical skills in assessment and diagnosis and in the specialty areas.

• ***Training Model***

The clinical program operates on the scientist-practitioner model of training. The course work emphasizes empirically based clinical methods and often requires research-based assignments. To further emphasize the "scientist" component of training, all students are required to take 6 semester hours of graduate statistics and to complete an empirical thesis, which students are required to present professionally. Recent students have presented their thesis work at AABT, APS, Society of Pediatric Psychology, and Society for Research in Child Development. For additional research experience, students may take an elective in Independent Research. For students interested in pursuing doctoral training, additional research and/or teaching experience is available through competitive graduate assistantships offered in the department and other university programs (e.g., Developmental Studies).

The "practitioner" component of the program is emphasized through course content, skills-based course work (e.g., cognitive assessment, personality assessment), and the clinical practica. A seminar on professional issues (e.g., applying for licensure or certifications, working in a managed care system) conducted by the practicum coordinator also is part of the required practicum course. Finally, the curriculum and practica are designed to meet certification requirements for the State of Tennessee's Certified Psychological Assistant (CPA), the current master's-level psychology certification.

• ***Unique Aspects of Program***

Two major aspects of the program at MTSU that make it a unique opportunity for students are the elective specializations and the collaborative nature of the psychology department. Students in the clinical program select one of three specializations, consistent with their long-term professional goals as well as their areas of personal interest. The specialization in behavior analysis provides training in the theory and application of behavioral assessment, intervention, and research. The course work fulfills requirements for the national Behavior Analyst Certification as well as the CPA. Through the health psychology/neuropsychology specialization students enhance their knowledge and skills in the areas of biologically/neurologically based assessment and physical/psychological health links. The general clinical specialization is designed to allow students to sample a broad range of electives, including additional course work in assessment. For students who plan to pursue doctoral training, any of the three tracks are appropriate because all emphasize the empirical basis of clinical skills. For those who plan to seek employment at the master's level, the specialization helps them develop marketable skills in a specialized area and meet course work requirements for certification.

A second unique aspect is the size and diversity of the psychology department at MTSU. The faculty currently consists of 45 full-time faculty, all of whom possess doctoral training. In addition to the clinical master's program, the department offers master's degrees in five other graduate programs: Quantitative, Experimental, Professional Counseling (including school counseling and mental health counseling), Industrial/Organizational, and School Psychology. We also offer an Ed.S. degree in School Psychology. Although the core faculty, admissions, and administration of the programs are separate, there is overlap in courses and research supervision opportunities.

• ***Student Placement***

For the past several years graduates of the clinical program at MTSU have primarily taken employment opportunities in forensic assessment, neuropsychological assessment, community mental health services, children and family mental health services, and research. Approximately 10% in the past 5 years have entered doctoral programs in either clinical or counseling psychology. This percentage is expected to increase in response to recent changes in our program (described above) that emphasize experiences that will help students to be more competitive candidates for doctoral training.

• ***Contact Information***

For additional information please visit our Web site at www.mtsu.edu/~psych/clinical.htm or contact the clinical program coordinator, Mary Ellen Fromuth, Ph.D., at mfromuth@mtsu.edu or call 615-898-2548. For information specific to the behavior analysis specialty within the clinical program, contact Kim Ujcich Ward, Ph.D., at ujcich@mtsu.edu or 615-898-2188.

WESTERN MICHIGAN UNIVERSITY

Behavior Analysis Master's Program

James E. Carr

• *Program Mission and Overview*

The department of psychology at Western Michigan University offers a 2-year master's degree program in behavior analysis that is accredited by the Association for Behavior Analysis. The program combines advanced course work in behavior analysis, practicum opportunities, and mentored research experience to prepare students for doctoral study or for employment at the master's level. All students take courses in the basic (e.g., conditioning and learning), conceptual (e.g., Skinner's behaviorism), and applied aspects (e.g., behavioral approaches to treatment) of the discipline and are offered 20 courses in behavior analysis and therapy from which to choose. Students also complete either a research thesis or an empirical application project. The program's main specialty areas are developmental disabilities, basic operant research with humans and nonhumans, organizational behavior management, behavioral community psychology, behavioral pharmacology, behavioral gerontology, and behavioral medicine. Currently, 8 faculty members mentor approximately 40 students in the behavior analysis master's program.

The program's missions are to (a) provide students with a strong foundation in behavior analysis, including its concepts and principles, theoretical systems, research methods, and behavior-change strategies, and (b) provide students with the specific skills necessary for them to be successful practitioners and researchers.

• *Training Model*

The program operates using a mentorship model under which students work closely with a major professor responsible for their program of study. For those students who have clinical and applied interests (e.g., developmental disabilities, behavioral medicine, organizational behavior management), their training follows a scientist-practitioner model. Students are provided with multiple, supervised practicum opportunities in which they can acquire repertoires in the ethical application of behavioral technology and in the empirical evaluation of treatment outcomes. These students complete an applied behavior-analytic research thesis or project. For students whose primary interest is the experimental analysis of behavior, their time is generally spent conducting research with their major professor.

• *Unique Aspects of Program*

The most unique aspect of our program is that it is housed within a department that has had a pervasive behavioral orientation since the late 1960s (Michael, 1993). In addition to the master's degree in behavior analysis, the department offers a master's degree in industrial/organizational psychology and doctoral degrees in clinical psychology (APA accredited) and behavior analysis—all offered from a behavioral perspective. The psychology department was recently ranked 5th out of 53 institutions for scholarly productivity in behavior analysis from 1992 to 2001 (Shabani et al., 2004). One of the benefits of a consistent departmental worldview is the ease with which students can "cross-train" with students and faculty from other programs. For example, it is not uncommon for clinical and behavior analysis students to work together acquiring applied skills, or for students who specialize in developmental disabilities or behavioral medicine to obtain a secondary specialization in organizational behavior management.

• *Student Placement*

Approximately one third of our students enter doctoral programs after graduation. Common doctoral programs include behavior analysis, clinical psychology, school psychology, and special education. The remaining students accept employment with individuals and organizations in developmental disabilities, mental illness, substance abuse, community mental health, education, government, business, and industry. In recent years, the program's student placement rate has been 100%. The program's core curriculum has been approved by the Behavior Analysis Certification Board (www.bacb.com), which facilitates subsequent certification in behavior analysis.

• *Contact Information*

More information on our program can be found on our Web site (www.wmich.edu/psychology/BA) and in our entry in the Association for Behavior Analysis Graduate Training Directory (www.abainternational.org/start/findgtd.asp). An application packet can be obtained from the program Web site, from our graduate-training secretary (linda.rowen@wmich.edu), or by calling the department: (269) 387-4500.

Reference

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JAMES MADISON UNIVERSITY

Psychological Sciences Program (Clinical Concentration)

Steven W. Evans and Gregg R. Henriques

• *Program Mission and Overview*

The clinical concentration in the psychological sciences at James Madison University's (JMU) master's program represents a unique set of training opportunities for students interested in pursuing a Ph.D. in clinical or school psychology with an emphasis on clinical research. The core of the psychological sciences program is a sequence of courses in statistics, measurement and research design, core content areas, a research apprenticeship, and a thesis. The core provides students with a strong foundation in the psychological sciences. This training equips them to contribute as an active member of a research team by participating in a variety of activities such as serving as a project coordinator, reading and discussing the research literature, working on empirical studies, presenting at professional conferences, and publishing in peer-reviewed journals.

Students in the clinical concentration receive training consistent with a scientist-practitioner orientation to the field of behavioral health. Faculty emphasize empirical approaches to treatment, methods of studying treatment outcome, and other clinical topics. All students in the clinical concentration are expected to present their research at professional conferences and to publish. Completion of core courses, a research apprenticeship, and a research paper

are the requirements for the first year. A clinical practicum experience and thesis are part of students' second year of study.

The mission of the psychological sciences program is to provide advanced training in empirical research in the psychological sciences. Students in the clinical concentration take core topic and statistics courses, but focus their work outside the classroom on clinical research. Students in other concentrations take many of the same courses, but focus their research on their respective interests (e.g., developmental, quantitative).

• *Training Model*

Students in the clinical concentration are trained using a mentoring model. Applicants request to work with a specific faculty member when they apply. Faculty interested in taking new students are indicated on the program Web site along with their areas of interest. Students work closely with their faculty mentor from the first day of the program throughout their graduate training (and frequently beyond). The students are members of their mentor's research team and receive guidance and assistance that supports their completion of the graduate program as well as to help them gain acceptance into preferred clinical or school psychology Ph.D. programs.

Students receive clinical training and experience in evidence-based assessment and treatment including a practicum during the second year. Although clinical training is provided, there is an emphasis on research training and course work. Students complete four statistics courses, including multivariate analysis and structural equation modeling, and contribute to research projects in addition to their thesis. Almost all clinical concentration students stay in Harrisonburg to work on program requirements and research projects during the summer between their first and second year of training.

• *Unique Aspects of the Program*

Research Roundtable: This is a weekly meeting of psychological science program faculty and students to hear presentations and discuss issues related to research, including topics such as the role of mediators and moderators, research design challenges, and ethical issues in research and practice. Once each month the roundtable is used for concentration-specific meetings. In the clinical concentration meetings clinical topics such as prescription privileges for psychologists and the economics of mental health care are discussed.

Presentations: Students present research posters and symposium papers at meetings on campus as well as regional, national, and international conferences. Graduate students in the clinical concentration have presented at professional conferences such as ABCT, APA, ISRCAP and others in Sydney, Honolulu, Vancouver, New Orleans, Boston, and other places. Most students receive some travel support for conference presentations.

Publications: Almost all students in the concentration have co-authored publications including empirical studies, book chapters, newsletter articles, and book reviews during their time in the program.

Funding: All students in the clinical concentration have been fully funded (tuition and stipend) during the academic year and most have been funded during the summer between their first and second year.

Meeting other clinical researchers: Students begin to establish their professional network through faculty-facilitated meetings with clinical researchers from other universities during conferences and during visits by faculty to JMU campus.

Resources: Most students in the concentration have space in comfortable offices with personal computers including the latest software such as SPSS and LISREL.

Exposure to variety of research programs: Faculty in the psychological sciences program who are not associated with the clinical concentration present their research at Research Roundtable meetings, collaborate with clinical faculty, and mentor students who take classes with graduate students in the clinical concentration. These opportunities to interact with other faculty and students outside of the classrooms provide students with a breadth of learning opportunities related to the diversity of psychological research.

• *Student Placement*

Over the last 4 years all graduates of the clinical concentration have applied to clinical or school scientist-practitioner Ph.D. programs and all have been accepted at one or more programs.

• *Contact Information*

WEB SITE: http://www.psyc.jmu.edu/psycsciences/
CHILD CLINICAL: Steven W. Evans, Ph.D., Professor of Psychology (evanssw@jmu.edu)
ADULT CLINICAL: Gregg Henriques, Ph.D., Assistant Professor of Graduate Psychology (henriqugx@jmu.edu)

NORTH DAKOTA STATE UNIVERSITY

Master's Program in Clinical Psychology

Raymond G. Miltenberger and Paul D. Rokke

• *Program Mission and Overview*

The 2-year master's program in clinical psychology at North Dakota State University combines training and mentoring of research skills with training and supervised practice of clinical skills. Our behavior therapy orientation naturally stresses the integration of clinical research and practice. Experiences and training are available in several areas, including behavioral medicine or health psychology; applied behavior analysis; developmental disabilities; and psychological interventions.

The mission of our master's program is to prepare graduates to be successful researchers and clinical practitioners so they can obtain employment in clinical or research settings or entry into clinical Ph.D. programs.

• *Training Model*

Clinical students are required to take a variety of clinical and experimental courses, engage in supervised research with a faculty mentor, and participate in practicum training. The first year of the program is fairly structured and is intended to provide students with the basic skills and knowledge required of behavior therapists. The second year of the program is much more flexible and allows students to individually tailor their training through the selection of practicum placements, elective courses, and thesis topics. Students conduct research throughout both years of the program.

Clinical courses consist of a sequence of behavior therapy and assessment courses, applied research methods, advanced psychological assessment, advanced psychopathology, and child psychopathology and therapy. Other specialized seminars are frequently available as electives (i.e., health psychology, behavior analysis in develop-

mental disabilities). Clinical courses are designed to provide knowledge of the current research literature in various areas and hands-on experience and training in behavior therapy procedures through lab work and projects.

Core courses, intended to ensure that our graduates have a strong background in general psychology, include memory, psychobiology, perception, personality, social, and developmental psychology. All students also take a seminar each term. As a part of this course, we bring in nationally known speakers to present their research and stimulate thinking on current topics.

Practicum training begins immediately in the first term and increases in time, complexity, and responsibility over the 2 years of study. Students begin with didactic and experiential training in general clinical and interviewing skills and basic behavioral assessment and treatment techniques. Later practica involve expanding and practicing these basic skills in a variety of service settings. Practicum settings include a regional human service center, outpatient mental health facilities, the public schools, two general medical hospitals, a neuropsychiatric institute, an inpatient psychiatric unit, a Veteran's Administration Hospital, and two college counseling centers.

A data-based thesis is required in the second year of the program. In preparation for their thesis, students write an area paper at the end of the first year. The area paper is a conceptual review of a specific area of research that sets the stage for a thesis project. In collaboration with their advisor, students develop a thesis proposal, carry out the project, analyze the data, and write the thesis manuscript. An oral defense is required for the proposal and final manuscript.

- ***Unique Aspects of the Program***

The graduate program at NDSU is distinguished from many other master's programs in its emphasis on providing students with substantial experience in research and clinical activities. Most students will be authors on national conference presentations and refereed journal publications as a result of their research in the program. Another noteworthy aspect of our master's program is that we support all of our graduate students financially with a teaching or research assistantship and a tuition waiver.

- ***Student Placement***

Our recent graduates have been accepted into doctoral programs in schools such as West Virginia University; Western Michigan University; University of Florida; University of Nevada, Reno; University of Kansas; Washington State University; University of Wisconsin, Milwaukee; University of Tennessee; University of Arkansas; Texas A & M; University of Montana; Purdue University; Oklahoma State; and the University of North Dakota. Students who opt to work immediately following their master's degree have accepted positions in public and private health and mental health settings. The changing nature of health care delivery has made practice at the M.S. level very possible and attractive in many areas of the country.

- ***Contact Information***

For more information, contact Dr. Ray Miltenberger, Director of Clinical Training, at (701) 231-8623 or ray.miltenberger@ndsu.edu. Students can examine faculty research programs, publications, graduate programs, and other information about the department on the department Web site (www.ndsu.nodak.edu/ndsu/psychology/gradpro/).

UNIVERSITY OF NORTHERN IOWA

Master of Arts in Clinical Science

John Williams

- ***Program Mission and Overview***

The University of Northern Iowa, Department of Psychology, offers a master of arts degree with an emphasis in clinical science. Combining empirically supported, scientifically based clinical training with a solid foundation in clinical research methodology, the program prepares students to pursue a doctoral degree. Faculty members are dedicated to research and actively involve students in ongoing and new areas of study. The program has a strong empirical orientation, emphasizes competence in research methodology, and requires that each graduate student complete a thesis. This reflects the views of department faculty that such training is essential for both educating consumers of psychological research at the master's level and preparing students interested in pursuing a doctoral degree.

In contrast to other clinical or counseling master's programs, the number of students is purposely limited to facilitate intensive training and frequent faculty-student contact. Admission is competitive, with our incoming students averaging over 1,100 on the GRE and over a 3.5 grade point average. Approximately 7 graduate students are admitted to the clinical science emphasis each year.

The clinical science emphasis prepares students to pursue doctoral degrees in clinical or counseling psychology. Given that an empirical approach is adopted, a cognitive-behavioral approach is prominent. Clinical faculty orientation is strongly cognitive-behavioral and stresses the scientific foundations of clinical psychology. Core courses include intellectual assessment, personality assessment, psychopathology, empirically supported interventions, and professional ethics.

Professional skills are developed through intensive practice and supervision within the program and through supervised activities in facilities within the community. Students are placed in a variety of settings including psychiatric hospitals, inpatient and outpatient drug treatment centers, neuropsychology units and clinics, correctional facilities, school settings, children group homes, and the in-house psychological assessment clinic. Within these settings, child, adolescent, and adult populations include the severely mentally ill, substance use problems, neurological conditions, academic disabilities, behavioral problems, and emotional problems. The department also houses The Psychological Assessment Clinic, which allows students to complete comprehensive psychological evaluations for members of the community.

- ***Training Model***

The department fosters a supportive atmosphere in which students work together and with faculty in collaborative relationships. The clinical science emphasis follows the scientist/practitioner model and focuses particularly on research and scientific method. While faculty members may differ in terms of methods of research, therapeutic focus, and areas of study, there is agreement that scientific inquiry should form the foundation of clinical psychology and the education received in this program. An empirical approach is emphasized by all faculty members, and applying research-based evidence to answer applied clinical problems is an essential part of the program. Professional development and identity is strongly

encouraged, with multiple opportunities for conference presentations, membership in professional organizations, and discussions of current topics in the field of clinical psychology.

• *Unique Aspects of the Program*

All faculty within the University of Northern Iowa's psychology department are available for possible research collaborations and thesis committees. In addition, the clinical faculty are active researchers in the following areas: psychological assessment, severe mental illness, psychometrics, health behaviors, and suicide. Students can also work with faculty in areas such as psychology and the law, biological bases of behavior, child development, personal relationships, spirituality, gerontology, and gambling. For additional information on faculty and research, please see our Web site at http://www.uni.edu/psych/grad.

• *Student Placement*

Following completion of the program, approximately half of our students apply to academically based doctoral programs in clinical, counseling, and educational psychology. Of those students who apply, nearly all have been admitted to one or more programs. Most of our students have been successful in waiving their thesis requirement, as well as a few course requirements at their prospective doctoral program, due to their graduate work at the University of Northern Iowa. Students recently have been placed or accepted at Kent State University, University of Kentucky, University of Minnesota, University of Akron, University of Mississippi, and others.

• *Contact Information*

Interested students are welcome to contact the clinical or graduate coordinators, as well as any of the faculty members. Minority and international students are encouraged to apply.

CLINICAL AREA COORDINATORS:
Seth Brown, Ph.D., (319) 273-6091; seth.brown@uni.edu
John Williams, Ph.D.(319) 273-6297; john.williams@uni.edu

COORDINATOR OF GRADUATE STUDIES:
Helen C. Harton, Ph.D., (319) 273-2235; helen.harton@uni.edu

UNIVERSITY OF THE PACIFIC

Master of Arts

Carolynn S. Kohn

• *Program Mission and Overview*

The psychology department at University of the Pacific offers a program of graduate study leading to the M.A. degree in psychology with a behavioral emphasis. We offer two tracks for students: an applied track for those seeking jobs after graduation and a doctoral preparation track for those seeking to enter a doctoral program after graduation. Research and applied experience are emphasized throughout the program. Students complete a research apprenticeship and an empirical thesis. They receive applied experience in the department's Psychology Clinic, learning to do evaluations and therapy throughout the 2-year program. Applied experience is also available in the department's Community Re-entry Program for the mentally disabled, in Valley Mountain Regional Center programs for the developmentally disabled, and in other behavioral and medical/health care settings in the local community. Our program has a strong focus on applied behavioral analysis, behavior and cognitive behavior therapy, and behavioral medicine. We provide practica opportunities in the areas of chronic mental illness, developmental disabilities, childhood behavior problems, behavioral medicine, health psychology, behavior therapy, and brief psychotherapy. Health care issues that can be studied include stress management, management of depressive and anxiety symptoms, behavioral treatment of chronic diseases, and assessment and treatment of brain dysfunction. Students also work in the on-site clinic with adults and families who are experiencing parent-child problems, depression, ADHD, anxiety, relationship problems or who are requesting custody, or other types of psychological evaluations. Our program is intended to provide extensive experience with behavioral/clinical/health care techniques; intense involvement in designing, conducting, and evaluating research; course work in theoretical and research foundations of behavioral psychology; and commitment to the development of student potential by active, supportive, involved faculty.

Students must complete 26 units of course work and 4 units of thesis, for a total of 30 units (normally 18 the first year, and 12 the second year). Full-time students are expected to spend four semesters and one summer in residence in Stockton as part of completing their program of studies. All students complete a 1-year research apprenticeship during the first year, and have the option of choosing to continue as a research apprentice in their second year. Students also typically complete a 2-year internship in the Psychology Clinic. We typically accept 7 to 10 students per year, allowing the faculty to give each student individualized time and attention.

The mission of our program is to focus on behavioral psychology, including applied behavior analysis, cognitive behavioral therapy, and behavioral medicine/health care. We provide students with multiple opportunities to gain applied experience, e.g., department-based Psychology Clinic, Community Re-entry Program, contracts with Valley Mountain Regional Center and Stockton Unified School District, as well as research experience. We provide excellent M.A.-level preparation for doctoral work, with a course in research design, a minimum 1-year research apprenticeship, an empirical thesis requirement, and strong emphasis on presenting research at conferences and publishing in peer-reviewed journals, providing the kind of research experience that doctoral programs seek in their applicants. We provide graduate students with ample opportunities to supervise undergraduates who are learning behavioral techniques, giving M.A. students supervision experience that will help them obtain quality jobs or secure positions in doctoral programs. Finally, our mission is to provide these opportunities to M.A. students, giving them a strong foundation for doctoral work, without the added stressor of student loans; therefore, we provide students with strong financial support while they work on their M.A., including a substantial tuition remission and stipend resulting in a total financial package of $20,000+ per year.

• *Training Model*

Our training model is based on the Boulder scientist-practitioner model. M.A. students are encouraged to use scientific inquiry in their applied work and also to raise applied questions to be answered by conducting research. We also provide our M.A. students with teaching and supervising experiences, knowing that many of them will

go on to teach and supervise in their doctoral programs and/or in their careers. We also believe that faculty should serve as models for students, and faculty actively conduct and present their research at regional and national conferences and provide the necessary resources for graduate students to conduct their own research.

• ***Unique Aspects of the Program***

Unique aspects of our program include strong training in applied and research skills, varied teaching and supervising experiences, a tight-knit and supportive faculty, and a strong financial aid package. We have a flexible program that meets the needs of diverse students whose goals are either to obtain employment or enter into a doctoral program upon graduating.

• ***Student Placement***

Nearly all of our graduates have been either accepted into doctoral programs or obtained employment after graduating. Since 1999, 28% of our students have been accepted into doctoral programs nationwide in clinical psychology (17%) and related fields (11%), including health psychology, behavioral analysis, and educational psychology. Over half of our graduates (56%) have obtained employment in the field of behavioral analysis, including becoming clinic directors, private vendors, and program coordinators. Other students have gone on to become research assistants (8%), special education teachers (2%), and behavioral medicine specialists (6%).

• ***Contact Information***

Carolynn Kohn, Ph.D., BCBA, Assistant Professor, Director, Graduate Program in Psychology, Co-Director, Psychology Clinic, University of the Pacific, Department of Psychology, 3601 Pacific Avenue, Stockton, CA 95211; 209-946-7316; ckohn@pacific.edu.

WAKE FOREST UNIVERSITY

Master of Arts

Dale Dagenbach

• ***Program Mission and Overview***

The psychology department at Wake Forest University offers a 2-year research-oriented general master's degree program. The program is small by design, with typical classes of 12 students per year (24 total) and a student-faculty ratio of less than 2:1 so that each student can receive extensive individual attention.

The program includes extensive research experience and course work. The research includes a first-year research apprenticeship and project and a second-year thesis. In addition, small stipends are available to support summer research between the first and second years.

The course work consists of eight core courses and one elective. The eight core courses are statistics and research methods (2), developmental, cognitive, social, biological, learning and motivation, and personality.

The program is designed primarily to prepare students for further doctoral training in any area of psychology. Students typically choose to come to this program because they want more experience before committing to a Ph.D. program in a given area or because they want to enhance the likelihood of their acceptance into a top-tier Ph.D. program in any area of psychology, including clinical. In addition to preparing students for doctoral training, the strong research emphasis of the program also provides a good foundation for employment as a research project manager or technician.

• ***Training Model***

The research training follows an apprenticeship model. Students are assigned to a faculty advisor at the beginning of the first year on the basis of mutual research interests, with strong weight given to the student's preferences. Individual research supervision varies according to the particular faculty mentor, but in all cases a first-year research project is conducted that culminates in a presentation to the psychology department at the end of the first year. Most of these also become future publications and/or conference presentations.

The second-year thesis process has three steps: A literature review paper is first required, followed by a thesis prospectus, and finally submission of the thesis itself after the data have been collected and analyzed.

• ***Unique Aspects of the Program***

There are a number of unique aspects of our program. First, computer facilities and support are very strong. We are one of the most wired (and now wireless) campuses in the United States, and each student is given his or her own IBM Thinkpad laptop computer upon arrival. Students have ready access to the latest integrated office and statistical software, a graphics lab, and connection to the campus mainframe.

The facilities also are noteworthy. In 1999, the psychology department moved into over 30,000 square feet of space for offices, classrooms, and labs in Greene Hall, a beautiful, brand-new high-tech classroom building. Space in Winston Hall was also renovated for animal research. There is generous office and lounge space for students, as well as a convenient departmental library.

For those interested in the biological and clinical sides of the field, there are possible connections with the Wake Forest University School of Medicine and affiliated graduate programs. A number of current faculty have collaborations with colleagues at the medical school, and student theses often come out of those collaborations as well.

• ***Student Placement***

Approximately 70% of students in our program go on to Ph.D. programs. Eight of the 12 members of last year's class, which was fairly typical, went on for Ph.D.s at University of Georgia (school), American University (clinical), University of Pittsburgh (health), Rice University (industrial-organizational), Duke University (social), University of Kentucky (cognitive), and Kent State University (cognitive).

• ***Contact Information***

Students interested in obtaining further information may visit the Web site at www.wfu.edu/academics/psychology/grad/index.html. You also may contact the Director of Graduate Studies, Dr. Dale Dagenbach, at dagenbac@wfu.edu or (336) 758-5740. ✍

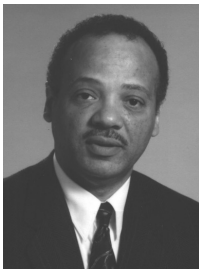
on-line

MENTOR PROGRAM

The Student SIG is proud to announce its upcoming mentors:

SEPTEMBER: Michael Zvolensky
OCTOBER: Michael Otto
NOVEMBER: Patricia Resick
DECEMBER: Gayle Iwamasa

To join the Student SIG and its listserve, send an email to Todd Smitherman: smitht7@auburn.edu.



1944–2005

In Memoriam

More Memories of Sam Turner

This tribute is continued from the June issue of tBT.

Nancy Heiser, Ph.D., *Independent contractor, Maria Cohn, Ph.D. & Associates (graduate student, University of Maryland College Park, 1998–2004)*

On December 19, 2004, after being my major professor and mentor for nearly 7 years, Dr. Samuel M. Turner "hooded" me at my graduation ceremony at the University of Maryland, College Park. I came to realize much too soon afterwards just how momentous and bittersweet this ceremony was. At his memorial service in Georgia, when fellow psychologists were asked to stand in honor of Dr. Turner as a talented, accomplished, dedicated, and veracious psychologist, it took me a moment to realize that I could stand. I had graduated from student to colleague and was proud to stand among the many psychologists who had followed in his footsteps, felt the power of his influence, and appreciated his unyielding pursuit of academic and clinical excellence.

I first met Dr. Turner when I knocked on his door, the day we both arrived at the University of Maryland, and asked him if he needed a research assistant. I was slated to work with another faculty member, and Dr. Turner, in his forthright manner, made it clear that if I wanted to work with him, it was all or nothing—I'm with him or I'm not . . . and that is the way it went. As we worked closely together crafting presentations, conducting literature reviews, preparing grants, and establishing the Maryland Center for Anxiety Disorders, among the many other demands and responsibilities of academia, I came to learn that Dr. Turner was supportive and encouraging but also forceful and demanding. I came to learn that actions mattered, not words. There was no wiggle room in his lab; the standards were clear and enforced.

More importantly, however, I learned that Dr. Turner had an unwavering confidence in me. He never questioned my ability to become a researcher and a clinician. I learned over time that he was more observant and accepting of my strengths and weaknesses than I ever imagined. When I began clinical work with my own apparent severe anxiety, keeping with his theoretical model, he did not talk to me about it or raise it as an issue, but instead, had me continue to do the work, over and over. And so, I learned firsthand that exposure does work. Dr. Turner taught me the tenets of behaviorism and the merits of behavior therapy, primarily through his detailed, perceptive, and pointed conceptualizations of clinical cases during many lengthy and challenging supervision sessions.

Although Dr. Turner kept his relationship with students very professional, I became attached to him. He had a very soft side and reached out to me in his private, quiet way. I remember him calling me to his office in a firm voice, only to find him waiting to show me a digital picture of his granddaughter on his computer. I thought he might cringe at the news I was pregnant in the middle of my graduate career, lest it slow down my research productivity, but instead, he spent considerable time convincing me to take a full semester of maternity leave, rather than just 6 weeks. And, Dr. Turner made me laugh—from the stories he told about growing up in the deep South, the rewards and toils of graduate school and an academic career, and his many and wide travels, to his wit about human nature.

I hope Sam knew, through my actions, behaviors, and loyalty, what a special place he holds in my life and my heart. I suspect he did. I feel his presence in everything I do today as a psychologist and I will miss being able to call on his guidance and strength during my career. I continued to work in his research lab after my graduation, in part to avoid saying goodbye. But, now, after truly being with him, giving him my all for 7 years, I have to say goodbye. I will miss him dearly, as will others who respected him, felt an attachment to him, and came to know and appreciate his generous and gentle side.

Robin Yeganeh, M.A., *University of Maryland at College Park (research assistant and graduate student, University of Maryland, College Park, 1998–2005*)

I worked with Dr. Sam Turner on a daily basis at the University of Maryland at College Park while under the primary mentorship of Dr. Deborah Beidel. My life has been greatly influenced as a result of their investment in my training. I first worked with Dr. Turner as an undergraduate research assistant and soon after as a doctoral student conducting research and treating anxiety disorders. The following are just a few thoughts that cross my mind when I reflect on what I know of my second mentor. Dr. Turner was a true behaviorist and made sure that, at a minimum, his students understood how to incorporate an empirical approach into the practice of psychotherapy. He had a very strong personality and held his beliefs and opinions with a sturdy grip. When he was asked for his opinion, he was not shy about giving it. Dr. Turner also had extremely high expectations for his students because he wanted his lab's treatments and research to be done in the way he considered proper. When Dr. Turner acknowledged me for my work in evaluation letters, it meant a lot because he was not the type to give compliments loosely.

Since his passing, I have spent a great deal of time reflecting on the 7 years that I knew Dr. Turner. I realize now that the amount of time and effort that he was willing to put into just one student or one clinical case was exceptional. Commonly, Dr. Turner spent 45 minutes or more on a student's case conceptualization. I believe this was because he had a genuine need to teach what he believed was the best treatment, no matter how long it took the student to "get it," or how many times he had to explain his theory. I think most people who have worked for Dr. Turner found it both challenging and intellectually stimulating. Although most people knew Dr. Turner as the accomplished clinical psychologist and researcher, most did not know of his personal characteristics outside of the workplace.

When I visited Dr. Turner in his home around the holidays, I had the pleasure of seeing a different side of him. He and his wife always greeted me with warmth, and were most gracious. He always had a kind smile on his face. We spoke of politics, world cultures, history, and music. He was well read in many areas of science and anthropology and this made for interesting conversations. As a host, Dr. Turner put his status aside and asked students what they would like to drink. He was a multifaceted man, and I regret that I will not be able to develop a more casual relationship with him at the conclusion of my graduate training. The thought that he will not be there when I defend my doctoral dissertation this summer is painful. I will always be thankful for the energy he put forth to train me. I will miss Dr. Turner's guidance and looks of approval. Most of all I will miss the times when we laughed together.

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Courtney Ferrell, Ph.D., *National Institute of Mental Health (graduate student, University of Maryland, College Park, 1999–2004)*

I remember the first time that I met Dr. Turner; he was sitting back in his office, listening to jazz, and tapping his foot. To me, this was an amazing sight, because it was the first time that I had the opportunity to work with a professor who looked like me. I had spent all of my education before graduate school in locations where I did not have a role model of color. Dr. Turner was about to become the first prominent African American role model in my life, aside from my parents. I did not realize the impact that this would have until much later in my graduate career. I knew that it was going to be important to see Dr. Turner in his leadership role and know that it would be possible for a minority person to hold a position like his, but I soon came to realize that having him as a mentor would mean much more.

Dr. Turner played a large part in why I did so well in graduate school. Although there were several challenges along the way, from course work to clinical work to research, nothing was as challenging as living up to Dr. Turner's expectations. I grew up in a family where high expectations were the norm, but I still was not quite prepared for the ones that Dr. Turner had for me. He always pushed me just a little bit further than even I thought I could go. For that, I am grateful. He was always candid, regardless of whether it was a job done well or a job done not so well. When Dr. Turner gave me a compliment, I knew that I had really done something well. It came to the point where I could not even think about turning in something that was not my best work. Hearing from Dr. Turner that he was proud of me or that he thought I would be an exceptional psychologist, meant too much to me for me to take for granted. I wanted to live up to each and every expectation that he had for me.

I also have several great memories of Dr. Turner's "warm and fuzzy side," a side that many students did not get the chance to see. For example, on my first trip to South Carolina to collect data for one of the grants, I was feeling somewhat down about the fact that I would be spending my birthday away from family and friends. But Dr. Turner was nice enough to make dinner reservations for all of us at his club. When we arrived at the restaurant, there was a card at my place that read HAPPY BIRTHDAY! I was really touched that he had remembered. Of course, there were also the candid camera moments that I first discovered on this same trip to South Carolina. Dr. Turner loved to take pictures of people, but not just your ordinary "smile for the camera" pictures. He loved to capture people when they would least expect it. For example, there are several shots of me making weird faces as I am conducting a social skills therapy group with socially anxious youngsters.

And then there was the Christmas party at his house where I discovered the "cool side" of Dr. Turner. I often think back to my total amazement when looking through his CD collection, I recognized CDs from the latest R&B singers like Alicia Keys and Jill Scott. All I could think was, "Wow, is Dr. Turner really this cool?"

I smile as I sit here and write about these memories of Dr. Turner and hope that they will bring a smile to others who knew him well. I shall miss him greatly, but I am forever thankful for the time that I have known him and for what he has brought to my life. I will remember the expectations that he had for me and will continue to use them to push myself forward just a little bit more. And who knows, maybe one day I can be the mentor to someone else that he was for me.

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Kimberly Adams, M.A., *University of Maryland, College Park (graduate student, University of Maryland, College Park, 2001–2005)*

I will remember Dr. Samuel Turner as a man I was proud to have known. I liked him from the moment that I met him—in his office during the interview process at the University of Maryland. At that time, I was completely unaware of his fearsome reputation, both as a brilliant researcher and intellectual, and a man who only the foolish would dare to cross. Thus ignorant, I was quite comfortable in his presence and we settled in for a brief and friendly chat. I left his office with a very good feeling—the feeling that I would be accepted into the program. And I was. I believe that it was largely due to his influence.

By the time I became acquainted with Dr. Turner's reputation, it was too late—I liked him too much to be intimidated by him. I came to look upon him as a mentor, even though I didn't get a chance to see him nearly as much as I would have liked, largely due to our busy schedules and our locations in different buildings. However, when I was going through a difficult time in school that caused a crisis of confidence and a deep uncertainty regarding my abilities, Dr. Turner demonstrated the depth of his kindness by consoling and encouraging me, reminding me that I *was* capable because I had been admitted into the program, and stating that he was completely confident that I would persevere and ultimately be victorious. Throughout my years in the program, he occasionally commented on my dedication, insight, and intelligence—always at the times when I needed it the most. Everyone who has been a graduate student in a similar program knows that encouragement comes rarely, and when it comes, it is often sparse. Therefore, positive comments from a man of his standing were surprising and gratifying, much more so than he could ever have known. I think I will best remember Dr. Turner for his constant support, timely comfort, and unlimited faith in my abilities. His tough exterior shielded a heart that was gentle, benevolent, humorous, and wise. In my opinion, he was a prince among men. He will be greatly missed.

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Will M. Aklin, M.A., *University of Maryland, College Park (graduate student, University of Maryland, College Park, 2001–2005)*

It is with great humbleness and honor that I share my reflection of what Dr. Samuel Turner has meant to me. Over the 4 years that I knew Dr. Turner, he influenced my life immensely. I valued his opinion from the time that I interviewed with him for admission into the University of Maryland clinical program to our most re-

cent meeting about my dissertation project. Dr. Turner is the type of person after whom I want to model myself. He inspired me as an African American male and continues to provide an excellent example of what hard work, dedication, and perseverance can produce. To me, this is so important, as there are relatively few minority clinical psychologists, and the number becomes even smaller when it comes to African American male clinical psychologists. In this way, I feel very fortunate to have worked with and learned from one of the best. Ultimately, he has inspired me to become a great clinical psychologist.

Dr. Turner motivated many undergraduate and graduate students to reach their full potential. He also inspired clinicians and researchers, as he moved the field of psychology to new directions through his articles, books, presentations and intriguing ideas. But more importantly, he was a trailblazer. Dr. Turner was the first African American to receive a Ph.D. in clinical psychology from the University of Georgia. In addition, he contributed significantly to transforming the once community/clinical psychology program at the University of Maryland to a well-renowned clinical psychology program (which is now in the top echelon of clinical programs in the nation). He set the bar high for himself, his students, and others around him. This alone influenced my work tremendously.

By setting the bar high, I had to perform my best to meet his expectations. His expectations, in turn, elevated me and my ability to work hard and put forth work that I did not know was possible. In my first class with Dr. Turner, Introduction to Clinical Psychology, I recall him saying, "Job well done!" in reference to a presentation I had done. This was a very rewarding moment for me. He also went out of his way to congratulate me for successfully proposing and defending my master's thesis even though he was not the chair of the committee. After being elected student representative to the clinical faculty, he highlighted the magnitude of this position and told me how proud he was of me. This was equally rewarding. Having served as a liaison between the clinical students and faculty, I was required to conduct meetings and normally wore business attire. A number of colleagues jokingly called me "Dr. Turner's clone." They were not aware, however, that their jokes were actually compliments. Aside from being known for his profound insight and brilliance, Dr. Turner was always well-dressed and very polished.

Though this is a very poignant moment for me, I am at ease for a number of reasons. Dr. Turner was one of our most devoted, visible, and visionary leaders, and he put forth a noble legacy that will not be forgotten. His influence will continue to be felt throughout ABCT and the entire profession of psychology. Most importantly, I am at ease because I had the chance to express to him what a great mentor he was to me and how much he has influenced my short career. I also had the chance to thank him for his helpful comments and suggestions on my comprehensive exam paper and countless other times that he lent his support. I can only hope that Dr. Turner knew how great of a role model he has been to me and how much he was and is still appreciated. The field of psychology has not only lost a great clinical psychologist, but a confident yet humble human being. His career will be noted as one marked by excellence.

Indeed, the thing that most impressed me about Dr. Turner was that he reached unbelievable heights not because of who he was or the popularity that he experienced, but because of the unrelenting work and academic vigor that he brought to every endeavor. As I embark on the final stages of my graduate career, with my dissertation project and internship selection in near sight, I now have a better sense of the type of work that is acceptable in Dr. Turner's view, after having worked so closely with him. I know I have my work cut out for me, but I am ready for the challenge. I will continue to make him proud. His legacy will live on and so will his influence.

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Yamalis Diaz, B.A., *University of Maryland, College Park (graduate student, University of Maryland, College Park, 2002–2005)*

In the short time I knew him, I came to regard Dr. Turner as a mentor. When I arrived at the University of Maryland in Fall 2002, my first impression was that he was "the boss." Dr. Turner earned and deserved the level of respect that students and faculty alike showed him. On the other hand, I was immediately comfortable talking with him about clinical and professional issues. Through these interactions, I came to admire Dr. Turner as a personal mentor. He was willing to discuss many aspects of clinical psychology with me, despite the fact that he was always very busy and he was not my faculty advisor. He also kept me informed about upcoming opportunities that might enhance my graduate school experience. Indeed, he told me about an NIH minority fellowship and later agreed to serve as a senior research mentor for that fellowship. When I asked him to serve on my Master's committee, he readily agreed. Soon after, he became ill, but true to form, he asked for a copy of the thesis so that he could provide feedback. It always surprised me that he took the time to do things like this for me considering the number of commitments he already had.

In addition to these interactions, I very much enjoyed my first graduate class, Introduction to Clinical Psychology, with Dr. Turner. In class, students were asked to present summaries of different articles. He often joked about the unusually long amount of time it took me to summarize an article, pointing out that I had essentially rewritten each sentence and had managed to be more verbose than him! This became a running joke in the class. During moments like this, I noticed that while Dr. Turner was certainly "the boss," who presented a very professional demeanor at all times, he had a very kind and good-humored manner that some may have missed. But it was always obvious to me.

Along with his endless contributions as a distinguished researcher and mentor, Dr. Turner's commitment to minority students is worthy of particular tribute. In the 3 years I have been at the University of Maryland, I have become convinced that Dr. Turner was dedicated to increasing the representation of minority students in this program. In fact, most of the current minority students were admitted when he was the Director of Clinical Training. I greatly admire and respect him for this given the lack of minority representation in the field as a whole.

I have nothing but fond memories of Dr. Turner. Given his role in my graduate school experience and professional development to date, I will always regard him as a mentor and hold him in very high regard. Though his passing leaves many people deeply saddened, I am comforted in knowing that his contributions to the field of psychology and his impact on many students will always be remembered.

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Tyish S. Hall Brown, M.A. *(graduate student, University of Maryland, College Park, 2002–2005)*

As always, when someone touches your life in a special way, it is hard to say goodbye. Dr. Turner was an inspiration to me in more ways than one. He took a chance on me as a student with little research experience and gave me an opportunity to pursue

a lifelong dream of becoming a clinical psychologist. He was an excellent mentor, with incredible patience and a tremendous gift for teaching. Dr. Turner had a way of guiding me through difficult tasks and challenging me to the limit, while supporting me every step of the way. He was a stern advisor at times, critically evaluating tasks. Yet, he freely gave compliments when he felt they were deserved. He was a courageous man, voicing his opinions despite what others thought. Dr. Turner commanded respect through both his actions and his words. His strength was unyielding as he went about his daily activities despite his illness. He never once complained or abandoned his responsibilities as an advisor even at the very end. I am proud to have been his student, and I take this chance to celebrate his life.

It is amazing to think about how many lives Dr. Turner has influenced in a positive way. Through his research, clinical work, conference talks, teaching, and mentorship, thousands of lives have been improved and inspired. I know that mine has been. I will always remember him for his sharp suits and matching accessories, his warm laugh, and his brilliant mind. I am so thankful to have had the opportunity to learn from him, and I will always strive to follow in his footsteps, footsteps that pointed toward excellence.

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Brooke Stipelman, B.A., *University of Maryland, College Park (graduate student, University of Maryland, College Park, 2003–2005)*

Although Dr. Turner was only my mentor for the last year and a half, I gained an immeasurable amount of admiration for him as a teacher and a person. He was a brilliant scientist and clinician who was always very devoted to his students, despite his hectic schedule. Even as he was sick and dealing with his own personal issues, he always made time for me and was willing to put aside what was going on his own life to help me with whatever I needed. One time when I went to him with a question regarding a complex theory, he took the time to sit with me and explain until I understood. From that time on, without my prompting, he occasionally left relevant book chapters and articles in my mailbox with notes attached, explaining how these readings tied into the conversation we once had. It was a small gesture, but very meaningful because it made me feel like his students were special to him, and that he thought of us even when we were not around. It was important to him that we were educated beyond just a superficial level, which set him apart from other mentors. I will also miss Dr. Turner's colorful stories about patients he once treated. He had a story for almost any situation. He had a wonderful sense of humor, and his anecdotes often added a touch of levity to our meetings.

Dr. Turner was truly a gifted and inspirational faculty mentor for whom I have nothing but profound respect. With his passing, the field of clinical psychology has suffered an incredible loss. Although I would have enjoyed spending the remainder of my graduate school career under his guidance, In the year and half that I had the pleasure of working with him I learned from someone who truly enjoyed his work and was eager to share his enthusiasm and expertise with others. I will take away valuable knowledge that I hope to one day share with others and fond memories that I will always hold in my heart. He will be missed.

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S. Lloyd Williams, Ph.D., *University of Basel, Switzerland (Postdoc, University of Pittsburgh, 1982–1984)*

I would like to say a few words about Sam Turner. He was an important mentor and teacher to me, an inspiring model of clinical and research excellence who had a lasting impact on my work. Under Sam's mentorship, I completed a postdoctoral fellowship from 1982 until 1984 in the Anxiety Disorders Clinic Sam directed within Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh. It was under his guidance during this period that I learned most of what I know about conducting psychopathology and psychotherapy research in a large clinical research setting.

Sam always had good advice, both scientific and parascientific. He was always supportive of my work and my career. In fact, he offered me more generous support than I was wise enough to accept. He thought that given my interests, my background training in experimental personality and psychopathology research could profitably be supplemented by broader general clinical psychology training. So he offered to structure and direct 1 year of my 2-year postdoc as a psychology internship similar to the predoctoral internship that he directed at WPIC. Despite my declining to accept his generous offer and the wise counsel that went with it, Sam remained my warm supporter and friend throughout the post-doc and beyond. Sam could sometimes be stern when a trainee or intern had fallen short, but he was gentle with me. I felt from him only the power of positive reinforcement and positive modeling and instruction. We collaborated fruitfully on several research projects on the nature and treatment of anxiety disorders, and he helped me make the transition from graduate student to assistant professor in ways too numerous to count.

An historical footnote of yet another of Sam's lasting contributions to anxiety research is his critical part in the 1983 birth of the annual abstracts book of the ABCT Anxiety Disorders Special Interest Group, now in its 22nd year. Dianne Chambless was chair of what was then the AABT Phobia SIG, and she asked me to compile for the SIG a list of anxiety-related papers from the past year. I thought it a good idea to not just list the citation data, but reproduce the abstracts too. Sam supported the project, and the result was the first annual abstract book, compiled and published in the WPIC Anxiety Disorders Clinic, but anonymously and without acknowledgement of Sam's or the Clinic's part in its creation.

Sam's premature death grieves me deeply. It is also a grievous loss for those with anxiety-related problems, whose suffering he so passionately wanted to alleviate. ✍

ABCT Convention Returns to Our Nation's Capital

Kelly J. Rohan, Local Arrangements Chair, *Uniformed Services University of the Health Sciences, Bethesda, MD*

Mark your calendars—ABCT's 2005 annual convention will be held November 17–20 in Washington, DC! With its backdrop of monuments and memorials, neoclassical government buildings, museums, eclectic neighborhoods, world-class restaurants, lively nightlife, and a performing arts scene second to only New York City in theatre seats, Washington represents an ideal convention city. Whether you are an ABCT newcomer or convention veteran, you are sure to enjoy this year's exciting ABCT convention program as well as spending time in our nation's capital.

Hotel and Immediate Surroundings

The meeting will take place at the Hilton Washington (1919 Connecticut Ave. NW; 202-483-3000). The Hilton is located in the vibrant, cosmopolitan Dupont Circle neighborhood known for its charming Victorian row houses, many of which have been converted into embassies, ethnic restaurants, sidewalk cafés, coffee bars, boutiques, bookstores, or private art galleries. The area features some unique museums including The Phillips Collection, the first modern art museum in the U.S., featuring works by Cezanne, Picasso, and Renoir, to name a few. The centerpiece of the Dupont community—an urban park with the white marble Dupont Memorial Fountain—will undoubtedly provide interesting people-watching opportunities between convention activities.

Planes, Trains, and Automobiles: Getting to DC

With its comprehensive air and rail service, it is relatively easy to get to Washington, DC, from just about anywhere in the world. The closest airport is the Ronald Reagan Washington National Aiport (DCA). A cab to the Washington Hilton will cost $18, plus tip. SuperShuttle is available at $12, and if you are traveling as a group additional people on SuperShuttle are $8 each. Two other airports serve the DC area: Dulles Internationaal (IAD) is 26 miles west of DC and a taxi ride of approximately $40 and Baltimore/Washington International Airport (BWI) is 30 miles east of DC and a taxi ride of approximately $45.

There is a full schedule of Amtrak trains into DC's Union Station and a taxi to the hotel will run $11. To make your SuperShuttle reservation, call 1-800-BLUEVAN.

Public Transportation: The Key to Getting Around in DC

Once you've arrived, Metrorail (A.K.A. "the Metro") and the Metrobus system provide the most efficient means to get around Washington, DC. Brown pylons, capped with an "M," mark the Metro station entrances. The five Metrorail lines are color coded (red, yellow, blue, green, and orange), and maps highlighted by colored stripes indicate the available lines at any given station. From the Hilton, simply walk four blocks south on Connecticut Avenue to Q Street to locate the Dupont Circle Metro Station (on the red line). The Metro opens at 5:00 A.M. on weekdays and at 7:00 A.M. on weekends and closes at midnight Sunday–Thursday and at 3:00 A.M. Friday–Saturday. One-way Metrorail fares vary with time of day and distance traveled and range from $1.35 to $3.90.

Weather

In November, the average high temperature in Washington, DC, is 57 degrees Fahrenheit. The average low average temperature is 39 degrees Fahrenheit.

On Being a Tourist in DC: Things to Do

As you might imagine, Washington, DC, plays host to a constantly revolving series of events and opportunities for entertainment ranging from the arenas to the small club venues. The Friday *Washington Post*'s Weekend section and *Washingtonian* magazine are great local resources to find what's hot and happening. You can also visit *Washingtonian* magazine's Web site (http://www.washingtonian.com) and click on ARTS AND ENTERTAINMENT for a local calendar of events or the *Washington Post*'s Web site (http://www.washingtonpost.com) and click on ENTERTAINMENT GUIDE.

The National Mall

If it is your first time in DC, you will probably want to set out for the National Mall to tour its well-known monuments and memorials. Affectionately known as the "nation's front yard," the Mall occupies the space between the Potomac River and Reflecting Pool. Here, among other things, is where you will find the Washington Monument; the Lincoln, Jefferson and Franklin Delano Roosevelt Memorials; the Korean War Veterans Memorial, and the Vietnam Veterans Memorial. For information about visiting the Mall, contact the National Park Service (202-426-6841; http://www.nps.gov/nama/index.htm).

The newest addition to the Mall is the National World War II Memorial (17th St. & Independence Ave., NW). Opened to the public in 2004, this dramatic and powerful memorial is flanked by the Washington Monument to the east and the Lincoln Memorial to the west. The memorial's features include two 43-foot arches, fifty-six 17-foot granite pillars for each state and territory, and the Freedom Wall of 4,000 sculpted gold stars honoring those who died.

A word to the wise: There is a tremendous amount of walking involved in touring the Mall area. Wear comfortable shoes and attire. The visual phenomenon that manifests while touring the Mall is the opposite of the rearview mirror effect of "Objects are closer than they appear." When at one attraction, the others are deceptively farther away than they appear. I find this to be particularly true of the Capitol Building.

Hopping aboard a sightseeing trolley is a good way to take in a lot of the congressionally authorized park icons and government buildings in a short period of time. Tourmobile Sightseeing (202-554-5100; http://www.tourmobile.com) offers 40 stops around the Mall area and Arlington National Cemetery (Kennedy graves and Women in the Military Memorial). Tourmobile's unlimited all-day reboarding allows you to customize your trip. You choose where you'll stop, how long to stay, and where to go next. Tourmobile operates 9:30 A.M.–4:30 P.M. daily. You can purchase Tourmobile tickets online or buy them at the Washington Monument Kiosk (1401 Jefferson Drive, NW).

An elegant and efficient way to see a lot of stuff is to take a dinner cruise. The monuments look splendid when they are illuminated at night. The Odyssey (www.odyssey.com, 1-888-741-0281) leaves from Gangplank Marina (6th and Water Streets, SW). Monday–Thursday board at 6:00 P.M., cruise 7:00–10:00 P.M. for $81; Friday ($88) and Saturday ($94) board at 7:00 P.M. and cruise 8:00–11:00 P.M.; and Sunday ($81) board at 5:00 P.M. and cruise 6:00–9:00 P.M. The Odyssey also offers brunch cruises on weekends for $52 with 11:15 A.M. board and 12:00–2:00 P.M. cruise.

Smithsonian and Museums

The Smithsonian Institution Museums (202-633-1000, www.smithsonian.org; all open daily, 10:00 A.M.–5:30 P.M.) is a complex of 15 museums, encompassing over a dozen buildings and the National Zoo. Some of the most popular Smithsonian museums include the National Air and Space Museum (Wright Brothers' 1903 Flyer, Apollo 11 lunar command module, Albert Einstein Planetarium), the National Museum of Natural History (dinosaur fossils, the 45.5-carat Hope Diamond, insect zoo), and the National Museum of American History (flag that inspired the Star Spangled Banner, first ladies' inaugural gowns).

At the National Zoological Park, you can view thousands of exotic animals, including two giant pandas, and, after many failed mating attempts and much anticipation, the new baby boy panda. Hopefully by November, Mama panda, Mei Xiang, will be comfortable leaving her cub, born on July 9, from time to time so visitors can get a look at him. The National Museum of the American Indian, the newest of the Smithsonian museums, opened its doors in September 2004. The museum features exhibitions on the ideas and experiences of indigenous peoples from across the Western Hemisphere. Please note that the Smithsonian American Art Museum is closed for renovations until 2006.

Book early for the National Holocaust Memorial Museum (100 Raoul Wallenberg Place, SW; 202-488-0400; www.ushmm.org/museum; open daily 10:00 A.M.–5:30 P.M.). Passes, which are free, can be ordered in advance with a convenience fee at http://www.tickets.com or 1-800-4000-9373. Also book early for the new and popular International Spy Museum, which opened in 2002 (800 F St., NW; 202-EYE-SPY-YOU; www.spymuseum.org; open daily, 10:00 A.M.–6:00 P.M. with last admission at 4:00 P.M.; $14 general admission). The Spy Museum is the world's only public museum dedicated to espionage, with a large collection of international espionage artifacts.

Art Galleries

European and American masterpieces and the only Leonardo da Vinci painting in North America are on display at the National Gallery of Art (On the Mall at 3rd & 7th Streets on Constitution Ave., NW; 202-737-4215; http://www.nga.gov; open Monday–Saturday, 10:00 A.M.–5:00 P.M. and Sunday, 11:00 A.M.–6:00 P.M.). The National Gallery also has an outdoor sculpture garden featuring bold works and an ice-skating rink, open November–April. The Corcoran Gallery of Art (500 17th St., NW; 202-639-1700; www.corcoran.org), DC's oldest art museum, is known for its distinguished collection of modern American art and European paintings and sculptures [open Wednesday–Sunday 10:00 A.M.–5:00 P.M. (to 9:00 P.M. Thursday) and closed Monday and Tuesday; admission $6.75 for adults and free for children].

Theatre

Thursday through Saturday nights during the convention, the John F. Kennedy Center for the Performing Arts (2700 F Street, NW; 1-800-444-1324; http://www.kennedy-center.org) will feature the Washington National Opera's presentation of Gershwin's *Porgy and Bess*.

Nightlife and Music Scene

The U Street neighborhood became known as "Black Broadway" because several leading pioneers of jazz music trained and performed there, including Duke Ellington, Cab Calloway, and Ella Fitzgerald. Today, U Street is a growing destination for jazz aficionados and is seeing a revival with a resurgence of nightclubs, renovation of its historic buildings, and a new Metro stop (U Street Cardozo Station on the green line).

Adams Morgan (18th St. & Columbia Rd., NW; Woodley Park-Zoo/Adams Morgan Metro stop on red line) is the young professionals' favorite hotspot for music, dancing, and bars in DC. Adams Morgan is a funky, eclectic neighborhood offering diverse options for late-night entertainment. Georgetown offers a lively night scene that caters to a slightly younger (college-aged) crowd. Georgetown is not accessible via Metro; however, you can take the Georgetown Metro Connection from the Dupont Circle Metro station at the corner of Sunderland and 19th St., NW. Buses leave every 10 minutes, and fares are $.35–$1.00.

Shopping

The 19th-century row-house neighborhood of Adams Morgan, noted above for its nightlife, offers a Bohemian shopping experience in a multicultural bazaarlike atmosphere. An impromptu stroll around Adams Morgan will be memorable for its bustling boutiques and hip specialty stores. Georgetown Park (3222 M St., NW; 202-342-8190; www.shopsatgeorgetownpark.com) is a multiple-level shopping center that houses over 100 boutiques and shops (open Monday–Saturday, 10:00 A.M.–9:00 P.M.; Sunday, noon–6:00 P.M.). As the name implies, the Old Post Office Pavilion (1100

Pennsylvania Ave., NW; 202-289-4224; http://www.oldpostofficedc.com) is a former post office. It is now a shopping center with an international food court, crowned by a dramatic 315-foot clock tower (open Monday–Saturday, 10:00 A.M.–7:00 P.M.; Sunday, noon–6:00 P.M.).

To immerse yourself in a unique DC shopping experience, visit Eastern Market (225 7th St., SE; www.easternmarket.net). Eastern Market is an amazing open-air European-style market on Capitol Hill and the sole survivor of DC's 19th-century markets. Surrounded by colorful flower stands, you can enjoy heavenly breakfasts and sift through fresh produce and cheeses. In the arts-and-crafts section, you can find homemade soaps and jewelry, tarot card readings, and much more. There are several sections to Eastern Market (e.g., food merchants, arts-and-crafts fair, farmers market, flea market), and each section has different hours of operation. However, most sections of the market are open and bustling on weekend mornings. Take the Metro to Eastern Market Station on the orange and blue lines.

Food, Marvelous Food!

On the whole, we ABCT-goers do like to eat, and DC will not disappoint. Just about any kind of food, including all ethnic varieties, can be found here. Please stop by the ABCT Local Arrangements table for recommendations and a restaurant guide. If you would like to search for interesting restaurants on your own, *Washingtonian* magazine offers a free and user-friendly Web site where you can read reviews and search for restaurants by neighborhood, type of food, and price range (www.washingtonian.com/dining). If you want to go all out, you can also view this year's list of the "100 Very Best Restaurants" in DC, Maryland, and Virginia (www.washingtonian.com/dining/05vbcontents.html). It is a good idea to make reservations as these in-demand upscale restaurants book early. If you are a starving graduate student looking for a great meal in DC, check out the "Cheap Eats" list of the 100 Best Bargain Restaurants (www.washingtonian.com/dining/cheapeats/05.html).

We hope that you enjoy the 2005 ABCT convention program and that you can also make some time to journey into DC's soul. Please visit me and other Washingtonians who belong to ABCT at the Local Arrangements table for more suggestions to make your visit an enjoyable one. ✍

Lighter Side

Noise From the President-Elect: Advice to Interns and Faculty Everywhere

Michael W. Otto, *Boston University*

Recently I had the opportunity to return to my internship alma mater to present Grand Rounds and discuss career-development issues with the current group of psychology interns. As is common for mentoring events of this kind, discussions turned to the role of publications in advertising one's areas of interest, competence, and productivity for future employment. I found myself saying the usual things about publications as they appear in a CV, including the balance of first-authorships and coauthorships, attention to the importance of publications rather than simply their number, and the need for a thematic series of publications that would allow the intern to best advertise her or his expertise in the job market.

Upon my return from this meeting, however, I wondered whether I had done my audience a disservice. After all, writing lots of papers, particularly important papers, is hard work. Had I condemned this class of interns to a life of Hard Work? Then it struck me; perhaps there were strategies for establishing a memorable presence in the field that require less dramatic effort. It is in response to this line of self-inquiry that I write the following, freely offering up a new strategy for citation/CV-building.

The key, of course, is well-crafted collaborations. I know this sounds like old advice—that collaboration with productive individuals is career enhancing—but my purpose is not to draw your attention to collaborator productivity or their standing in the field, but to the value of their surname outright. This strategy works for investigators at every level of seniority. Allow me to provide some examples, starting with a recommendation for our current ABCT president, Gayle Beck. Would it not make sense for Gayle to team up with someone like Joseph Call, who does work on the use of social interaction and social problem solving in primates, to study dominance and communication patterns in marital relationships? As for me, I can hardly wait to cite the Beck and Call paper on Dominance Patterns in Couples Communications. Likewise, imagine how memorable the paper would be if Tim Brown, Associate Editor of *Behavior Therapy*, were to team up with Robert Ian (who has authored papers on educational issues and public safety) for a paper on educational issues in graduate training programs in psychology. No doubt the Brown-Ian paper on the "Movement of Graduate Students Toward Dissertation Completion" would become a classic citation.

Although senior investigators can benefit from this strategy, it is even more important for junior faculty. For example, I recommend that the new assistant professor at the University of Arkansas, Matt Feldner, team up with Laura Mee, who is a coauthor on investigations of PTSD in medical populations, to produce the Feldner-Mee investigations on the "Prevalence of PTSD in Loggers" (please read aloud if you are not following me here). At the mid-level, Yale Assistant Professor specializing in generalized anxiety disorder, Doug Mennin, could do well to collaborate with Donald Black, also an anxiety researcher, to produce the Mennin-Black paper on "Worries About Alien Abduction."

I should make clear that I am eager to follow this strategy myself. Soon I will be contacting Richard Mattick, a researcher in social phobia, to propose the Otto-Mattick paper on "Non-Effortful Processing of Social-Threat Stimuli." Staying in the area of social phobia (remember that a thematic CV is still important), I will next contact Paul Tom to expand his work on anxiety and affective disorders to a more detailed study of the determinants of facial flushing. I will generously suggest that he take the first author role, and look forward to the impact of the Tom-Otto article on "Facial Flushing Intensity During Public Speaking" on the field, and particularly, on my CV.

To psychology interns, I hope that this advice on how to increase the citation impact of your future work is taken with all the gravity with which it is offered. If these strategies don't work, you can always rely on the tired old standbys: good ideas combined with hard work and collaborative support. ✍

Causes of Conduct Disorder and Juvenile Delinquency

Edited by Benjamin B. Lahey, Terrie E. Moffitt, and Avshalom Caspi (2003)

New York: The Guilford Press

Reviewed by Tana L. Clarke & Andrea M. Chronis, *University of Maryland, College Park*

Early conceptualizations of the etiology and development of child and adolescent conduct problems have contributed much-needed information regarding the correlates of antisocial behavior in youth, but research has largely failed to identify causes of conduct problems. In recognizing the limitations of the available literature, the editors of *Causes of Conduct Disorder and Juvenile Delinquency* have undertaken the task of propelling the field toward an examination of causal mechanisms. This text focuses almost exclusively on longitudinal investigations that elucidate the developmental course and causal mechanisms at play in conduct disorder. The editors have assembled leaders in the field to outline their respective theories. In each chapter, authors attempt to advance these theories by offering testable hypotheses regarding causal mechanisms that inform clinical practice.

The carefully chosen chapters of this volume represent diverse approaches to analyzing the causes of antisocial behavior. There are several factors that contribute to a child's success or failure at navigating his or her way through developmental challenges. In keeping with multifactorial nature of conduct problems, the book does not focus solely on one approach. Rather, while different theories will emphasize different dimensions of a multifactorial model, each theory incorporates the complex, dynamic interplay between biological and psychosocial factors, as well as between the individual and his or her environment. Rutter opens the book with a general discussion of the empirical progression of risk indicator to causal mechanism, which sets the tone for a conscientious and critical examination of research methodologies aimed at identifying the varying pathways to juvenile delinquency. While observing that uncovering the multifactorial nature of these paths is a daunting task, Rutter notes that this text summarizes many promising approaches to accomplishing this goal.

Because of the progressive nature of this book, one almost forgets the wealth of clinically relevant information about conduct disorder that has accumulated. Under the umbrella of several different integrative theories, themes begin to emerge that are relevant not only to researchers, but to clinicians as well. The book begins by examining general causal models, taking into account group differences in gender and ethnicity, as well as individual differences in personality, genetics, caregiving, and neurobiology. Throughout this volume, the reciprocal and complex nature of child and contextual factors is illustrated. Specifically, the reader begins to understand how children born with risk factors such as a difficult or reactive temperament or deficits in intelligence combined with an inauspicious environment such as maladaptive parenting or community violence, are vulnerable to increased likelihood of conduct problems and criminality. Later chapters present more targeted causal models, one of which desribes in detail how high irritability and emotionality in infancy and toddlerhood can combine with overstimulation on the part of the parent to propel a young child into disruptive school years. According to this theory, the reverse may also be true: when an infant is underaroused and caregiving is characterized as understimulating, the resulting pathway may be more likely to lead to antisocial behavior. In a notable chapter by Tremblay, it is suggested that, in light of the decline in aggressive acts seen in the majority of young children as they mature, we might view physical aggression as being an unlearned process, rather than the traditional conceptualization of aggression as a learned behavior. So, rather than focusing on how children with conduct problems learn to be aggressive, we might consider how other children learn to control their natural tendency to be aggressive. Within this model, treatments might focus on teaching young children more socialized behaviors to replace "instinctive," aggressive behaviors.

The following chapters focus more on pathways to juvenile delinquency and conduct problems. Chapters on executive functioning, intelligence, and social information processing are nicely set up by earlier chapters that introduce these concepts. The final chapters review the genetic, environmental, and biological influences on antisocial behavior and continue to examine how specific individual vulnerabilities interact within a broader model of the development of criminality. The most refreshing aspect of this book is that each theorist outlines testable research hypotheses that are likely to advance our understanding of developmental psychopathology in their respective areas of specialization,

In an ambitious undertaking, the editors have succeeded in compiling an important synthesis of progressive ideas that elucidate causal mechanisms for conduct disorder and juvenile delinquency. Because the authors are cognizant of one another's work and so often discuss how their own theory compares to other models, this volume often reads like a dialogue between leading researchers. Consistent with the developmental psychopathology perspective offered by the editors, the book addresses factors that have largely been ignored in conduct disorder literature, namely gender and race/ethnicity.

The risk and protective factors described in this volume are useful for conceptualizing and treating conduct disorder. Understanding that gender differences in social contingencies may contribute to lower risk for antisocial behavior in girls can prove useful in the clinical setting. For example, the book explains how this gender difference diminishes during adolescence as girls broaden their association with opposite-sex peers or find antisocial partners. In the context of treatment, these environmental contingencies become crucial in maintaining antisocial behaviors and should be carefully evaluated. Because risk and protective factors are constantly changing, both in the maturing child and his or her dynamic environment, repeated assessments of these factors are a fundamental part of treatment. This book also highlights the importance of early identification and treatment of children with conduct problems, as early-onset problems have consistently been associated with poor developmental outcomes. The trajectory of antisocial behavior is influenced by numerous and ever-changing risk and protective factors. Editors Lahey, Moffitt, and Caspi have taken an important first step in identifying the most salient causal mechanisms of these factors. *Causes of*

Conduct Disorder and Juvenile Delinquency is a remarkable contribution to the literature, providing an innovative look into existing and future targets for intervention. ✍

Cognitive Therapy of Schizophrenia

David G. Kingdon and Douglas Turkington (2005) New York: The Guilford Press

Reviewed by Joanna Strong Kinnaman, *VA Maryland Health Care System*, and Melanie Bennett, *University of Maryland School of Medicine*

Cognitive Therapy of Schizophrenia is the first book in a series of guides for individualized evidence-based treatments (Series Editor: Jacqueline B. Persons). The goals of the book are to provide clinicians with a background in both schizophrenia and cognitive therapy, as well as a practical guide for using cognitive therapy techniques in treating persons diagnosed with schizophrenia. This book is aimed at clinicians at different levels of experience who work regularly with this population. This volume begins by emphasizing that although schizophrenia has traditionally been seen as a purely biological disorder for which psychological interventions would not be useful, cognitive therapy can, in fact, have an impact on the distressing symptoms that patients experience.

The authors present a helpful and detailed review of the etiology and symptomatology of schizophrenia based on the biopsychosocial model of psychopathology. Even more beneficial is the thorough review of research that has demonstrated the effectiveness of cognitive therapy and cognitive behavioral therapy with persons with schizophrenia. The authors describe the existing literature and also elucidate the populations (e.g., patients under age 16) that have had limited or no exposure to controlled trials of cognitive therapy.

The subsequent chapters provide a comprehensive framework for the process of treatment of persons with schizophrenia. To begin, several chapters are devoted to methods of establishing an effective therapeutic relationship, including orienting patients to treatment as well as using psychoeducation at the start of treatment to help patients understand their illness. The authors delineate the unique challenges of building relationships with these patients, and underscore the importance of thorough and continual assessment in therapeutic practice utilizing both nomothetic and idiographic procedures. The authors consider how medications and cognitive therapy can be used together in treatment and recognize the need for individualized planning and goal setting, consistent with the recovery model of treatment.

One way in which this guide is particularly effective is its thorough description of how to use cognitive therapy to address the multiple symptom domains seen in schizophrenia, including positive symptoms, negative symptoms, and thought disorder. The book provides an eye-opening conceptualization of symptoms as malleable effects of antecedents, which provides a clear rationale for the role of psychotherapy in the treatment of schizophrenia patients. The authors do an admirable job accounting for the challenges of therapy with this population. They devote one chapter to comorbid conditions that can complicate treatment and another to other difficulties that are commonly encountered (e.g., working with individuals who lack insight), as well as elucidating possible pitfalls in the therapeutic process throughout the book.

Despite the obvious expertise of the authors and thorough nature of the book, a few matters deserve consideration. Readers should approach this book as a guide that needs to be read in its entirety rather than as a step-by-step treatment manual. Although the authors provide reproducible materials, such as psychoeducational handouts in the appendices, a companion handbook might prove helpful for many busy clinicians. Also, the authors place a well-guided emphasis on comprehensive, time-intensive assessment and conceptualization. An important practical consideration worthy of discussion is how practitioners can utilize this approach given the current, albeit unfortunate, milieu of time-limited treatment. The book also utilizes four specific case examples to illustrate the process of assessment and treatment. While these case illustrations provide specific clinical anecdotes which are quite helpful, the breakdown of cases into subgroups (i.e., sensitivity, traumatic, drug-related, and anxiety psychosis) does not inform our understanding of the disorder or its treatment. It seems most important that treatment be conceptualized and implemented based on the individual rather than the clinical subtype into which the person falls. Additionally, the authors frequently draw upon their professional experiences when describing the process of treatment. Although the general strategies are enlightening, presenting additional specific descriptions of the treatment process in terms of quantitative results (e.g., frequencies with which persons with schizophrenia keep thought diaries; rates of engagement and dropout) would be valuable. In the literature review and suggestions for future directions, one missing consideration is that future work in this area should delineate the exact components of cognitive and related therapies that are helpful for persons with schizophrenia.

In summary, this work from two leaders in the field provides a thoughtful review of cognitive therapy with persons with schizophrenia. The authors have drawn on their many years of clinical experience to provide a balanced view of treatment planning and implementation as well as barriers to achieving successful outcomes. This volume will provide excellent training for treatment teams that are moving from utilizing the medical model to more rehabilitative, biopsychosocial approaches and want to implement evidence-based treatments. Any clinician—novice or seasoned—would likely improve their conceptualization of psychotherapy for persons with schizophrenia after reading this book. As such, instructors should consider adding this as required reading for trainees. If the obvious expertise of the authors in this volume is any indication of what can be anticipated, we look forward to future volumes in this series. ✍

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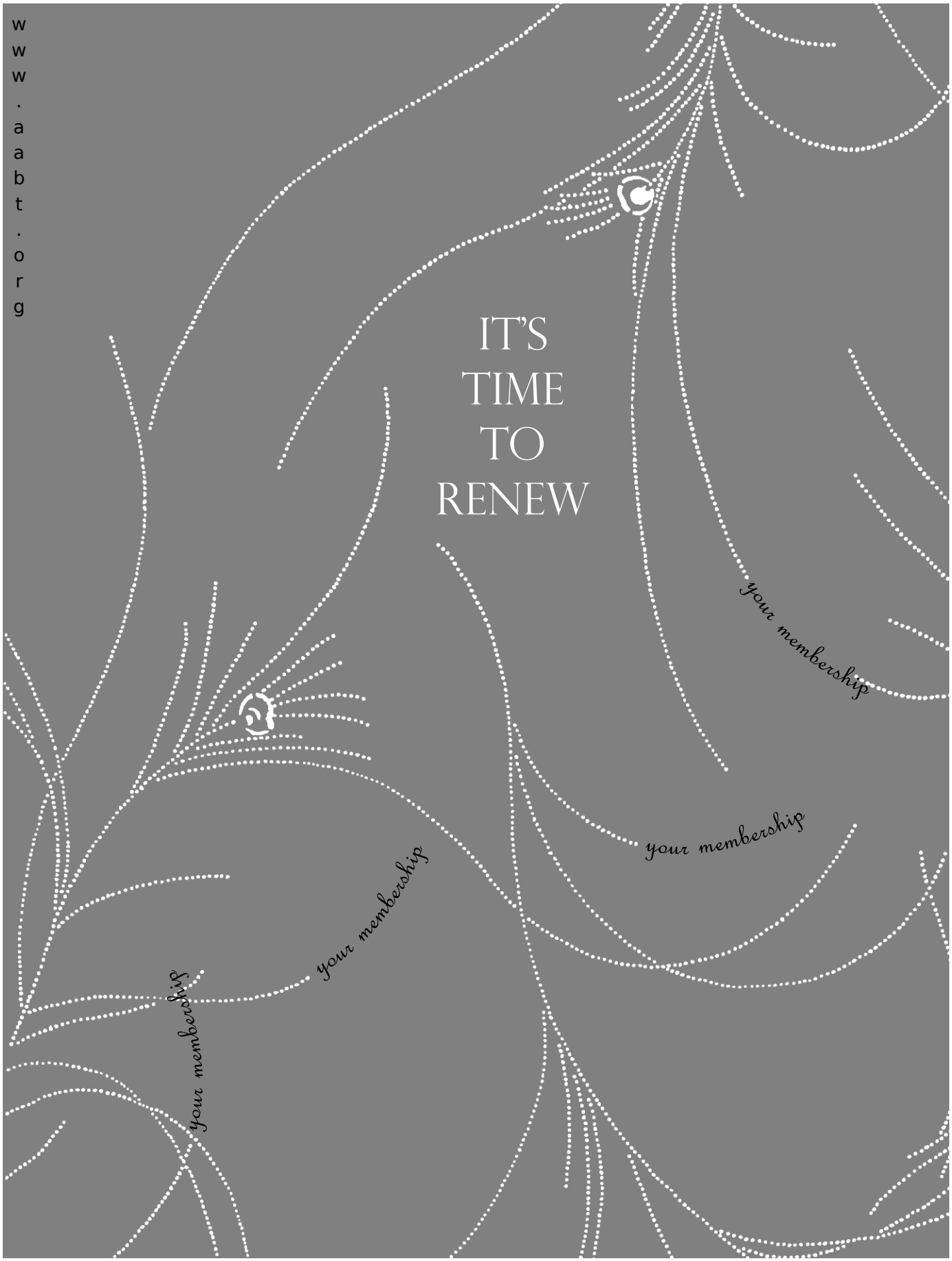
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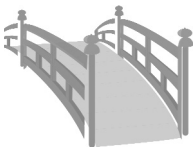

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  Does Psychology Have a Future?
- DREW WESTEN, Emory University
  Personality as a Context for Psychopathology
- JILL M. HOOLEY, Harvard University
  Understanding the Role of the Family in Major Mental Disorders
- WILLIAM R. MILLER, University of New Mexico
  Believe Your Data: Research, Theory, Practice and Training of Motivational Interviewing

Clinical Grand Rounds

Comprehensive Treatment Planning of Anxiety in Youth: Integrating CBT, Medication Management, and School Mental Health Services

- ANNE MARIE ALBANO, Columbia University/NYSPI
- JOHN WALKUP, Johns Hopkins Hospital
- LYNN MILLER, University of British Columbia

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