the Behavior Therapist

Contents

President's Message

Culture Matters

Stefan G. Hofmann, *Boston University*

Culture, race, and ethnicity have become important issues in research studies and clinical practice. Every grant application instructs the principle investigator to include an Ethnic and Minority Inclusion Table; every reviewer is asked to consider ethnicity issues when reviewing a grant; many journal editors ask authors to provide information on the ethnic background of study participants; and every human subjects committee requires investigators to describe the ethnic composition of the subject sample. Those of us who are in the enviable position of needing to submit progress reports to NIH have to categorize the sample into the various ethnic and minority subgroups, including Hispanic or Latino, American-Indian/Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, and White. As has become apparent during our last presidential election, culture, race, and ethnicity are also important political forces in the U.S. in general. According to the 2000 census report, 12.5% of the 281.4 million Americans are Hispanic, 12.3% are Black or African-American, and 4.2% are Asian.

Despite the explicit emphasis on culture, race, and ethnicity by funding agencies, journals, and ethics boards, very few studies exist that have systematically examined cultural and racial difference in the various disorders. In my own experience, it is very challenging to publish papers on these issues, let alone receive grant money to fund such studies. Ignoring those differences, especially in treatment research, is not only a political misstep, but it can also lead to serious misinterpretations of study findings.

ABCT
ELECTION RESULTS

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INSTRUCTIONS *for* AUTHORS

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor at **gunthert@american.edu**. Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

Studies have found that people who grow up in different cultures not only think about different things, they also seem to think differently. This has direct relevance for psychopathology and treatment of psychological disorders. For example, Richard Nisbett and colleagues have conducted a number of fascinating experiments with people from different cultures (for a recent review, see Vanum, Grossman, Kitayama, & Nisbett, 2010). His research team observed that Westerners (Americans or Europeans) think much more analytically, whereas people from Eastern cultures think more holistically (Nisbett & Miyamoto, 2005). For example, whereas Westerners tend to detach objects from the context, try to resolve contradictions, and rely more heavily on formal logic, people from Eastern cultures pay much greater attention to the context and relationship, rely more on experience-based knowledge than abstract logic, and show more tolerance for contradiction. American Asians (Asian students born and raised in the U.S.) were similar to non–Asian Americans, suggesting that these differences are not genetically based, but are indeed a product of cultural and environmental factors.

Peng and Nisbett (1999) also found interesting differences in reasoning between Easterners and Westerners. These differences seem particularly important because they have direct implications for CBT. For example, students were presented with a choice between two different types of philosophical arguments: one was based on analytical logic, encouraging subjects to resolve the contradiction, and the other was based on a dialectical approach, accepting the contradiction. The authors found that Asians were more likely to prefer the dialectical approach, whereas Americans favored the logical arguments.

Americans view contradictory statements as unacceptable by the laws of formal logic, which have been part of the Western tradition since Aristotle. Therefore, Westerners respond to such propositions by deciding which of the two propositions is true. In contrast, Asians typically deal with contradictions through what might be a compromise approach. For example, they may believe that the world is in constant flux and that the part cannot be understood without considering the whole. This leads to greater tolerance of contradiction, exemplified in the "yin and yang" of the Eastern approach. This might also be the reason why many Asian proverbs contain a contradiction, such as "too modest is half boastful." When presenting these proverbs to students, Asians tend to like them, whereas Americans tend to find them ridiculous, annoying, or even irritating.

What are the probable implications of these cultural differences in perception and reasoning for CBT, a therapy that is firmly based on formal analytic reasoning? A case in point might be the patient with panic disorder who is afraid that heart palpitations are a sign of an impending heart attack. In therapy, the patient may be presented with evidence for and against this assumption. It is implicitly assumed that the patient will apply a differentiation approach to resolve an apparent contradiction. For example, the patient who believes that a racing heart is the sign of a heart attack may be confronted with an alternative explanation that contradicts the person's initial belief (e.g., "My heart is racing because I just had a strong cup of coffee").

As in the case of Nisbett's earlier contradiction (Peng & Nisbett, 1999), CBT encourages the patient to apply a formal-logic approach by replacing the initial belief that heart racing is dangerous and precedes a heart attack with an alternative and adaptive belief that heart palpitations are harmless and caused by coffee. Such a method should and does work very well for Westerners. However, this apparent contradiction can also be resolved with a dialectic and compromise approach (after all, even people with heart disease can have heart palpitations because of coffee). Traditional CBT might therefore not be as effective for Easterners as for Westerners when the arguments are based on traditional formal logic. Therefore, CBT may be more effective for some cultures when making the specific style of reasoning and thinking compatible with the particular culture.

So be aware when treating patients from different cultures. And as for us researchers: let's get serious on culture!

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Call for
Proposals

The incoming editor of *Behavior Therapy*, Michelle Newman, is soliciting proposals leading to original manuscripts for two special series:

Using Experimental Psychopathology to Advance Cognitive-Behavior Therapy

Questions about appropriate topics, as well as the 1-page proposals, can be sent to Dr. Denise Sloan, who will serve as the guest editor for this section.
Email: denise.sloan@va.gov

Autism Spectrum Disorders

The guest editors of this special section are Drs. Bryce McLeod and Jeffrey Wood, who should be contacted for further information at: bmcleod@vcu.edu or jeffwood@ucla.edu

We are calling for original manuscripts within these two broad areas. Authors interested in having a manuscript considered for either of these special sections need to first submit a 1-page proposal outlining the full manuscript by July 1, 2013.

Authors of selected proposals will be invited to submit a full paper due September 1, 2013.
All invited manuscripts will undergo the normal peer review process.

For full details regarding the special series, visit ABCT' home page, www.abct.org.

BEHAVIOR THERAPY

Cultural Competence at the Intersection of Research, Practice, and Training

Editor's Introduction

Kathleen Gunthert, *American University*

Most of us have witnessed a clear shift toward emphasizing cultural competence in clinical practice and research, and this value is reflected in practice guidelines, funding requirements, accreditation criteria, and training curricula across the country. We have come quite far. But there is the need for continued focus and discourse on issues of diversity in research and practice. Despite increased efforts to improve the cultural sensitivity of our interventions, we are still grappling with problems such as underutilization (Whaley & Davis, 2007), higher attrition (e.g., Forman, Butryn, Hoffman, & Herbert, 2009), and worse outcomes (e.g., Jelalian et al., 2008) among minority populations. If we want our empirically supported interventions to be portable to real-world clinical settings, cultural considerations are integral to the success of our efforts (Whaley & Davis).

This special series is assembled with the hope of bringing together exemplars of some of the clinical, research, and training programs that have lessons to share from their efforts to promote cultural awareness and to serve diverse populations. One of our Associate Editors, Susan Wenze, approached me with the idea of a special issue after a great discussion on diversity and mentoring at an ABCT symposium. We reached out to the leaders of ABCT Special Interest Groups (SIG) related to diversity, and the response was enthusiastic; many SIG leaders echoed the need for greater attention to these issues in *the Behavior Therapist*. We were hoping to put together one special issue, but we received so many interesting perspectives that we decided to feature the pieces in a two-issue series.

There was some question of framing this special series—should we focus in on cultural competency in practice, research, or training? There is certainly some value in centering the discourse on one somewhat focused issue. But the truth is that when we reflect on the complexities of cultural competency, we find a theme that is at the core of our organization—that research, practice, and training are inextricably linked in the movement toward improving services and outcomes. This group of articles nicely illustrates why we need to think about cultural competency as an area where research, practice, and training intersect. Developing clinical assessments and treatments that are responsive to the needs of marginalized groups is at the heart of much of this work, and it is complemented by research supporting the usefulness of these new treatments and modifications (though some have noted that certain cultural adjustments are necessary from an ethical-moral standpoint, separate from empirical justification; Sue, 2003; Whaley & Davis, 2007). Further, basic research on the needs and cognitive, behavioral, and emotional processes of diverse groups will inform treatment development. In order for culturally mindful practice and research to evolve, we need to provide thorough training on processes of cultural competence, not simply knowledge of different cultures (Whaley & Davis). Finally, both research and clinical practice will benefit from greater attention to supporting and mentoring students and colleagues from diverse backgrounds.

The authors of these articles challenge us to think deliberately and flexibly about culture in our interactions. With greater emphasis on understanding diverse perspectives, there is more attention to the modal experiences of marginalized or underrepresented groups. However, a number of the articles in this special series remind us of the need to test multiple hypotheses, including culturally specific and alternative hypotheses (Lopez, 2002; see Graham, Sorenson, & Hayes-Skelton, 2013, this issue). We have to be careful not to rely on stereotypes in a well-meaning effort to attend to culture. Further, a number of these articles remind us that knowledge of other cultures is not enough to bring us to cultural competence. We need also to reflect on ourselves as products of specific cultures, and to aim for an open and frank introspection of the biases we bring to the table (Fields, 2010).

The topics covered in the special series include cultural adaptations to cognitive and behavioral therapies (see Graham et al., 2013, this issue; Greenfield et al., in press; Hong, in press), establishing research with minority populations (see Bridges & Cooper, 2013, this issue; Cwik, Green, Hayes, & O'Keefe, 2013, this issue; Williams et al., in press), and strategies to secure funding for health disparities research (see Thurston et al., in press). We also have two pieces on training and professional issues, specifically focused on clinical supervision (see Johnson, 2013, this issue) and developing formal mentoring programs (see de Dios et al., 2013, this issue). Readers come to the special series with variable backgrounds in cultural exposure, knowledge, and competency. I am confident that throughout the special series, there will be some perspectives and strategies that many of us have not considered before. Readers might also be reminded of some advice or thoughts that they have encountered before. Both the new perspectives and the reminders should serve us well in our efforts to meet the needs of all of those who are struggling with mental health issues. It is gratifying to see the increasing attention to culture in our field, and we put this series together with the idea that it is important to continue bringing together experts on diverse perspectives and to generate discourse on how we can do better in our work, whether it be treatment, research, or training.

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Enhancing the Cultural Sensitivity of Cognitive Behavioral Interventions for Anxiety in Diverse Populations

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The diversity among individuals living in the United States has rapidly increased over the past few decades, with people of color making up 36.2% of the population in 2011 (U.S. Census, 2011). In addition, 3.4% of adults living in the United States identify as gay, lesbian, bisexual, or transgender in 2012 (Gates & Newport, 2012) and 32.8% of Americans experience physical functioning impairments or disabilities in 2011 (Centers for Disease Control and Prevention, 2011). While these statistics represent just a few of several marginalized and underserved populations in the United States, this rapid increase highlights the importance of focusing on the mental health needs of diverse populations, including the treatment of anxiety disorders within marginalized populations. In reference to diverse populations, we will use the term "marginalized groups," groups that are often perceived negatively in society, which can result in separation or exclusion from mainstream society, unequal treatment, unequal access to resources, and overall social devaluation (Sue, 2010). In the context of the United States, marginalized groups can include racial and ethnic minorities, LBGT individuals, women, people who identify as working class, and individuals with disabilities.

Because clinicians with higher levels of cultural competence experience more favorable outcomes with their clients (Sue, 2001), utilizing multicultural competency to effectively tailor CBT may better serve the mental health needs of marginalized populations (Hofmann, 2006; Pantalone, Iwamasa, & Martell, 2009; Safren, 2001). While many authors (e.g., Hofmann; Pantalone et al.; Safren) have highlighted the need for including cultural considerations in CBT, provided a framework for incorporating multicultural principles, and provided suggestions to consider when working with marginalized populations, the current paper focuses on a few specific examples of how we have adapted CBT in our work treating individuals with social anxiety disorder.

Specifically, this paper will explore ways to enhance common elements of CBT for anxiety disorders in diverse populations. Through case examples taken from our work on a CBT treatment study for social anxiety disorder, we will discuss our use of CBT strategies with individuals who identify with marginalized groups and the ways that we have integrated multicultural perspectives.

CBT for Anxiety

CBT has been efficacious in treating anxiety disorders among majority White populations for decades (Deacon & Abramowitz, 2004); however, studies exploring more general efficacy of CBT for anxiety have often neglected to take marginalized status into consideration. For example, Stewart and Chambless (2009) conducted a meta-analysis of 57 effectiveness studies of CBT for adult anxiety disorders and found CBT to be effective across samples; however, in only 6 (10.5%) of these studies did African Americans or Caribbean Americans of African descent make up at least 20% of the sample, and in only 2 (3.5%) did Latinos make up at least 20% of the sample.

There have been a few studies that explicitly explored the efficacy of CBT in marginalized groups. For example, a study of exposure-based CBT for Latino and European American youth with anxiety disorders found that both Latino and European American youth responded positively to the intervention (Pina et al., 2003). Additionally, case examples have shown the effectiveness of culturally sensitive CBT for GLB clients suffering from anxiety (Martell, Safren, & Prince, 2004) and for two clients who immigrated to the United States from China and Central America (Weiss, Singh, & Hope, 2011). Given the overwhelming evidence for the efficacy of CBT in majority White, heterosexual populations and limited examples in diverse samples, it is important to think of ways to enhance CBT to better serve marginalized populations. One such avenue is to explore ways to include multicultural perspectives into CBT.

Defining Multiculturalism and Multicultural Counseling Perspectives

Multiculturalism is characterized by the theoretical and philosophical ways that cultures vary in norms, values, worldviews, and traditions, with an emphasis on there being no superior or inferior status and an assumption of equality across cultures (Talbot, 2003). Within the field of psychology, multicultural counseling can be described as a therapy process that applies treatment approaches and therapy goals that are consistent with the life experiences, contexts, and cultural values of clients from diverse backgrounds. Hays (2008) presents an acronym, the ADDRESSING framework, to help clinicians attend to the diverse backgrounds and lived experiences of clients, while keeping their own backgrounds and identities in mind. This framework focuses on nine cultural factors that merit attention in the context of therapy (the parenthetical additions are our own expansions): Age and generational influences, Development disabilities, acquired Disabilities, Religion and spiritual orientation, Ethnicity (and race), Socioeconomic status, which includes education, Sexual orientation, Indigenous heritage, National origin (and generational status), and Gender. In the context of these facets of identity, multicultural counseling focuses on issues of power, privilege, and marginalization and the impact of these constructs on the experiences of clients from diverse backgrounds. *Power* is the ability to decide who has access to resources, while *privilege* is characterized by the advantages and benefits afforded to members of the dominant group in society.

At the core of multicultural counseling is the ability to connect with clients and understand influences on identity development and diverse world perspectives referenced in the ADDRESSING framework. Sue and Sue (2004) describe two different approaches to counseling, the etic and emic approaches, with the latter being a multicultural approach. The etic approach, which describes the way that therapy is traditionally practiced, is housed in the theory of cultural universality and operates under the assumptions that prevention and intervention approaches are universal, that disorders like anxiety appear similarly across cultures, and that the most effective treatment approach for anxiety disorders should be uniformly applied cross-culturally. Although this approach is widespread, it may impose dominant group cultural biases on clients from diverse backgrounds

(e.g., that all clients hold the dominant group value of individuality). The emic approach challenges the assumptions that mental health difficulties are of the same nature and development across cultures. This approach suggests that culture and life experiences significantly influence the development, course, and expression of anxiety, and should also influence our prevention and intervention efforts.

Integration of Multicultural Perspectives and CBT for Anxiety

As highlighted in the literature on multicultural competency, attention should be paid to tailoring treatments for anxiety disorders to better serve individuals from diverse and marginalized populations (Fuchs, Lee, Roemer, & Orsillo, in press; Sue & Sue, 2004). There are several ways that we can enhance the cultural sensitivity of common components of CBT for anxiety. While some of these suggestions are specific to CBT, others are related to the process elements relevant for a wide range of therapeutic approaches. Specifically, clinicians can begin to think of ways to cultivate a general therapeutic attitude or "therapeutic stance" that involves the appreciation and understanding of the complexities of clients' lived experiences. In addition, we can tailor psychoeducation, cognitive restructuring, and exposure processes to better reflect the struggles specific to clients from traditionally marginalized groups. What follows are some examples of the ways that we have used this multicultural lens within CBT for social anxiety disorder within our practice. We have chosen to focus on a few specific CBT elements here, recognizing that we are intentionally omitting many other commonly used CBT techniques.

Therapeutic Stance

Integrating a multicultural perspective with CBT for anxiety requires clinicians to educate themselves about the modal experiences of individuals from diverse cultural backgrounds. Because modal experiences do not describe the full range of varied experiences within any group, clinicians must also remain open to each client's individual experiences and life contexts. This self-education begins by learning about the history, beliefs, values, and modal experiences of diverse groups (including institutional and systemic barriers to mental health treatment), which will enable clinicians to connect with clients' experiences, improving their case conceptualizations and intervention

tion approaches (see Sue & Sue, 2004, for a list of resources). An important facet of the modal experiences of diverse groups is the way each group experiences marginalization within our societal context. As described above, marginalization is characterized by being perceived negatively in society, which can result in separation or exclusion from mainstream society, unequal treatment, unequal access to resources, and overall social devaluation. Experiences of individuals from marginalized groups may include barriers to health care, jobs, and experiences of social injustices and threats to their civil liberties. These oppressive experiences often play a significant role in clinical presentations of anxiety and can affect the development of the therapeutic relationship and the effectiveness of cognitive behavioral interventions (Hunter & Schmidt, 2010; Soto, Dawson-Andoh, & Belue, 2011). For instance, it may be difficult for a client from a working class background who works 70 hour per week and has three children to engage in therapy, particularly a therapy that involves a significant amount of time outside of work and away from family. If the clinician is aware of the client's life context, treatment can be tailored to the needs of the specific client given his identity status, perhaps by integrating exposures into his daily life.

In addition to these more systemic experiences of marginalization, discrimination has shifted and often manifests in more covert forms of discrimination, called microaggressions (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978). Microaggressions are intentional or unintentional disparaging comments, slights, or environmental indignities based on an individual's marginalized group status (Sue et al., 2007) that occur in many different forms and affect a diverse range of marginalized groups. For example, a racial microaggression may be when a White woman clutches her purse as an individual of color approaches on the sidewalk. Gender microaggressions include female professors being referred to as "Ms." while their male counterparts are referred to as "Dr." A sexual orientation microaggression may be when two men holding hands in public are told not to flaunt their sexuality. Experiences of microaggression can contribute to the anxiety individuals experience in their everyday life contexts. Educating ourselves about such experiences is the first step in providing a safe and effective therapeutic environment.

Inviting Conversations About Marginalized Statuses

As highlighted in Hays' (2008) framework, it is important to introduce issues that clients from diverse backgrounds may experience based on their marginalized identities early in treatment. Clinicians can begin this conversation by introducing some of their own identities and checking in with clients about any concern surrounding potential differences or similarities.

In addition, addressing potential experiences of discrimination or marginalization in the beginning sessions of therapy can show clients that the therapy room is a safe space where these experiences can be discussed. We systematically do this in the initial therapy session when assessing the situations that create the most anxiety for our clients and by asking clients whether the identity of individuals they are interacting with influences their experiences of social anxiety. For example, with an African American client who was experiencing significant anxiety interacting with her colleagues, her White male therapist explicitly asked if the race and/or gender of her coworkers played a role in her anxiety and whether she had experienced racism at work. In this context, the client expressed gratitude to the therapist for initiating a conversation about race in the therapy room and acknowledged that she had much more anxiety at work than other places, partly because her coworkers were mostly White. We then talked about the difficult experiences of racism she endured at work, which included her boss consistently calling her by the name of the only other African American employee, even after being corrected several times.

By having this explicit conversation about race in the initial therapy session, we were able to tailor both the cognitive restructuring and exposures to her lived experiences of marginalization. Because individuals from marginalized statuses are socialized to not talk about experiences of marginalization, particularly to individuals who do not identify with the same marginalized status, it is especially important that the clinician, who typically holds more power and privilege in the therapy context (i.e., does not identify with marginalized statuses or holds power in the room as a therapist), initiates these conversations. These types of conversations open the door for further discussion about experiences of discrimination, thereby helping clinicians to think deeply about issues of marginalization in their case conceptualizations and enhance the application of treatment components.

Enhancing Psychoeducation

It is common practice for clinicians to provide psychoeducation about the function of emotions and the cycle of anxiety when treating clients struggling with anxiety. With clients from traditionally marginalized backgrounds, it is important to connect aspects of psychoeducation directly to their lived experiences. For example, when describing the ways anxiety develops with a visually impaired, 34-year-old Latino male client, Carlos, we connected the psychoeducation to experiences Carlos shared with us related to aspects of his identity. For instance, we talked explicitly about Carlos' experiences of people walking away from him in the middle of conversations without him knowing—something that happened often because of his visual impairment. We discussed how it makes sense to fear these social situations, considering the number of embarrassing situations he has found himself in when he has been unaware that others had already left the conversation. Carlos also mentioned that in his childhood his mother had been very concerned about his grammar while interacting with others because she thought that people would judge him more stringently due to his visual impairment. It was transformative for Carlos to hear and understand the ways that he learned to be anxious through these experiences. Carlos was also able to engage more effectively in therapy because of our explicit validation and acknowledgment of the unfair ways that he was often treated because of his visual impairment.

Adapting Cognitive Restructuring

Another common component of traditional CBT for anxiety is the use of cognitive restructuring. CBT often focuses on assumptions that individuals experiencing pathological anxiety are victims of faulty, irrational thinking and that therapy should help clients become aware of these irrational or automatic thoughts and change them through cognitive restructuring. When working with clients from traditionally marginalized backgrounds, clinicians need to think deeply about the ways they are teaching clients to restructure their thoughts and the implications of these decisions. One of the challenges is that individuals from marginalized groups often have negative and automatic thoughts that are not irrational given their experiences. For instance, a client of color may express that they fear social situations with their White peers because they fear that their White peers may say something racist in their interactions. In such cases where the client feels discriminated against, questioning the validity of the client's fears that racism is possible enacts a microaggression that can contribute to and exacerbate the client's experiences of anxiety, and become a barrier to positive therapeutic change (Chang & Berk, 2010). Instead, clinicians should explicitly validate these experiences by allowing the client to talk openly about his or her experiences of discrimination, validating the painful emotions that may arise in the face of these experiences, and explicitly acknowledging that we live in a society where these painful experiences occur.

At the same time, the clinician may choose to help the client reframe what these experiences mean about him or her. As seen in the examples below, cognitive restructuring can address the biases in what living in an oppressive society means about the client (i.e., "there is something wrong with me because I am gay"), but should not challenge that incidents of discrimination do exist or that a specific incident was discriminatory. For example, a clinician would not want to ask for other explanations for why a jewelry store clerk would not wait on a client without explicitly having discrimination being one of the "valid" possibilities. In our work with a 25-year-old African American female, Corinna, we shifted our use of the common cognitive restructuring "disputing" questions to target the negative self-focused automatic thoughts that came up for her around experiences of racism. Corinna worked as a receptionist at a large medical practice that serviced a predominantly White customer base. She feared going to work because of previous experiences of racism, which contributed to her difficulties interacting with her coworkers and customers. We began by validating the emotions that came up for her when she experienced racism and explicitly acknowledged that we live in a world where social injustices occur and that it is unfair that she has to experience these social injustices. Her initial automatic thoughts were, "People will judge me because I am Black" and "People will think I'm stupid because I am Black." Some commonly used disputing questions would result in the client asking herself, "Am I 100% sure people will judge me based on my skin color?" and "What evidence do I have that people will think I'm stupid based on my race?" However, the use of these disputing questions in this context would invalidate the client's painful experi-

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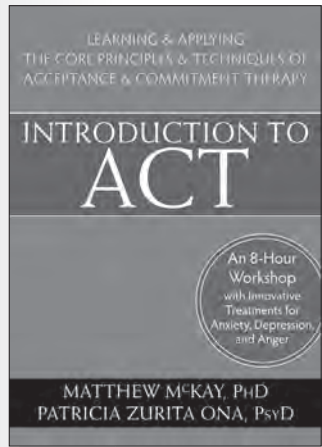
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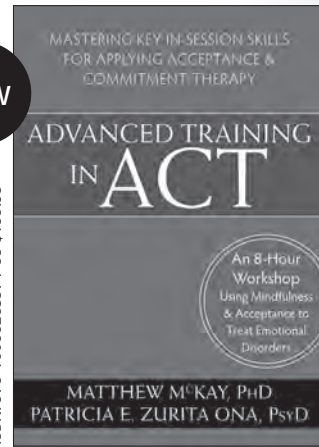
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FRAME
THEORY

RESEARCH &
APPLICATION

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ences and serve as barriers for effective intervention because she has likely had many experiences where people have judged her because of her skin color or have thought that she is inferior because of her race. Instead, we chose to target the internalization of racism by asking her disputing questions that referenced her competence, intelligence, and self-worth, rather than the experiences themselves. For example, we asked her, "What evidence do you have that you are stupid?" For this particular client, she was able to point to her strong grades as well as family members and friends who consistently applauded her for her work ethic and intelligence. The goal of this line of questioning was to help Corinna develop a defense against the internalization of racism and to have a rational response that might remind her that often her negative self-focused thoughts that arise in the face of discrimination are untrue. The rational response she developed was, "Even though I sometimes feel stupid, I have always done well in school and I know that I am a worthwhile and intelligent person." By validating her experiences of racism, while simultaneously disputing the veracity of her negative self-focused thoughts, Corinna was able to attend work and engage with her coworkers and customers in a way that felt safe and productive.

Another example of modifying cognitive restructuring techniques is illustrated with a 21-year-old White male client, Tim, who identified as gay and presented with social anxiety surrounding his interactions with the other players on his football team. He said that even though he had not come out to his team, he felt like less of a football player because of the insensitive jokes that were told in the locker room. Upon further exploration, much of Tim's anxiety was the result of feeling as if he were less of a "man" than the other men on his team. During therapy, we discovered that these feelings stemmed from a history of hearing offensive and crude jokes in football locker rooms since childhood, which often insinuated that men who are gay are not really "men." Rather than focusing disputing questions on the presence of homophobia and heterosexism in his daily experiences, we instead validated his experiences of heterosexism and allowed time for an open conversation about the ways that it is unfair that he experiences discrimination based on his sexual orientation. The disputing questions and cognitive restructuring process then focused on the meaning of being a man. Over the course of treatment, we were able to come to a less rigid meaning of maleness

and help Tim develop the rational response, "There is not one way to be a man and I can make choices about my gender identity." This rational response helped Tim combat the internalization of heterosexism that he was experiencing on a consistent basis with his teammates. It also motivated him to work on ways that he might ask his teammates to stop making offensive jokes.

Modifying Exposure Situations

Exposure is a commonly used CBT method to treat anxiety. There are specific ways that we can enhance exposure experiences for individuals from marginalized backgrounds who are struggling with anxiety. As an example, a 26-year-old Puerto Rican woman experienced a significant amount of social anxiety in many situations. As therapy progressed, a pattern evolved in Maria's automatic thought process in that she tended to experience social anxiety in situations that involved men, including dating situations, her job as a bank teller, and with male professors in school. In conceptualizing Maria's case, we called upon our knowledge and understanding of Puerto Rican modal cultural experiences and the gender roles that exist within this culture, specifically that traditional Puerto Rican families give men authority over women (Sue & Sue, 2004). With this knowledge in mind, we were able to explicitly ask Maria about her family background to get a sense of whether or not her cultural values were in line with traditional Puerto Rican standards. It is important to note that we did not make the assumption that Maria had traditional values based on her cultural background, but drew upon our knowledge of modal experiences within Puerto Rican culture and explicitly asked her if these values applied to her lived experiences. Maria's core beliefs about her role as a woman within the context of her work as a bank teller, her interactions with male faculty and students, and in dating situations were based in the ways that she learned to defer to male figures when growing up. By addressing Maria's cultural understanding of gender roles within these contexts, we were able to explore and tailor her exposures based on her choices around her interactions with men that felt in line with her cultural values. Maria was able to practice raising her hand in class and commenting on the material being presented by male professors because she valued her education and wanted to engage in class; however, she did not feel comfortable being more assertive in dating situations as assertive behavior

within these contexts was not in line with her cultural values. This meant that we did not work on these situations in therapy; however, we expressed to her that we could talk about this decision more at any point in therapy.

As another example, a White, 55-year-old female client, Sarah, presented to therapy to reduce the social anxiety she experienced with her work colleagues at an architecture firm. She described having multiple experiences of marginalization at work based on her conservative religious views, which were different from those expressed by many of the people in her workplace. Specifically, she talked about how her colleagues would shift the conversation from work-related topics to conversations about religion, which would result in them questioning her character when she expressed different viewpoints. Given her experiences with coworkers inappropriately chastising and alienating Sarah at work, the exposures we planned were not focused on talking with coworkers about her views but instead focused on helping her to assertively end the conversations by saying that it made her uncomfortable to talk about her religious views at work and that she would prefer to focus on the work projects. In addition, we helped Sarah plan between-session exposures that might help her feel less isolated in her life by reconnecting with friends who shared her religious views.

In a different example, a 22-year-old client, Tonya, who identified as a Korean American male-to-female transgender individual, reported experiencing significant anxiety with one-on-one social interactions and public speaking, particularly when talking about issues related to her identity as a transgender woman. She felt that her anxiety was preventing her from following her dream of being an advocate for transgender issues. In therapy, we conducted a progression of exposures that began with one-on-one conversations to help her become more comfortable about her fears of interacting with other people more generally. Next, we moved on to one-on-one conversations about the transgender issues she wanted addressed on campus. To address her public speaking fears, we then had her prepare two 5-minute speeches about mitosis and adolescent development (two things she was learning about in her courses). Finally, we had her prepare a speech that advocated for gender-neutral bathrooms on campus. She then gave this speech in front of her University's student assembly. This last speech represented the convergence of her general social fears about giving

speeches and her more specific fears related to her ability to be an advocate for transgender rights.

Conclusions

Given both the efficacy of CBT for anxiety and the focus on culturally competent practice in psychology, researchers and clinicians need to begin thinking of ways to integrate multicultural counseling and CBT. While the research, training, and application of culturally competent psychotherapy have increased over the last several decades, there is a continued need for culturally responsive clinicians to deliver CBT for diverse populations experiencing anxiety. We hope that the few examples presented here provide some ways that principles of multicultural counseling can be used to enhance CBT for clients from diverse populations.

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Conducting Research With Latino Participants: Blending Community and Science

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Although Latinos comprise 16% of the U.S. population and are the fastest-growing ethnic minority group in the country (U.S. Census, 2011), psychological research that includes significant portions of Latino participants or explicitly seeks to explore the extent to which findings from majority groups generalize to Latinos is sorely lacking. For instance, a PsycInfo search on {cognitive behavio* therapy} AND {efficacy OR effectiveness} within the abstract yielded 3,150 results, while the same search limited to those articles whose abstracts also included the words {Latin* OR Hispanic} yielded only 25 results, or .008% of articles whose main focus was to explore the efficacy of cognitive-behavioral treatments for myriad disorders. Furthermore, recent research reveals significant disparities in even basic social science research when findings that have been derived primarily from White samples were attempted to be duplicated in different cultural groups (Henrich, Heine, & Norenzayan, 2010). Taken together, such data suggest our field would be wise to increasingly direct efforts to study ethnic minority populations in general and Latinos specifically.

In this paper, we provide advice for researchers who are interested in focusing their efforts on studying minority populations. Our advice comes from a combined 20-plus years of experience researching and working with Latinos in our respective communities, as well as recommendations from ethnic minority scholars. Following our top-10 list of recommendations, we briefly describe our own programs of research and the specific ways in which we have attempted to implement these recommendations.

Just like when trying to understand lower participation in psychotherapy in general, understanding barriers to research participation by minorities may be conceptualized according to stages. The first stage involves determining what research questions to ask; next is selecting methods to answer the question; third is facilitating participation; and fourth is disseminating findings. At each stage, there are strategies investigators can utilize to reduce barriers and increase culturally appropriate research practices.

Stage 1: Determining Research Questions

#1: Be a Part of the Community You Wish to Research

Research, like psychotherapy (Bernal & Scharron del Rio, 2001), is a culturally infused endeavor. Being part of the community you wish to research can help you better identify the unique questions or contextual factors that impact a particular community. We do not mean to imply there must be an ethnic match between researcher and participants; instead, being part of the community means the researcher is actively engaged with the culture of her participants, whether this be through attendance at special cultural events, befriending members of the community, or serving community members through volunteer or other work. In so doing, the researcher gains important knowledge about the community of interest. Such knowledge may shape or mold research questions or can assist with generation of culturally specific hypotheses. Being involved in the community also has the added benefit of increasing the likelihood that the questions asked are meaningful to the group under investigation and align well with their concerns.

#2: Consider Cultural Values and Proximal Variables

Just as psychotherapy is enhanced when cultural adaptations are made (Griner & Smith, 2006), so too can many research studies be enhanced when investigators consider measuring cultural variables. Consider more proximal variables (e.g., linguistic competence, acculturation, acculturative stress, socioeconomic status, or discrimination experiences) and not only race or ethnicity to help interpret your results and to further advance understanding of the mechanisms by which culture may exert influence in psychological phenomena. There are excellent reviews available of acculturation measures (e.g., Wallace, Pomery, Latimer, Martinez, & Salovey, 2010) and numerous studies have pointed

to the importance of proximal variables in explaining apparent ethnic and racial differences (Williams, Yu, Jackson, & Anderson, 1997).

Stage 2: Selecting Methods

#3: Ensure Measures Are Conceptually Equivalent

Utilize translation methods that are meaning-based, not simply linguistically based, to enhance construct validity (Sidani, Guruge, Miranda, Ford-Gilboe, & Varcoe, 2010). Because many dialects differ, it is best if translated materials are geared towards the particular cultural group you intend to study. For instance, *coraje* in Mexico means anger, but in Argentina it means bravery. A questionnaire on responses to anger that uses the term *coraje* may be nonsensical to Argentinians if it was developed with Mexicans. Conceptual equivalence and culturally appropriate language are equally important in recruitment materials such as flyers, posters, and print or spoken advertisement.

#4: Pilot Test Research Protocols Prior to Implementation

Even when a person is embedded in the local community and has taken time to ensure measurement equivalence, misunderstandings regarding the participants' tasks are not uncommon. In our own work, for instance, we have found some of our participants have relatively little familiarity with Likert-type scales or the use of first-person vignettes to present research materials. In one study of discrimination perceptions, we found when we asked people questions that were prefaced with "Imagine you are looking for a job," many responded with comments such as, "But I am not looking for a job." In such a case, the use of third-person vignettes facilitated data collection. In all cases, piloting our protocols helped us understand where participants were likely to become confused or struggled with the tasks, allowing us to modify the research protocol and enhance valid data collection. Pilot or feasibility tests have also been recommended by others as a way to enhance participation of minorities in research (Yancey, Ortega, & Kumanyika, 2006).

Stage 3: Facilitating Participation

#5: Location, Location, Location

Facilitate participation by recruiting and collecting data in locations that are convenient to participants. Recruitment efforts should occur in locations or in media that are ideally geared towards your population of interest, such as Spanish-language newspapers or flyers in neighborhood churches or markets. Many times, the university campus will not be the most convenient or appropriate location for recruitment and data collection (Burlew et al., 2011). Of course, some studies require laboratory-based protocols; we address recommendations below for such cases. However, for studies that are not compromised by community-based data collection procedures, such procedures are often preferable for enhanced participation. In our own work, we have recruited and collected data from primary care waiting rooms, cultural festivals, community recreation centers, public libraries, and other spaces the Latino community frequents.

#6: Reduce Instrumental Barriers to Participation

In your research protocols, if you are able, it is best to provide child care, transportation vouchers or cab fare, convenient or flexible hours for participation, and/or other supports to your participants. Although these methods of recruitment have not been systematically tested (Yancey et al., 2006), our experience suggests they remove important barriers to participation, particularly for studies in which many people may not meet eligibility criteria for study inclusion.

#7: Utilize Local Leaders to Assist With Recruitment (Even Better, Become a Local Leader Yourself)

Myriad researchers (reviewed in Yancey et al., 2006) have utilized local leaders to increase community involvement and enhance minority participation in research. One reason this may be a particularly effective recruitment method is because local leaders have the community's trust, while researchers often do not (Yancey et al.). If recruitment materials have been placed in culturally appropriate locations and utilize language that is meaningful to the community, trust between the community and research team can begin to develop even prior to data collection. Another related recommendation is to utilize bilingual and bicultural research assistants. Although some studies have suggested this does not enhance recruitment of minorities (Woodall, Morgan, Sloan, & Howard, 2010), it may assist with trust building.

#8: Enhance Informed Consent and Debriefing Procedures

In part because of historical exploitation of minority research participants (Scharff et al., 2010), and in part because some research protocols require disclosure of sensitive, stigmatizing, or even illegal behavior (such as immigration status), informed consent and debriefing procedures should be thorough and address the particular concerns minority participants may have. In our experience, many Latinos are unfamiliar with psychological research because it is often not part of advanced degree requirements in Latin American universities. A thorough consenting procedure can help reduce suspicion and engender trust.

#9: Appeal to Community Values

Incentives for research participation are often phrased in terms of the individual (e.g., payments, treatment, or knowledge gains for the participant). However, appealing to how participation can benefit the community may be as or more effective for Latino participants. In our own work, many participants have commented during debriefing that their biggest hope is that results will be used to help others.

Stage 4: Disseminating Findings

#10: Gear Dissemination Efforts to the Local, Not Only the Scientific, Community

Psychological research is often of inherent interest to others, particularly those who have participated in our studies. As a final recommendation to enhance participation in future studies, we have found it important to disseminate our research findings to the local community. Our dissemination efforts have been through newspaper and radio interviews, free psychoeducational workshops, and other outreach efforts. These have the dual purpose of disseminating our findings and enhancing our visibility and credibility in the local community (see recommendations #1 and #7).

Examples From Our Research Programs

Program of Research Example A: University of Arkansas

The program of research at the University of Arkansas primarily focuses on factors that impede mental health service utilization for Latinos (e.g., Bridges, Andrews, & Deen, 2012). A related branch of research examines the efficacy of integrating mental health services into primary care as a way to increase access to mental health services for underserved populations (e.g., Bridges et al., under review). When I (Bridges) first arrived at the university, I was the only ethnic minority faculty member in our department and the local community of approximately 450,000 did not include a single Spanish-speaking psychologist. My initial efforts to study utilization barriers in the community were a disaster: Hanging flyers and putting advertisements in local papers, even Spanish-language papers, was not at all successful. After many months of unsuccessful attempts with traditional recruitment methods, I sought mentorship from a colleague of mine in another department who also did work with the local Latino and Marshallese populations. He taught me the importance of recruiting local leaders who could in turn recruit from the communities of interest. I met with religious leaders, local nonprofit organizations, radio and television personalities, and other figureheads in the Latino community. I attended community events where these local leaders would introduce me to potential participants, "vouching" for me (*personalismo*). This "blessing" I received from a trusted resource was instrumental in getting my research started.

Since then, while I continue to work closely with local leaders, I have in the intervening 5 years also focused on becoming a local leader and resource myself. I began providing workshops on behavioral health topics such as depression, parenting, and sleep problems that were free, given at local community centers that already served large portions of the Latino population in Northwest Arkansas, and in Spanish. I also became involved in two local nonprofit organizations, serving on the board of one and providing consultation services to the other.

The ability for participants to see the direct connection between my research and the local needs of the community was important; many participants thank us when we have completed data collection and expressed specifically their participation was motivated by a desire to help others who were in similar situations or faced similar stressors. Our recruitment materials and consent forms therefore include the ability to help the local community as one benefit of participation, in addition to monetary or other personal compensation.

Our data collection rarely occurs on the university campus. Instead, most of our studies take place in community recreation centers, at local festivals that are targeted towards Latinos (e.g., annual Cinco de Mayo festivals), churches, and community health clinics that serve large portions of minority residents. These are not only places where the population of interest already congregates, but also most are on major thoroughfares that are accessible with public transportation.

My program of research has attracted very talented ethnic minority students, both graduate and undergraduate, which has helped with recruitment and research participation tremendously. These bilingual and bicultural students have also helped with linguistic and conceptual equivalency of translated materials and piloting of measures with local residents. The ability to shift from English to Spanish has been very important in the research we have conducted, in which participants' level of acculturation may dictate a "Spanglish" interview at times. It also permits researchers to note when protocols appear to be confusing or questions are unclear and increases rapport.

Program of Research Example B:
University of Texas at El Paso

The Clinical Practice Guideline for treating tobacco use and dependence (Fiore et al., 2008) recommends that researchers attend to developing, assessing, and implementing culturally sensitive approaches to smoking cessation. Tobacco control, particularly smoking cessation, has been underresearched in Hispanics (Webb, Rodríguez-Esquivel, & Baker, 2010). Dr. Cooper's research aims to enhance cessation services and more generally public health-based tobacco control for Hispanic/Latinos.

When I (Cooper) transitioned from working with veterans to border region Hispanic/Latinos, the change was striking. Not only were cultural considerations salient but smoking patterns varied dramatically from quite heavy smoking to light and intermittent smoking. At the time, little research had addressed Hispanic and/or light and intermittent smoking, necessitating assessment studies highlighting Hispanic smoking profiles and correlates of Hispanic smoking to inform future intervention efforts (Cooper, Rodríguez de Ybarra, Charter, & Blow, 2011; Rodríguez-Esquivel, Cooper, Blow, & Resor, 2009). For

these assessment studies, we recognized the need for recruitment advertising to be both in English and Spanish, the importance of using media outlets that would reach potential participants (i.e., Thrifty Nickel and El Paso Times), the need for consent forms and surveys to be offered in both languages, and the importance of offering multiple times throughout the day and evening to facilitate accessibility and participation. Results from these studies and focus groups assisted in piloting a smoking cessation intervention for college student smokers in the Student Health Center (Cooper et al., 2012). Results from assessment and intervention studies confirmed the need for the development of cessation efforts that clearly focused on light and intermittent smoking on the border, as well as the need to continue to work on the university campus, yet also to broaden to other clinics and medical centers to promote cessation in community smokers.

Simultaneously, our research laboratory sought funding from a regional foundation (Paso del Norte Health Foundation) to assume leadership of the A Smoke Free Paso del Norte initiative. In this role, leadership in population-level tobacco control and

public health and wellness efforts crystallized, and soon we were leading a thriving Paso del Norte Tobacco Control Network comprised each month of over 40 regional tobacco control stakeholders from El Paso, New Mexico, and México. This new leadership role led to having access to multiple individuals from regional clinics and medical centers, which allowed for the promotion of our light and intermittent cessation program. Shortly afterward, our cessation program was actively being offered not only on the university campus but in two major medical centers and a community-based clinic (Cabriales, Cooper, Salgado-Garcia, Naylor, & Gonzalez, 2012).

Throughout all of these efforts, multiple lessons were learned in attempting to reach traditionally underserved populations in research. First, not only did all materials need to be in both languages, they required systematic translation, back translation, and the review and collaboration of a panel of linguistic experts and lay people familiar with border region Spanish usage. Second, location is critical. Being in the clinics and not just on campus heightened accessibility, trust, and ultimately participation. Third, making the shift to community-based clinics

necessitated multiple changes to the program, including the following: adjustments in reading level of materials, offering multiple contact modalities for follow-up (internet for campus students, telephone or postal mail for community smokers), and alterations in the types of incentives provided (e.g., different gift card sites for students and community residents, water bottle promotionals for students, pill dispensers, playing cards, and grocery bags for community smokers). Finally, the use of resources was critical from funding to networking opportunities. However, likely the most vital resource was and is a remarkable team of undergraduate and graduate students whose practice and research efforts not only allowed for successful implementation of our programs but also provided feedback for needed programmatic changes to enhance the cultural sensitivity of our initiatives.

Conclusion

Reaching underserved populations such as Latinos and other ethnic and racial minorities is feasible yet challenging. The challenges are particularly amplified in the case of recent immigrants, who face additional barriers to health care access that mirror barriers to research participation. If the science of psychology seeks to better understand the experiences of underserved populations and work to reduce health disparities, greater efforts towards the recognition and amelioration of research participation barriers will be required. In this paper, we have articulated a set of recommendations to overcome the challenges researchers may face when trying to study underserved Latino populations. In our own work, we have found these challenges often stimulate leadership and community outreach efforts. Furthermore, they may facilitate and enhance the mentor/student relationship. In addition to advancing our fields of study in important ways (for instance, by helping us identify the universality or limits of our behavioral interventions), reaching underserved populations is critical to improving the health and mental health of our communities.

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Building Research Relationships With American Indian Tribal Communities: Experiences and Lessons Learned

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Since 1492, American Indians/Alaska Natives (AIs/ANs) have been subjected to systematic attacks on their culture, religion, and way of life through colonization (Thornton, 1987). Researchers who implemented Western scientific methods to "help" Native communities (Davis & Keemer, 2002) only perpetuated mistreatment and degradation of Native communities and culture. Often, researchers would collect data without full consent of AI/AN community members or use data without disseminating the findings in a productive or helpful manner (Davis & Keemer). Not surprisingly, AIs/ANs may be reticent to participate in research and feel the need to protect their communities. In the 2010 Census, 2.9 million individuals self-identified as only AI or AN (Norris, Vines, & Hoeffel, 2012). Research has shown that AI/AN communities experience mental health disparities, including substance use, suicidal behavior, and trauma (Gone & Trimble, 2012); however, tribal diversity must be taken into account when working with a particular community. Research on AI/AN mental health began approximately 40 years ago and great progress has been made in the last 13 years (Gone & Trimble).

In the current paper, researchers who have worked in Indian Country, representing both faculty- and student-level perspectives, will share their experiences and lessons learned. The first perspective discusses the overall research process and lessons learned from a well-established research collaboration with a tribe, and the latter perspective provides a specific case example of forming new relationships as part of a dissertation project.

Building a Collaboration With an AI Tribal Community

The Johns Hopkins Center for American Indian Health (JHU CAIH) in Baltimore, Maryland, has a 30-plus year relationship with the White Mountain Apache Tribe (Apache) in Northeastern Arizona, consisting of service and Community Based Participatory Research (CBPR) projects related to infectious diseases and behavioral and mental health. Many of the evidence-based interventions developed by the collaboration have been replicated with other similarly-challenged communities around the world. How does a long-standing (and

in our case, long-distance) tribal-university collaboration process work?

Engaging the community and building relationships is critical. Even with the support of this infrastructure, team members must devote sincere efforts to these responsibilities, especially at the start. Making oneself known to the community and building trust involves learning from them what mental health issues are their top priorities. There will be a time and place to share your background and expertise; however, it is important to do more listening than talking and honor their lead. *For example, the Apache first reached out to JHU in 1993 to work on mental health issues in the midst of a youth suicide epidemic on the reservation (Mullany et al., 2009; Wissow, Walkup, Barlow, Reid, & Kane, 2001), because of the history of jointly working together to eradicate childhood mortality due to infectious diseases. At both a policy and service level, this partnership has resulted in the first mandated community surveillance system for suicide and related behaviors of its kind.* It is important to be present in the community and set aside time during visits to meet with different stakeholders, ranging from the tribal chairman to elders, and express interest in participating in local events, such as traditional ceremonies, community fairs, and sporting events. As someone who is not AI or from the community, these informal opportunities allow me to meet other individuals and to humbly learn about the community, often leading to greater clarity about something I may have misunderstood about the culture. These relationship-building opportunities are even more critical when distance between the collaborators is a concern. As a result, there is a need for investing time in maintaining regular in-person visits and phone contacts.

Each tribal community will have different levels of readiness to engage in research and it is important to start where they are. This process can be facilitated by first conducting service or formative/qualitative projects. *For example, our "Cradling Our Future" line of research started many years prior by providing parent training to the community, then receiving foundation money to develop and evaluate the intervention, and culminating in an NIH-funded randomized controlled trial (Walkup et al., 2009). This intervention is being disseminated across the country and integrated into local urban and reservation care systems, including Early Head Start programs. Similar to our projects, the Indian Health Service is using a range of interventionists, from paraprofessionals to public health nurses. In another instance, a case-control study of youth who engaged in binge drinking started with a qualitative component that helped to* better inform the researchers of community and cultural perspectives on the issue (Tingey et al., 2012). Foundations and organizations like Substance Abuse and Mental Health Services Administration (SAMHSA) are excellent resources to fund formative work and mental-health-related services, which can have program evaluation. In addition, you can assist the tribe to analyze data they already collect, which could lead to prioritizing your areas of expertise and provide the foundation for future grant applications. *For example, the Apache collect surveillance data on self-injury. We were able to help them identify and examine nonsuicidal self-injury and binge drinking as pressing public health concerns (Barlow et al., 2012; Cwik et al., 2011).* For long-distance relationships, it is beneficial to be approached by the tribe as a result of previous collaboration, or to have a connection to the community. It is even more important to bring special expertise, some service or training to the community, and the possibility of a long-term relationship, as the tribe may have other university partners closer by.

Formative Work to Understand the Problem, Generate Ideas, and Draft the Proposal

Once you have come to an understanding of a joint priority mental-health-related issue, *meet with various stakeholders to discuss the problem*—medical and mental health staff, Health Board, Tribal Council, Elder's Council, newspaper staff, local radio station, and Elder's Council. Based on this feedback and our expertise, CAIH designs various proposals. Thereafter, we bring proposals back to these groups for further feedback and to determine if the proposals addressed their needs. It is erroneous to think that you will always get an "answer" to your question when asked through this more formal process—while important, it is often the times when you are building the relationship or talking about something else that you might learn the most. The process for drafting proposals is iterative and collaborative. We have a scientific review of proposals by JHU Baltimore-based and Apache team members. Next, we garner support from all groups to proceed for various IRB approvals, in our case, Tribal Health Board, Tribal Council, Phoenix Area Indian Health Service, and JHU. Due to interactions with several IRBs, this process can take longer, but is important because ethical concerns related to research with AI communities are paramount. Special attention must be paid to research burden, noncoercive incentives, culturally appropriate measures, choice of comparison groups, and randomization. When interacting with tribes around these issues, transparency is key and education about balancing scientific and ethical issues is welcome.

Conducting the Research

CAIH has used a model of hiring and training local Apache staff to conduct the research with technical assistance from JHU. This model is appropriate for any type of tribal research, but can be especially important in mental health because of stigma and possible preferences for sharing information or receiving interventions from local community members. This approach also shows a commitment to the community to employ members and provide them with additional skills, as well as being practical given our long distance. *For example, in an open trial of a brief Emergency Department–linked intervention for youth who made suicide attempts, Apache were trained and employed to recruit participants and deliver the follow-up and intervention components, and they were integral in the development of this tribally owned intervention.* Using a CBPR process is important throughout the study. We have ongoing collaboration in implementing research and interpreting data. There is tribal approval of *all* data distribution. CAIH's model maintains that the tribe owns the data and we are the stewards who provide technical assistance in data analysis. Additionally, it is important to circulate the results back to the community in meaningful ways (e.g., newsletters, community events and local media).

Case Example: Building Research Partnerships With Two AI Tribal Communities to Address Intimate Partner Violence

A growing literature documents the troubling nexus between historical trauma, intimate partner violence (IPV), and substance use in many AI communities (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Koss et al., 2003; Walters, Simoni, & Evans-Campbell, 2002). This case example details one researcher's progress in building strong research relationships to address these critical issues in the Indian Health Service's (IHS) Aberdeen Service Area and the upper Midwest. It was important for me to review AI research, AI research methodologies, and cultural customs of the communities with whom I was considering partnering. Approximately 104,000 AI/ANs living in rural areas of the IHS

Aberdeen Area in North and South Dakota, Nebraska, and Iowa endure challenges with poverty, limited health care, unemployment, and few educational opportunities (Thomas, Rosa, Forcehimes, & Donovan , 2011). There is a distinct interplay between the role of alcohol and drug abuse on mental health disparities, including suicide, among AIs/ANs in the Aberdeen Area (LeMaster, Beals, Novins, & Manson, 2004; Olson & Wahab, 2006). Fewer studies have included these factors in the context of IPV (Evans-Kipp, 2004; Green, 2012).

Research Within the Northern Plains and Upper Midwest

Northern Plains. Before meeting with a Northern Plains AI community, I established a continuing relationship with a Native research mentor at the University of North Dakota (UND) and her AI research team. Dr. Jacqueline Gray (Cherokee/Choctaw), Director of the Seven Generations Center of Excellence in Native Behavioral Health, encouraged me to engage in local IPV advocacy efforts as a starting point. Additionally, Dr. Gray introduced me to an AI community liaison, a key domestic violence stakeholder within her

community. I was asked who my relatives were and where I grew up; as a psychologist I was trained to be objective and cautious when revealing "personal" information. However, I realized that would not work for my community partners and I shared some of my ethnic/cultural history (African American and Eastern Band Cherokee) and discussed the meaningfulness of conducting culturally sensitive research. The AI leader shared her life journey with me and provided cultural insights into the community's primary concerns of IPV, sexual assault, and child abuse.

After initial discussions about culturally appropriate ways of connecting with community members, I was invited to participate in health-wellness conferences and community events (e.g., pow-wow and community outreach). The formal and informal connections with the reservation community led to a meeting with key tribal organizations. A needs assessment was conducted informally and the outcomes identified included IPV advocates and tribal community needs broadly (e.g., issues with family relationships, substance use, IPV and related trauma, cultural identity, and resilience). As a result of the needs assess-

ment, a collaborative parenting program was developed that incorporated traditional cultural practices and developmental psychology.

Upper Midwest. When attending a historical trauma and AI health disparities themed conference (hosted by White Bison) in the upper Midwest, I became familiar with the reservation community and met a variety of formal and informal community leaders (e.g., IPV advocates, Tribal Council members, traditional healers). Additionally, I was introduced to an IPV advocate (aligned with key stakeholders in her community) and we discussed the concerns within her reservation community. She identified similar themes as the Northern Plains community, including IPV, sexual assault and child abuse, with a specific focus on how these issues impact girls and women. Many of the experiences were not evaluated in the context of mother-daughter relationships, and, as a result, the collaborators planned to make it a research focus. Subsequent meetings with the upper Midwest liaison, the Northern Plains liaison, and my dissertation committee led to a more formal community assessment and organization of my dissertation research.

Developing Research Relationships

After meeting with liaisons from both reservation communities separately, the groups agreed on key factors to consider and supported the selection of measures focused on IPV/trauma, ethnic/cultural identity (bicultural American Indian identity), attachment, and resilience. An additional review of the information with tribal agencies transpired, and a gathering of feedback from AI community experts about appropriate qualitative questions to ask participants followed. Each of the liaisons went to their tribes on my institution's behalf to ask for permission to conduct the research. In one community, I participated in the tribe's meeting and provided further information. These efforts were extended in order to demystify the research process, facilitate trust building, and discuss ways to best collaborate. Recruitment strategies were collectively developed and put into place and included media (e.g., local tribal newspapers, radio ads) as well as snowball sampling. It was important that I learned about and incorporated aspects of cultural customs (e.g., traditional healers/practices, smudging sage, tobacco, etc.) that might be helpful for participants and/or AI community stakeholders. Partnering with traditional healers and IPV advocates in each community also helped me to direct participants to immediate support as needed.

The research project took approximately 2 years to complete and is among the first to include mother-daughter dyadic outcomes, attachment, PTSD symptoms, substance use, and ethnic/cultural identity. In my initial research plan, I did not factor in an extended time frame. Therefore, I had to reestablish relationships with newly elected Tribal Council members, as well as adjust my graduation date. As part of the tribal resolutions, the data remain with the AI communities and short write-ups of the research, as well as related research proposals, are being developed with the respective tribes' approval. Plans are in place to work on sustainability efforts (e.g., grants) and tribal policy briefs regarding domestic violence in Native families. Additionally, tribal domestic violence shelters were identified as necessary in the communities surveyed and are in the process of being built. Finally, it was important to evaluate the process through reflecting on the research, receiving feedback from collaborators, and making necessary adjustments. This process was helpful because the reservation communities were actively engaged in aspects of the research and felt that their voices were heard when changes were made.

Conclusion

Despite growing awareness of the issues facing AI/AN communities among health professionals, significant physical and mental health disparities remain, thus creating a great need to conduct culturally relevant research (e.g., CBPR) with tribal communities. Some of the issues facing some AI/AN communities include poverty, health care and educational access, IPV, substance abuse, and suicide. Clinical psychologists have unique research and clinical training appropriate for understanding many of these issues and developing and evaluating culturally appropriate, evidence-based interventions.

The imminent need for services in many AI communities may tempt psychologists to "jump in" to research, ready to go with their expertise and related research goals. However, it is only through a secure collaboration and thoughtful research process that we can serve as advocates for the needs of AI/AN communities and create sustainable solutions to long-standing problems. As the aforementioned researchers emphasized through their own experiences, researchers must engage the community from start to finish, beginning with developing trust with community stakeholders. Researchers should involve the community in formative/qualitative research to determine the most pressing health needs of the community. Additionally, when possible, community members should be hired to conduct the research. After the project has ended, researchers should maintain a mutually beneficial relationship with the community and conduct a process evaluation of the research.

In summary, conducting research according to CBPR principles with tribal communities may include a lot of activities (*and time*), which researchers (*and sometimes funders*) do not normally take into account; however, the benefits of engaging in this collaborative process outweigh the challenges. By allowing the tribal community to gather data, there will be a better understanding of community issues and resources to address said issues. More important, tribal communities that participate in research can serve as models for empowering other communities to be involved in the research process. Continued research with tribal communities has the potential to combat physical and mental health disparities and has great implications for culturally-relevant prevention and treatment programs.

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Therapist, Know Thyself: Fostering Cultural Competence in Clinical Supervision

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Twenty years ago Sue, Arredondo, and McDavis (1992) issued a call to the profession regarding multicultural counseling competencies and standards. They offered a pivotal three-dimensional conceptual framework proposing that development in cultural competence address the attitudes and beliefs, knowledge, and skills of the counselor. These have become known broadly as multicultural competencies. Despite the usefulness of competencies, Arredondo (1999) provides a caveat for contextualizing multicultural competencies, noting, "there is no cookie cutter recipe for how to counsel an African American, Latino, etc. . . . these guidelines provide a way to investigate the client's sociopolitical context" (p. 104). So, along with didactic courses in multicultural issues, experiential training and direct supervision from a culturally competent supervisor are essential to becoming a culturally competent clinician (Constantine, 2001; Hill, 2003; Miville, Rosa, & Constantine, 2005; Sue & Sue, 2012).

Furthermore, experiential training is an effective method for fostering multicultural competence in psychology trainees (Roysicar, Card, Hubbell, & Ortega (2005), and when executed appropriately, trained supervisors can be a gateway to multicultural knowledge and skills for trainees (Ladany, Inman, Constantine, & Hofheinz, 1997). Culturally competent supervisors actively convey acceptance of cultural differences in supervision and assist counseling students in examining the impact of their cultural background on clients and exploring the client's perspective (Ancis & Marshall, 2010). While many training programs in psychology offer courses in diversity issues or multicultural psychology, provision of direct training and supervision in cultural issues is less common (McMahon & Simons, 2004). The dearth of psychologists who have had multicultural training themselves has contributed to the lack of available culturally competent supervision (Wong, 2006).

Experiences as a Supervisor of African Descent

Though multicultural competence in supervision has become more prominent in psychology literature (Butler-Byrd, 2010; Jernigan et al., 2010; Pack-Brown, Coulter, & Fuller, 2011), much of the current research addresses the experience of European American supervisors with supervisees of color (Burkard et al., 2006; Utsey, Hammar, & Gernat, 2005). Few published articles discuss the experiences of supervisors of color. In this paper I will discuss the ways I engage in multicultural supervision as a woman of color and foster development of cultural competency with supervisees.

Since beginning my path in psychology, I have heard and read several psychologists quote the great Frantz Fanon, a Martinique-born psychiatrist and revolutionary, who said that people of African descent seeking to rise above oppression must be prepared to answer three profound fundamental questions: Who am I? Am I who I say that I am? Am I all I ought to be? (Fanon, 1967). Thus, I begin my discussion on multicultural competence in supervision by answering this question "Who am I?" I am a woman of African descent, raised by southern-born, working-class parents who were politically and socially active in the Black community in an urban, segregated city (Milwaukee, Wisconsin—one of the most segregated cities in the United States; Bradford, 2011). I recognize that my upbringing and collectivistic cultural experiences have undoubtedly shaped my interest in social justice, far before I even truly understood what the term meant.

Learning about the sociopolitical and historical context of racism and oppression inherent in traditional psychology (Guthrie, 1998) as an undergraduate fueled my interest in decolonizing the discipline. Decolonization of psychology has begun in a variety of ways—for example, the contributions of Black psychological theoretical perspectives, feminist psychological theory, and the multicultural competence literature. These approaches are examples of perspectives that challenged the White, male Eurocentric worldview that dominates Western psychology. For me, the choice to pursue graduate training in counseling psychology was due to the focus on social justice in the subdiscipline, and the challenges that I saw being offered about mainstream psychology. As a graduate student, I focused on culturally relevant approaches that were intended to service the needs of oppressed peoples. Over the years, I have developed an integrative theoretical orientation that is a combination of African-centered approaches to psychology (Akbar, 2003; Myers, 1993; Parham, 2011; Wilson, 1993) and systemic therapy (Boyd-Franklin, 2003). Additionally, I hold a transformative view of humanity (i.e., I believe that individuals hold within them the power to change and can heal themselves), and I value a holistic approach to healing that honors the interconnectedness of mind, body, and spirit.

Comparatively, my supervision style is rooted in understanding my supervisees' cultural contexts, the cultural values and central needs of their clients, and how, along with my cultural lens, these all influence the supervision relationship and development of therapeutic knowledge and skills. Use of self and acknowledgment of value conflicts is central to the feedback I provide on supervisees' behavior in the therapy room. While I provide a supportive, safe environment in which they can explore their progress toward goals, I employ Socratic questioning to encourage critical thinking and intentionality. In review of their written work, I comment on their ability to provide an integrative description of the client and a collaborative, holistic approach to interventions. This paper explores my approach to fostering cultural competence development through facilitating self-awareness, use of the therapeutic relationship, and exposure to diverse approaches to therapy and alternative resources.

Self-Awareness

The Western, positivistic epistemological perspective in psychology purports that bias must be eliminated from our research and practice. More modern, critical, and decolonizing approaches to psychology recognize how inherent bias is in our work as clinicians and researchers. Cultural competence literature suggests what may be more useful is to examine our biases, how they have become a part of who we are and how we work, and then develop a plan for how to minimize the negative impact of these biases on our work. Hays (2008) notes that in response to the need for understanding individual manifestations of culture, clinicians may attempt to take an approach of not making any assumptions about their clients and to let clients disclose important cultural information.

> Although such an approach is well motivated, it contains a problematic assumption, namely, that therapists are able to assume nothing about their clients if they choose. The idea

that one can "turn off" preconceptions about groups of people is appealing. (p. 25)

Unfortunately, this approach usually leads to a lessened awareness to the assumptions that one is undoubtedly bound to have. I believe that self-awareness is absolutely essential for supervisees' foundational development of cultural competence. Just as I have shared my identity and background in this paper to contextualize my perspectives on cultural competence in supervision, I ask supervisees to consider their own identities and how they shape their beliefs about human behavior, the change process, and their gravitation towards a theoretical orientation.

During the first few weeks of the semester, students are asked to develop a supervision contract highlighting their perceived strengths, and areas of growth and the training goals they have for the semester. They also evaluate their learning styles and how they like to receive challenging or constructive feedback. Thomas (2000) refers to this as "goaling" and believes that this can be a way of fostering a collaborative, competency-based approach to supervision. I follow review of the goaling document in session with a conversation about their person-of-the-therapist identity. Aponte's person-of-the-therapist model is a training and supervision approach with the primary focus of maximizing the effectiveness of the use of self in therapy (2013). Central goals of the model are

> increased knowledge of self, meaning identifying our own personal issues, their histories and how they manifest themselves in our work with clients…. Achieving a greater mastery of self, with all our assets and woundedness, that allows for a more active, conscious and purposeful use of self in our relationships with clients, and in the implementation of our technical tools in assessing and intervening with clients. (p. 1)

Using goaling (Thomas, 2000) and person-as-the-therapist (Aponte, 2013) perspectives, I ask supervisees to examine their own identities and who they are as cultural beings, and how this impacts their work with clients. Moreover, I ask them to reflect on the stereotypes they hold about people who belong to historically marginalized groups and what efforts they plan to make to address their biases. Within group supervision, for instance, supervisees are questioned about their expectations from clients along with personality traits and behaviors of clients that are most valued in the thera-

peutic process. Also, supervisees are asked to discuss their fears or challenges with particular types of clients and how this may relate to their interpersonal experiences outside of training. This is intended to promote consideration of how, if at all, students are drawn to particular orientations because of their personal value system. For example, a heterosexual student with strong religious beliefs indicated the need to work on perceptions of homosexuality when faced with two gay clients on her caseload. The student was quite open to discussion regarding the ways her views may be influencing the development of the therapeutic alliance with her clients who identified as gay. While I certainly avoid turning group supervision into therapy, students find it quite valuable to share and hear others speak about what shapes their perceptions of humanity and the therapeutic process. This knowledge of self often spurs greater intentionality in conceptualization, treatment planning, and interventions with clients (Parham, 2002).

Use of the Supervision Relationship

Developing trust in the supervision relationship is different for supervisors of color (Reynaga-Abiko, 2010). As a woman of African descent, I am often the first professor of color most of my European American students have encountered and almost certainly their first supervisor of color. For some, the absence of experience with my demographic in a position of authority can lead to questioning my expertise and intelligence. Supervisees might seek out a "second opinion" when provided with directives regarding therapy with their clients.

For example, a doctoral supervisee of European decent was adamant about her stance on maintaining an individual therapy relationship with a female, teenage client when both the client and her mother described serious challenges in the mother-daughter relationship. After several weeks of my suggesting family therapy to the supervisee, she conducted a presentation in a didactic course where the White, male professor suggested family therapy. The student returned to supervision the week after her presentation with a sudden readiness to entertain family therapy with the client. I processed the sudden change with the supervisee, noting that she previously seemed resistant to that modality. She noted that the presentation feedback from the professor and her peers was additional data for her and confirmed what I had been suggesting for weeks. It was not until another (White) professor and about 20 students co-signed my assessment of the case that the super-

visee trusted me enough to follow my suggestions for treatment. This discussion was a turning point in the relationship. The week following our session where she shared her presentation experience, I raised the issue of what I perceived as resistance from the supervisee. We processed her experiences as an international student and how she often felt incompetent. I shared my experience as one of two Black professors in a predominantly European American body of faculty within a predominantly White institution where I often experienced microaggressions from European American students who questioned my authority. Microaggressions are subtle, innocuous, preconscious, or unconscious degradations and putdowns, often kinetic but capable of being verbal and/or kinetic. In and of itself a microaggression may seem harmless, but the cumulative burden of a lifetime of microaggressions can theoretically contribute to diminished mortality, augmented morbidity, and flattened confidence (Pierce, 1995, p. 281). This experience of microaggressions led to a warm, yet frank exchange about the supervision relationship and the dynamics that might be influencing our interactions. With this open discussion about our cultural backgrounds came greater inclusion of cultural factors in her case conceptualizations of her clients.

Exposure to Diverse Counseling Approaches and Resources

It is important for students to acknowledge that approaches to therapy that were created in one cultural context may not fit those from another cultural group (Pack-Brown et al., 2011). If clinicians have been mandated to engage in self-reflection, knowledge, and skill development in preparation to treat clients from an equitable and respectful orientation, they must be exposed to diverse approaches to counseling.

Throughout the academic year with doctoral trainees in a group supervision course, I infuse both critical perspectives of traditional psychotherapy approaches and introduce culturally specific modalities. Specifically, supervisees are encouraged to contemplate the challenges that using a traditional approach might pose with a client who belongs to a traditionally marginalized group. For instance, a White trainee in a group supervision class expressed difficulty in completing intakes and developing rapport with African American families. I introduced the students to Nancy Boyd-Franklin's *Black Families in Therapy* (2003) and discussed her broad approach to completing intakes and how to gather in-

formation about the families in a way that honored their collectivistic nature. We discussed the role of the extended family and fictive kin for families of African descent. For instance, asking clients about people who are important to them who may not be biologically related not only provides information about additional sources of support, but conveys an awareness of African worldviews.

Furthermore, use of culturally responsive diagnosis is a topic I discuss in group and individual supervision. Often, people of color and those from lower socioeconomic backgounds are overpathologized or misdiagnosed (Whaley & Davis, 2007). To promote awareness of cultural influence in the diagnosis process, I incorporate Hays' (2008) ADDRESSING model and proposed sixth axis when using the DSM-IV-TR. The ADDRESSING model is a broad way to consider the experiences of historically marginalized groups in the United States and Canada: "age and generational influences; developmental disabilities; disabilities acquired later in life; religion and spiritual orientation; ethnic and racial identity; socioeconomic status; sexual orientation, indigenous heritage; national origin; and gender" (Hays, 1996, p. 4). She proposes that making a culturally responsive diagnosis calls for examining the influence of cultural factors on the client, or a sixth axis, which she argues should be the first step in the diagnostic process.

When supervisees have received a new client intake, I ask them to consider the client's cultural identities and consider cultural influences as they take a holistic assessment of the client. This includes how clients conceptualize problems from their own perspectives (Hays, 2008).

The incorporation of questions about culture, in addition to required intakes, can sometimes be cumbersome for new clinicians, particularly if they have not had previous training that highlighted the psychological importance of cultural variables. An illustration of this occurred after group and individual supervision meetings about gathering data from clients about the role of culture in their lives. A European American woman supervisee felt ready to explore the role of race in her therapeutic relationship with a Latino teenage boy she had been working with for about three sessions. She fumbled through her introduction of the idea of "seen and unseen differences" only to find that, in their fourth session together, the client "didn't have a problem" with having a therapist of a different race and gender. In retrospect, the su-

pervisee reflected on a need for developmentally appropriate language and a more direct description. What she described as a failure was actually useful in several ways—by actively engaging in a discussion about culture with a client, she created a baseline for what she might say to clients to introduce diversity issues, and she communicated a willingness to have what may be perceived as difficult conversations with her client. A few months later, the client spontaneously reported an incident at his predominantly White school where he had been the victim of microaggressions from peers and discrimination from school staff. The supervisee believed that her initial discussion about therapy being a safe domain to discuss issues of diversity opened space (White & Epson, 1990) for the client to raise this experience. The supervisee had considered her own salience value and the cultural identity of her client when first broaching the topic of race and other diversity factors, which facilitate openness to discuss it in the future (Boyd-Franklin, 2003).

Another way I teach supervisees to value diverse cultural perspectives is to learn about sources of support in the communities where clients live. In addition to the inherent bias towards epistemological approaches that are not positivistic in nature, there is a bias in the psychological community that help can only come from us (or medication). Supervisees in clinical training settings often have access to referral lists for clients for medical or psychological services; I charge trainees with the task of exploring, according to the client's values and identity, sources of support for contextual factors present in their client's life. One White male supervisee, for example, was working with a middle-school-aged Black male in therapy who expressed a lack of time and attention from his divorced mother and father. The client's mother signed the client up for a "big brother" mentor through a local organization, but the client still expressed a desire for more community interaction as he often spent his afternoons alone while his mother worked a second job. The supervisee was given the task of researching mentoring and extracurricular programs in the child's neighborhood. This not only allowed him to familiarize himself with what was available in the city, but he had to consider the child's context beyond the therapeutic relationship, which fostered greater empathy and understanding in the therapeutic relationship.

Conclusion

As the demographics of the U.S. become increasingly culturally diverse, the discipline of psychology must educate and train clinicians who are multiculturally competent (American Psychological Association, 1993, 2003). The diversity in training relationship is becoming more complex as well (Butler-Byrd, 2010). The presence of diverse clinicians in the field will certainly benefit the numbers of persons from various cultural groups—racial/ethnic, sexual orientation, ability status, etc. (Hays, 2008). It is imperative, however, to ensure that clinicians posses the cultural competence, particularly self-awareness, to meet the needs of culturally diverse clientele.

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The Development of a Diversity Mentoring Program for Faculty and Trainees: A Program at the Brown Clinical Psychology Training Consortium

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Faculty and student diversity have become important and explicit goals of academic and research institutions (Brown, 2004). Diversity has been defined as the whole array of human characteristics that shapes our experience, including, but not limited to, race/ethnicity, gender, culture, disability, socioeconomic background, age, religion, and language. There are compelling reasons to increase diversity in the biomedical workforce. Diversity is beneficial to scientific research in that diverse research teams are known to solve complex scientific problems by bringing together contrasting perspectives, leading to more refined scientific questions, hypotheses, and study design (Bickel et al., 2002). Diverse research teams are also thought to be more likely and willing to challenge prevailing assumptions and offer contrasting perspectives to traditional orthodoxy (Harding, 1998).

Recruiting and retaining diverse faculty has important implications for addressing health disparities among underserved populations (Smedley, Stith, & Nelson, 2002; U.S. Department of Health and Human Services, 2001). Faculty from underserved communities often dedicate skills to serving these communities and, in so doing, directly address health disparities (Komaromy et al., 1996) while also employing community-based and culturally competent scientific approaches (Cohen, Gabriel, & Terrell, 2002). Diverse faculty also contribute to the training and retention of new diverse researchers and clinicians by serving as role models and mentors (Ku, Li, Prober, Valentine, & Girod, 2011; Price et al., 2005). In turn, this enhances the recruitment of additional diverse trainees, which ultimately improves the overall diversity of the academic environment (Whitla et al., 2003). Lastly, diverse faculty and practitioners help to ameliorate health access barriers; for example, serving minority clients that may prefer treatment from minority clinicians (Cooper & Powe, 2004; Komaromy et al., 1996).

Despite efforts towards promoting diversity in biomedical and health science, the field continues to struggle with diversity-related disparities (National Science Foundation [NSF], 2009). For instance, racial and ethnic minorities, particularly Latinos and African Americans, are underrepresented as health practitioners (Smedley, Butler, & Bristow, 2004), and

African Americans are significantly less likely to receive NIH funding than their Caucasian colleagues (Ginther et al., 2011). Several factors are thought to contribute to institutional climate and disparities in faculty recruitment, promotion, and retention (Price et al., 2005). Namely, the high turnover (Thomas & Asunka, 1995), poor retention, and unequal promotion of diverse individuals have been implicated (Fang, Moy, Colburn, & Hurley, 2000). Furthermore, the increased likelihood of harassment and bias toward minority faculty has also received considerable attention as a barrier to promotion and retention (Corbie-Smith, Frank, Nickens, & Elon, 1999; Peterson, Friedman, Ash, Franco, & Carr, 2004). Finally, minority faculty face increased pressure to participate in administrative activities due to their minority status, which may lead to undue demands on their time and conflicts with opportunities for career development (Jagsi et al., 2012; Mahoney, Wilson, Odom, Flowers, & Adler, 2008).

Clearly, there is a need for improved strategies for recruiting, training, and retaining diverse trainees and faculty. Such strategies require institutional-level initiatives such as formalized mentoring programs, which are known to offer benefits to the recruitment, training, and retention of diverse trainees and faculty (Davis, 2002; Piercy et al., 2005; Sambunjak, Straus, & Marusic, 2006). Compared to more informal arrangements, formal mentoring programs are more successful in promoting diversity (Piercy et al.), partly due to the fact that underrepresented minorities are often excluded from informal networks, making it difficult to access adequate mentorship opportunities (Sambunjak et al., 2006; Smith, Smith, & Markham, 2000). Mentoring may help to overcome diversity-related barriers in the work place, including lack of opportunities for networking (Price et al., 2005). Mentoring may also contribute to faculty success by providing support for specific career areas such as publications, grants, and presentations (Mahoney et al., 2008; Perna & Lerner, 1995; Price et al.).

In this paper, we report on the development and pilot implementation of a formalized diversity mentoring program involving Brown's Department of Psychiatry and Human Behavior (DPHB), the Center for Alcohol and Addiction Studies (CAAS), the Department of Behavioral and Social Sciences, the Brown Clinical Psychology Training Consortium, and the affiliated hospitals and centers. We aimed to develop a program that would provide diversity-focused mentorship to junior faculty and trainees with the underlying goal of promoting an academic climate supportive of diversity. When we initiated this program we searched the programmatic literature in order to guide and inform the development and implementation of the program. The dearth of published articles in this area was apparent (for some exceptions, see Bickel et al., 2002; Lopez Viets et al., 2009; Piercy et al., 2005). Therefore, in this paper we aim to offer an account of our developmental and implementation experience so that future efforts towards developing similar diversity mentoring programs could draw from our experience.

Institutional Setting and the Parent Diversity Committee

The development of the diversity mentoring program occurred within the context of various institutional entities affiliated with the Warren Alpert Medical School of Brown University. However, the core group of developers was affiliated with the Brown Clinical Psychology Training Consortium, an American Psychological Association–accredited internship program and a member of the Association of Psychology Postdoctoral and Internship Centers. The Consortium offers intensive training in four specific areas (tracks) of clinical psychology: (a) adult clinical; (b) child; (c) health psychology/behavioral medicine; and (d) neuropsychology with an emphasis on applying scientific knowledge to human behavior and advancing clinical science research. Program development also included (and the program was open to) trainees and faculty of the Brown Psychiatry Residency program, which is based within the DPHB, and which provides training to medical residents within four tracks: (a) child; (b) general; (c) geriatric; and (d) neurology. Clinical and research rotations exist at eight affiliated hospitals and clinics.

The Diversity Committee was formed in the year 2000 in order to coalesce a wide array of diversity-related initiates within the DPHB, Department of Behavioral and Social Sciences, and the CAAS. The committee was charged with advocating for diversity throughout all sites in the Training Consortium and in the affiliated hospitals and centers. To that end, the committee has maintained an active role within the Training Consortium and continually sponsors diversity-related events. The committee also advocates for the recruitment and retention of faculty and trainees from diverse backgrounds or who have an interest in diversity-related research or clinical practice. Members often serve as liaisons to the tracks of the training programs and have played a central role in the admissions process. The committee is comprised of clinical psychology residents, postdoctoral fellows, and junior and senior faculty.

Diversity Mentoring Program Development

In 2009, the idea of creating a diversity mentoring program emerged during discussions in committee meetings and informal surveys of current trainees and faculty. The committee recognized the potential for such a program to have a significant impact on the retention of diverse trainees and faculty members. A work group was formed and given the task of exploring the feasibility and utility of creating such a program. The potential for the program to offer diverse mentees a unique opportunity to seek advice, support, and guidance on issues related to diversity was very appealing and consistent with the mission of the parent Diversity Committee and Training Consortium. Existing literature suggested that such diversity-focused mentoring could enhance recruitment, retention, and overall satisfaction of diverse trainees and faculty (Sambunjak et al., 2006; Waitzkin, Yager, Parker & Duran 2006; Yager, Waitzkin, Parker, & Duran, 2007). Additionally, the committee envisioned that participating mentors would benefit from additional training on diversity-related mentoring skills. Based on these findings, the idea of creating a diversity mentoring program was moved forward and approved by the Diversity Committee. The Training Consortium and the affiliated departmental leadership were very receptive to the proposal and offered administrative and financial support for the program.

Planning

Planning began in 2010. During the initial stages of development a number of strategic decisions were made which ultimately impacted the program implementation and success (e.g., feasibility, acceptability, satisfaction). One of the first questions the work group focused on was the breadth of the term "diversity." That is, which diversity-related characteristics should be used as inclusion criteria for the program? One option that was carefully considered was to include only those individuals who self-identify as being part of an ethnic and/or racial group recognized by the

NSF (2010a; 2010b) as underrepresented in the sciences: African Americans, American Indians and Alaskans, Hispanic/Latino Americans, and U.S. Pacific Islanders. However, applying the NSF criteria would have significantly limited both the number of individuals eligible to participate in our program and the scope of diversity characteristics addressed, so a broader definition of diversity was utilized. Specifically, in referring to "diversity," our program attempted to account for the entire array of human characteristics that can shape experience, including, but not limited to, "race/ethnicity, gender, culture, disability, socioeconomic background, age, religion, sexual orientation, and language." This definition is consistent with the mission of the larger Diversity Committee and Training Consortium and also accounts for a multitude of diversity-related traits and experiences that intersect to form an individual's identity (Cole, 2009; Hankivsky et al., 2010). Given the larger institutional mission of providing high-quality, culturally sensitive training, individuals with professional interests in research and clinical work with diverse populations were also invited to participate.

The strategy for matching mentors and mentees was also an important aspect of the planning phase. Our approach was consistent with Bozeman and Feeney's (2008) goodness-of-fit model, which posits that the quality of a mentorship relationship is a function of the goodness of fit between mentors and mentees on preferences, incentives, and valuations (Bozeman & Feeney). Accordingly, we utilized a brief interest form questionnaire, which asked mentors and mentees to state their preferences regarding the attributes of their match, as well as topics they wished to discuss. Topics included those related to diversity (e.g., working with diverse populations, funding opportunities for underrepresented groups) and professional development (e.g., promotion and tenure, teaching, time management). Responses from the interest form were then used to guide our matching process (described further below).

A final issue that we considered during the planning phase was the inevitable variation in mentorship expertise and experience among potential mentors, particularly diversity-related mentorship. The committee struggled with the level of guidance the program would provide mentors on issues such as the frequency of meetings, how to initiate and engage in discussions regarding diversity, or the availability of diversity-related resources (e.g., funding opportuni-ties for ethnic/racial minorities). Given that a primary aim of the program was to create an environment where individuals could comfortably seek advice, support, and guidance on issues related to diversity, the work group settled on a generalized approach, with a limited amount of imposed structure on mentors. We focused mostly on training and encouraging mentors to openly discuss issues related to diversity with their mentees. For example, we provided mentors with general suggestions and reviewed skills that were consistent with the Training Consortium's mentoring guidelines, we encouraged mentors to seek guidance from the work group, and we conducted a diversity mentorship workshop for all mentors with an expert in this field (described further below).

Implementation

Our first program cohort was enrolled in the 2010–2011 academic year. Recruitment of mentors and mentees was accomplished through announcements at various meetings and through a series of emails describing the program. Emails were sent to all training directors, trainees, and faculty members within DPHB, the Training Consortium, and CAAS. In addition, members of the work group and of the Diversity Committee approached potential mentors and mentees to raise interest about the program and to solicit their participation. In total, 29 potential mentors and 14 mentees expressed an interest in the program and completed the interest form.

After approximately 1 month of recruitment, the work group met to match the 14 mentees with mentors. The mentees were interns ($n = 2$), postdoctoral fellows ($n = 7$), or junior faculty ($n = 5$). They were predominantly female ($n = 13$), and the average age was 33.79 years ($SD = 4.98$). They identified as Asian ($n = 2$), biracial ($n = 1$), Black ($n = 3$), and Caucasian ($n = 8$). All mentees identified as heterosexual. Each mentee was matched with a mentor according to their stated preferences on the interest form. Typical preferences for mentees included mentoring in grant writing and funding opportunities ($n = 11$), diversity-related issues ($n = 11$), or promotion and tenure ($n = 9$). Of the 14 mentees, 2 preferred a mentor of the same gender, 1 preferred a mentor of the same race, and 1 preferred a mentor of the same gender and race. The majority ($n = 10$) indicated that they did not have a preference regarding the background characteristics of their mentor. The mentors who volunteered were professors ($n = 8$), associate professors ($n = 7$), and assistant professors ($n = 14$). Twenty-one were psychologists and 8 were psychiatrists. The majority of mentors were female ($n = 18$), and the average age was 47.76 years ($SD = 12.26$). The mentors identified as Asian ($n = 3$), biracial ($n = 2$), Caucasian ($n = 18$), and Latino/a ($n = 1$), and 5 were unknown. The majority identified as heterosexual ($n = 19$) with 3 identifying as homosexual and 7 unknown. In addition to matching based on preferences, the process of matching pairs was an iterative and, at times, an intuitive process. Not only were preferences considered, but senior faculty members of the work group personally familiar with the mentors and mentees also provided guidance on ideal mentorship pairings.

Once the matching process was completed, we sent an email to each mentor and mentee, which introduced their match, provided general information about one another, and encouraged them to set up their first meeting. We also provided mentors with a packet of resources on diversity-related funding opportunities, programs, general mentorship guidelines, tips on how to comfortably address issues related to diversity, community resources, and local events they could attend together. Of the 29 potential mentors and 14 potential mentees, a total of 14 mentor and mentee dyads were matched. Mentors that were not matched were thanked for their willingness to participate and encouraged to participate in future cohorts of the mentoring program.

Mentors were strongly encouraged to attend a diversity mentorship workshop entitled, "Mentoring Across Difference: A Training Workshop for Multicultural Faculty Mentoring," coordinated by the Diversity Committee. This workshop was led by an expert in multicultural sensitivity training and mentoring within educational contexts. Mentors that were not matched were also invited to attend. Workshop objectives included the following: (a) gaining a better understanding of the direct impact that mentoring can have on the increased retention of underrepresented trainees and faculty; (b) exploring the intersectionality of identities and roles; and (c) developing individualized support systems and culturally appropriate plans of action congruent with the unique experiences and challenges of underrepresented trainees and faculty. The workshop included didactics that focused on enhancing mentorship skills, case studies, and role-playing exercises involving mentors enacting specific behavioral mentoring skills covered in the didactic presentations. Slides and workshop materials were

shared with mentors who were unable to attend. Evaluations indicated that 50% of participants found the workshop to be "helpful" and thought no improvements were needed, whereas 41.7% found the workshop to be "somewhat helpful" and thought some improvements (such as a greater focus on more "hands-on" techniques) would be beneficial.

Preliminary Program Evaluation

Approximately 6 months after the dyads were matched, mentors and mentees were invited to complete a confidential online program evaluation survey. Surveys assessed participants' satisfaction with the mentoring program and their mentoring relationship, and whether the program was successful in helping to meet their goals. Our self-developed survey measure asked mentors and mentees to rate a number of dimensions including perceived success of the program, satisfaction with the program, and more. A 4-point Likert-type response scale was used for items (e.g., very satisfied, satisfied, moderately satisfied, and not at all satisfied). Butler Hospital's Institutional Review Board (IRB) approved the use of participant survey data in deidentified form and issued a waiver of informed consent for the current manuscript.

Mentor Survey

Of the 14 matched mentors, 12 completed the evaluative survey. Results indicated that 16.7% ($n = 2$) of mentors found the mentorship program to be "very successful," 58.3% ($n = 7$) found it to be "successful," and 25% ($n = 3$) rated it as "moderately successful" in meeting their mentee's goals. Mentors also rated their satisfaction with their mentee match; 41.7% ($n = 5$) of the mentors were "very satisfied," 50% ($n = 6$) were "satisfied," and 8.3% ($n = 1$) were "dissatisfied" with their match. Overall, mentors were either "very satisfied" (16.7%; $n = 2$) or "satisfied" (75%; $n = 9$) with their experience as a mentor. Further, mentors were asked to rate their effectiveness on mentoring in general and mentoring on diversity issues. The majority of mentors felt they were either "very effective" (16.7%; $n = 2$) or "effective" (66.7%; $n = 8$) mentors in general. Mentors rated themselves similarly on effectiveness in mentoring on diversity-related issues; about 75% ($n = 9$) evaluated themselves as either "very effective" (8.3%; $n = 1$) or "effective" (66.7%; $n = 8$). A small proportion of mentors rated themselves as "not very effective"

mentors in general (16.7%; $n = 2$) and on diversity-related issues (25%; $n = 3$).

Mentors were also asked to rate specific components of the program. The majority of mentors (91.7%; $n = 11$) reported being "satisfied" with the mentor recruitment strategies and with the mentor survey they completed prior to being matched to a mentee. However, 58.4% ($n = 7$) of mentors felt that they could have used more information about their mentee prior to meeting with them, and 50% ($n = 6$) felt that they would have benefitted from greater diversity-related mentoring training. In addition, 33.3% ($n = 4$) of mentors reported wanting greater programmatic mentor support and 50% ($n = 6$) wanted more opportunities to network with other mentors. Among mentors, 41.7% ($n = 5$) expressed a need for greater programmatic guidance on the logistics of the mentoring relationship (e.g., frequency of meetings) and 50% ($n = 6$) expressed a desire for more frequent meetings with mentees.

Mentors were also asked to complete open-ended questions regarding their general impressions of the program and to offer feedback and suggestions on how to improve the program. Overall, mentors reported being satisfied with the program and their match, and stated that they had developed good rapport with their mentees. Nevertheless, several mentors reported needing more clarification on expectations, the structure of discussion topics, and guidelines on mentoring on issues of diversity. A few mentors struggled with the issue of defining their role with mentees given the fact that mentees already had other mentoring relationships. Finally, a small number of mentors reported some difficulty scheduling meetings and meeting regularly.

Despite the concerns and challenges that were noted, the overwhelming consensus among mentors was that the experience fostered a greater awareness and knowledge of important topics related to diversity. For instance, some mentors reported a greater understanding of the multiple clinical and academic pressures that may affect mentees, particularly those from diverse backgrounds. Furthermore, many expressed a strong sense of connection with mentees, which may not have occurred without the mentoring program.

Mentee Survey

Of the 14 matched mentees, 11 completed the evaluative survey. Results from the mentee satisfaction survey demonstrated that 36.4% ($n = 4$) of mentees found the program to be "very successful,"

54.5% ($n = 6$) found it to be "successful," and 9.1% ($n = 1$) found it to be "moderately successful" in meeting their goals. 72.7% ($n = 8$) of mentees reported being "very satisfied" and 27.3% ($n = 3$) reported being "satisfied" with their match. Overall, mentees were either "very satisfied" (54.5%; $n = 6$) or "satisfied" (45.5%; $n = 5$) with their experience as a mentee in the program. Further, the majority of mentees (90.9%; $n = 10$) expressed desire to continue their relationships with their mentors and to continue participating in the program.

Mentees were also asked to rate specific components of the program. The majority of mentees were "satisfied" with the mentee recruitment strategies (81.8%; $n = 9$), the mentee survey they were asked to complete prior to being matched (90.9%; $n = 10$), and the information provided to them about their mentor (72.7%; $n = 8$). A large proportion of the mentees (81.8%; $n = 9$) reported that they wanted more opportunities to network with other mentees participating in the program. Furthermore, 63.6% ($n = 7$) reported wanting greater logistical or structural guidance to help facilitate the mentoring relationship and its goals. Whereas mentors expressed wanting to meet with their mentees more frequently, the majority of mentees (72.7%; $n = 8$) reported being satisfied with the frequency of meetings. 72.7% ($n = 8$) felt that the mentoring relationship met their expectations, 81.8% ($n = 9$) reported feeling that their mentors were easy to approach and talk with, and 81.8% ($n = 9$) reported feeling satisfied with the style of their mentoring relationship. Finally, when asked how often issues of diversity had been discussed with their mentors, 9.1% ($n = 1$) reported that they had been discussed "very frequently," 36.4% ($n = 4$) reported "frequently," 45.5% ($n = 5$) reported "occasionally," and 9.1% ($n = 1$) reported that these issues had "never been discussed."

Mentees were also asked to complete open-ended questions regarding their general impressions of the program and to offer feedback and suggestions on how to improve the program. Overall, mentees reported being satisfied with the program and with their mentors. Specifically, mentees stated that they enjoyed having an additional mentor to turn to for support and that they benefited from having someone outside of their research group/track to offer a different perspective on professional issues and concerns. Several mentees characterized their mentor as warm, supportive, accessible, or easy to talk to. Nevertheless,

some mentees reported that sustaining the mentoring relationship proved to be challenging. Similar to mentors' concerns and suggestions, mentees also reported that their mentors would have benefited from having more direction and structure with respect to expectations, goals, and meeting discussion topics. Finally, several mentees suggested that the program offer more opportunities for networking through informal social gatherings with other mentees and mentors.

Discussion

Within the period of 1 year, we were able to develop and implement a diversity mentorship program within a multisite, multidepartmental Training Consortium in a medical school setting. During the initial development, we faced a number of challenges that required a thoughtful consideration of the existing literature as well as more practical factors related to the feasibility and sustainability of the program within the context of our academic community.

Our approach emphasized a thoughtful consideration of both feasibility and the values and goals of our training program. Despite our limited sample size and the preliminary nature of our findings, the process of developing and implementing our program may offer other programs and institutions lessons to draw from as they contemplate developing their own programs.

Obtaining administrative support was critical to developing and implementing our program. Garnering this support was relatively uncomplicated, enhanced by the fact that the goals of the program matched closely with the mission of the DPHB and Brown University. Nonetheless, we acknowledge that maintaining support for the program will be an essential element of its continued growth and success. For other departments seeking to develop similar programs, we strongly recommend that this aspect of development not be overlooked.

One of the challenges that we faced in developing our program was the issue of how to account for the variability of mentor skills and experience with respect to mentorship specifically focused on diversity. In retrospect, our approach (conducting a mentor training seminar with a nationally recognized expert in the field) could have been more comprehensive. The fact that 25% of mentors ultimately rated themselves as "not very effective" at mentoring with respect to issues of diversity may indi-

cate that mentors were in need of more than didactic and experiential opportunities for developing and refining specific mentoring skills. In order for mentors to attain a greater level of comfort and mastery with respect to the skills learned during the workshop, trainings can also include activities that aim to bolster mentors' self-efficacy. Possible models to draw from in future planning are the mentoring programs of Lopez Viets and colleagues (2009) and Johnson and colleagues (2010). These programs included more frequent meetings, seminars, and symposia, which can allow for programming that addresses self-efficacy through peer feedback. Similarly, more comprehensive assessments of mentors' expertise and self-efficacy may offer an opportunity to dynamically utilize obtained data for the tailoring of subsequent training sessions.

As we plan for future cohorts of our program we will attempt to address these training needs in several ways. We plan to expand the existing training seminar to include a greater focus on more practical aspects of diversity mentoring, including recommendations for the frequency and location of meetings, ways to discuss diversity, and what it means to be an "effective" mentor. In addition, we will offer mentors opportunities for peer support and guidance through regular meetings with the program developers, other mentors, and mentees. Finally, we will provide mentors with suggested readings and additional local and national resources.

We recognize that continually monitoring and surveying program participants will facilitate the evolution of our program so that the changing needs and goals of both mentors and mentees are identified and addressed. In our pilot cohort our pre- and postsurvey methods were relatively brief and emphasized the reduction of participant burden. As the work group moves forward with the program, our approach will become more sophisticated. For example, we plan to collect data on factors known to impact the experience of mentors and mentees, such as hierarchical power differentials (Eby, 1997). Asking mentees to clearly specify their goals for the mentoring relationship at the outset, and having them evaluate what factors ultimately enabled or disabled goal achievement, will also be useful. Finally, informal interviews and group meetings can be conducted with participants to obtain qualitative feedback and judge overall satisfaction.

A large proportion of program participants recommended that the work group

provide greater opportunities for networking via social events and gatherings. This was a relatively unexpected yet exciting survey finding, which we believe reflects a willingness and desire to strengthen mentor-mentee relationships through multicontextual interaction. Hence, the work group is very enthusiastic about expanding this aspect of our program.

Overall, the diversity mentoring program committee considers the program's ongoing development successful and the program implementation to be both feasible and acceptable. Most notably, the vast majority of our participants rated their experience in a highly favorable manner and expressed a desire to continue their current mentoring relationship. Yet it should be noted that these results are preliminary as they reflect the initial year of the program; longitudinal data regarding program follow-up are not yet unavailable. In future years, we may expand the measurement time frame to ascertain, for example, what professional roles diverse mentees ultimately adopt and the impact of the mentor-mentee relationship on those roles.

On a final note, the development and implementation of this program offered our team a rich opportunity to expand our understanding of the needs of our junior faculty and trainees. This understanding extended beyond the scope of the mentoring program and has been used to advance the goals of the Diversity Committee and the Training Consortium. As the work group reflects back on the lessons learned from our initial cohort, we are optimistic about the growth and vitality of our program and its potential to increase the diversity of our academic community.

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Obituary

In Memoriam: Nathan Azrin (1930-2013)

David Reitman, *Nova Southeastern University*

On March 29, 2013, the behavior therapy community lost a trailblazer and friend responsible for the development or refinement of many of the most powerful behavior change strategies available to contemporary cognitive behavior therapists. Spanning discipline practices employed by parents (e.g., time-out and overcorrection), adults suffering with alcohol problems or habit control issues (e.g., trichotillomania), stuttering, unemployment (the "job club"), care of institutionalized persons (i.e., the token economy) and perhaps his best known work in the area of toilet training (i.e., *Toilet Training in Less Than a Day*, 1974, with Foxx), Nathan Azrin attacked clinical problems with remarkable tenacity.

Pioneering "translational" research came easily to "Nate" as he and a small group of young behavior analysts set about applying techniques learned in B. F. Skinner's laboratory to the "environment" outside of the lab. Indeed, 50 years after the work was completed, Nate's studies of punishment (and its alternatives) still serve as testament to how basic science can serve clinical practice (see Azrin & Holz, 1966). His many other contributions, summarized in Nate's own recounting (Azrin, 2005), generally followed a natural science approach characterized by careful observation of the clinical phenomena via naturalistic observation, establishment of baseline frequencies of the target behavior, and ongoing tests of the clinical procedures until they reliably produced the desired results.

In addition to his research and clinical contributions, Nate also served as past-president of both the Association of Behavior Analysis (ABA) and the Association for Advancement of Behavior Therapy (AABT; now ABCT), to name just two of his many leadership roles. Nate's work on toilet training was probably his best known work to the lay public and is remarkable for its prominent avoidance of any technical jargon or reference to the theoretical foundation that the procedures were built upon. Nate's assertion that "learning and situational factors can overcome strong biological, societal, family, and medical factors by maximizing learning and situational influences" (p. 42) is especially pertinent today as we face controversial changes in DSM-5 and in NIMH funding for clinical problems that are increasingly being framed in solely neurobiological or genetic (as opposed to epigenetic) terms. Doubtless, we owe much to Nate and can continue to profit from his unique perspective on clinical science and dissemination.

Nate is survived by his wife, Vicky; his daughter, Rachel; and three sons, David, Rick, and Michael; and their many grandchildren. Nate's funeral was attended by administration, faculty, and staff colleagues from Nova Southeastern University as well as past students, colleagues, and old friends. Shiva was held in the week following his funeral at the Azrin family home in Fort Lauderdale surrounded by the many awards and memorabilia collected by Nate and his family over the course of his very full lifetime. Indeed, perhaps the most notable thing about Nate, especially in light of his numerous professional accomplishments, is the equally strong commitment he demonstrated to his family and friends. In reflecting on Nate's personal and professional life, one can only note that this was a life very well lived.

Terrific pictures of Nate, his family, and many professional acquaintances maintained over the years can be found at www.nathanazrin.com. Donations to the Nathan Azrin Foundation can be made via the webpage or mailed to: Nathan Azrin Foundation, 2018 Brookwood Medical Center Drive, Professional Office Building #310, Birmingham, AL 35209.

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Reflections on Nate Azrin

The loss of Nate Azrin prompted much reflection and discussion among the past presidents of ABCT. Following Nate's passing, the ABCT past president's list serve was quite active with wonderful memories of Nate's work and personality. We asked the past presidents for permission to print their comments in tBT.

In the 1970s, a group of behavioral/empirical types (Nathan Azrin, Stewart Agras, Walter Mischel, Jack Rachman, Terry Wilson, and I) was assembled for a year at the Center for Advanced Study in the Behavioral Sciences (Stanford, CA) to work on our own projects but also to collaborate and assess the status of behavior therapy given its strong and burgeoning evidence base. During that time we worked closely, collaborated, met, and got to know each other and the friendships endured long after the year ended. At the Center, there was some initial confusion of staff between "Azrin" and "Kazdin." This even led to me being given a pseudonym (Kazrin), which is another story. Yet, to me the confusion was professionally ludicrous. For anyone who knows me and has had at least a nanosecond of exposure to Nate's mind, perspective, and creativity, leaving aside accomplishments, there could never be any confusion.

Among his enduring talents was his ability to cut through all sorts of highfalutin theory and move to creative and practical hypotheses about interventions. In the mid-1950s with laboratory work on cooperation with children (with Ogden Lindsley) and then in the early 1960s in hospital work with psychiatric patients (with Ted Ayllon), he already had empirical demonstrations of this type using contingencies to alter behaviors. By the time of the first ever book on the token economy (1968) he was on the steep cumulative

record slope of creative interventions. His intervention research was innovative, his designs often novel, and his thinking cutting-through and cutting edge. I wonder if he was amused at the much later emergence or delineation of evidence-based treatments given he was a one-man anthology of so many of them long before that term was common in psychology.

At the beginning of the year with him, it was immediately apparent how quickly and easily he moved to creative ideas often with just little twists of things that were known but made for bigger ideas. I would be sitting across from him at a table with just 4 or 5 other people and he would take a deliberative turn to speak and fairly slowly present a stunning alternative approach to something. After watching him, I was one of his most appreciative fans. I never felt for a moment anything like the thought, "I could have thought of that." No, I could not have, even if aided by the infinite number of monkeys plunking at their tablets or laptops to write all the great novels. Being with him at small meetings would be like watching Picasso begin with a white canvas and quickly stroke some lines, add a few colors, and now there would be a face, a mood, a message, and something truly novel. How did a few lines lead to that? Nate did this with his mind, knowledge, and creative palate. A pleasure to watch in part because he made nothing of it—presumably Picasso did not paint a stroke and stop to say, "Hey did you see that?" Natural talent coupled with disciplined training is such a pleasure to watch. That same creativity smeared into his humor. He could turn a point so quickly and have you expecting one of his genuinely novel substantive hypotheses about how to change a clinical problem or address a weighty professional issue, when the surprise came of some clever quip about a what if this or that—and great humor he sneaked in while you might be waiting for great science.

There will be scores of wonderful stories from his collaborators in praise of his genius and they all deserve to be told. Here is one slightly more personal and of a different nature. One of my daughters was at toilet training age at the rise of then recently published Azrin and Richard Foxx's *Toilet Training in Less Than a Day* (1974). Nate and I just arrived at my home and we were looking at my daughter with parental admiration and joy commonly (and pretty noncontingently) heaped on one's children. I was holding her and thought it would be amusing to ask, "So how do you think we

should toilet train her?" Without hesitating and with a mischievous smile, he said, "Just keep the door open when you and your wife go to the bathroom and that should take care of it." I was stunned and teased him. I said with stunned disbelief, "Mahhdling? modeling? Are you kidding?!" After all that?!" ("All that" being his book, translations of the book all over the world, most of the people on the planet under 5 being trained in a day, and half of those being trained personally by Azrin and Foxx). He was serious and equally amused and we had yet one more Nate-generated source of joy.

He will be missed. Of all colleagues, I thought it would be so valuable to society and individuals in need of care to begin the process of identifying viable solutions by putting Nate in a room with a few like minds and have them brainstorm on strategies that could genuinely help people. The process might be accelerated by substituting mannequins for the other people so there no interruptions of Nate's enormously creative ideas. What a privilege to have known him and to have been exposed to his mind and wit. The loss as well as his impact will be enduring.

—ALAN KAZDIN

What sad news! I wanted to add a few thoughts to Alan's reflections.

Alan and I were the "youth movement" that started at the Center for Advanced Study in the Behavioral Sciences in 1976. It is certainly no exaggeration to say that Nate was at the time one of the most famous "behavior therapists" in the world—so influential in so many different areas of applied behavior analysis. I felt very much like a graduate student in first meeting with this famous man. Yet I quickly learned how humble and friendly a person he was—and how generous he was in sharing his experience and knowledge with our group. Nate and his wife, Vicky, were always very kind to my wife and me.

It was always great to touch base with Nate over the following years—usually at AABT meetings. It was wonderful to reminisce about that year. But then I did not see him for a long period—until two years ago. Lars Goran Öst organized a major CBT meeting in Stockholm. I was one of the participants, and Nate was one of the other keynote speakers. I learned why I had seen little of him for the past 10 years or so. He had been struggling—bravely—with a challenging illness. Yet at this meeting it was the same old Nate! Quintessential Nate—enthusiastic about new develop-

ments, curious about how we might develop even more effective interventions, and always encouraging the various students and colleagues who were eager to talk with him. He gave a marvelous talk, although even in very summary form he did not have enough time to comment on the many innovations he had made. At a dinner one of the nights with me and Lars Goran he explained how as a graduate student at Harvard he had ended up working with Skinner—and the rest is history, as they say. In short, he wanted to help people and promote change. His goal was to take the principles and philosophy of applied behavior analysis and apply them to social behavior.

Aside from his own immense contributions to the field, he inspired countless colleagues and students around the world. What a lovely and brilliant man!

—TERRY WILSON

In the late 1960s when I first became interested in behavior therapy I subscribed to *Behaviour Research and Therapy* and was astounded how in every issue there was a seminal article by Nate. I particularly was impressed by the broad range of issues that he tackled with ingenuity and absolute methodological rigor. I didn't know him personally at that time but realized what a seminal thinker he was in our fledgling field. Later on between 1992 and 1997 I was privileged to be a colleague of his at Nova Southeastern University. I think that the field of behavior therapy owes him an enormous debt of gratitude for how he relentlessly developed, advanced, and perfected so many therapeutic modalities. He was our quintessential pioneer.

—MICHEL HERSEN

Michel's post reminded me of a time among basic behavior analysts, before he moved into the applied arena, that Nate was so powerful, creative, and hardworking that people practically quaked when they were working in areas he was involved in. Nate was there first, over and over again.

He practically owned the area of punishment and aversive conditioning in animal operant work (until he moved on to applied work). When a new issue of JEAB came out, you could be certain Nate would have something groundbreaking in it. I've never seen anything like it since—in which a single individual so towered over an area that everyone was in his shadow. Despite his productivity, he cared about the work

more so than the praise … it wasn't a big ego thing with him. He was just more creative and harder working than anyone else.

You saw those same qualities after he entered into the applied arena. Over and over again he came up with creative ideas that have withstood the test of time. To this day, many of them are gold standards.

The word "giant" is not overblown in his case. The guy truly was a giant.

—STEVEN C. HAYES

Well, what remains to be said after the eloquent comments offered by so many of you? Although I was somewhat later to arrive on the AABT scene than some of you, I recall with great admiration his early work. At that time in the mid to late 70's, I was at Western Psychiatric Institute in Pittsburgh and working with developmentally delayed and highly aggressive children and adolescents. I was actually trained in the psychodynamic tradition, and I remember thinking we could and must do more for these youngsters. Every time we set about establishing a program, Nate's name came up and whatever we sought to do, he had already done it! And, we were able to "replicate" his work! That was very rewarding, both for us and the youth we served. Like Alan Kazdin, I remember talking with him about toilet training—only in this instance about training some of the youngsters on that unit at WPIC. You might recall he wrote a book on that topic with Dick Foxx based on their work at Anna State Hospital in Southern Illinois. Nate always suggested a positive reinforcement approach, followed if necessary by a reductive approach including overcorrection and other forms of "mild" punishment. Yes, his early work was seminal. Moreover, his work over the years continued to be cutting edge, yet he rarely used a razor to get his points across. He influenced us by his behavior. Echoing what Steve Hayes had to say, he was truly a giant in our field—no, he was a gentle giant. We owe him much in the evolution and application of applied behavior analysis and behavior therapy, and his work has had a lasting impact on us and those we serve. His shoes will be very difficult to fill.

—TOM OLLENDICK

One lasting memory for me was our joint service on the ABCT board in the 1970s. Nate came in with an already well-established international reputation for scholarship and creativity and yet his demeanor

was at all times humble and soft-spoken. This set a great example for me and probably for all of us as we dealt with the controversial issues and occasional outright attacks we occasionally endured as we tried to establish a science of behavior change. Nate was not only present at the creation, he was a large part of creation.

—DAVID H. BARLOW

Yes Alan your description of Nate was excellent. Being in Champaign Illinois when Nate was an Anna State, he had an influence on many of us there in the late 60s, and my advisors/profs Becker, Ullmann, Bijou, and Paul all had great respect for Nate for his JEAB and animal work, even before he designed the token economy for patients with Ted Allyon. But as Alan said once he moved to the applied areas, he amazed us all with his truly diverse contributions, *Tiolet Training in Less Than a Day*, changing marital discord, enhancing work skills and employment, etc., etc., and all with humility. Fortunately for many of us, Nate was instrumental in getting JABA started with some other great contributors like Todd Risley and Mont Wolf. And, with all due respect to statistical modeling, odds ratios, and other ways of parsing data (which I use), I still remember Nate saying if we need all those stats to make our point, do we really have much of an effect, and when I see manuscripts with statistically significant effects for some variable with a very small amount of variance accounted for I think of Nate and am reminded of what he might say. He definitely was one of our greats!

—K. DANIEL O'LEARY

Nate was the eye of a ripple effect. He was able to strip away the irrelevant and articulate the dynamics of human behavior at its simplest level. He demonstrated the essence of the goal of science: replicatable parsimonious explanation.

My first indirect contact with him was through his token economies work with Ted Ayllon. I had psychoanalytic training and just started teaching at the University of Michigan and was doing some consulting at Ypsilanti State Hospital. As such I was stupidly (though I didn't realize it at the time) trying to identify early infantile fixations in chronic schizophrenics. I was skeptical about what Nate and Ted had written so I wrote to him. To my amazement he responded by challenging me: why dismiss any idea that had a chance of

being credible without testing it? Because what I was doing was getting nowhere I tried to crudely replicate what he was doing and saw some immediate changes. So I tried the same logic with the obese women and couples I was working with at the time and the results made me an analyst no more.

That was the kind of impact that the sharpness of Nate's thinking had on me—and a great many others. We have lost one of the prime movers of applied behavioral analysis, a man who played a key role in spawning an intellectual revolution in mental health. The best way to honor his memory is to critically analyze all of our core beliefs, find ways to simplify them and expand their impact, measure the results, and disseminate what we have learned so others can do better. As I got to know him over the years, it was always Nate's hope that someone would outdo his thinking and take the field another step ahead. And as he liked to say, the measure of impact was the extent to which people used your ideas without citing you because they had become axioms. By that standard Nate's impact is in everything we do today.

—DICK STUART

His work and that of Wolpe and Lazarus inspired me in the early years. And we still benefit daily from his genius.

—ROBERT L. LEAHY

Yes, he will be missed . . . a major pioneer and thinker! Very, very sad.

—DICK SUINN

A major loss to the field. A great scientist who also was just a very decent human being. He will be missed.

—STEVE HOLLON

Major loss. Nate was one of the most creative of our pioneers. A great and mischievous wit and a thoroughly nice person. A mensch.

—JERRY DAVISON

ABCT has lost a pioneer and a past president. Nate Azrin, whose career includes creative and influential work in basic and applied behavior analysis, passed away on Friday, March 29.

—LINDA SOBELL

At ABCT

Congratulations to Mary Jane Eimer and David Teisler

Dean McKay, *ABCT President-Elect*, **and Stefan G. Hofmann,** *ABCT President*

MARY JANE EIMER, DEAN McKAY, AND DAVID TEISLER

At the annual ABCT conference, we hold an awards ceremony where we honor prominent members of our professional community. This event is typically very well attended where we have the opportunity to hear from the association leadership, and share in the joy of our colleagues' accomplishments.

On Wednesday April 17, 2013, it was our distinct pleasure and honor when one of us (Dean McKay) was able to represent the Board and ABCT in general at the meeting of the New York Society of Association Executives (NYSAE). It was here that the NYSAE honored the Executive Director of ABCT, Mary Jane (MJ) Eimer, with its Diplomat award (http://www.nysaenet. org/awardsapplications/xvaward/), and ABCT's Director of Communications, David Teisler, with its Outstanding Association/Nonprofit Executive Award (http://www.nysaenet.org/awardsapplications/outstandingassociationexecutive/). David's award was described at the meeting as its "most prestigious award bestowed on an association executive." The awards ceremony was held in true New York style, in the banquet hall of the New Yorker Hotel over an excellent catered lunch. The entire ABCT central office staff was in attendance, and it was a proud day for our organization. At the upcoming conference or in your next correspondence with the office staff, be sure to congratulate MJ, David, and the entire central office staff for their excellent work. It is great to know that their efforts have been rightly recognized by their professional peers.

Be Our Friend: ABCT's Facebook Challenge

On behalf of the Social Networking Media Committee:

Joshua C. Magee, *Chair, University of Cincinnati College of Medicine*
Andrea M. Macari, *Suffolk County Community College*
John A. Richey, *Virginia Tech*
Elise M. Clerkin, *Miami University*

We know you love ABCT, but do you "like" us? Recently, we relaunched the Association's Facebook page with a new, streamlined format that can act as a hub for the ever-evolving world of science and practice in our field. In addition to facilitating communication within the organization, this exciting change enhances how we disseminate information, grow our membership, and improve the visibility of ABCT and CBT, priorities highlighted by Stefan G. Hofmann in his recent President's Message (2013). We are thrilled at the initial response to the relaunch, and we want to issue our next challenge: 1,500 members!

The Setup

One task of the Social Networking Media Committee (SNMC) is to manage ABCT's social media presence, which includes Facebook. Our goal is to cultivate an online culture of fun, respectful, and scholarly discussion characterized by the free exchange of ideas and opinions. As an almost completely user-driven environment, members can post content, debate hot topics, or contribute to virtual discussions on all things B and C. We believe that this approach will have the effect of promoting ABCT as the vibrant and energetic intellectual community that it is. Additionally, ABCT's leadership, Special Interest Groups, and committees use the page as a way to connect with membership and the general public by sharing organizational announcements, relevant research findings, and even the occasional attempt at humor. During the convention, visit the page for real-time conference updates, photos, restaurant tips, and member interviews.

The Challenge

We need your help to reach our next Facebook milestone: 1,500 likes. Are you ready to join the challenge? Here is what you can do:

Be Our Friend

If you haven't already "liked" the page, please visit https://www.facebook.com/ AssociationForBehavioralAndCognitiveTherapies and click the "like" button on the right-hand side. You can also find the page by searching for "Association for Behavioral and Cognitive Therapies" in the Facebook search bar.

Join the Conversation

With near-daily posts, there is certain to be something that captures your attention. Whether it is our weekly Wednesday question—*If you could have dinner with any psychologist (dead or alive), who would it be and why?*—or an article on the latest scientific finding, please contribute to the discussion.

Share the Page and Posts

Consider sharing the page on your wall, or messaging others who may be interested. Don't be surprised if some of your personal friends "like" the page and begin to receive updates, despite not being members of any related profession. Having a diverse community enriches the experience for everyone and disseminates evidence-based practice to the public.

The Reward

All challenges need a handsome reward waiting at the end. When ABCT reaches its goal of 1,500 Facebook members, three individuals will be randomly selected to receive a free online webinar (value $45) of their choice. Imagine learning about PTSD from Patricia Resick or Acceptance and Commitment Therapy from James D. Herbert in the comfort of your own home!

Even if you aren't one of the fortunate three to win a free webinar, you will still benefit from ABCT's Facebook membership of 1,500+ strong. Harnessing the power of organizational social networking has limitless opportunities for the individual, and has the potential to accelerate professional development across both time and space. Perhaps you could use the page to connect with potential collaborators. Or, maybe you could find an audience for a symposium you are organizing? A chair or co-chair could announce a planning session for a symposium on eating disorders, potentially finding interested collaborators from

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ABCT

our over 1,100 "friends" and over 400,000 "friends of friends."

Advancement in our field has reached unprecedented heights. We believe that on-line social networks are, as a consequence, a great fit with the dynamic and rapidly evolving nature of ABCT. An old but popular saying borrowed from software development and computer science makes the distinction between the English adjective free as: "free as in beer" vs. "free as in speech." The latter refers to the free exchange of ideas without constraint (*libre*), and the former to the provision of a service at no cost (*gratis*). We are committed to both ideals and hope that you consider participating in this online community to exchange ideas without constraints in either sense. Remember, it all starts with one "like"!

If you have questions, suggestions, or want to join the committee, please email Josh Magee: joshuacmagee@gmail.com.

Reference

Hofmann, S. G. (2013). Three of my favorite ABCT priorities. *the Behavior Therapist, 36,* 71-75.

A New Learning Format Added to ABCT Convention at Opryland in Nashville, November 21–24, 2013:
Mini-Workshops

To expand sessions that directly address evidence-based clinical skills and applications, ABCT is pilot testing a new format: FREE Mini-Workshops. These 90-minute events will be offered at no additional cost to general conference registrants, and will address direct clinical care, professional issues, or training at a broad, introductory level. These sessions will be useful for the practitioner, educator, and student.

Writing Productivity and the Academic Peer-Review Process: A Workshop for Graduate Students, Early-Career Professionals, and Academic Advisors
Andres De Los Reyes, *University of Maryland at College Park*

Psychopharmacology for Mental Health Providers: Mood, Medication, and Genetics
Sharon M. Freeman Clevenger, *Indiana Center for Cognitive Behavior Therapy*

Addressing Functional Impairments in ADHD: Assessment and Treatment of Organizational Deficits in Children With ADHD | Richard Gallagher & Lauren Knickerbocker, *NYU Child Study Center and NYU School of Medicine*

Cultural Competence in CBT: A Process, Skills-Based Model | Steven Lopez, *University of Southern California*, Gabriela Nagy, Maria Santos, & Jonathan Kanter, *University of Wisconsin-Milwaukee*

Signaling Matters: New Skills-Based Approaches for Enhancing Social Connectedness
Thomas R. Lynch, *University of Southampton*

Taking Anxiety Disorder Treatment to the Next Level: Using Exposure and Response Prevention for Maximum Effect | Patrick B. McGrath, *Alexian Brothers Center for Anxiety and Obsessive Compulsive Disorders*

Core Competencies in CBT: Becoming an Effective and Competent Cognitive-Behavioral Therapist | Cory F. Newman, *University of Pennsylvania*

Running Into Well-Being: Exercise for Mood and Anxiety Disorders | Michael W. Otto, *Boston University*, & Jasper A. J. Smits, *Southern Methodist University*

Effectively Interacting With the Media | Simon A. Rego, *Montefiore Medical Center*

A Team Approach to Training and Clinical Care of Behavioral Problems in Primary Care
Patricia Robinson, Debra Gould, & Kirk Strosahl, *Community Health of Central Washington*

How to Integrate Spirituality Into CBT: A Brief Intervention
David H. Rosmarin, *McLean Hospital/Harvard Medical School*

Introduction to Mindfulness-Based Cognitive Therapy for Children
Randye J. Semple, *University of Southern California*

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online

FB Weekly Wednesday Question
"Do you do self-therapy? If so, what techniques do you use on yourself?"

⦿ https://www..facebook.com/

in-press article

Using Techniques via the Therapeutic Relationship
INTRODUCTION TO THE SPECIAL SERIES: COLLABORATIVE EMPIRICISM

"A moment in therapy is a long time, yet our current research methodologies attempt to characterize an entire session."

Kazantzis, Cronin, Dattilio, & Dobson
Cognitive and Behavioral Practice
in press
doi:10.1016/j.cbpra.2013.03.001

archive

"I see an urgent need to bring together once again the research conducted in the laboratory and in the field with the treatment conducted in the consulting room, the schoolhouse, the home, and the hospital."

Ross, A., 1984
"It Is Time to Stop Standing Still"
Presidential Address to ABCT

ABCT WEBINAR

Friday, July 26

11:00 A.M. – 12:30 P.M. Eastern
10:00 A.M. – 11:30 A.M. Central
9:00 A.M. – 10:30 A.M. Mountain
8:00 A.M. – 9:30 A.M. Pacific

Earn 1.5 hours of CE credit
Members: $30; Nonmembers $45

Outpatient CBT for Alcohol and Other Substance Use Disorders: Challenges in the Real World

Barbara McCrady, Ph.D.

Barbara S. McCrady, Ph.D. is a Distinguished Professor of Psychology and the Director of The Center on Alcoholism, Substance Abuse, and Addictions (CASAA) at the University of New Mexico. Dr. McCrady has focused her career on the development and testing of effective treatments for persons with substance use disorders. She created one of the first substance abuse treatment programs based on CBT principles and tested the effectiveness and cost-effectiveness of this treatment model. She has developed an original, conjoint treatment model for substance abusers and their spouses, and has conducted programmatic research on this treatment model. Dr. McCrady also has been active in bringing scientific attention to Alcoholics Anonymous, and has conducted controlled research evaluating alternative women's treatment models for women with alcohol and other substance use disorders, with a special focus on women in poverty. Her work has been funded by the NIH since 1979. Dr. McCrady has published more than 235 scientific articles, chapters, and books, and has lectured widely on her work in the United States, Canada, and Europe. **Registration opens online Friday, June 21**