Clinical Psychology Program* Training Manual

2016-2017

Department of Psychology

University of Washington

***The Clinical Psychology program is accredited by the American Psychological Association.**
APA Office of Program Consultation and Accreditation
750 1st Street NE
Washington, DC 20002
(202) 336-5979

TABLE OF CONTENTS

I.	**General Description and Training Model**	4
	A. Curriculum	4
	B. Clinical Training	5
	C. Research Training	6
	D. Teaching	6
	E. Competency Demonstration/ "Generals"	6
	F. Admission Procedures	7
	G. Student Characteristics and Attrition	7
	H. Financial Support	8
	I. Student Evaluation	8
	J. Job Placements	8
	K. Philosophy About Program Requirements	8
	L. Student Records	9
	M. Getting Assistance	9
II.	**Program Faculty**	10
	A. Ana Mari Cauce, Ph.D.	10
	B. Shannon Dorsey, Ph.D.	11
	C. Corey Fagan, Ph.D.	12
	D. William H. George, Ph.D.	13
	E. Jonathan Kanter, Ph.D.	15
	F. Lynn Fainsilber Katz, Ph.D.	16
	G. Kevin M. King, Ph.D.	17
	H. Robert J. Kohlenberg, Ph.D.	19
	I. Mary E. Larimer, Ph.D.	21
	J. Liliana J. Lengua, Ph.D.	22
	K. Marsha M. Linehan, Ph.D.	23
	L. Kate A. McLaughlin, Ph.D.	24
	M. Irwin Sarason, Ph.D.	26
	N. Jane M. Simoni, Ph.D.	26
	O. Ronald E. Smith, Ph.D.	27
	P. Wendy Stone, Ph.D.	28
	Q. Lori A. Zoellner, Ph.D.	30
III.	**Typical Training Sequence** (Appendix A)	32
	A. First Year	32
	B. Second Year	33
	C. Third Year	34
	D. Fourth Year and Beyond	34
	1. Science-Informed Case Presentation (SICP)	35

2. Predoctoral Internship 37
3. Quick Listing of All Required Courses for Clinical Psychology 38
4. APA-Required Discipline-Specific Knowledge Requirements 38
5. Practicum Requirements 39
6. Out-of-Area Requirements 39
7. Domain-Specific Knowledge and Profession-Wide Competency and Curricular Elements 40
8. Other Requirements 41

IV. **Second Year Project and Proposal** (Appendix B) 42
A. Second Year Project Proposal 42
B. Evaluation of the Project 43
C. Time Lines 43

V. **Practicum Requirements** (Appendix C) 45

VI. **Competency Demonstration/ General Examinations** (Appendix D) 47
A. Supervisory Committee 47
B. General Examination 49

VII. **Dissertation Proposals** (Appendix E) 50
A. Application for Internships 50
B. Final Examination/ Dissertation Defense 51

VIII. **Excerpts From the Graduate/Faculty Manual** (Appendix F) 53
A. Sexual Offenses 53
B. Standards of Conduct 53
C. Disciplinary Actions 53
D. Disciplinary Sanctions 54
E. Procedures for Review of Allegations of Academic and Scientific/Professional Misconduct 55
F. Student Academic Grievance Procedures 56

IX. **Financial Support, Tuition, and Fees** (Appendix G) 57
A. TA and RA Policy 57
B. Tuition and Residency 60

General Description and Training Model

The Clinical Psychology Program at the University of Washington is a Ph.D. program designed to achieve an integration of academic, scientific, and professional training. This program is fully accredited by the American Psychological Association and is a founding member of the Academy for Clinical Science. The goal of the program is to develop competent and creative clinical scientists who are capable of functioning successfully in academic, research, clinical, and community settings. Within this multifaceted training framework, we seek to train students who are interested in research careers. Our training program is primarily an apprenticeship for a career that will encompass making significant contributions to scientific clinical psychology. This is not the right program for those planning to pur
sue non-research oriented careers as clinicians.

This training program places a strong emphasis on flexibility so that students can identify and work toward their own specialized clinical research goals while at the same time attaining the general knowledge and skill competencies required of clinical psychologists today. An effort is made to create a learning environment that capitalizes on students' inherent motivation to learn and develop, and one in which students and faculty work closely together in collegial relationships.

The Clinical Psychology Program values ethnic and cultural diversity and makes available training experiences with traditionally underserved populations, including ethnic minority groups, those with developmental disabilities, and children. The program has a specialty track in Child Clinical Psychology. This is a formal area of specialization and students must apply specifically for admission to this track.

In addition to the formal specialty track in Child Clinical, students with interests in evaluating process issues, outcome in psychotherapy, community interventions, prevention programs, close relationships and social support, affective and emotional development, developmental disabilities, neuropsychology, psychophysiology, brain-behavior relations and research on parenting and family influences will find that there are faculty members conducting research in these specialty areas.

Curriculum

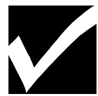
The program emphasizes academic research, while also providing opportunities for applied clinical training. Thus, our curriculum includes supervised clinical training in psychological assessment and treatment within our own training clinic, clerkship and internship training in settings outside the Department of Psychology. Completion of the Ph.D. in Clinical Psychology is expected to take five to seven years, including a full-time one year clinical internship at an independent training facility.

As an APA approved program, instruction is provided in scientific and professional ethics and standards, research design and methodology, statistics, psychological assessment and historical developments in psychology. Students typically take most of their required courses in clinical psychology during the first two years and complete their departmental and breadth (now referred to as Discipline-Specific Knowledge (DSK]) requirements by the third or fourth year. By meeting program requirements, students gain basic knowledge of biological, cognitive, affective, and social bases of behavior. Required courses in the clinical area include: Issues in Clinical Psychology, Research Methods in Clinical and Community Psychology; Behavior Disorders or Child Psychopathology, Systems of Psychotherapy, Clinical Personality Assessment, and Minority Mental Health. Elective courses in the Clinical Program include Behavioral Assessment, Single Subject Design, Cognitive Therapy for Depression, clinical practica in Dialectical Behavior Therapy, Functional Analytic Psychotherapy, and Treatment of Anxiety Disorders, and courses in addictive behaviors assessment and treatment In addition, students specializing in Child Clinical Psychology take several courses relevant to this specialty, such as, intelligence assessment, child treatment, and advanced child assessment. Various

additional assessment courses are available to all students as electives. A complete list of all required courses, and a typical student sequence of courses are included in the Appendix A of this manual.

The clinical psychology curriculum is organized around five competency areas. These areas are: personality, psychopathology, psychological assessment, psychotherapy and behavior change, and community-diversity studies. A wide array of course offerings, seminars, clinical practica, and research experiences are available for competency training in each area. Students are also encouraged to view the University as a rich resource that they can use to their benefit.

The Psychology Department itself is large and many classes offered by other areas, including cognitive, social, developmental, quantitative, and behavioral neuroscience, are relevant for student training. Other departments in the College of Arts and Sciences that may offer coursework of interest to clinical students include educational psychology, neurobiology, sociology, political science, anthropology, and American ethnic studies. In addition, within the University there is a School of Social Work, a College of Education, a School of Public Health and Community Medicine, and a College of Architecture and Urban Planning in addition to the School of Medicine. We highly encourage students to take advantage of the many opportunities throughout the University of Washington community.



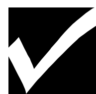
Clinical Training

Didactic training related to clinical issues, assessment of clinical problems, psychopathology, and the principles of psychotherapy and behavior change begins in the first year. Students typically begin their work with clinic clients in their second year and continue to see clients throughout their course of studies. The second year Clinical Methods sequence provides supervised psychotherapy and assessment experiences in the Psychological Services & Training Center (Clinic), which is located on campus. While completing the second year placement at the Clinic, students receive at least one hour of supervision for each hour of case contact. Supervision is provided either by core clinical faculty or by affiliated faculty who are clinicians in the community. Our supervisors represent diverse therapeutic models and orientations, ranging from psychodynamic to cognitive-behavioral to family systems, with an emphasis on empirically-supported interventions.

Supervised clinical practica outside of the Department are available after the second year and provide additional breadth of training. Students can select practica in numerous Seattle-area settings including Children's Hospital and Medical Center, the Center on Human Development and Disability, the Pain Clinic, the Autism Center, and Rehabilitation Medicine, all of which are affiliated with the University of Washington School of Medicine. Two Veterans Administration Hospitals and various community mental health centers also offer training opportunities for students.

The Seattle area has many wonderful resources for clinical training. In addition, faculty members offer clinical training opportunities in conjunction with their research on areas such as cognitive-behavioral therapies for depression and anxiety, dialectical behavior therapy (DBT) for borderline personality disorder, functional analytic psychotherapy (FAP), social skills training approaches to working with conduct problem children, therapy for children with autism and developmental disabilities, and motivational interviewing and relapse prevention therapy for addictive behaviors. As with coursework, students have considerable flexibility in choosing clinical training experiences.

Clinical training culminates with the internship, which is a required year of full-time intensive clinical training at a facility outside of the Psychology Department. Students must independently apply and compete for internship appointments. The internship is typically completed in the fifth or sixth year of study. Students in our program typically have been very successful in obtaining their top choices of internships. Recent students in our program have been offered internships at Stanford University Children's Hospital, Harvard Medical School, Brown University Medical Center, UCLA Medical Center, University of California at San Francisco Medical Hospital, the University of Washington Medical School, Denver Children's Hospital, Oregon Health Sciences University, and other leading medical and psychological training centers.

 **Research Training**

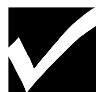
Students are assigned a research advisor and a co-advisor upon admission to the program. Students are expected to be involved in research throughout their years in the program. Research training begins in the first year with coursework in statistics and research design, and computer skills. Students collaborate with faculty on a variety of research projects and also engage in independent research. By the end of the first year, students have developed a formal research proposal for an initial study (typically, the Second Year Project).

All students are required to complete a Second Year Project, which is similar to a Master's thesis and must be submitted in written form according to APA-format. A formal presentation of the study is presented at the annual departmental Research Festival, held at the end of the academic year. Upon formation of an appropriate committee, the Second Year Project can be used to obtain a Master's Degree. However, it should be noted that the University of Washington Clinical Program does not grant a terminal Master's Degree. Obtaining the Master's is merely an optional step in the process of completing the doctoral program. (A full description of requirements for the Second Year Project is contained in Appendix B of this manual.)

Every year since 1974, the University of Washington has been the nation's top-ranked public university in terms of federal grant funding, garnering more than $1.3 billion in grants and contracts in 2014. The clinical faculty is extremely productive both in terms of professional publications and in obtaining research grant funding, and the clinical program has consistently been ranked in the top five nationally. In 2003, the program received the Distinguished Program Award from the Association for the Advancement of Behavior Therapy (now the Association for Behavioral & Cognitive Therapies) for the quality of its faculty and its longstanding history of producing exceptionally well-trained clinical scientists. Most faculty members hold a major federally funded research grant and several hold multiple grants. These research grants provide many students with financial support as Research Assistants while offering research experience. Students are also quite successful in having their research accepted for presentation at professional conferences and in publishing the results of their research. We highly encourage students to become involved in conference presentations and publishing their work as early as possible. The Wagner Fund, through a competitive application process, provides clinical students with some financial support for conference presentations. Research training culminates in the doctoral dissertation, which typically represents a line of research inquiry initiated by the student.

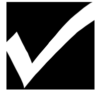
Teaching

We strongly recommend that all students obtain some teaching experience during their years in the program. Teaching experience in undergraduate courses is available through departmental teaching assistantships. Clinical teaching and supervisory experience can also be obtained through teaching assistantships in clinical assessment, or at the clinic during one's advanced years in the program. Faculty members supervise the teaching experiences obtained by graduate students. Advanced students may also have the opportunity to teach daytime or evening classes.

 **Competency Demonstration/"Generals"***

The General Examination is typically completed during the third or fourth year. In order to complete "Generals," which is required to formally become a Ph.D. candidate, students must demonstrate a satisfactory degree of competence in research and writing. Each student chooses a committee consisting of at least four faculty members (two must be in

clinical and one, the Graduate School Representative, is chosen by the student and appointed by the Graduate School). The student works closely with this committee to select a topic and procedures for competency demonstration. Demonstration will be accomplished through producing a publication-quality empirical article, presenting a Psychological Bulletin type review paper, and presenting an approved dissertation proposal that includes a comprehensive literature review. Finally, students will defend their written papers or proposals orally to their committee. A full description of the requirements for the General Examination is included in Appendix D of this manual.

 **Admission Procedures**

The Clinical Psychology Program and the specialty track in Child Clinical typically attract very highly qualified applicants. Several hundred applicants each year compete for the few spots in either the clinical program or the child track within the program, which have separate application procedures. As such, admission to the program is highly competitive and entering students have very strong credentials, excellent letters of recommendation and previous research experience. We value diversity in our program, and ethnic minority students and male as well as female students are strongly encouraged to apply.

Students must indicate at the time of application whether they are applying to the Clinical program or to the Child Clinical track within this program. Admissions procedures for the child track are separate from that for the rest of the program.

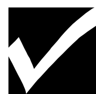
Although some attempt to match applicants with individual faculty member interests is made during this process, final admission decisions are made by the full faculty. As such, it is recommended that students review the list of faculty research interests since it has been our experience that students do best in the program if their interests are represented among the core faculty.

As part of the admission process, we do not encourage applicants to contact us with requests for interviews. Due to the large applicant pool and the time and energy involved in interviewing, phone and personal interviews are generally reserved for applicants who are being considered in the final pool from which offers of admission will be made.

Student Characteristics and Attrition

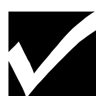
The program is presently comprised of 50 students. Students vary widely in their backgrounds, experiences, and characteristics with no one typical "profile" other than that of excellence. Approximately 80% of our currently enrolled students are female, and ages range from early 20's to mid-30's. Most often, entering students have taken at least one year off after obtaining their undergraduate degree to gain further research and/or clinical experience. The program has traditionally had a strong commitment to the recruitment and training of ethnic minority students; approximately 35% of our students are ethnic minority group members. Over the last five years, entering class sizes have ranged from 5 to 9, with about 40 percent of the class in the child clinical track.

We accept very few students from a large pool of qualified applicants. Once admitted, we fully expect that all students will complete the program, and we do everything possible to facilitate that process. Student morale is generally high and attrition from the program is quite low (less than 2 percent over the past decade).

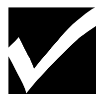
 **Financial Support**

Al students admitted to the program are guaranteed academic year financial support for their first four years in the program. Summer support is available through research appointments and a limited number of TA appointments. Though not contractually obligated to do so beyond that point, we have always been able to support students throughout their stay in the program. Support occurs through teaching and research assistants and through both internal (e.g., U.W. Royalty Research Awards) and competitive extramural grants (e.g., National Research Service Awards, National Science Foundation Graduate Fellowships) that students obtain.

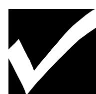
More specific information on financial support is to be found in the Department's Graduate Program Manual. The most recent version of that section in the departmental manual is reproduced in Appendix G. As noted there, please see the Graduate program Administrator (Jeanny Mai) for any updates that might occur during the academic year.

 **Student Evaluation**

In addition to evaluations received in the form of grades for formal coursework, graduate student progress in the program is evaluated yearly by both the clinical program and the Department of Psychology. The evaluation for the first two years is especially thorough and students are provided with specific and detailed feedback from the clinical area. The evaluation is meant to let students know about accomplishments that we consider to be especially noteworthy, as well as to inform them of any potential problem areas in a timely fashion. In addition to formal feedback from the academic advisor, students also receive feedback from their clinical supervisors in conjunction with all practicum placements, either in our own clinic or at other approved settings. Students are also encouraged to maintain close contact with their advisors, mentors and advisory committee throughout their time in the program. We make every effort to let students know about potential problems by both formal and informal means. We are also committed to helping students work through difficulties that they may encounter in their coursework, clinical work, or research.

 **Job Placements**

Graduates of our program generally have been very successful in obtaining employment in the area of their choice. Our students can be found in a wide array of settings including Departments of Psychology in major universities, medical centers, postdoctoral positions, and mental health centers. Among our recent graduates, two have recently been awarded prestigious FIRST grant awards from the National Institute of Mental Health and one has received a teaching award at her university.

 **Philosophy About Program Requirements**

Our commitment to a flexible program that is aimed at helping to maximize the ability of all students to pursue their own goals and interests is something that we value highly. This means that there is variability from student to student in the amount of coursework they take and the nature of Second Year Projects, Generals, and the dissertation. The guidelines that follow in the appendices set basic standards for the completion of these requirements; however, some latitude exists for the student to negotiate with his or her advisor or advisory committee as to the exact nature and scope of each undertaking.

The Department of Psychology's Graduate Program Manual and various other handouts are available to all students in helping them to develop an annual plan for meeting department-wide or university-wide requirements. Your mentor , other advisors, , the clinical faculty, and the Director of Clinical Training are important sources of support and guidance, but ultimately we expect students to be in charge of developing their own program of studies that is tailored to their unique goals, yet meets the requirements of the program, the APA's Standards of Accreditation, the Department, and the University.

Student Records

Your official graduate student file is kept in the office of the Department's Graduate Program Advisor (Jeanny Mai). It includes every official document including your application materials; graduate transcripts; Annual Plans and feedback letters from your advisor; communications (if any) from the Graduate Training Committee; a record of your financial support (TA's RAs, etc.); your progress in satisfying course requirements and program milestones to allow you to take generals and advance to doctoral candidacy; degrees obtained; eligibility for internship, hooding, and graduation. Jeanny can make this file accessible to you upon request. The Registrar's office retains your degree-relevant information and transcript indefinitely.

The Director of Clinical Training also maintains a program-oriented file containing relevant written and e-mail correspondence, Annual Plans, your first year proposal, your second year writeup, clinical supervisor ratings, letters of recommendation written on your behalf; APPI certification forms for internship, feedback from internship directors, and certification that your internship has been satisfactorily completed. These materials, kept in a locked file cabinet in the DCT's office, are helpful in writing letters of reference before and after graduation, certifying that you have completed program requirements and graduated, communicating with licensing boards, etc. We retain these files for 6 years after graduation in accordance with University policy. This file can be accessed by you upon request to the DCT.

Getting Assistance

The departmental Graduate Student Manual (https://depts.washington.edu/psych/files/graduate/MANUAL-15.pdf) contains detailed information on how to obtain assistance for a wide variety of needs, including technical and electronic support, computers and equipment, funding matters, residency requirements mentoring resources, summer support and departmental financial awards, and all departmental academic and graduation requirements. The Graduate Program Advisor, Jeanny Mai, can provide consultation, information, and assistance on a wide array of topics.

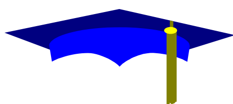
Statistical consulting services are available by appointment from faculty members Kevin King and Bryan Flaherty and also through the Center for Social Science Computation and Research (CSSCR), located in Savery Hall.

Personal counseling is available to students at the University's Counseling Center and at Hall Health Center (both free for a limited number of sessions, after which your graduate student insurance provides coverage). Corey Fagan also maintains a list of licensed psychologists in the community who provide therapy for clinical graduate students at a reduced rate. Several of these professionals have also provided group therapy for students in the past. Your insurance also provides for mental health services. For coverage information, see https://www.washington.edu/admin/hr/benefits/insure/gaip/ .

Program Faculty

There are currently 17 faculty members in the Clinical Psychology Training Program. Ronald Smith is Director of the Clinical Psychology Training Program. Liliana Lengua is Head of the Child Clinical Track and Lori Zoellner is the Head of the Adult Clinical Track. Clinical students may have primary advisors outside of the clinical program; however, there must be representation from the core clinical faculty on the advisory committee of all clinical students.

A brief description of clinical faculty members and their current research interests follows, together with a list of representative publications.



Ana Mari Cauce,
Professor and Interim President, Ph.D., Yale, 1984.

I am a child clinical-community psychologist with a particular interest in adolescent development within ethnic minority and high-risk communities. My research program stresses the importance of ecological/contextual factors in development, including neighborhood features, social support networks, and cultural factors, as they affect families with adolescent children.

Together with faculty and student colleagues, I have most recently been conducting longitudinal research with Mexican American adolescents and their families in California, focusing on factors that lead to positive school, mental health, and competence outcomes. My approach to research draws heavily from community psychology principles and perspectives, which include an emphasis on competency, prevention, empowerment, and a respect for individual and cultural differences. In order to best meet the needs of children and families, I believe that we will need to develop more complex interactional models which take into account the ecological niches that individuals inhabit.

I am spending the bulk of my time in University administration and not presently taking new graduate students.

Representative Publications

Cauce, A.M., **Domenech-Rodriguez, M., Paradise, M., Cochran, B., Shea, J.M**., Srebnik, D. & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70,* 44-55.

Cauce. A.M., & **Costigan, C**. (2007). Changes in African-American Mother-Daughter relationships during adolescence: Conflict, autonomy, and warmth. In B.A.Leadbeater (Ed). *Urban Adolescent Girls: Risk and Resilience.*

Cauce, A.M. (2007). Bringing community psychology home: The leadership, Community and values initiative. *American Journal of Community Psychology, 39,* 1-11.

Cauce, A. M. (2008). Parenting, Culture, and Context: Reflections on Excavating Culture. *Applied Developmental Psychology, 12 (4),* 227-229.

Cauce, A.M**., Cruz, R., Corona, M.** & Conger, R. (2010). Developmental pathways to substance use and abuse among Mexican-American Youth. Nebraska Symposium Series on Latinos in the U.S. University of Nebraska Press, Lincoln, NK

Cauce, A.M. (2011). Is multicultural psychology a-scientific? Diverse methods for diversity research. Cultural Diversity and Ethnic Minority Psychology, 17, 228-233.

Cauce, A.M., Cruz, R., Corona, M. & Conger, R. (2011). The face of the future: Risk and resilience in minority youth. In Gustavo Carlo, Lisa J Crockett, & Miguel Carranzana. *Health Disparities in Youth and Families*, University of Nebraska Press, Lincoln, NB

Cruz, R.A., King, K.M., Widaman, K.F., Leu, J., Cauce, A.M., & Conger, R.D. (2011). Cultural influences on positive father involvement in two-parent Mexican-origin families. *Journal of Family Psychology*, 25, 731-740.

Cauce, A.M. & Gordon, E.W. (2012). Toward the measurement of human agency and the disposition to express it. In Gordon Commission on the Future of Assessment in Education. New Jersey: ETS Press.

Corona, M., McCarty, C., Cauce, A.M., Robins, R.W., Widaman, K.F., & Conger, R.D. (2012). The relation between maternal and child depression in Mexican American families. Hispanic Journal of Behavioral Sciences, 34, 539-556.

Conger, R.D., Song, H., Stockdale, G.D., Ferrer, E., Widaman, K.H., & Cauce, A.M. (in press). Resilience and vulnerability of Mexican origin youth and their families: A test of a culturally-informed model of family economic stress. *Adolescence and Beyond: Family Processes and Development.* New York: Oxford University Press

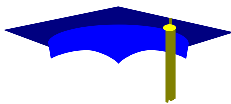
Cruz, R.A. Gonzales, N.A., Corona, M., King, K. Cauce, A.M., Robins, R.W., Widaman, K.F., & Conger, R.D. (2014). Cultural dynamics and marital relationship quality in Mexican-origin families. *Journal of Family Psychology, 28*, 844-854.

Cauce, A.M. (2015). My life in administration: From accident to career. In R. J. Sternberg, E. Davis, A.C. Mason, R.V. Smith, J.S. Vitter, & M. Wheatly (Eds.). *Academic leadership in higher education: From the top down and the bottom up*. Lanham, MD: Rowman-Littlefield.

Cauce, A.M. & Friedman, D. (2015 in progress). Creating access with excellence. In J. Antony, A.M. Cauce, & D. Shalala (Eds). Challenges in academic leadership. NY: Routledge.

Cruz, R.A.; King, K.M., Cauce, A.M., Conger, R.D., Robins, R. Cultural orientation trajectories and substance abuse: Findings from a longitudinal study of Mexican-origin youth (under review at *Child Development*).

Antony, J., Cauce, A.M., & Shalala, D. (Eds.) (2015 in progress). Challenges in Higher Education Leadership. NY, Routledge.



Shannon Dorsey
External Practicum Coordinator, Associate Professor, PhD, University of Georgia, 2003

My research is on evidence-based treatments (EBT) for children and adolescents, with a particular focus on dissemination and implementation of EBT domestically and internationally. I have often focused on Trauma-focused Cognitive Behavioral Therapy (TF-CBT), with hybrid research designs that include both effectiveness and implementation questions. Within these broad areas, I have studied EBT adaptation for unique populations (e.g., foster care) and training and supervision strategies to deliver TF-CBT and other EBT. I am currently conducting a study of supervision of TF-CBT in community mental health settings, which includes a descriptive study of common supervision practices and a randomized controlled trial (RCT) of “gold standard” supervision strategies. A second RCT, in Tanzania and Kenya, uses a task-shifting/task-sharing model in which lay counselors, with little to no prior mental health training, deliver group-based TF-CBT to children and adolescents who have experienced the death of one or both parents, under close supervision by TF-CBT experts. I am also interested testing EBT in other low and middle income countries (LMIC), with current work in Southern Iraq, the Thai-Burmese border, Colombia, Zambia, and Ethiopia. In collaboration with a colleague at Johns Hopkins, I developed a common elements intervention for use by lay counselors in LMIC. The ultimate goal of my research is to improve mental health services for children, adolescents and their families.

My clinical orientation is cognitive behavioral, with a specialty in EBT for child trauma exposure (TF-CBT) and behavioral problems (Helping the NonCompliant Child, Parent-Child Interaction Therapy).

Representative Publications (Student/mentee authors starred)

Murray, L. K., *Skavenski, S., Kane, J. C., Mayeya, J., Dorsey, S., Cohen, J. A., . . . Bolton, P. A. (in press). *Effectiveness of Trauma Focused Cognitive Behavioral among trauma-affected children in Lusaka, Zambia: A randomized controlled trial. JAMA Pediatrics.*

O’Donnell, K., Dorsey, S., *Gong, W., Ostermann, J., Whetten, R., Cohen, J., Itemba, D., Manongi, R., & Whetten, K. (2014). Treating maladaptive grief and posttraumatic stress symptoms in orphaned children in Tanzania: Group-based trauma-focused cognitive–behavioral therapy. *Journal of Traumatic Stress, 27*(6).

Dorsey, S., Berliner, L., Lyon, A. R., Pullmann, M., & Murray, L. K. (2014). A statewide common elements initiative for children's mental health. *Journal of Behavioral Health Services and Research*. Advance online publication.

Bolton, P., Lee, C., *Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., ... & Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: Development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Medicine, 11*(11), e1001757.

Lyon, A. R., Dorsey, S., Pullman, M. *Silbaugh-Cowdin, J. , & Berliner, L. (2014). Clinician use of standardized assessments following a common elements psychotherapy training and consultation program. *Administration and Policy in Mental Health.*

Dorsey, S., *Lucid, L., Murray, L.K., Bolton, P., O'Donnell, K., Itemba, D., Manongi, R., & Whetten, K. (in press). *A qualitative study of mental health problems among orphaned children and adolescents in Tanzania*. *Journal of Nervous and Mental Disease.*

Murray, L. K., Dorsey, S., *Haroz, E.' Lee, C., Alsiary, M., Haydary, A., Weiss, W. M., & Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice, 21*(2), 111-123.

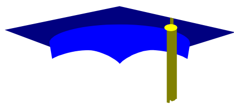
Dorsey, S., Kerns, S. E. U., Trupin, E. W., *Conover, K. L., & Berliner, L. (2012). Child welfare social workers as service brokers for youth in foster care: Findings from project focus. *Child Maltreatment. Special Issue: Disseminating child maltreatment interventions: Research on implementing evidence-based programs, 17*, 22–31.

Dorsey, S., Pullmann, M., Berliner, L., Koschmann, E. F., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies. *Child Abuse and Neglect*.

Murray, L.K., Dorsey, S., Bolton, P., Jordans, M., Rahman, A., Bass, J. & Verdeli, H. (2011). Building capacity in mental health in low-resource countries: An apprenticeship model for training local providers. *International Journal of Mental Health Systems, 5,* 1–12.

Forehand, R., Dorsey, S., Jones, D. J., Long, N., & McMahon, R. J. (2010). Adherence and flexibility: They can (and do) coexist. *Clinical Psychology: Science and Practice*, 17, 258–264.

Dorsey, S., Farmer, E. M. Z., Barth, R. P, *Greene, K. M., Reid, J., & Landsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents. *Children and Youth Services Review, 30,* 1403–1416.



Corey Fagan,
Director, Psychological Services and Training Center, Ph.D.,
University of Massachusetts, 1988

I direct the Psychological Services and Training Center (the Clinic), which is the primary clinical training site for graduate students in the clinical psychology program. The mission of the Clinic is to train future clinical scientists and scientist/practitioners.

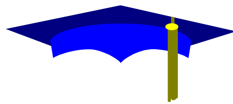
My responsibilities include managing a support staff of two full-time, and up to five part-time employees, two Clinic teaching assistants and approximately thirty to forty graduate student trainees. I oversee the selection and assignment of all prospective clients and the recruitment and assignment of clinical supervisors. As such, I am the primary liaison between the in-house faculty and the community-based supervisors. In conjunction with the DCT, I develop and enforce Clinic policies and procedures.

Each year I teach the Clinical Methods sequence for second year students which consists of an Introduction to Clinical Interviewing and a Clinical Ethics course. I also organize the Clinical Colloquium in which I bring in outside speakers to address important clinical issues such as working with ethnically and culturally diverse populations. And I run the Clinic Practicum, providing both individual supervision and small group consultation to graduate students. Periodically, I also teach CBT for Depression and a class on Consultation and Supervisory Skills.

In concert with Jon Hauser, I oversee the development of OwlOutcomes, a software platform designed to allow clinicians to easily collect outcome data on client progress. I am also conducting research on the functionality and usability of the system, with the goal of using it as a tool to train clinicians in how to integrate science into practice.

Representative Publication (bold indicates student or postdoc co-author)

Smith, R. E., Fagan, C., Wilson, N. L., **Chen, J., Corona, Marissa, Nguyen, H., Racz, S.,** & Shoda, Y. (in press). Internet-based approaches to collaborative therapeutic assessment: New Opportunities for professional psychologists. *Professional Psychology: Research and Practice*.



William H. George,
Acting Head, 2014-15, Adult Clinical Track; Professor, Ph.D., University of Washington, 1982

Alcohol has been linked with various social problems, particularly violence, sexual assault, and HIV/AIDS related sexual risk taking. My primary research focuses on alcohol's role in such problems and emphasizes two theoretical approaches: Alcohol Expectancy Theory and Alcohol Myopia Theory. Alcohol expectancies are beliefs about the effects of alcohol that are acquired through personal and/or vicarious drinking experiences. Expectancies influence the initiation of drinking episodes; and they shape what one experiences and how one behaves after drinking. Alcohol myopia is a product of physiologically impaired cognitive functioning and results in a tendency to over-focus on cues that impel behavior and to under-focus on cues that inhibit behavior. Alcohol's involvement in acquaintance and date rape evokes additional formulations. Gender differences in socialization about sexuality prepare men and women to adopt adversarial roles in social interactions characterized by romantic/sexual overtones. The addition of alcohol to such interactions may fuel patterns of misperception and miscommunication that increase the likelihood of sexually coercive and/or aggressive behaviors. We have also begun to investigate the role of sexual victimization history (both child and adult sexual assault) in these behaviors as well as in sexual risk taking behaviors. Drawing on these ideas, my colleagues, my students, and I conduct experiments examining alcohol's effects on responses related to sexual assault and risk taking. These studies typically involve questionnaires assessing expectancies, background personality factors, and sexual victimization history; followed by administration of alcohol or control beverages and presentation of sexual and/or violent stimuli. I am also interested in cultural issues in psychology. This especially includes cultural factors pertinent to sexuality, sexual victimization/perpetration, substance use, clinical forensic services, and clinical practice. These interests manifest primarily in studies investigating racial and ethnic factors in sexual perception and behavior. Related emerging research activities focus on the role of cultural factors in Asian American alcohol use, perceptions of Asian American women, and sexual risk behaviors among African American women and men.

Representative and Selected Recent Publications

Andrasik, M.P., Woods, B., & George, W.H. (2011). The need for culturally competent Harm Reduction and Relapse Prevention interventions for African Americans. In G. A. Marlatt, M. E. Larimer, & K. Witkiewitz (Eds.), Harm Reduction 2nd Edition.

Barrett, K. H. & George, W. H. (Eds.) (2005). *Race, Culture, Psychology, and the Law*. Sage: Thousand Oaks, CA.

Crowe, L. C., & George, W. H. (1989). Alcohol and human sexuality: Review and integration. *Psychological Bulletin, 105*, 374-386.

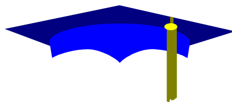
Davis, K. C., George, W. H., Norris, J., Schacht, R., Stoner, S. A., Hendershot, C. S., & Kajumulo, K. (2009). The effects of alcohol and blood alcohol concentration limb on sexual risk intentions. *Journal of Studies on Alcohol and Drugs*, 70, 499-507.

Davis, K.C., Hendershot, C.S, George, W.H., Norris, J., & Heiman, J.R., (2007). Alcohol's effects on sexual decision making: An integration of alcohol myopia and individual differences. *Journal of Studies on Alcohol & Drugs*, 68, 843-851.

George, W. H., & Stoner, S. A. (2000). Understanding alcohol and sexual behavior. *Annual Review of Sex Research*, *11*, 125-157.

George, W. H., Davis, K. C., Norris, J., Heiman, R. J., Schacht, R., Stoner, S. A., & Kajumulo, K. F. (2006). Alcohol and erectile response: The effects of high dosage in the context of demands to maximize sexual arousal. *Experimental & Clinical Psychopharmacology*, *14*, 461-470.

George, W.H., & Martinez, L. (2002). Victim blaming in rape: effects of victim and perpetrator race, type of rape, and participant racism. *Psychology of Women Quarterly*, *26*, 110-119.
George, W.H., Davis, K. C., Norris, J., Heiman, R. J., Schacht, R., Stoner, S. A., Hendershot, C. S., & Kajumulo, K. (2011). Women's Sexual Arousal: Effects of High Alcohol Dosages and Self-Control Instructions. *Hormones and Behavior*.
George, W.H., Davis, K. C., Norris, J., Heiman, J. R., Stoner, S. A., Schacht, R., Hendershot, C. S., & Kajumulo, K. (2009). Indirect effects of acute alcohol intoxication on sexual risk-taking: The roles of subjective and physiological sexual arousal. *Archives of Sexual Behavior*, *38*, 498-513. PMID: 18431618
George, W.H., Stoner, S. A., Davis, K. C., Lindgren, K. P., Norris, J. & Lopez, P.A. (2006). Postdrinking sexual perceptions and behaviors toward another person: Alcohol expectancy set and gender differences. *The Journal of Sex Research, 43*, 282-292.
George, W.H., Stoner, S. A., Norris, J, Lopez, P.A, & Lehman, G.L. (2000). Alcohol expectancies and sexuality: A self-fulfilling prophecy analysis of dyadic perceptions and behavior. *Journal of Studies on Alcohol*, *61*, 168-176.
Gilmore, A. K., Schacht, R. L., George, W. H., Otto, J. M., Davis K. C., Heiman, J. R., Norris J., and Kajumulo K. F., (2010). Assessing women's sexual arousal in the context of sexual assault history and acute alcohol intoxication. *Journal of Sexual Medicine*, *7*, 2112-2119.
Hendershot, C. S, Stoner, S. A., George, W. H., & Norris, J. (2007). Alcohol use, expectancies and sexual sensation seeking as correlates of HIV risk behavior in heterosexual young adults. Psychology of Addictive Behaviors, 21, 365-372.
Hendershot, C. S, &. George, W. H., (2007). Alcohol and sexuality research in the AIDS era: Trends in publication activity, target populations and research design. *AIDS and Behavior, 11*, 227-237.
Hendershot, C.S., Witkiewitz, K., George, W.H., & Marlatt, G.A. (in press). Relapse Prevention for Addictive Behaviors: Review and Update. *Substance Abuse Treatment, Prevention, and Policy*.
Koo, K. H. Stephens, K. A. Lindgren, K. P. & George, W. H., (in press). Misogyny, acculturation, and ethnic identity: Relation to rape-supportive attitudes in Asian American college men. *Archives of Sexual Behavior*.
Lindgren, K. P., Parkhill, M. R., George, W. H., Hendershot, C.S. (2008). Gender differences in perceptions of sexual intent: A qualitative review and integration. *Psychology of Women Quarterly, 32*, 423-439.
Norris, J., George, W. H., Stoner, S. A., Masters, N. T., Zawacki, T., & Davis, K. C. (2006). Women's responses to sexual aggression: The effects of childhood trauma, alcohol, & prior relationship. *Experimental & Clinical Psychopharmacology, 14*, 402-11.
Schacht, R. L., Stoner S. A., George W. H., & Norris J. (2010). Idiographically-determined versus standard absorption periods in alcohol administration studies. *Alcoholism: Clinical & Experimental Research, 34*, 925-927. PMID: 20331574
Schacht, R.L., George, W.H., Davis, K.C., Heiman, J.R., Norris, J., Stoner, S.A., & Kajumulo, K.F. (2010). Sexual abuse history, alcohol intoxication, and women's sexual risk behavior. *Archives of Sexual Behavior, 39*, 898-906.
Schraufnagel, T. J. Davis, K. C. George, W. H. Norris, J. (2010). Childhood sexual abuse in males and subsequent risky sexual behavior: A potential alcohol use pathway. *Child Abuse & Neglect, 34*, 369-378.
Stephens, K., & George, W. H. (2009). Rape Prevention with College Men: Evaluating Risk Status. *Journal of Interpersonal Violence, 24*, 996-1013.
Stephens, K.A., & George, W. H. (2004). Effects of anti-rape video content on sexually coercive and non-coercive college men's attitudes and alcohol expectancies. *Journal of Applied Social Psychology, 34*, 402-416.
Stoner, S. A., George, W. H., Norris, J., & Peters, L. M. (2006). Liquid courage: Alcohol fosters risky sexual decision-making in individuals with sexual fears. *AIDS and Behavior*. *11,* 217-226.
Stoner, S. A., Norris, J., George, W. H., Davis, K. C., Masters, N. T., &. Hessler, D. M. (2007). Effects of alcohol intoxication and victimization history on women's sexual assault resistance intentions: The role of secondary cognitive appraisals. *Psychology of Women Quarterly, 31*, 344-356.
Stoner, S. A., Norris, J., George, W. H., Morrison, D. M., Zawacki, T., Davis, K. C., & Hessler, D. M. (2008). Women's condom use assertiveness and sexual risk-taking: Effects of alcohol intoxication and adult victimization. *Addictive Behaviors, 33*, 1167-1176.
Wheeler, J. G., & George, W. H. (2005). Rape and Race: An Overview. In K. Barrett, K. H. & W. H. George (Eds.). *Race, Culture, Psychology, and the Law*. Sage: Thousand Oaks, CA.



Jonathan Kanter
Research Associate Professor, Ph.D., University of Washington, 2002

My research focuses on Functional Analytic Psychotherapy (FAP), a functional contextual psychotherapy approach targeting human closeness and connection, hypothesized to be a trans-diagnostic dimension that mediates outcomes with respect to broad and significant domains of human functioning. My research lab is focused on the proposition that FAP's functional contextual model of awareness, courage, and love can serve as a foundation behind meaningful and powerful human relationships. We plan to execute and stimulate a progressive, contextual behavioral science research agenda that explores this model with precision, scope and depth. Over the next several years, we will engage in research on FAP efficacy and effectiveness with respect to populations that may include depression, anxiety, personality disorders, and co-morbid health conditions such as smoking and obesity. We are also planning research on FAP training and dissemination, and mechanism and process, as well as research to validate multi-modal measures of FAP outcomes and processes as necessary precursors to the above work. We also are interested in research on applications of the FAP model for the general public, targeting not just the amelioration of individual suffering but improved relationships in general, group cohesion and productivity, discrimination and racism, and aggression towards others, among other topics.

My clinical orientation is functional contextual behavioral, with expertise in treatment of depression and great interest in working cross-culturally and with ethnic minorities.

Representative Publications (*denotes student first author):

*Landes, S. J., Kanter, J. W., Weeks, C.E., & Busch, A. M. (in press). The impact of the active components of Functional Analytic Psychotherapy on idiographic target behaviors. *Journal of Contextual Behavioral Science.*

Kanter, J. W. (in press). The vision of a progressive clinical science to guide clinical practice. *Behavior Therapy.*

Kanter, J. W., Tsai, M., Holman, G., & Koerner, K. (2013). Preliminary data from a randomized pilot study of web-based Functional Analytic Psychotherapy therapist training. *Psychotherapy: Research, Theory, Practice, Training, 50,* 248-255.

*Mangabeira, V., Kanter, J. W., & Del Prette, G. (2012). Functional Analytic Psychotherapy (FAP): A review of publications from 1990 to 2010. *International Journal of Behavioral Consultation and Therapy, 7,* 78-89.

*Weeks, C. E., Kanter, J. W., Bonow, J. T., Landes, S. J., & Busch, A. M. (2012). Translating the theoretical into practical: A logical framework of Functional Analytic Psychotherapy interactions for research, training and clinical purposes. *Behavior Modification, 36,* 87-119.

*Busch, A. M., Callaghan, G. C., Kanter, J. W., Baruch, D. E., & Weeks, C. E. (2010). The Functional Analytic Psychotherapy Rating Scale: A replication and extension. *Journal of Contemporary Psychotherapy*, *40,* 11-19.

Busch, A. M., Kanter, J. W., Callaghan, G. M., Baruch, D. E., Weeks, C. E., & Berlin, K. S. (2009). A micro-process analysis of functional analytic psychotherapy's mechanism of change.* *Behavior Therapy, 40,* 280-290.

Kanter, J. W., Rusch, L. C., Landes, S. L., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Research, Theory, Practice, Training, 46*, 220-232.

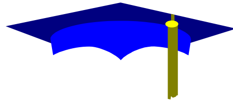
Kanter, J. W., Manos, R. C., Busch, A. M., & Rusch, L. C. (2008). Making behavioral activation more behavioral. *Behavior Modification, 32,* 780-803.

Kanter, J. W., Landes, S. J., Busch, A. M., Rusch, L. C., Brown, K. R., Baruch, D. E., & Holman, G. (2006). The effect of contingent reinforcement on target variables in outpatient psychotherapy for depression: A successful and unsuccessful case using functional analytic psychotherapy. *Journal of Applied Behavior Analysis*, 39, 463-467.

Kanter, J. W., Schildcrout, J. S., & Kohlenberg, R. J. (2005). In-vivo processes in Cognitive Therapy for depression: Frequency and benefits. *Psychotherapy Research, 15*, 366-373.

Kohlenberg, R. J., Kanter, J. W., Bolling, M. Y., Parker, C. R., & Tsai, M. (2002). Enhancing cognitive therapy for depression with functional analytic psychotherapy: Treatment guidelines and empirical findings. *Cognitive and Behavioral Practice, 9*, 213-229.

Kanter, J. W., Parker, C. R., & Kohlenberg, R. J. (2001). Finding the self: A behavioral measure and its clinical implications. *Psychotherapy: Theory, Research, Practice, Training, 38*, 198-211.



Lynn Fainsilber Katz,
Research Professor, Ph.D., University of Illinois at Urbana-Champaign, 1991

Lynn Fainsilber Katz,
Research Professor, Ph.D., University of Illinois at Urbana-Champaign, 1991

My primary research interests are in examining familial factors related to risk and resilience in children's socioemotional development. I am particularly interested in children's ability to regulate emotion in face of adverse environments and life events, and how parenting both supports the development of child emotion regulation abilities and buffers children from negative developmental outcomes. My research integrates theorizing on biological processes (autonomic nervous system and neuroendocrine functioning) and social processes to develop theoretical models of family relationships.

One major focus of my current efforts is in understanding adjustment and coping in families with children who have been newly diagnosed with cancer. We will be assessing families over the course of their first year of cancer treatment to identify when families are at greatest risk for psychological distress. The quality of family relationships will be examined in multiple family subsystems, including the inter-adult, parent-child and sibling relationships. Our focus is on the stresses families experience, changes in family relationships over the course of treatment, and both risk and protective factors that are associated with adjustment outcomes in children and caregivers.

Another adverse life event currently being investigated is the effects of intimate partner violence on children. We have taken our basic research findings on child adjustment in face of intimate partner violence and developed a parenting intervention for female survivors. We have found that when parents are aware of and coaching children's emotions even within the context of family violence, children show better adjustment than when parents are unaware and do not coach children's emotions. We have completed the intervention in partnership with domestic violence agencies in the greater Puget Sound area, and are currently analyzing results.

We are also expanding our intervention work to other at-risk populations. We are now developing a parenting intervention that combined parent training with emotion coaching to help young children with oppositional defiant disorder and low prosocial emotions. This is a new direction my work is taking in collaboration with mental health agencies in the King County area.

My approach to research emphasizes the importance of specificity in understanding those processes that lead to risk for psychopathology. I believe that only by understanding the specific interpersonal and intrapersonal processes most detrimental to children's development that successful intervention programs can be developed to address those risk factors. I am also committed to understanding family strength as well as weakness, and in identifying protective mechanisms that buffer children from negative outcomes.

<u>Representative Publications</u>

Katz, L.F., Shortt, J.W., Allen, N., Davis, B., Hunter, E., Leve, C., & Sheeber, L. (2014). Parental emotion socialization in clinically depressed adolescents: Accepting, dampening and enhancing positive affect. *Journal of Abnormal Child Psychology, 42(2),* 205-215.

Maliken, A., & Katz, L.F. (2013). Exploring the impact of parental psychopathology and emotion regulation on evidence-based parenting interventions: A transdiagnostic approach to improving treatment effectiveness. *Clinical Child and Family Psychology Review, 16,* 173-186. DOI 10.1007/S10567-013-0132-4.

Maliken, A., & Katz, L.F. (2013). Fathers' Emotional Awareness and Children's Empathy and Externalizing Problems: The Role of Intimate Partner Violence. *Journal of Interpersonal Violence*, *28*, 718-734.

Katz, L.F., Maliken, A., & Stettler, N. (2012). Parental Meta-Emotion Philosophy: A Review of Research and Theoretical Framework. *Child Development Perspectives,* 6, 417-422.

Sheeber, L., Kuppens, P., Shortt, J.W., Katz, L.F., Davis, B., & Allen, N. (2012). Depression is associated with adolescent's dysphoric behavior during interactions with parents. *Emotion*, *12*, 913-918.

Katz, L.F., & Rigterink, T. (2012). Domestic violence and emotion socialization. In Dennis, T., Buss, K., & Hastings, P. (Eds.) Physiological Measures of Emotion from a Developmental Perspective: State of the Science. *Monograph for the Society of Research in Child Development, 77(2),* 52-60.

Katz, L.F., Leary, A., Breiger, D., & Friedman, D. (2011). Pediatric cancer and the quality of children's dyadic peer interaction. *Journal of Pediatric Psychology*. *36,* 237-247.

Hunter, E., Katz, L.F., Leve, C., Davis, B., Shortt, J.W., Allen, N.B., & Sheeber, L. (2011). How do I feel about feelings? Emotion socialization in families of depressed and healthy adolescents. *Journal of Youth and Adolescence, 40,* 428-441.

Rigterink, T., & Katz, L.F. (2010). Domestic violence and longitudinal associations with children's physiological regulation abilities. *Journal of Interpersonal Violence, 25,* 1669-1683.

Katz, L.F., Hunter, E., & Klowden, A. (2008). Intimate partner violence and children's reactions to peer provocation: The moderating role of emotion coaching. *Journal of Family Psychology*, *22*, 614-621.

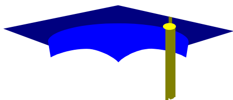
Yap, M., Allen, N., Leve, C., & Katz, L.F. (2008). Maternal meta-emotion philosophy and socialization of adolescent affect: The moderating role of adolescent temperament. *Journal of Family Psychology*, *22*, 688-700.

Katz, L.F., Hessler, D.H., & Annest, A. (2007). Domestic violence, child emotional competence, and child adjustment. Social Development. 16, 513-538.

Katz, L.F., Hunter, E.C.. (2007). Maternal meta-emotion philosophy and adolescent depressive symptomatology. Social Development. 16, 343-360.

Katz, L.F., & Windecker-Nelson, B. (2006). Domestic violence, emotion coaching and child adjustment. Journal of Family Psychology, 20, 56-67.

Gottman, J.M., Katz, L.F., & Hooven, C. (1996). Parental meta-emotion structure and the emotional life of families: Theoretical models and preliminary analyses. Journal of Family Psychology, 10, 243-268.



Kevin M. King,
Associate Professor, Ph.D., Arizona State University, 2007

The focus of research in my lab is on the developmental psychopathology of substance use in adolescence and young adulthood. Although nearly all adolescents experiment with alcohol use, and nearly half of them experiment with some kind of illegal drug (usually marijuana), most adolescents do not develop into adults with a substance use disorder. Thus the goals of our work are to elucidate both who is most at risk for the development of substance use disorders and to understand how that risk unfolds across development.

We have been attempting to understand how the cognitive and emotional aspects of self-regulation develop across adolescence, how that development is associated with risky behaviors, including substance use, how context shapes their development, and how these forms of self-regulation may either enhance or buffer the effects of other risk factors on problematic alcohol and drug use.

Our research explores and utilizes advanced statistical methods to study development and change over time, including latent growth curve modeling, structural equation modeling, hierarchical linear modeling, IRT and measurement models, and advanced tests and forms of mediational processes. We are currently investigating best practices for data cleaning and screening, as well as working to gain a broader understanding of the application of quantitative methods.

My clinical work focuses on the assessment and treatment of adolescents and adults with comorbid substance use and psychiatric disorders, with a secondary interest in adolescent mood disorders. My primary therapeutic approach is motivational interviewing; and I am an active member of the Motivational Interviewing Network of Trainers (MINT). My secondary clinical expertise is in cognitive-behavioral therapies.

<u>Representative Publications</u> (*italics* indicates student or postdoc co-author)

Emery, R.L., Fischer, S.J., Davis, S. & **King, K.M.** *(*2013*).* The moderating role of negative urgency on the prospective association between dietary restraint and binge eating. *Appetite,* 71, 113-119.

Karyadi, K.A. & **King, K.M.** (2012). Positive urgency and negative emotions: Evidence for moderation on negative alcohol consequences. *Personality and Individual Differences, 51,* 635-640.

King, K.M., Fleming, C.P., Monahan, K. & Catalano, R. (2011). Changes in self-control and attention problems during middle school predict alcohol and marijuana use during high school. *Psychology of Addictive Behaviors, 25,* 69-79.

King, K.M., *Karyadi, K.A., Luk, J.W.* & Patock-Peckham, J.A. (2011). Dispositions to rash action moderate the associations between concurrent drinking, depressive symptoms and alcohol problems during emerging adulthood. *Psychology of Addictive Behaviors, 25,* 446-454.

King, K.M., Lengua, L.J., & Monahan, K. (2013). Individual Differences in the Development of Self-Regulation During Pre-adolescence: Connections to Context and Adjustment. *Journal of Abnormal Child Psychology, 41*, 57-69.

King, K.M., Molina, B.S.G., & Chassin, L. (2008). A state-trait model of stressful life events in adolescence: Predictors of stability in the occurrence of stressors. *Journal of Clinical Child and Adolescent Psychology, 37,* 848-859.

King, K.M., *Nguyen, H.V.,* Kosterman, R., Bailey, J.A., Hawkins, J.D. (2012). Co-occurrence of sexual risk behaviors and substance use across emerging adulthood: Evidence for state- and trait-level associations. *Addiction, 107,* 1288-1296.

King, K.M., Patock-Peckham, J.A., Dager, A.D., *Thimm, K.* & Gates, J.R. (2014). On the mismeasurement of impulsivity: Trait, behavioral, and neural models in alcohol research among adolescents and young adults. *Current Addiction Reports, 1,* 19-32.

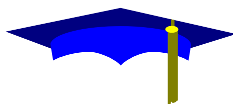
McCabe, C.; Louie, K.T. & **King, K.M.** (*in press*). Premeditation moderates the relation between sensation seeking and risky substance use among young adults. *Psychology of Addictive Behaviors.*

McLaughlin, K.A., **King, K.M.** (2015*)*. Developmental trajectories of anxiety and depressive symptoms in early adolescence. *Journal of Abnormal Child Psychology, 43,* 311-323.

Monahan, K.C.; **King, K.M.;** Shulman, E.P.; Cauffman; & Chassin, L. (*in press*). The effects of violence exposure on the development of impulse control and future orientation across adolescence and early adulthood: Time specific and generalized effects in a sample of juvenile offenders, *Development and Psychopathology.*

Racz, S.J., **King, K.M.**, Wu, J., Witkiewitz, K., McMahon, R.J. & CPPRG (2013*).* The Predictive Utility of a Brief Kindergarten Screening Measure of Child Behavior Problems. *Journal of Consulting and Clinical Psychology, 81,* 588-599.

Witkiewitz, K., **King, K. M.,** McMahon, R. J., *Wu, J., Luk, J.* and the Conduct Problems Prevention Research Group (2013). Evidence for a multi-dimensional latent structural model of externalizing disorders. *Journal of Abnormal Child Psychology, 41,* 223-237.



Robert J. Kohlenberg,
Professor, Ph.D., ABPP, UCLA, 1968

My major interests are in enhancing the efficacy of behavior therapy and mindfulness based procedures for anxiety disorders, OCD, mood disorders and co-morbid substance abuse (smoking); psychotherapy integration; the self and the client-therapist relationship. My approach to these topics is based on functional analysis and the therapy is known as Functional Analytic Psychotherapy and is described in

Tsai, M., Kohlenberg, R. J., Kanter, J. W., Holman, G. I., & Loudon, M. P. (2012). Functional analytic psychotherapy: Distinctive features. New York, NY US: Routledge/Taylor & Francis Group.

Kanter, J., Tsai, M., & Kohlenberg, R.J. (Eds.) (2010). FAP in practice. New York: Springer.

Tsai, M., Kohlenberg, R. J., Kanter, J. W., Kohlenberg, B., Follette, W. C., & Callaghan, G. M. (2009). A guide to functional analytic psychotherapy: Awareness, courage, love, and behaviorism. New York, NY US: Springer Science + Business Media.

Kohlenberg, R. J. & Tsai, M. (1991). Functional Analytic Psychotherapy: A guide for creating intense and curative therapeutic relationships. New York: Plenum.

Secondary interest: Qualitative research methods and single subject designs.

Representative Publications

Nelson, K. M., Yang, J. P., Maliken, A. C., Tsai, M., & Kohlenberg, R. J. (2014). Introduction to using structured evocative activities in functional analytic psychotherapy. Cognitive and Behavioral Practice. doi: 10.1016/j.cbpra.2013.12.009

Holman, G., Kohlenberg, R. J., Tsai, M., Haworth, K., Jacobson, E., & Liu, S. (2012). Functional Analytic Psychotherapy is a framework for implementing evidence-based practices: The example of integrated smoking cessation and depression treatment. International Journal of Behavioral Consultation and Therapy, 7(2-3), 58-62.

Bowen, S., Haworth, K., Grow, J., Tsai, M., & Kohlenberg, R. (2012). Interpersonal mindfulness informed by Functional Analytic Psychotherapy: Findings from a pilot randomized trial. International Journal of Behavioral Consultation and Therapy, 7(2-3), 9-15.

Holman, G., Kohlenberg, R. J., & Tsai, M. (2012). Development and preliminary evaluation of a FAP protocol: Brief relationship enhancement. International Journal of Behavioral Consultation and Therapy, 7(2-3), 52-57.

Holman, G., Kohlenberg, R. J., Tsai, M., Haworth, K., Jacobson, E., & Liu, S. (2012). Functional Analytic Psychotherapy is a framework for implementing evidence-based practices: The example of integrated smoking cessation and depression treatment. International Journal of Behavioral Consultation and Therapy, 7(2-3), 58-62.

Terry, C. M., & Kohlenberg, R. J. (2012). Therapists' attitudes about and preferences to use Relationship Focused Interventions: New tools to measure a critical component of Functional Analytic Psychotherapy (FAP). International Journal of Behavioral Consultation and Therapy, 7(2-3), 138-146.

Valero-Aguayo, L., Ferro-Garcia, R., Kohlenberg, R. T., & Tsai, M. (2011). Therapeutic change processes in functional analytic psychotherapy. Clínica y Salud, 22(3), 209-221. doi: 10.5093/cl2011v22n3a2

Kohlenberg, R. J., Kanter, J. W., Tsai, M., & Weeks, C. E. (2010). FAP and cognitive behavior therapy. In J. W. Kanter, M. Tsai & R. J. Kohlenberg (Eds.), *The practice of functional analytic psychotherapy.* (pp. 11-30). New York, NY US: Springer Science + Business Media.

Kohlenberg, R. J., Tsai, M., & Kanter, J. (2010). La psicoterapia analiticco finzionale (FAP). In F. Bulli & G. Melli (Eds.),, Mindfulness and acceptance in psicoterapia (pp 125-150). Firenze, Italy: Eclipsi di Ipsico.

Tsai, M., Kohlenberg, R. J.,& Kanter, (2010) A functional analytic psychotherapy (FAP) approach to therapeutic alliance. In Muran, C. & Barber, J. (Eds) Therapeutic alliance: An evidence-based approach to practice New York: Guilford.

Tsai, M., Plummer, M., Kanter, J., Newring, R., & Kohlenberg, R. (2010) Therapist Grief and Functional Analytic Psychotherapy: Strategic Self-Disclosure of Personal Loss. Journal of Contemporary Psychotherapy, 40(1), 1-10.

Dobson, K. S., Dimidjian, S., Kohlenberg, R. J., Rizvi, S. L., Dunner, D. L., Jacobson, N. S., et al. (2008). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the prevention of relapse and recurrence in major depression. Journal of Consulting and Clinical Psychology, 76(3), 468-477.

Holman, G. & Kohlenberg, R. J. (2008) Biologism is behavior. Behavior and Social Issues, 16, 214-220.

Kohlenberg, R. J., & Vandenberghe, L. (2007). Treatment resistant OCD, inflated responsibility, and the therapeutic relationship: Two case examples. Psychology and Psychotherapy-Theory Research and Practice, 80, 455–465.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., et al. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. Journal of Consulting and Clinical Psychology, 74(4), 658-670.

Vandenberghe, L., Coppede, A.M., & Kohlenberg, R.J. (2006). Client's Curiosity about the Therapist's Private Life: Hindrance or Therapeutic Aid? The Behavior Therapist. 29, 41-46.

Kohlenberg, B. S., Tsai, M., & Kohlenberg, R. J. (2006). Healing interpersonal trauma with the intimacy of the therapeutic relationship. In Follette, V. & Ruzek, J. (eds.) Cognitive-Behavioral Therapies for Trauma, Second Edition. New York: Guilford.

Bolling, M. Y., Terry, Christeine, and Kohlenberg, R. J. (2006).
Behavioral Theories. In Vol. 1 of M. Hersen & J. C. Thomas (Eds.),
Comprehensive Handbook of Personality and Psychopathology, Vol. 1 Personality and Everyday Functioning (pp 142-157). . NY: Wiley.

Whiteside, U.S., Kohlenberg, R. J., Tsai, M. (2005). Functional Analytic Psychotherapy. In Hersen, M. & Rosqvist, J. (eds.) Encyclopedia of behavior modification and cognitive behavior therapy (Volume I: Adult Clinical Applications). Newbury Park, CA: Sage Publications.

Kanter, J. W., Schildcrout, J. S., & Kohlenberg, R. J. (2005). In-vivo processes in cognitive therapy for depression: Frequency and benefits. Psychotherapy Research, 15(4), 366-373.

Kohlenberg, R. J., Tsai, M., Ferro García, R., Aguayo, L. V., Fernández Parra, and Virués-Ortega, J. (2005) Psicoterapia analítico-funcional y terapia de aceptación y compromiso: teoría,aplicaciones y continuidad con el análisis del comportamiento. International Journal of Clinical and Health Psychology, 5, 2, 37-67.

Kohlenberg, R. J. (2004). AABT, human misery and transference: A response to Arnold Lazarus. The Behavior Therapist. 26, 7.

Kohlenberg, R. J., Kanter, J. W., Bolling, M., Wexner, R., Parker, C., Tsai, M. (2004). Functional Analytic Psychotherapy, cognitive therapy, and acceptance. In S. C. Hayes, V. M. Follette, & M. Linehan (Eds.) The new behavior therapies: Expanding the cognitive behavioral tradition. New York: Guilford Press.

Kohlenberg, R. J. (2003). AABT: On the precipice of becoming dysfunctional. The Behavior Therapist, 26, 284-286,

Kanter, J. W., Kohlenberg, R. J., & Loftus, E. F. (2002). Demand characteristics, treatment rationales, and cognitive therapy for depression. Prevention & Treatment, 5, Article 41. Available at http://journals.apa.org/prevention/volume5/pre0050041c.html

Kohlenberg, R. J., Bolling, M, Kanter, J., & Parker, C., (2002) Clinical behavior analysis: Where it went wrong, how it was made good again, and why its future is so bright. Behavior Analyst Today, 3, 246-251.

Kohlenberg, R. J., Kanter, J., Bolling, M., Parker, C., &. Tsai, M., (2002) Enhancing cognitive therapy for depression with Functional Analytic Psychotherapy: Treatment guidelines and empirical findings. Cognitive and Behavioral Practice, 9, 213-229.

Kohlenberg, R. J. & Tsai, M. (2002). Functional Analytic Psychotherapy. In Zimmar, G. (ed.) Encyclopedia of psychotherapy. New York: Academic Press.

Kanter, J., Parker, C., & Kohlenberg, R. J. (2001) Finding the self: A behavioral measure and its clinical implications. Psychotherapy: Theory, Research and Practice, 38, 198-211.

Bolling, M., Parker, C., Kanter, J., Kohlenberg, R. J., & Tsai, M., (2000) The client-therapist interaction: The core of a behavioral approach. European Psychotherapie,1, 21-29

Kohlenberg, R. J. & Tsai, M. (2000). Some radical behavioral help for Katrina. Cognitive and Behavioral Practice, 7, 486-489.

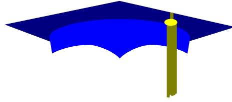
Bolling, M., Kohlenberg, R. J., & Parker, C. (1999) Behavior analysis and depression . In Dougher, M. (ed.) Clinical behavior: Analytic approaches to treatment. Reno: Context Press.

Kohlenberg, R. J. & Tsai, M. (1998). Healing interpersonal trauma with the intimacy of the therapeutic relationship. In Abueg, F. R., Follette, V., & Ruzek, J. (eds.) Trauma in context: A cognitive behavioral approach. New York: Guilford.

Kohlenberg, B. S., Yeater, E.A., & Kohlenberg, R. J. (1998). Functional Analytic Psychotherapy: A behavioral approach to intensive treatment. In Safran, J. & Muran, C. (eds.) The therapeutic alliance in brief psychotherapy. Washington, D.C.: American Psychological Association.

Parker, C., Bolling, M., & Kohlenberg, R. J. (1998) The operant approach to personality. In Hersen, M (ed.) Advanced personality theory. New York: Plenum.

Koerner, K., Kohlenberg, R. J., & Parker, C. (1996). Diagnosis of personality disorder: A radical behavioral alternative. Journal of Consulting and Clinical Psychology, 64, 1169-76.



Mary E. Larimer,
Professor, Ph.D., University of Washington, 1992

I received my doctorate from this program in 1992, and have been a member of the faculty since 1995. My primary focus for both research and clinical practice is the prevention of alcohol problems among adolescents and young adults, although I also conduct research on prevention of problem gambling and disordered eating. I currently have multiple grants funded by NIAAA and NIDA to conduct longitudinal prevention efficacy trials with both college-attending and non-college young adults. As Director of the Center for the Study of Health and Risk Behaviors and an Associate Director of the Addictive Behaviors Research Center on campus, I am also involved in several other studies of alcohol and drug prevention and treatment, involving diverse and often underserved populations.

Representative Publications (bold indicates student or postdoc co-author)

Larimer, M.E., Lee, C.M., Kilmer, J.R., Fabiano, P., Stark, C., **Geisner, I.M., Mallett, K.A**., **Lostutter, T.W**., Cronce, J.M., Feeney, M., & Neighbors, C. (2007). Personalized mailed feedback for drinking prevention: One year outcomes from a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *75*, 285-293.

Whiteside, U., Chen, E., Neighbors, C., **Hunter, D**., Lo, T., & Larimer, M.E. (2007). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate negative affect? *Eating Behaviors, 8,* 162-169.

Neighbors, C., **Lostutter, T. W**., **Whiteside, U**., **Fossos, N**., Walker, D. D., & Larimer, M. E. (2007). Injunctive norms and problem gambling among college students. *Journal of Gambling Studies, 23,* 259-273.

Geisner, I. M., Neighbors, C., Lee, C. M., & Larimer, M. E. (2007). Personal alcohol feedback as an adjunct to a brief depression treatment: changes in norms reduce drinking and related consequences. *Addictive Behaviors*, *32*, 2776-2787.

Osilla, K.C., Lonczak, H.S., Mail, P.D., Larimer, M.E., & Marlatt, G.A. (2008). Regular tobacco use among American Indian and Alaska native adolescents: An examination of protective mechanisms. *Journal of Ethnicity in Substance Abuse, 6 (3 & 4)*, 143-153.

Dejong, W., Larimer, M.E., Wood, M.D., Hartman, R. (2009). NIAAA's rapid response to college drinking problems initiative: reinforcing the use of evidence-based approaches in college alcohol prevention. *Journal of Studies on Alcohol and Drugs, Sup 16*, 5-7.

Dillworth, T.M., Kaysen, D., **Montoya, H.D.**, Larimer, M.E. (2009). Identification with mainstream culture and Preference for alternative alcohol treatment approaches in a community sample. *Behavior Therapy, 40*(1), pp. 72-81.

Grossbard, J.R., Lee, C.M., Neighbors, C., & Larimer, M.E. (2009). Body image concerns and contingent self-esteem in male and female college students. *Sex Roles, 60*, 198.

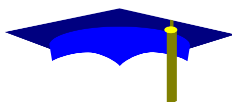
Hendershot, C.S., Collins, S.E., George, W.H., Wall, T.L., McCarthy, D.M., Liang, T., & Larimer M.E. (2009). Associations of ALDH2 and ADH1B genotypes with alcohol-related phenotypes in Asian young adults. Alcoholism: Clinical and Experimental Research, 33, 839-847.

Larimer, M. E., Kaysen, D., Lee, C. M., Kilmer, J. R., Lewis, M.A., **Dillworth, T**., **Montoya, H.** & Neighbors, C. (2009). Evaluating levels of specificity in normative referents in relation to personal drinking behavior. *Journal of Studies on Alcohol and Drugs,* Sup 16, 115-121.

Larimer, M.E., Malone, D.K**.,** Garner, M.D., Atkins, D., **Burlingham, B.**, Lonczak, H.S., Tanzer, K., Ginzler, J., Clifasefi, S.L., Hobson, W.G., & Marlatt, G.A. (2009). Health care and public service utilization and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of the American Medical Association, 301*, 1349-1357.

Turrisi, R., Larimer, M.E., Mallett, K.A., Kilmer, J.R., **Ray, A.E., Mastroleo, N.R., Geisner, I.M., Grossbard, J., Tollison, S., Lostutter, T.W., & Montoya, H.** (2009). A randomized clinical trial evaluating a combined alcohol intervention for high-risk college students. *Journal of Studies on Alcohol and Drugs, 70,* 555-567.

Whiteside, U., Cronce, J.M., Pedersen, E.R., & Larimer, M.E. (2010). Brief motivational feedback for college students and adolescents: A harm reduction approach. *Journal of Clinical Psychology, 66*, 150-163.



Liliana J. Lengua

Professor, Ph.D., Arizona State University, 1994

My research uses a bioecological framework to understand the development of children's emotional, social and behavioral adjustment during early and middle childhood. I study the complex relations among individual, interpersonal, and contextual factors in development. I am particularly interested in individual differences in children's responses to disadvantage and stress with the goal of identifying children who are at heightened risk for developing problems, as well as children who are resilient in the face of risk. Thus, my research examines children's temperament, appraisals and coping as potential mediators and moderators of the effects of disadvantage, negative life events, and family factors on children's adjustment. In addition, I have been studying children's individual differences in response to parenting by examining temperament as it interacts and transacts with parenting to predict children's adjustment. My goal is to enhance our understanding of the etiology of adjustment problems and positive adjustment, both for basic knowledge about development and to inform interventions aimed at preventing adjustment problems and promoting positive adjustment.

My clinical orientation combines a cognitive-behavioral and family systems approach in conceptualizing cases and intervening with children and families. I am also interested in community and prevention interventions, such as self-regulation and coping enhancement programs for children.

Representative Publications (*Italics indicates student or postdoc co-author***)**

Lengua, L. J., *Kiff, C. Moran, L. R., Zalewski, M., Thompson, S. F., &* Cortes, R. *& Ruberry, E.* (2014). Parenting Mediates the Effects of Income and Cumulative Risk on the Development of Effortful Control. *Social Development.*

Lengua, L. J. *Zalewski, M.,* Fisher, P., *Moran, L.* (*2013*). Does HPA-axis Dysregulation Account for the Effects of Income on Effortful Control and Adjustment in Preschool Children? *Infant and Child Development, 22, 439-458.* DOI: 10.1002/icd.1805, NIHMS599969

Lengua, L. J., & Wachs, T. D. (2012). Temperament and Risk: Resilient and Vulnerable Responses to Adversity. In M. Zentner & R. Shiner (Eds.), *The Handbook of Temperament.* Guilford Press. pp. 519-540

Kiff, C., **Lengua, L. J.**, *& Zalewski, M. (2011).* Nature and nurturing: Parenting in the context of children's temperament. *Journal of Clinica Child and Family Review, 14,* 251-301.

Zalewski, M., **Lengua, L. J**., *Long, A. C., Trancik, A., & Bazinet. A*. (2011). Associations of Coping and Appraisal Styles with Emotion Regulation During Pre-adolescence. *Journal of Experimental Child Psychology, 110,* 141-158. DOI: 10.1016/j.jecp.2011.03.001, PMID# 21507423

Lengua, L. J. (2008) Anxiousness, frustration, and effortful control as moderators of the relation between parenting and adjustment problems in middle-childhood. *Social Development, 17*.

Lengua, L. J., *Bush, N., Long, A. C., Trancik, A. M., & Kovacs, E. A.* (2008). Effortful Control as a Moderator of the Relation between Contextual Risk and Growth in Adjustment Problems. *Development & Psychopathology, 20*, 509-528.

Lengua, L. J., *Honorado, E., & Bush, N.* (2007*)*. Cumulative Risk and Parenting as Predictors of Effortful Control and Social Competence in Preschool Children. *Journal of Applied Developmental Psychology, 28*, 40-55.

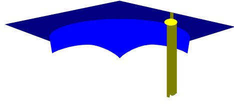
Lengua, L. J. (2006). Growth in Temperament and Parenting as Predictors of Adjustment During Children's Transition to Adolescence. *Developmental Psychology, 42*, 819-832.

Lengua, L. J., & *Kovacs, E. A.* (2005). Bidirectional Associations between Temperament and Parenting, and the Prediction of Adjustment Problems in Middle Childhood. *Journal of Applied Developmental Psychology, 26*, 21-38.

Lengua, L. J. (2003). Associations among emotionality, self-regulation, adjustment problems and positive adjustment in middle childhood. *Journal of Applied Developmental Psychology, 24*, 595-618.

Lengua, L. J. (2002). The contribution of emotionality and self-regulation to the understanding of children's response to multiple risk. *Child Development, 73*, 144-161.

Lengua, L. J., & *Long, A. C.* (2002). The role of emotionality and self-regulation in the appraisal-coping process: Tests of direct and moderating effects. *Journal of Applied Developmental Psychology, 23*, 471-493.



Marsha M. Linehan,
Professor, Ph.D., Loyola - Chicago, 1971

I am the Director of the Behavioral Research and Therapy Clinics which specializes in the understanding and treatment of high risk for suicide difficult to treat individuals with multi-diagnostic disorders. I am the developer of Dialectical Behavior Therapy (DBT) and am the primary professor of the Treatment Development Clinic (TDC) that trains graduate clinical students in the treatment of high risk for suicide difficult to treat individuals. The TDC currently provides DBT treatment for adolescents and their parents and for adults, and also conducts a DBT skills training program for friends and families.

My research lab also conducts an annual strategic planning meeting for individuals currently engaged in DBT research studies aimed at addressing current research needs.

Our experimental training group is focused on providing DBT training to those who need training and to simultaneously evaluating how to improve such training. We are looking forward also to obtaining funding and carrying out our plans to develop a completely computerized version of DBT.

My clinical interests, naturally, overlap considerably with my research interests. I am particularly interested in developing models to train therapists and to factors interfering with effective treatment of "difficult" patients by otherwise competent therapist.

Representative Publications (bold indicates student or postdoc co-author)

Linehan, M.M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, Guildford Press.

Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder*. New York, Guildford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & **Heard, H. L**. (1991). Behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1065.

Linehan, M. M., **Heard, H. L.,** & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50*, 971-974.

Linehan, M. M. & **Heard, H. L**. (1993). Impact of treatment accessibility on clinical course of parasuicidal patients: In reply to R.E. Hoffman. [Letter to the editor]. *Archives of General Psychiatry, 50*, 157-158.

Linehan, M. M., **Tutek, D. A., Heard, H. L.** & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151*, 1771-1776.

Linehan, M.M., **Schmidt, H., Dimeff, L.A**., **Craft, J.C., Kanter, J**., Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *The American Journal on Addictions*, 8, 279-292.

Linehan, M.M., Dimeff, L.A., **Reynolds, S.K**., Comtois, K.A., **Shaw-Welch, S**., Heagerty, P., Kivlahan, D.R. (2002). Dialectical behavior therapy versus comprehensive validation plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*, 13-26.

Linehan, M.M., Comtois, K.A., Murray, A.M., **Brown, M.Z**., Gallop, R.J., **Heard, H.L**., **Korslund, K.E., Tutek, D.A., Reynolds, S.K**., **Lindenboim, N**. (2006). Two-Year Randomized Trial + Follow-up of Dialectical Behavior Therapy vs. Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. *Archives of General Psychiatry,* 63(7): 757-766.

Linehan, M.M., Comtois, K.A., **Brown, M., Heard, H.L**., **Wagner, A**. (2006). Suicide Attempt Self-Injury Interview (SASII): Development, Reliability, And Validity of A Scale To Assess Suicide Attempts And Intentional Self-Injury. *Psychological Assessment.* 18 (3), 303-312.

Linehan, M.M., McDavid, J., **Brown, M.Z., Sayrs, J.H.R**., Gallop, R.J. (2008). Olanzapine plus dialectical behavior therapy for women with high irritability who meet criteria for borderline personality disorder: A double blind, placebo-controlled pilot study. *Journal of Clinical Psychiatry,* 69: 999-1005.

Harned, M. S., Jackson, S. C., Comtois, K. A., & Linehan, M. M. (2010). Dialectical behavior therapy as a precursor to PTSD treatment for suicidal and/or self-injuring women with borderline personality disorder. *Journal of Traumatic Stress*, 23 (4) 421-429.

Harned, M. S., Rizvi, S. L., & Linehan, M. M. (2010). The impact of co-occurring posttraumatic stress disorder on suicidal women with borderline personality disorder. *American Journal of Psychiatry*, 167, 1210-1217.

Harned, M. S., Pantalone, D. W., Ward-Ciesielski, E. F., Lynch, T. R., & Linehan, M. M. (2011). The prevalence and correlates of sexual risk behaviors and sexually transmitted infections in borderline personality disorder outpatients. *Journal of Nervous and Mental Disease, 199,* 832-838.

Neacsiu, A., D., Ward-Ciesielski, E.F., Linehan, M.M. (2012) Emerging Approaches to Counseling Intervention: Dialectical Behavior Therapy. *The Counseling Psychologist.* 0011000011421023.

Bedics, J. D., Atkins, D. C., Comtois, K. A., & Linehan, M. M. (2012). Treatment differences in the therapeutic relationship and introject during a 2-year randomized controlled trial of dialectical behavior therapy versus non-behavioral psychotherapy experts for borderline personality disorder. *Journal of Consulting and Clinical Psychology,* 80, (1) 66-77.

Bedics, J. D., Atkins, D. C., Comtois, K. A., & Linehan, M. M. (2012). Weekly ratings of the therapeutic relationship and introject during the course of dialectical behavior therapy for the treatment of borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training*. 29 (2), 231-240.

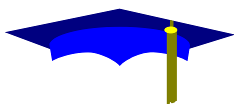
Harned, M. S., Korslund, K. E., Foa, E. B., & Linehan, M. M. (2012). Treating PTSD in suicidal and self-injuring women with borderline personality disorder: Development and preliminary evaluation of a dialectical behavior therapy prolonged exposure protocol. *Behaviour Research and Therapy,* 50(6)*,* 381-386.

Harned, M. S., Korslund, K. E., & Linehan, M. M. (2014). A pilot randomized controlled trial of Dialectical Behavior Therapy with and without the Dialectical Behavior Therapy Prolonged Exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behaviour Research and Therapy, 55,* 7-1

Bedics, J. D., Atkins, D. C., Harned, M. S., & Linehan, M. M. (2015). The therapeutic alliance as a predictor of outcome in dialectical behavior therapy versus nonbehavioral psychotherapy by experts for borderline personality disorder. *Psychotherapy.* Mar; 52(1):67-77.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., McDavid, J., Comtois, K. A., & Murray-Gregory, A. M. (2015). Dialectical Behavior Therapy for high suicide risk in borderline personality disorder: A component analysis. *JAMA Psychiatry.* doi:10.1001/jamapsychiatry.2014.3039.

Beckstead, D.J.; Lambert, M.J., DuBose, A.P., & Linehan M. (2015). Dialectical behavior therapy with American Indian/Alaska Native adolescents diagnosed with substance use disorders: Combining and evidence based treatment with cultural, traditional and spiritual beliefs. *Addictive Behaviors.* 51: 84-87.



Kate A. McLaughlin,
Assistant Professor, Ph.D., Yale University, 2008

My research examines how the childhood social environment influences development in ways that increase risk for psychopathology. I am specifically interested in how three dimensions of environmental experience influence emotional and cognitive development in children and adolescents: 1) exposure to trauma/threat, 2) deprivation in resources, and 3) environmental predictability/stability. Most of my research seeks to identify psychological and neurobiological mechanisms linking these dimensions of environmental experience to the onset of psychopathology in youths. My lab uses a variety of tools to study these questions, including behavioral tasks, cognitive assessments, electrophysiology (e.g., measures of autonomic nervous system function, EEG) and brain imaging, including structural and functional MRI. We have used these tools to study children and adolescents exposed to a wide range of adverse environmental experiences, including caregiver maltreatment, community violence exposure, institutional rearing, and poverty. This approach has allowed my lab to identify a variety of neurodevelopmental mechanisms that underlie the relationship between adverse environments in childhood and the subsequent onset of mental disorders, including elevated emotional and physiological reactivity to stress, poor emotion regulation skills, executive functioning deficits, and disruptions in social cognition.

My lab is also actively involved in the development and evaluation of interventions aimed at preventing the onset of mental disorders in children and adolescents. For example, I am currently working with the Boston Public Schools to develop and implement a stress-reduction intervention aimed at preventing the onset of anxiety and mood disorders in high school students.

Representative Publications (* represents student or mentee):

McLaughlin, K.A., Sheridan, M.A., *Winter, W., Fox, N.A., Zeanah, C.H., & Nelson, C.A. (in press). Widespread reductions in cortical thickness following severe early-life deprivation: A neurodevelopmental pathway to ADHD. *Biological Psychiatry.*

McLaughlin, K.A., *Rith-Najarian, L., Dirks, M.A., & Sheridan, M.A. (in press). Low vagal tone magnifies the association between psychosocial stress exposure and internalizing psychopathology in adolescents. *Journal of Clinical Child and Adolescent Psychology.*

McLaughlin, K.A., Koenen, K.C., Hill, E.D., Petukhova, M., Sampson, N.A., Zaslavsky, A.M., Kessler, R.C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 815-830.

*Michl, L.A., McLaughlin, K.A., Shepherd, K., & Nolen-Hoeksema, S. (2013). Stressful life events as a determinant of rumination: Longitudinal associations among early adolescents and adults. *Journal of Abnormal Psychology, 122,* 339-352.

McLaughlin, K.A., Green, J.G., Gruber, M.J., Sampson, N.A., Zaslavsky, A.M., Kessler, R.C. (2012). Childhood adversities and first onset of psychiatric disorders in a national sample of adolescents. *Archives of General Psychiatry, 69,* 1151-1160.

McLaughlin, K.A., Costello, E.J., LeBlanc, W., Sampson, N.A., & Kessler, R.C. (2012). Socioeconomic status and adolescent mental disorders. *American Journal of Public Health, 102,* 1742-1750.

McLaughlin, K.A., Nelson, C.A., Fox, N.A., & Zeanah, C.H. (2012). Attachment security as a mechanism linking foster care placement with improved mental health outcomes in previously institutionalized children. *Journal of Child Psychology and Psychiatry, 53,* 46-55.

McLaughlin, K.A., Green, J.G., Alegria, M., Costello, E.J., Gruber, M.G., Sampson, N.A., Kessler, R.C. (2012). Food insecurity and mental disorders in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 51,* 1293-1303.

Sheridan, M.A., Fox, N.A., Zeanah, C.H., McLaughlin, K.A., & Nelson, C.A. (2012). Variation in neural development as a result of exposure to institutionalization early in childhood. *Proceedings of the National Academy of Sciences, 109,* 12927–12932.

McLaughlin, K.A. & Nolen-Hoeksema, S. (2012). Interpersonal stress generation as a mechanism linking rumination to internalizing symptoms in early adolescents. *Journal of Clinical Child and Adolescent Psychology, 41,* 584-597.

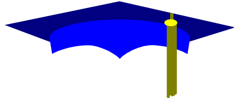
*Slopen, N., McLaughlin, K.A., Fox, N.A., Zeanah, C.H., & Nelson, C.A. (2012). Alternations in neural processing and psychopathology in children raised in institutions. *Archives of General Psychiatry, 69,* 1022-1030.

McLaughlin, K.A., Fox, N.A., Zeanah, C.H., & Nelson, C.A., (2011). Adverse rearing environments and neural development in children: The development of frontal electroencephalogram (EEG) asymmetry. *Biological Psychiatry, 70,* 1008-1015.

McLaughlin, K.A., Breslau, J., Green, J.G., Lakoma, M.D., Sampson, N.A., Zaslavsky, A.M., & Kessler, R.C. (2011). Childhood family socioeconomic status and the onset, persistence, and severity of DSM-IV disorders in a U.S. national sample. *Social Science and Medicine, 73,* 1088-1096.

McLaughlin, K.A., Fox, N.A., Zeanah, C.H., Sheridan, M.A., Marshall, P.J., & Nelson, C.A. (2010). Delayed maturation in brain electrical activity partially explains the association between early environmental deprivation and symptoms of attention-deficit hyperactivity disorder (ADHD). *Biological Psychiatry, 68,* 329-336.

McLaughlin, K.A., Hatzenbuehler, M.L., & Hilt, L.M. (2009). Emotion dysregulation as a mechanism linking peer victimization to internalizing symptoms in adolescents. *Journal of Consulting and Clinical Psychology, 77*, 894-904.



Irwin Sarason,
Professor Emeritus, Ph.D., Indiana University, 1955

Over the years, I have been interested in the question: where does maladaptation come from? I see it as coming from a joint interaction of vulnerabilities (historical, physiological) and the experiences to which individuals are exposed.

My current work is especially concerned with one environmental resource, social support, and the nature of social relationships among people who have close ties to each other (for example, child and parent). Another of my interests is prevention, not just of mental disorder but physical disorder as well.

A long-term interest concerns the effects of anxiety on behavior. Our research has shown that anxiety has a very debilitating effect on performance and on personal happiness. One of the major vehicles through which anxiety exerts its unwanted effects is cognitive interference. Anxious people are often highly preoccupied and by virtue of that fact are unable to attend to important reality factors in their lives. While anxiety can be a positive force in the lives of people (for example, by serving as a motivator for behavior change) we are usually most aware of anxiety's negative effects and the need for the development of treatments to facilitate better coping skills so as to reduce anxiety.

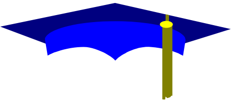
Representative Publications

Spielberger, C.D. & Sarason, I.G. (Eds.) (2005). *Stress and emotions: Anxiety, anger, and curiosity.* NY: Routledge

Rascle, N., Bruchon-Schweitzer, M., & Sarason, I.G. (2005). Short form of Sarason's Social Support Questionnaire: French adaptation and validation. *Psychological Reports, 97*, 195-202.

Kim, D.-Y., Sarason, B., & Sarason, I. G. (2006). Implicit social cognition and culture: Explicit and implicit psychological acculturation, and distress of Korean-American young adults. *Journal of Social and Clinical Psychology, 25,* 1-32.

Sarason, B. R., & Sarason, I. G. (2006). Close relationships and social support: Implications for the measurement of social support. In A.L. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships* (pp. 429-443). NY: Cambridge University Press.



Jane M. Simoni
Professor, Ph.D., UCLA, 1993

My research interests lie primarily within the realm of stress and coping in clinical and clinical health psychology. I study trauma, chronic illness, and other stressful life events and am particularly interested in whether individuals from historically oppressed or stigmatized groups experience unique stressors or exhibit culturally specific coping processes. Much of my research, therefore, targets ethnic/racial minorities, women, GLBT populations, and persons living with HIV/AIDS. Moreover, I am interested in developing culturally appropriate health promotion and disease prevention interventions targeting these groups.

My current research includes work on HIV medication adherence. I just finished a large project to evaluate the effectiveness of peer support and two-way pager messaging to enhance antiretroviral medication adherence among a population of HIV+ clinic patients in Seattle. In a second project on antiretroviral adherence, we conducted qualitative work as well as a survey and pilot RCT in Beijing, China. We are now working on the U.S.-Mexico border in treating depression as a way to improve quality of life and HIV medication adherence. Finally, we are exploring options for further work in the area of HIV medication adherence as well as HIV prevention in China. I also work closely with the UW Indigenous Wellness Research Institute (IWRI.org) and have collaborated on health research in Native American communities for two decades. Other projects include formal mentoring programs and addressing mental health in a global context.

I provide supervision in the department's clinic, employing an interpersonal process orientation to time-limited therapy. Courses I teach have included Abnormal Psychology, Minority Mental Health, and a research seminar on risky behaviors, all of which highlight a multicultural perspective.

Representative Publications

Simoni, J. M., Smith, L., Lehavot, K., & Walters, K. L.. (in press). Sexual orientation and lesbian and bisexual women's health. In C. J. Patterson & A. R. D'Augelli (Eds.), Handbook of psychology and sexual orientation.

Simoni, J. M., Franks, J., Lehavot, K., & Yard, S. A. (in press). Peer interventions to promote health: Conceptual Considerations. Journal of Orthopsychiatry.

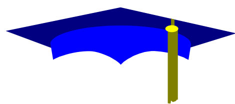
Rao, D., Chen, W-T., Pearson, C., Simoni, J. M., Fredriksen-Goldsen, K., Nelson, K., Zhao, H., & Zhang, F. (in press). Social support mediates the relationship between HIV stigma and depression/quality of life among people living with HIV in Beijing, China. International Journal of STD and AIDS.

Simoni, J. M., Evans-Campbell, T., Andrasik, M. P., Lehavot, K., Valencia-Garcia, D., & Walters, K. L. (2010). HIV/AIDS among women of color and sexual minority women (pp. 335-366). In H. Landrine & N. F. Russo (Eds.), Handbook of diversity in feminist psychology. NY: Springer.

Simoni, J. M., Amico, K. R., Smith, L., & Nelson, K. (2010). Antiretroviral adherence interventions: Translating research findings to the real world clinic. Current HIV/AIDS Reports, 7.

Simoni, J. M., Huh, D., Frick, P. A., Pearson, C. R., Andrasik, M. P., Dunbar, P. J., & Hooton, T. (2009). A randomized controlled trial of peer support and pager messaging to promote antiretroviral therapy adherence and clinical outcomes. Journal of Acquired Immune Deficiency Syndromes, 52, 465-473.

Lehavot, K., Walters, K. L., & Simoni, J. M. (2009). Abuse, mastery, and health among lesbian, bisexual, and two-spirit American Indian and Alaska Native women. Cultural Diversity and Ethnic Minority Psychology, 15, 275-284.



Ronald E. Smith,
Professor and Director of Clinical Training, Ph.D., Southern Illinois University, 1968

My major interests are in the areas of stress and coping, personality assessment, and performance enhancement. Recently, Yuichi Shoda of the Social-Personality area, Peter Vitaliano from Psychiatry and Behavioral Sciences, and I have formed a collabotrative stress and coping group, together with our students. Vitaliano studies stress and coping in Alzheimer's caregivers, and Shoda studies stress and coping using the Cognitive-Affective Processing System metamodel developed with his mentor, Walter Mischel. We have been doing studies of stress and coping using daily diary methods to study the effects of different patterns of coping on psychological and physical well-being and have developed a manualized cognitive-affective stress management program. Another project involves the use of feedback from psychological tests as a means of enhancing psychotherapy process and outcome. This is being conducted as a means of validating the OwlOutcomes assessment system,, a computerized system for tracking psychotherapy process and outcome developed by Corey Fagan and collaborators.

Representative Publications (bold indicates student or postdoc co-author)

Smith, R. E., & Ascough, J. C. (2016). *Promoting emotional resilience: Cognitive-Affective Stress Management Training.* New York: Guilford Press.

Smith, R. E., & Shoda, Y. (in press). The Cognitive-Affective Processing System: Understanding person, anxiety, mental toughness, and self-regulation in sport. In Y. P. Zinchenko & J. Hanin (Eds.), *Sport psychology: On the way to the Olympic Games*. Moscow State University Press.

Shoda, Y., **Wilson, N. L.**, **Chen, J., Gilmore, A. K.**, & Smith, R. E. (2013). Cognitive-Affective Processing System analysis of intra-individual dynamics in collaborative therapeutic assessment: Translating basic theory and research into clinical applications. *Journal of Personality*, 81, 554-568.

Jacobs, R. S., Smith, R. E., Fiedler, F. E., & **Link, T. G**. (2013). Using stress management training to enhance leader performance and the utilization of intellectual abilities during stressful military training: An application of cognitive resource theory. In J. D. VanVactor (Ed.), *Perspectives on leadership*. New York: Nova Science Publishers.

O'Rourke, D. J., Smith, R. E., Smoll, F. L., & **Cumming, S. P.** (2012). Parent-initiated motivational climate, self-esteem, and autonomous motivation in young athletes: Testing propositions from achievement goal and self-determination theories. *Child Development Research,* Article ID 393914, doi:10.1155/2012/393914

Smith, R. E., Fagan, C., **Wilson, N. L., Chen, J., Corona, M., Nguyen, H., Racz, S**., & Shoda, Y. (2011). Internet-based approaches to collaborative therapeutic assessment: New opportunities for professional psychologists. *Professional Psychology: Research and Practice, 42,* 494-504. DOI: 10.1037/a0025392.

O'Rourke, D. J., Smith, R. E., Smoll, F. L., & Cumming, S. P. (2011). Trait anxiety as a function of parental pressure and motivational climate: Is parental pressure always harmful? *Journal of Applied Sport Psychology,23,* 398-412.

Smith, R. E., & Smoll, F. L. (2011). Cognitive-behavioral coach training: A translational approach to theory, research, and intervention. In J. K. Luiselli & D. D. Reed (Eds.), *Behavioral sport psychology: Evidence-based approaches to performance enhancement*. New York: Springer.

Smith, R. E., Smoll, F. L., & **O'Rourke, M. J**. (2011). Anxiety management. In T. Morris & P. Terry (Eds.)*, Sport and exercise psychology: The cutting edge.* Morgantown, WV: Fitness Information Technology.

Smith, R. E., & Shoda, Y. (2009). Personality as a cognitive-affective processing system. In P. Corr & G. Matthews (Eds.), *The Cambridge handbook of personality*. Cambridge, England: Cambridge University Press.

Smith, R. E., Shoda, Y., **Cumming, S. P**., & Smoll, F. L. (2009). Behavioral signatures at the ballpark: Intraindividual consistency of adults' situation-behavior patterns and their interpersonal consequences. *Journal of Research in Personality, 43,* 187-195.

Ptacek, J. T., Smith, R. E., **Raffety, B**, & **Lindgren, K. P**. (2008). Coherence and transituational generality in coping: The unity and the diversity. *Anxiety, Stress & Coping, 21,* 155-172.

Smith, R. E., Smoll, F. L., & **Cumming, S**. P. (2007). Effects of a motivational climate intervention for coaches on young athletes' sport performance anxiety. *Journal of Sport & Exercise Psychology, 29*, 38-58.

Cervone, D., Shadel, W. G., Smith, R. E., & Fiori, M. (2006). Self-regulation: Reminders and suggestions from personality science. *Applied Psychology: An International Review, 55* ,333-385.

Yi, J. P., Smith, R. E., & Vitaliano, P. P. (2005). Stress-resilience, illness, and coping: A person-focused investigation of female athletes. *Journal of Behavioral Medicine 28, 257-265..*

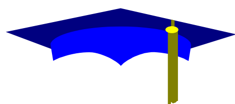
Shoda, Y., & Smith, R. E. (2004). Conceptualizing personality as a cognitive-affective processing system: A framework for models of maladaptive behavior patterns and change. *Behavior Therapy, 35,* 147-165.

Weitlauf, J., Smith, R. E., & Cervone, D. (2000). Generalization effects of coping skills training: Influence of self-defense training on women's efficacy beliefs, assertiveness, and aggression. *Journal of Applied Psychology, 85,* 625-633.

Smith, R. E., **Ptacek, J.** T., & **Patterson, E**. (2000). Moderator effects of cognitive and somatic trait anxiety on the relation between life stress and physical injuries. *Anxiety, Stress, and Coping, 13,* 269-288.

Smith, R. E. (1999). Generalization effects of coping skills training. *Journal of Sport and Exercise Psychology, 21,* 189-204.

Smith, R. E., **Leffingwell, T. R**., & **Ptacek, J. T**. (1999). Can people remember how they coped? Factors associated with discordance between same-day and retrospective reports. *Journal of Personality and Social Psychology, 76,* 1050-1061.



Wendy Stone
Head, Child Clinical Track; Professor, Ph.D., University of Miami, 1981

My general area of research interest is early identification and early intervention for children with autism spectrum disorders (ASD). A specific focus of my work is the characterization of early-emerging social-communicative and neurocognitive features of autism, with the goals of pinpointing the core deficits, as well as implementing interventions to prevent or attenuate symptom development. Toward this end, my lab has been following the early development of infant siblings of children with autism, who are at elevated risk for an autism spectrum diagnosis, to identify developmental pathways and risk/protective factors that contribute to the tremendous variability in their social, learning, and behavioral outcomes.

I am committed to translational science, and our research projects in the READi Lab (Research in Early Autism Detection and Intervention) include both experimental and community-based studies. Current projects are examining: associative learning in one-month-old infant siblings; the utility of eyeglass-embedded cameras for improving measurement of eye-to-eye gaze; the effectiveness of a parent-implemented intervention for infant siblings of children with ASD; the accuracy of a streamlined ASD diagnostic measure designed for use by community providers; a preventive model for community-based service delivery for children with suspected autism; and the utility of a web-based tutorial for parents designed to increase their child's participation in everyday home routines.

Representative Publications (**bold denotes students, post-docs, or other mentees**)

Stone, W.L., **Coonrod, E.E., Turner, L.M., & Pozdol, S.L.** (2004). Psychometric properties of the STAT for early autism screening. *Journal of Autism and Developmental Disorders, 34,* 691-701.

Yoder, P., & Stone, W.L. (2006). Randomized comparison of two communication interventions for preschoolers with autism spectrum disorders. *Journal of Clinical and Consulting Psychology, 74*, 426-435.

McDuffie, A., Turner, L.M., Stone, W.L., Yoder P.J., Wolery, M., & **Ulman, T.** (2007). Developmental correlates of different types of motor imitation in young children with autism spectrum disorders. *Journal of Autism and Developmental Disorders, 37,* 401-412.

Stone, W.L., **McMahon, C.R.,** Yoder, P.J., & Walden, T.A. (2007). Early social-communicative and cognitive development of younger siblings of children with autism spectrum disorders. *Archives of Pediatrics and Adolescent Medicine, 161,* 384-390.

Turner, L.M., & Stone, W.L. (2007). Variability in outcome for children with an ASD diagnosis at age 2. *Journal of Child Psychology and Psychiatry, 48,* 793-802.

Yoder, P.J., Stone, W.L., Walden, T.A., & **Malesa, E.E.** (2009). Predicting social impairment in younger siblings of children with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 39,* 1381-1391.

Carter, A.S., Messinger, D.S., Stone, W.L., Celimli, S., **Nahmias, A.S.,** Yoder, P. (2011). A randomized trial of More Than Words in toddlers with early autism symptoms. *Journal of Child Psychology and Psychiatry, 52,* 741-752.

Ozonoff, S., Young, G.S., Carter, A., Messinger, D., Yirmiya, N., Zwaigenbaum, L., Bryson, S., Carver, L.J., Constantino, J., Dobkins, K., Hutman, T., Iverson, J., Landa, R., Rogers, S.J., Sigman, M., & Stone, W.L. (2011). Recurrence risk in younger siblings of children with autism spectrum disorders: A BSRC study. *Pediatrics, 128*, 488-495.

Warren, Z.E., **Foss-Feig, J.H., Malesa, E.E.,** Lee, E.B., Lounds Taylor, J., Newsom, C.R., Crittendon, J., & Stone, W.L. (2012). Neurocognitive and behavioral outcomes of younger siblings of children with autism spectrum disorder at age five. *Journal of Autism and Developmental Disorders, 42,* 409-418.

Key, A.P.F., & Stone, W.L. (2012). Processing of novel and familiar faces in infants at average and high risk for autism. *Developmental Cognitive Neuroscience, 2,* 244-255.

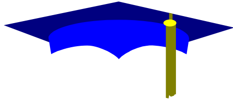
Damiano, C., Nahmias, A., Hogan-Brown, A.L., & Stone, W.L. (2013). What do repetitive and stereotyped movements mean for infant siblings of children with ASD? *Journal of Autism and Developmental Disorders, 43,* 1326-1335.

Malesa, E., Foss-Feig, J., Warren, Z., Yoder, P., Walden, T., & Stone, W.L. (2013). Predicting age 5 language and social outcomes for later-born siblings of children with autism spectrum disorders. *Autism, 17,* 558-570.

Nichols, C.M., Ibanez, L.I., Foss-Feig, J.H., & Stone, W.L. (2014). Social smiling and its components in high-risk infant siblings with and without later ASD symptomatology. *Journal of Autism and Developmental Disorders, 44*, 894-902.

Swanson, A., Warren, Z., Stone, W.L., Vehorn, A., Dohrmann, E., & Humberd, Q. (2014). The diagnosis of autism in community practice settings: Does advanced training facilitate practice change? *Autism, 18,* 555-561.

Ozonoff, S., Young, G.S., Landa, R.J., Brian, J., Bryson, S., Charman, T., Chawarska, K., Macari, S.L., Messinger, D., Stone, W.L., Zwaigenbaum, & Iosif, A. (2015). Diagnostic stability in young children at risk for autism spectrum disorder: A Baby Siblings Research Consortium study. Journal of Child Psychology and Psychiatry. Advance online publication. PMID: 25921776. DOI:10.1111/jcpp.12421.



Lori A. Zoellner
Head, Adult Clinical Track; Professor, Ph.D., UCLA, 1997

Not everyone experiences a traumatic event such as a car accident, sexual assault, combat, or natural disaster in the same way. Although some may recovery with time, others may experience symptoms months and even years after the traumatic event. Indeed, individuals with posttraumatic stress disorder (PTSD) often report involuntary retrieval of horrific memories, including intrusive thoughts, flashbacks, and nightmares. This clinical presentation strongly suggests that memory abnormalities underlie many symptoms. Indeed, many researchers believe that disrupted retrieval processes may reduce optimal recall of the traumatic event and may mediate posttrauma adjustment. By understanding these cognitive processes, we hope to learn about mechanisms underlying both therapeutic and natural recovery. My research is characterized by applying experimental paradigms to elucidate these phenomena in the laboratory.

By better understanding the mechanisms underlying psychopathology, we may be able to prevent the development of chronic pathology and enhance the efficacy of our treatments. A closely related interest of mine is in the area of treatment outcome research, in PTSD and across the anxiety disorders. Theoretically, I am a cognitive-behavioral psychologist, treating individuals with PTSD, obsessive-compulsive disorder, panic disorder, and social phobia. I am committed to training students in assessment of the anxiety disorders and in empirically supported treatments for the anxiety disorders.

My teaching interests include information processing models of psychopathology, clinical research methods, behavior disorders, and cognitive behavioral treatment for the anxiety disorders.

Representative Publications (bold indicates student or postdoc co-author)

Echiverri, A., Jaeger, J., Chen, J., Moore, S., & Zoellner, L. A. (in press). Dwelling in the past: The role of rumination in the treatment of posttraumatic stress disorder. *Cognitive and Behavioral Practice.*

Keller, S.M., Zoellner, L.A., & Feeny, N.C. (in press). Understanding factors associated with early therapeutic alliance in PTSD treatment: adherence, childhood sexual abuse history, and social support. *Journal of Consulting and Clinical Psychology.*

Stines Doane, L., Feeny, N.C., & Zoellner, L. A. (2010). Sudden gains in exposure therapy for PTSD. *Behaviour Research and Therapy, 48,* 555-560.

Eftekhari, A., Zoellner, L. A., & **Vigil, S.** (2009). Patterns of emotion regulation and psychopathology. *Anxiety, Stress, and Coping: An International Journal, 22,* 571-586.

Feeny, N. C., Zoellner, L. A., Mavissakalian, M.R., & Roy-Byrne, P.P. (2009). What would you choose? Sertraline or prolonged exposure in community and PTSD treatment seeking women. *Depression and Anxiety, 28,* 724-731.

Feeny, N.C., Zoellner, L. A., & **Kahana, S.** (2009). Providing a treatment rationale for PTSD: Does what we say matter? *Behaviour Research and Therapy, 47,* 752-760.

Zoellner, L. A., Abramowitz, J. S., **Moore, S. A., & Slagle, D. M** (2009). Flooding. In W. O'Donohue & J. Fisher (Eds). *General Principles and Empirically Supported Techniques of Cognitive Behavior Therapy.* New York: John Wiley & Sons, Inc.

Zoellner, L.A., **Eftekhari, A., & Bedard, M.** (2009). Psychological models of posttraumatic stress disorder and acute stress disorder. In M. Antony & M. Stein (Eds.), *Oxford Handbook of Anxiety and Anxiety Disorders (p. 250-261).* New York, NY: Oxford Press.

Angelo, F. N., Miller, H. E., Zoellner, L. A., & Feeny, N. C. (2008). "I need to talk about it": A qualitative analysis of trauma-exposed women's reasons for treatment choice, *Behavior Therapy, 39,* 13-21.

Bedard, M. A. & Zoellner, L. A. (2008). The utility of the criteria A1 and A2 stressors in the diagnosis of PTSD. *Behaviour Research and Therapy, 46,* 1062-1069.

Moore, S. A., Zoellner, L. A., & **Mollenhout, N.** (2008). Are expressive suppression and cognitive reappraisal associated with stress-related symptoms? *Behaviour Research and Therapy, 46,* 993-1000.

Pruitt, L. A., & Zoellner, L. A. (2008). The impact of social support: An analogue investigation of the aftermath of trauma exposure. *Journal of Anxiety Disorders,* 22, 253-262.

Zoellner, L. A. (2008). Translational challenges with tonic immobility. *Clinical Psychology: Science and Practice, 15,* 93-101.

Moore, S. A. & Zoellner, L. A. (2007). Overgeneral Autobiographical Memory and Traumatic Events: An Evaluative Review. *Psychological Bulletin,* Vol 133(3), 419-437.

Zoellner, L. A., Sacks, M. B., & Foa, E. B. (2007). Dissociation and serenity induction. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 252-262.

Foa, E., Zoellner, L.A., & Feeny, N.C. (2006). An evaluation of three brief programs for facilitating recovery after assault. *Journal of Traumatic Stress, 19,* 29-43.

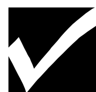
APPENDIX A

Typical Training Sequence

Our program requires a minimum of three academic years of full-time in-residence study, followed by a one-year full-time internship (or, in rare cases, a two year half-time internship). The typical student spends at least 5 years in residence prior to the internship.

The typical sequence of courses and major requirements for each year are described below. This is meant to provide an overview and guideline. There are some individual variations from this sequence. Students are expected to work closely with their faculty advisors and mentors to plan the sequence of training experiences that is most consistent with their interests and goals. All students and their advisors develop a formal Annual Plan to facilitate this process.

Orientation
Prior to the first week of class, the Department of Psychology provides a week long orientation. All students are required to register and attend. This orientation will provide students with a general overview of university and departmental policies and expectations and an introduction to the clinical program.



First Year

The first year is intended to introduce students to the major issues in clinical research, as well as providing them with a foundation for understanding psychopathology and basic approaches to working with clinical problems. Students also take the first year statistics sequence, which provides them with the basic skills necessary for conceptualizing and carrying out data analysis.

All students are required to take at least two assessment courses (and, preferably, courses in cognitive, personality, and behavioral assessment), and Child Clinical students are required to take the intelligence assessment course *in their first year*. In the description below, we use the colloquial term "Adult" (A) to denote the General Clinical track.

In addition to completing the basic coursework described below, in order to progress through the program at a normal rate, it is essential for students to build a relationship with their advisor and mentor and begin to delineate their research interests as early as possible. Students are assigned a research advisor as well as a secondary co-advisor upon admission to the program. Although students are free to switch advisors at any point, early in the first year or the third year are those times in which changes of advisor are apt to be least disruptive to their progress. Students who have been most successful in the program often credit it to establishing and maintaining a good relationship with their advisor. Students may also choose to broaden their research interests and skills by working in the lab of their co-advisor, or with other clinical or non-clinical faculty.

General Program

AUTUMN QUARTER

500A	(1)	Orientation	(**A & C**)
500B	(1)	Proseminar	(**A & C**)
550A	(1)	Psychology Dept Colloquium	(**A & C**)
553	(1)	Seminar in Child Clinical Psychology	(**C**)
591	(1)	Issues in Clinical Psychology	(**A & C**)
524	(4)	Intro. to Statistics and Data Analysis	(**A & C**)
522	(2)	Laboratory in Statistical Computation I	(required for those taking 524)

517	(3)	Core Concepts in Systems of Psychotherapy	(**A & C**)
531	(4)	Research Methods in Clinical and Community Psychology	(A & **C**)

WINTER QUARTER

500B	(1)	Proseminar	(**A & C**)
550A	(1)	Psychology Dept Colloquium	(**A & C**)
553	(1)	Seminar in Child Clinical Psychology	(**C**)
591	(1)	Issues in Clinical Psychology	(**A & C**)
525	(4)	Linear Models and Data Analysis	(**A & C**)
523	(2)	Laboratory in Statistical Computation II…	(required for those taking 525)
518	(5)	Core Concepts in Behavior Disorders	(**A**)
571	(5)	Child Psychopathology	(**C**, ☑)

SPRING QUARTER

500B	(1)	Proseminar	(**A & C**)
550A	(1)	Psychology Dept Colloquium	(**A & C**)
553	(1)	Seminar in Child Clinical Psychology	(**C**)
519	(5)	Behavior Change	(**A**)
572	(4)	Approaches to Child Treatment	(**C**, ☑)
576	(5)	Assessment of Intelligence …………………	(**C,** an **Adult assessment option**)
590	(2)	Practicum in Psych Assessment …. ……….	(Lab *required for those taking 576*)
578	(5)	Approaches to Psych Assessment …	(an **Adult assessment option**)
590	(2)	Practicum in Psych Assessment …. ……….	(Lab *required for those taking 578*)

(**A**) This course is **required** for students in the clinical program who are not in the Child track. These students must also take an optional course in assessment prior to Generals.

(**C**) This course is **required** for students in the Child track only.

☑ Adult students are required to take **one** of the following courses at some point in their program: 571 (Child Psychopathlogy), 572 (App's to Child Treatment) **or** 515 (Personality and Social Development).

Additional Major Requirement (A & C)

Proposal for the Second Year Project is *due by June 1st* *during Spring Quarter.*

Second Year

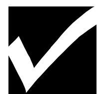
Coursework in the second year emphasizes the clinical component of the training program. This is also the year in which students typically begin to see clients through the program's Psychological Services and Training Center, located behind Guthrie Hall in Annex I. Furthermore, all students are required to have formed their supervisory committee (see page 23-24) during the Autumn Quarter of the second year.

Although clients with psychotic disorders and severe suicidal risk are generally screened out from the Clinic, clients at the Clinic represent a very broad range of disorders and functioning levels. Typical cases seen at the Clinic include families in distress, couples experiencing marital discord, children with conduct problems, and adults or children who are depressed. Students receive one hour of face-to-face clinical supervision for every hour of therapy. Clinical supervisors are drawn from the pool of core faculty within the clinical program or faculty affiliated with the clinical program who have primary appointments outside the Department of Psychology or who maintain private practices in

the community. Details about clinic policies and procedures are available in the Clinic Handbook, which is made available to all students in their second year by the Clinic Director.

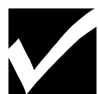
In addition to their involvement in a sequence of clinically oriented coursework, students should work on completing their out-of-area requirements. For students in the Child Clinical track, the out-of-area coursework must include the developmental psychology core courses. They also are required to take a course in Advanced Child Assessment during their second or third year. Other students are required to take a course in Personality some time prior to Generals. As part of the out-of-area requirements, prior to Generals, all students are expected to take a course in physiological/biological psychology, cognitive psychology, and social psychology in order to meet APA requirements. (Please see pages 25-26 for details on out-of-area requirements.) All students in the clinical program are expected to take a course in community psychology or minority mental health (Psych 580 or Psych 574) prior to Generals. Students typically take this course in their second or third year.

Additional Major Requirement
At the end of the second year, all students are expected to complete a Second Year Project, which is presented at a Research Festival, held by the Department of Psychology on the Wednesday after Memorial Day weekend. This is a day long program that is much like a professional convention. In addition, students must submit a written version of their Second Year Project in APA format (that is, submission-ready) by the end of the first week of classes in the third year. A full description of the Second Year Project is included in Appendix B.

 **Third Year**

Students in their third year typically complete any additional coursework required for their concentration in clinical, such as taking the course in community psychology or minority mental health. By the third year, students are beginning to tailor their curriculum to meet their own interests and needs. It is typical for students to be concentrating on work in their out-of-area requirements, as well as taking elective clinical courses or seminars. Some students will elect to submit their Second Year Projects as a Master's thesis and all are encouraged to submit their projects, or portions of their projects, to a scientific journal for publication. In addition, students continue to develop their clinical skills either through a continuation of their practica at the clinic, completion of a practica outside of the clinic (see Appendix C), or through participation in other advanced practica offered by the clinical faculty. As such, students in their third year typically work closely with their advisor and supervisory committee in selecting coursework and practica. Close work with the supervisory committee, which is chaired by the advisor, is also necessary in development of the dissertation proposal.

Students generally select their supervisory committee when they begin to concentrate on work for their Generals. The completion of Generals by the end of the third year, or as soon thereafter as possible, is highly recommended for those students planning to complete their degree in a five-year sequence. S**tudents are required to have completed their Generals and to have a written dissertation proposal approved by their committee prior to application for internship, which typically begins by October 1st.**

 **Fourth Year and Beyond**

Students beyond the third year typically finish up required coursework, as well as taking elective courses and dissertation credits. Students typically complete their Generals in the fourth year and defend their dissertation proposal

either in the fourth year or early in the fifth year. Students who have not defended their dissertation proposal early in the fifth year will not be able to complete the program within a six-year framework.

Fourth Year Science- Informed Clinical Case Presentation

A science-informed clinical case presentation (SICP) is required during Spring quarter of the fourth year. The SICP is always scheduled on the second Friday of Spring quarter. In the same way that the Research Festival allows students to demonstrate their emerging competence in the research domain, the SICP allows students to demonstrate foundational competencies in the clinical domain (e.g., case conceptualization, assessment, diagnosis, and intervention). Consistent with the scientist-practitioner focus of our program, students are expected to demonstrate that they have integrated scientific principles into their clinical work. The purpose of the SICP is three-fold: (1) to help students develop and demonstrate competencies as scientist-practitioners; (2) to help students build the case presentation skills that they may need for internship interviews or academic job talks; and (3) to integrate students' research and clinical training.

Clinical faculty, clinical students, and supervisors of the cases presented are all invited to attend. All Clinic clients sign consent forms that permit discussions of their cases and viewing of their videotapes for training purposes, such as these presentations. Nonetheless, in order to protect client confidentiality as much as possible, students are asked to remove personal identifiers. If you wish to present a case involving a non-Clinic client, you will need to obtain written permission from the client, and a copy must be placed in the client's chart at the other setting.

Presentations last 20 minutes, with 10 minutes for questions and discussion. An informal reception after the presentations allows additional time for more personalized discussion of cases with faculty and other attendees. SCIP thus provides an opportunity not only for faculty to assess student competencies in the clinical domain, but also for faculty to provide support, input and modeling for students in the seamless integration of science and practice.

"Science-informed" is broadly defined and relates as much to the process that leads to the formal presentation as it does to the final product. We would like you to think about your clinical interventions in much the same way as you would in planning an experiment. Good research is informed by psychological theory and by previous research findings, and what you do clinically should be similarly informed. To carry the parallels farther, the clinical intervention is like the independent variable in a psychological experiment and the target behaviors are like dependent variables. Both need to be operationally defined in terms of specific procedures and measurable outcomes. The underlying case conceptualization should specify functional relations between external and internal antecedents, mediating factors, and the client's adaptive and dysfunctional behaviors. These functional relations may be based on theoretical understandings of a particular disorder as well as on clinical data you have collected concerning the client. Your intervention will be directed at increasing the client's adaptive behaviors and strengths, reducing maladaptive target behaviors, or both. Whatever the intervention focus, it is important to find a way to measure the changes that occur, either in terms of standardized instruments (such as those administered routinely to our Clinic clients) or by means of measures you introduce or develop that are tailored to the particular client's target behaviors. Ideally, you would have measures administered before, during, and after treatment.

This process of case conceptualization, treatment planning, and choice of outcome measures will be facilitated by discussions with your supervisor. In addition, it is essential that your primary advisor be involved from the very beginning and throughout the process, including assisting you in your choice of the case to present. Beyond this, your presentation should be prepared in consultation with at least one member of the clinical faculty (who may be your advisor) chosen on the basis of expertise in evaluating and/or treating the type of client with whom you are working or some aspect of scientifically informed practice (e.g., single-subject designs). Consulting with in-house clinical faculty is a part of the requirement, and clinical faculty expect to be contacted for this just as they expect to be consulted on your research projects. Please remember that while we anticipate that the in-house faculty will provide invaluable consultation, ultimately it is your clinical supervisor who holds the responsibility for your case and who must approve any proposed interventions, outcome measures, etc. To the extent that there may be differences of opinion, consider that a valuable part of the learning process regarding the integration of science and practice.

The case study you present is of your choosing, in consultation with your advisor, and this exercise is intended to foster scientist-practitioner thinking in relation to your cases from your earliest experiences in the Clinic or other settings. It is *not* required that the treatment involve a specific empirically supported *manualized* treatment, or that the case be one with a successful outcome. Sometimes, less successful cases are the most informative in terms of clinical insights and treatment development. However, it is expected that you will utilize empirically supported *principles* of change. The faculty's major interest is in how the scientific literature informed your conceptualization of the case, your choice of interventions and outcome measures, and your understanding of your client's progress or lack thereof. Finally, as in the case of an experiment, you should discuss threats to internal validity (i.e., causal relations between treatment and outcome) that might have affected the outcome, as well as issues of external validity (generalization to similar cases) and the theoretical and practical conclusions you can draw from the case. The following checklist may be useful as a guide to preparing your SICP:

Prior to the Presentation:

- ✓ Consult with both your advisor and your clinical supervisor about the SICP. Consult with additional in-house faculty as needed.

During the SICP:

- ✓ **Client Description**: Include only demographic information that is relevant to the presentation. Attend to confidentiality and use HIPAA's guidelines for de-identifying personal data (e.g., use pseudonyms, give general rather than specific information about education, occupation, etc.)
- ✓ **Contextual Factors**: Describe individual, developmental, family, cultural, ethnic and other differences and cite any literature relevant to how these factors might impact internal and external validity.
- ✓ **Ethical and Legal Issues**: Convey an understanding of relevant ethics and laws (e.g., reporting of child abuse).
- ✓ **Assessment**: Describe the ways in which science informed your assessment of your client's presenting problems and strengths, history of presenting problems, your diagnostic formulation, etc. (e.g., did you use structured diagnostic interviews, reliable and valid baseline assessment measures, etc.?).
- ✓ **Case Conceptualization**: Cogently depict your case conceptualization. A graphic representation is usually helpful. Cite theoretical and empirical literature relevant to the case conceptualization.
- ✓ **Treatment Plan, Treatment Rationale and Intervention**: Let the audience know not only *how* you intervened with your client but also *why* you intervened as you did. Cite theoretical and empirical literature relevant to your treatment plan and interventions.
- ✓ **Outcome assessment**: Inform the audience of how you tracked your client's therapy progress and process and how that data informed your treatment. Discuss the outcome of your interventions and how you understand the progress or lack of progress. Consider internal and external validity concerns. Discuss mediators and moderators of change, if relevant.
- ✓ **Self-reflection**: Discuss what you learned from this case; what challenges or obstacles did you overcome? How has this case impacted your development? What, if anything, would you do differently, and why.

After the successful completion of this requirement, you will have had specific practice in how to integrate science into clinical practice, and you should have some confidence in your ability to do so on a regular basis. You should also feel prepared to give a similar talk on internship or on a job interview. And, you should feel that both your research faculty

and your clinical supervisors (to the extent that they are different people) are supportive and involved in your development as a clinical scientist.

Predoctoral Internship

Early in the fourth or fifth year, students typically apply for internships if all requirements have been completed, including required courses, Generals, and an approved dissertation proposal. Students must complete a one-year APA-accredited internship before the Ph.D will be conferred**.** During the internship application process, the Director of Clinical Training is required to certify that applicants are in good standing. If students are on WARN or PROBATION status, they should clear this up before asking for a letter of recommendation, for there is a specific question on the DCT Certification Form about probation. In addition, any student who has repeatedly been on Warn or Probation status will have that noted in their letter.

The fourth year and beyond can be the most creative and rewarding portion of the graduate student years. Students in these years have acquired basic and often, advanced clinical skills, feel confident in their ability to work with clients, and are pursuing independent research ideas that will culminate in the dissertation. Students may also have the opportunity to teach courses in the department with mentorship from core clinical faculty. By the end of the dissertation and internship we expect students to be able to function autonomously and competently as both clinicians and researchers.

Students on NRSAs that extend into the internship year are required by departmental and NIH policy to either terminate the award or to request a leave of absence prior to the beginning of the internship.

Spring Hooding and Commencement Ceremonies, Graduation, Post-docs, and Jobs

Students who are on internship often wish to participate in our spring hooding ceremony and the June Commencement Exercise. Although, according to both APA and University regulations, you cannot formally receive your degree before the internship is completed and the dissertation is turned in to the Graduate School, you can participate in these spring activities if you obtain a letter or e-mail from your internship director stating that you will successfully complete your internship on (date). It is necessary to turn in the paperwork by the end of spring quarter in order to participate in hooding and commencement activities. At commencement, you will receive an empty diploma cover, and the diploma itself will be conferred at the end of the quarter in which you complete all requirements. Thus, if your internship ends after the last day of Summer quarter, the degree will be formally conferred at the end of Fall quarter, but you can still do Spring hooding. Please note that because the internship is an integral part of the degree, clinical students are not allowed to participate in hooding or Commencement prior to beginning their internship even if they have already defended their dissertation.

A related issue occurs when a job or postdoctoral appointment requires that the degree be completed. In such instances, the letter from the internship director, plus one from the UW Director of Clinical Training stating that you will finish all degree requirements by the closing date of the internship, has been sufficient to start jobs and postdocs that begin before the next formal graduation date. This is another good reason to make every effort to defend your thesis before the internship year ends (and, even better, before it begins).

In either of these instances, please provide three copies of the internship director's letter or e-mail certification for (1) the Director of Clinical Training, (2) the Graduate Program Advisor, and (3) your advisor.

A statement concerning where and when you completed your internship will be added to your final post-graduation UW transcript. This will be helpful when you apply for licensure. Please let the Director of Clinical Training know the specific date your internship will end.

Internship: Hours versus Duration

Please note that if your internship ending date is after the end of Summer quarter, it is not possible according to APA regulations to finish an internship early so that you can receive your degree at the end of Summer quarter even if you have satisfied the internship's hours requirement before the end of the designated 12-month period. APA and licensing boards operate on a calendar year rather than an hours basis.

Quick Listing of All Required Courses for Clinical Psychology

Course	Credits	Title	Notes
500 Sec A	1 credit	Psychology Orientation	(register 1st quarter only)
500 Sec B	Total of 3 credits	Proseminar	(register AWS qtrs during 1st year)
550 Sec A	Total of 3 credits	Psychology Colloquium	(register AWS qtrs during 1st year)
591	Total of 2 credits	Issues in Clinical Psychology	(register A&W qtrs during 1st year)
524	4 credits	Intro to Stats. & Data Analysis	(**must** register also for lab: Psych 522)
522	2 credits	Lab. in Statistical Computation I	(required for those taking Psych 524)
525	4 credits	Linear Models & Data Analysis	(**must** register also for lab: Psych 523)
523	2 credits	Lab. in Statistical Computation II	(required for those taking Psych 525)
531	4 credits	Research Methods in Clinical and Community Psychology	
517	3 credits	Core Concepts in Systems of Psychotherapy	
560	2-30 credits total	Research Strategies (lab-based research seminar; sign up whenever offered by your advisor and you are participating in lab meetings)	
580	3 credits	Minority Mental Health	
586	3 credits	Clinical Personality Assessment	
587	2 credits	Clinical Methods: Interview	
588	2 credits	Clinical Methods: Ethics	
589	Total of 8 credits	*Clinical Supervision*	(2nd year students **must** register for AWSS)
593A	Var. credit (1-6 cr/qtr)	Clinical *Practica*/Colloquium**	(A - 2nd yr students – Coll. attend. req'd)
593B	Var. credit (1-6 cr/qtr)	Clinical *Practica*/Colloquium**	(B - 3rd yr and above)

**Required for all students seeing clients in the clinic.

APA-Required Discipline-Specific Knowledge Requirements

As an APA-accredited program, we adhere to mandated requirements for demonstrated breadth of knowledge (discipline-specific knowledge or DSK) outside of the clinical specialty**. Specifically, students must complete coursework in the following discipline-specific areas: (1) biological aspects of behavior; (2) cognitive aspects of behavior; (3) social aspects of behavior; (4) human development; (5) affective aspects of behavior; and (6) history and systems of psychology.** Courses offered within the clinical area do *not* satisfy these requirements. For example, a course in child psychopathology will not satisfy the developmental DSK requirement, nor will a course in cognitive therapy satisfy the cognitive requirement. Since licensing boards scrutinize graduate school transcripts to make sure these DSK requirements have been satisfied, it is recommended that whenever possible, you satisfy the requirement with a major course (i.e., a *Core Concepts in* ...or *Advances in* ...course) offered by faculty in other major areas of the department. Highly specific courses (e.g., courses in psychopharmacology or fMRI techniques for "biological bases") do not meet the APA "broad and general" DSK course requirement. Likewise, Psych 550-level seminars do not satisfy this requirement. Non-clinical courses in other departments may sometimes satisfy a DSK requirement. If in doubt, consult with the Director of Clinical Training.

Additional Requirements for General ("Adult") Track Students

Course	Credits	Title
511	3 credits	Core Concepts in Personality
519	5 credits	Core Concepts in Psychology of Behavior Change
518	5 credits	Core Concepts in Behavior Disorders

plus……

One course each in *Biological*, *Social, Cognitive, Developmental, and Affective Bases of Behavior*, *(see APA DSK requirements above) The History and Systems requirement is satisfied by directed readings in Psych. 591.*

One of the following courses Note: Cannot be used as an out-of-area (developmental) DSK course; see below)

571 Child Psychopathology <u>or</u>

572 Child Treatment

Two courses in Assessment (but all three of the courses listed below are recommended for coverage of personality, cognitive, and behavioral assessment):

586 Clinical Personality Assessment

and *a choice of***:**

576 (Assessment of Intelligence w/ 590 practicum), **or 577 (Psychological Assessment)**

Please note that training in cognitive assessment is required as a basis for neuropsychological assessment training, certain outside practica, and internship assignments. Ideally, students in our program will have training in personality, cognitive, and behavioral assessment.

<u>Additional Requirements for Child Track Students</u>

553	6 total	Seminar in Child Clinical Psychology	(required AWS qtrs for 1st & 2nd year)
571	5 credits	Child Psychopathology	
572	4 credits	Approaches to Child Treatment	
576	5 credits	Assessment of Intelligence	(**must** register for Psych 590 also)
590	2 credits	Practicum in Psych. Assessment	(**required** for those taking 576)
573	5 credits	Psychological Assessment of Children	

plus……

At least one treatment seminar.
One additional quantitative methods course.

<u>Practicum Requirements</u>

Practicum placements may occur either within the department (internal practica taught by clinical faculty) or outside the department (external practica). In addition to internal (Psych 594) practica, at least one external practicum is required for students in the adult track (must register for Psych 597 credit). Two practica, ideally one assessment-based and one treatment-based, (either internal [Psych 594] or external [Psych 597]), are required for child track students. See Appendix C for complete registration information.

<u>Out-of-Area Requirements</u>

The Director of Clinical Training has no official say over what is required or offered in other areas in the Psychology Department. In general, courses used to fulfill within-area requirements may not also be used to fulfill out-of-area requirements. In addition, non-clinical courses taken at previous institutions toward another degree (e.g., a master's degree) may not be used toward fulfilling course requirements for the Ph.D. at the University of Washington unless approved by the head of the area in question based on the syllabus from the course in question.

For Adult clinical students, <u>six or more courses must</u> be taken from curriculum offerings <u>outside the clinical area</u>. Five of these courses must meet the APA curriculum guidelines for "discipline-specific knowledge." Therefore, students must complete one "broad and general" course each covering biological, cognitive, affective, developmental, diversity/individual differences, and social aspects of behavior, plus at least one course in psychological measurement (see next section). The balance of the six-or-more courses is to be determined by mutual agreement between the student and co-advisors or supervisory committee. These courses should be selected with an eye toward developing cohesive themes of subspecialty expertise pertinent to the student's future research and clinical endeavors.

For Child clinical students, the out-of-area coursework consists of the three core developmental courses listed below, which also serve to meet the aforementioned APA guidelines for one course each in social, cognitive, and

biological bases of behavior. One 400-level course on the same topic may be substituted for the following courses with the approval of the advisor. A course cannot satisfy both the developmental and another DSK requirement.

Psych 513	Core Concepts in Biological Basis of Development	(4)
Psych 514	Core Concepts in Early Cognitive and Linguistic Development	(4)
Psych 515	Core Concepts in Personality and Social Development	(4)

Domain-Specific and Profession-Wide Competency and Curricular Elements

According to current regulations of the APA Commission on Accreditation, students in accredited programs must develop and demonstrate doctoral-level competency in the following domains of knowledge and behavior:

1. History and systems of psychology
2. Affective aspects of behavior
3. Biological aspects of behavior
4. Cognitive aspects of behavior
5. Developmental aspects of behavior
6. Social aspects of behavior
7. Advanced integrative knowledge combining the above areas
8. Psychometrics and measurement
9. Research methodology
10. Techniques of data analysis
11. Psychopathology (a program-specific topic)
12. Theories and techniques of assessment and diagnosis
13. Theories and methods of intervention
14. Professional values, attitudes, and behaviors
15. Communication and interpersonal skills
16. Ethical and legal standards
17. Theories and methods of supervision
18. Theories and methods of consultation and interprofessional collaboration
19. Individual and cultural diversity (e.g., personality, ethnic, cultural, gender-related, etc.) relevant to all of the areas above

20. We add Psychopathology (a program-specific topic) to this list of knowledge competencies

As a program, we are expected to provide coursework and other modes of training in all of the above areas, and to foster "attitudes essential to lifelong learning, scholarly inquiry, and professional problem solving." (Colloquia and seminars are one vehicle for the latter.)

Licensure considerations. State licensing boards expect your transcript to reflect formal coursework in all of the above areas. Our clinical curriculum covers all of the topics relevant to the clinical and professional domains. Areas (1) through (9) are the "Discipline –Specific Knowledge" areas that are satisfied by coursework in other areas of the department (History and Systems being covered in Psych 591) and should be taken very seriously if you expect to get licensed in some states. As noted elsewhere, graduate "Core Concepts" and comprehensive "Advances in…" courses offered by other areas of the department will pass muster, but highly specific courses (e.g., courses in psychopharmacology or fMRI techniques for "biological bases") do not meet either APA or most licensing board requirements. Licensure applicants in some states have been asked to provide copies of the course syllabi in areas where there are questions, so by all means save hard and/or electronic copies of every course syllabus you ever receive, even in your clinical courses. One issue we sometimes have to deal with is designated "semester hour" requirements in certain states, which can cause problems because of our quarter system. You'll need to demonstrate that your course is

as comprehensive as a semester course (they are, of course, and in a shorter time span, which is why you're always feeling overwhelmed), and you'll need your syllabus for this as well.

Finally, in addition to keeping an electronic or hard copy of every course syllabus syllabus as you go through the program, it is strongly recommended that when you graduate you deposit all relevant materials (syllabi, transcript, etc.) with the Association of State and Provincial Licensing Board's Credentials Bank. For a modest fee, this will keep everything you need for licensure in any state or province available to be forwarded to the particular licensing board. The web address is <http://www.asppb.net/i4a/pages/index.cfm?pageid=3463>.

Other Requirements:

Psych 800 – **27** Minimum Required Credits in Dissertation Research

A one-year APA-accredited predoctoral internship or its equivalent. An unaccredited internship (rarely requested and definitely not recommended) must be approved by the clinical area faculty.

Note: A masters thesis is not required, but virtually all students submit the required write-up of the second-year research project and submit it to the Graduate School to satisfy this requirement for the masters degree. We strongly recommend this course of action so that, in the event that unexpected events should prevent you from completing the doctoral program, you will have the masters degree. The masters is also desirable for some sources of employment outside the department even while you're working toward the doctorate.

APPENDIX B

Second Year Project and Proposal

Purpose

The Second Year Project is intended to provide the student an opportunity to become involved in research and acquire competencies in experimental design and data analysis. It is the key research requirement prior to the dissertation and at its culmination, the student is expected to have demonstrated the basic component skills required to conduct independent research, including the ability to conceptualize a research problem and interpret empirical data.

Scope of the Project

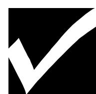
Although the Second Year Project varies in scope and the degree to which the student works independently, the student works more directly under the guidance of the advisor, and the scope of the project is narrower than would be the case for a dissertation.

Although it is highly desirable that the project be publishable, this is not a requirement. Neither originality nor involvement in data collection is required. For example, replication of an already published study or analysis of an already existing data set is perfectly acceptable. However, except in highly unusual circumstances, students are expected to conduct their own data analysis. In ALL cases, students are required to write the project on their own, although extensive guidance from the advisor is provided.

There is no page limit requirement for the project, and the length of the final manuscript varies widely. However, a journal length manuscript is generally expected. Abstracts or submissions for convention presentations are not acceptable. A published article, a manuscript under review, or a manuscript to be submitted is NOT acceptable UNLESS the student is the first author. In those cases where the student will not be a first author on a publication related to the project, the student is expected to write an independent report of their research for the Second Year Project.

The fact that a student submits an independent report for the Second Year Project carries no implication for the order of authorship on a final manuscript which may be submitted for publication. Students are urged to negotiate terms of authorship directly with their advisors. This type of negotiation is an important aspect of the student's training. For this reason, and to guard against potential misunderstanding, students and advisors are STRONGLY urged to negotiate about authorship PRIOR to submission of the student's proposal for the Second Year Project.

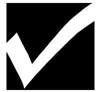
It is expected that the Second Year project be completed and the written report submitted to the advisor and DCT by the end of the second year (i.e. by the first week of Fall Quarter of the third year). See Time Lines below.

 **Second Year Project Proposal**

Just as the scope and length of the Second Year Project itself varies, so does the length and scope of proposals. However, it is expected that the proposal will be the equivalent of the final manuscript minus the results and discussions

(i.e., a five to ten page review of the literature, full methods section, hypotheses, and a more brief section on data analysis). This format will provide training in writing journal articles, will help in conceptualizing the project itself and will greatly expedite writing up the second year project and submitting it for publication if results warrant.

The Second Year Project proposal is due by June 1st of the first year and should be signed by both the student and the advisor. See Time Lines below.



Evaluation of the Project

Unlike Generals and the dissertation, the Second Year Project does not require the approval of a committee. * As long as the project meets the general guidelines described herein, the project is approved at the sole discretion of the student's advisor. Expectations for what constitutes an acceptable project vary widely from advisor to advisor, and it is up to the student and advisor to negotiate what will make for an acceptable project.

To ensure minimal standards, however, all Second Year Projects are to be submitted to the Director of Clinical Training for review. In those highly unusual cases where the Director of Clinical Training does not feel that the Second Year Project submitted by a student, already approved by the advisor, meets the minimal requirements discussed here, the Director of Clinical Training will ask the area's advisory board to review the project. If the advisory board believes that the project is unacceptable, a full faculty meeting to review the project will be called.

Time Lines

As stated before, the Second Year Project proposal is due on *June 1st* at the end of the first year, submitted in hard copy to the Director of Clinical Training. Students who fail to turn in a proposal by this date will be discussed at the end-of-the-year review. Except for unusual circumstances, such students will be placed on Warning Status by the Department's Graduate Training Committee. All students who do not submit a second year proposal by the end of the first quarter of their second year will AUTOMATICALLY be placed on probation.

A completed Second Year Project is due in hard copy to the Director of Clinical Training by the end of the first week of the third year. Except for unusual circumstances, students who fail to meet this deadline will be placed on *academic warn status*. All students who do not submit a completed Second Year Project by the first week of the second quarter of their third year will be automatically placed on *probation*. Students not submitting completed Second Year Projects by the first week of the third quarter of the third year will be automatically placed on *final probation*.

A letter from the student's advisor will be sufficient to substantiate "unusual" circumstances. In those cases where a student does not have an advisor, the Director of Clinical Training will decide whether unusual circumstances apply. Computer malfunctions, delays in project funding, or difficulties in recruiting participants will NOT be considered as "unusual" circumstances. These are the usual, ordinary, and routine problems that plague research with human participants and human researchers. They should be taken into account when planning your personal timetable for the project.

* Students who plan on submitting their Second Year Project for a M.S. degree are required to form a two-person committee. See departmental guidelines about the requirements for a M.S in the departmental Graduate Program Manual and consult with Jeanny Mai if you have any questions.

Overview of Deadlines

Expected	Due by...
Second Year Project Proposal	June 1st, end of first year
Probation Status if Proposal is not in by	End of Fall quarter of second year
Second Year Project	First week of Fall quarter of the third year
Probation Status if Project is not in by	First week of Winter quarter of third year
Final Probation if Project is not in by	First week of Spring quarter of third year

APPENDIX C

Practicum Requirements

What is required?
The General Clinical track requires that all its students complete at least one year-long practicum under Psych 597 (outside the department) or Psych 594 (internal practicum) course credit. Most students complete more than one.

The Child Clinical track requires all its students to complete a one year-long practicum in assessment and one in treatment, generally during their third and fourth years in the program. The practica should be child-focused, ideally providing opportunities for direct clinical contact with child clients. To fulfill the requirement for treatment, the practicum experience should be significantly if not exclusively treatment-related. Similarly, the assessment experience should be significantly if not exclusively assessment-related. The practica can be taken under either 597 (outside the department) or Psych 594 (internal practicum) credit.

Students in both tracks should consult with their advisor and Practicum Coordinator (Shannon Dorsey) regarding practicum plans and, when possible, include practica they plan to take in their spring Annual Plan.

Information about practicum/pesponses to student questions are updated through the year—so please see the Practicum FAQ document posted online here (as it will include the most updated and detailed information):

https://drive.google.com/open?id=0B_dzzp8ZE04lNTQ1M0xxVmw4OTg

What is the procedure for selecting a practicum?
Currently approved practicum are listed on the shared clinic google drive document here: https://docs.Google.com/spreadsheets/d/1cGkYYCoq0GCUA7FRfKDJusSwy25zo34H6BK8Syym5fo/edit#gid=1065455210 or via the Psychology Internet: https://depts.washington.edu/psych/department/gradstudents/index.php

This document includes active external practicum, internal practicum, and student evaluations of practicum. Practicum students have completed in the past 5 years are in green. You can search by sites that focus on adult, child/adolescent, or both, based on your interests/practicum needs, which will greatly reduce the number of programs you have to review. Inactive/Archived and unresponsive practicum sites (when requested to update their materials yearly) are in separate tabs.

Students can also explore new opportunities for practicum experiences, be creative, and find something that fits well with their interests and future career goals. An online version of past practica is also available through the Program Coordinator. Talk to your more advanced classmates about possible placements. Consult with the Practicum Director (currently Shannon Dorsey).

What is the procedure for registering and gaining approval for new practicum sites?
Site personnel should contact the Practicum Director (currently Shannon Dorsey), who will request they complete an online Practicum Registration Form at: https://catalyst.uw.edu/webq/survey/psychcom/7825
In consultation with the appropriate area track and concurrence by the clinical faculty, the Practicum Director will authorize the site. You should not do practica at nonapproved sites.

What is an appropriate time commitment?
In recognition of the many competing demands on students' time, the faculty suggest that practicum responsibilities not greatly exceed 4-8 hours per week over the course of three academic quarters for each year-long placement. When the setting generally requires an 8-12 hour commitment, this is allowable.

Are there any requirements in terms of initial training?
The practicum should provide an initial amount of training that is appropriate to the duties required.

How much supervision and what kind is required?
Regular supervision is required, normally defined as one hour of face-to-face individual supervision for every eight hours of client contact. However, slightly less supervision and group supervision are acceptable. At least some of the supervision must involve observation of your activities. This can involve either direct or electronic (audio or audiovisual) observation.

Who may serve as a supervisor?
Supervisors need not always be licensed clinical psychologists. If they have appropriate expertise (which we assess when the practicum site applies), they may hold a degree in a related field. They need not be licensed in their field.

Are students covered for liability with respect to their work at a practicum site?
According to the UW Office of Risk Management, all UW students are covered by Washington State as long as they are acting as part of a university-approved program. All are covered under an umbrella indemnification policy with no monetary limits. Students must be receiving credit for the program, and, if so, they are covered for professional liability through the UW's policy. This means they have to register for the course for credit during Fall, Winter, and Spring quarters, and during Summer session as well if they have support that pays summer tuition (see exception below). Students also are covered if they are *volunteering* without credit in a university-sponsored program IF it takes place geographically on this campus. The university is responsible for UW students, not for the supervisors, who may be subject to related claims.

Once I have selected a practicum, what do I have to do before I start?
Complete the online Practicum Registration Form at: https://catalyst.uw.edu/webq/survey/psychcom/7834
AND register for the correct section of Psychology 597 (approximately one credit for every 3 hours per week of work). If this is your first quarter at the practicum site, consult with the Practicum Director first. Note that you need to complete the Practicum Registration Form and register for Psychology 597 EVERY QUARTER you are involved in an external practicum. If the practicum is an internal one, register for the appropriate section of Psychology 594.

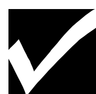
Is any other paper work required?
Complete the yearly evaluation form, which will be sent to you in the spring. Your responses on this form will provide feedback to us and will be shared with the practicum site. In addition, you will be asked to complete an additional internal "comment" portion (not shared with the practicum site) that may be useful to future students considering this practicum. This will be filed in our catalogue of practicum sites.

What if I have no summer support?
As noted above, students must register for practicum hours **(Psych 593, 594, or Psych 597)** during the academic year, and during Summer session as well if they have University or extramural support (e.g., an NRSA award) that pays tuition. Students who do not have Summer support may nonetheless avail themselves of practicum training under a special provision designed to avoid financial hardship for students who would have to pay their own tuition in order to continue to see their clients in the Clinic or work at a practicum site. In such instances, with the permission of the student's advisor, the Psych 593 (for Clinic), 594 (for an internal practicum), or 597 (for external placements) instructor, and the Director of Clinical Training, the student may participate in practicum activities and obtain clinical hours for internship application and future licensure. Students who exercise this option will formally agree to exercise the same level of professional and scholarly accountability that would be expected were they actually registered for Psych 593, 594, or 597. In order to be eligible for this tuition waiver, students must be in good academic standing and up to date on all Clinic paperwork and other requirements. They must also complete the Practicum Registration Form.

APPENDIX D

Competency Demonstration/General Examinations

The General Examination is a requirement of the Graduate School and must meet the general guidelines specified by the Graduate School. In addition, the clinical area has some separate but not incompatible expectations. Both sets of guidelines are outlined here. Keep in mind that both must be met.



Supervisory Committee

Your Supervisory Committee's roles are to guide you in the preparation of your graduate program, to conduct your General Examination, and to conduct your Final Examination.

1. ***Composition of the Supervisory Committee***: You must set up a Supervisory Committee consisting of at least four members and not more than seven members. It is advisable to have one or more members over the minimum number to assure a necessary quorum for meetings and examinations. The following are considerations for the composition of the committee:

    A. Members of the committee must be members of the appointed Graduate Faculty, with one exception allowed. One, but not more than one, person may be appointed who is not on the Graduate Faculty. Not every faculty member is a member of the Graduate Faculty, although most are. Some new Assistant Professors, Lecturers, and Research Associates positions are not on the Graduate Faculty. If in doubt, ask the person you are considering having on your committee, call the Graduate School's Student Services Office at 543-8720, or check the Graduate Faculty Locator: http://www.grad.washington.edu/gradfac/

    B. The majority of your members must be from your major area. Adult clinical students must initially have three clinical faculty. Child clinical students must have at least one additional child clinical faculty member besides the chair and another member who is not a member of either the adult or child clinical area. That person may be from another area of the department (e.g., Developmental, Social), or from another department or school in the University. Rounding out the committee is the Graduate School Representative (GSR; see D, below). It is wise to have at least one additional committee member because an examination requires a quorum consisting of the chair, the Graduate School Representative, and two other committee members. Having an additional member protects you in case one of your committee members cannot attend.

    C. One member of an adult student's committee should also be from outside the clinical area (not including the GSR).

    D. You must have a Graduate School Representative (GSR) who is from a field other than Psychology**.** The GSR is a voting member of the committee, chosen by you on the basis of expertise in your area of study or in data analysis. The role of the GSR includes monitoring the conduct of the student's exams, resolving potential conflicts, and facilitating communications between committee members and the student. The GSR is charged with the additional responsibility of reporting directly to the Dean of the Graduate School on the content and quality of the General and Final Examinations. The main function of the GSR is to ensure that the process allows for fairness to all parties.

2. ***When to Form Your Supervisory Committee***: Your supervisory committee should be formed during your second year in the program. It is important to form this committee at this point so that your committee members can have a voice in the curriculum you follow in preparation for your General Examination (see General Examination section in this manual.) Your Supervisory Committee should be officially formed at least four months prior to the time the warrant for the General Examination is presented to the Graduate School. The committee should be formed by the first week of classes in the third year of study with the concurrence of the Director of Clinical Training (see 3 B below).

3. ***Procedures for Formation of the Supervisory Committee***:

   A. Get an "Application for Ph.D. Supervisory Committee" form from the Graduate Program Office, by emailing Jeanny (jeanny@uw.edu).

   B. Discuss your committee with each potential member and get a signature (or email confirmation) on the form from each member who is willing to serve on the committee. Get the concurrence signature (or email) from the Director of Clinical Training. As noted above, this must occur by the beginning of your third year to avoid unwelcome attention from the Department's Graduate Training Committee.

   C. Return the completed form with signatures or emails to the Psychology Graduate Program Office. After the Graduate Program Coordinator evaluates the representation on your proposed committee, an official request will be prepared and sent to the Graduate School.

4. ***Changing (Reconstituting) your Committee***: For appropriate reasons, it is possible to change the members of your committee. For example, if your dissertation focus has changed, a different committee member (or even a different committee) may be more appropriate. If a change is needed, follow the steps outlined below.

   A. Get a "Request for Supervisory Committee Reconstitution" form from the Graduate Program Office, by emailing Jeanny (jeanny@uw.edu).

   B. Indicate the changes to be made, and your reasons for making these changes.

   C. Get the signatures/emails of any members who are being added to, or removed from, the committee.

   C. Return the completed form with signatures or emails to the Graduate Program Office. After the Graduate Program Coordinator evaluates the change(s) proposed, an official request will be prepared and sent to the Graduate School.

5. Meetings with your Supervisory Committee

   A. During your second year in our program, you should form and meet with your Supervisory Committee to plan the course work, reading, and other activity you will do in preparation for your General Exam.

   B. The committee will meet for the oral portion of your General Examination. If your exam is entirely written, then the committee will meet to evaluate the written exam.

   C. A formal meeting is held to approve your dissertation proposal as part of the General Exam procedure.

   D. The committee will meet for your Final Examination, during which you will defend your dissertation.

   E. Other meetings may be scheduled as you and the chair of your committee deem necessary.

General Examination

In order to successfully pass generals four things are required:

1. A written publication-quality empirical article conducted after beginning graduate school at the University of Washington. The student should have played a key role, both conceptually and analytically, in preparing the study on which the article is based, and the student should be first or sole author. This study will usually be the student's second year project. However, in cases where the second year project is not publication-worthy, another piece of work can be used to meet this requirement. The requirement is that students will have to submit the article to a peer-reviewed journal for review**.**

2. A comprehensive written review of the literature on a topic of the student's choice, based on consultation with the student's advisor and committee. The form and nature of the review should be agreed upon before the student begins work so that shared expectations are clear. The general exam review paper would ideally be in the form of a *Clinical Psychology Review* or *Psychological Bulletin* article. The paper should be in the 30-50-page range and should include a thorough and critical review of the relevant literature. It should discuss important theoretical and methodological issues in the topic area and address future directions in which empirical and theoretical development should proceed. Expository methods could include qualitative analysis of the extant literature and/or, if desired, a meta-analysis of the body of relevant empirical results that also addresses the elements described above.

3. A formal written research proposal that will be the basis for the doctoral dissertation. The proposal will typically be in the same area as the literature review paper, but it may also be in a different area, reflecting the student's current research interests. In the latter case, the dissertation research proposal should include a review of the relevant literature on the new topic. This review need not be as comprehensive as the literature review in (Requirement 2), but it needs to be at least at the level of a literature review for a major journal article or NRSA/NSF proposal and demonstrate that you know the background literature. A first draft of the proposal should be distributed to the committee at least three weeks prior to the examination date to ensure the opportunity to incorporate feedback into the final proposal.

4. An oral defense of the literature review paper (Requirement 2) and the dissertation research proposal (Requirement 3), planned in consultation with the chair and other members of the committee. This oral defense before the student's doctoral committee will include both a presentation by the student and a period of questioning from the committee.

Protocol for papers to your committee: Check with your committee members to see if they would like a hard copy of general exam materials and dissertations. Some may be satisfied with an electronic version, whereas others would rather not have to print large documents or would prefer a hard copy to write on. You should also submit a copy of your vita to your committee members.

Scheduling the General Exam

Your General Examination must be officially scheduled with the Graduate School at least three weeks prior to the actual date of your exam. The Graduate Program Advisor can provide directions on how to do this, email jeanny@uw.edu. If all is in order (your committee was set up in time, all members of your committee are in residence, you are registered) a warrant will be created and emailed to you as a pdf by the Graduate Program Advisor. If your written exam is to be the only requirement, schedule the date of that with the Graduate School as your General Examination. If there will be some additional meeting, schedule the final meeting or requirement as the General Examination.

Please print out one copy of your warrant and bring it to your exam. Your Graduate School Representative (GSR), your committee chairperson and two additional committee members must sign the warrant before it is returned to the

Graduate Program Advisor, G-127. Your GSR will have his/her own paperwork to complete for the Graduate School directly and s/he will know where to obtain this form. Jeanny can help if s/he is unable to locate the form.

APPENDIX E

Dissertation Proposals

The clinical program requires that all students submit a written dissertation proposal to their Supervisory Committee, and have it approved, prior to application for internship. The length, breadth, and detail contained in this proposal is up to the discretion of the committee. Typically, the dissertation proposal is similar to a journal article, without the full results and discussion section. Modifications to the dissertation plans approved by the committee should be discussed with the committee as they occur. This is suggested as a safeguard for the student. Indeed**, *seeking close consultation with committee members throughout the dissertation process is always a good idea.*** The Graduate School Manual spells out detailed procedures for the final examination and dissertation defense.

Application for Internships

Application for internships is a process much like applying to graduate school. In order to meet the Ph.D. requirement in our program, the internship must be APA accredited. Under both University and APA regulations, the Ph.D. cannot be formally conferred until the internship is completed and the dissertation defended. Whenever possible, we strongly recommend completion and, if possible, defense of the dissertation before beginning the internship so that you can devote yourself entirely to the internship.

Nonetheless, all internships in the National Match require as part of the APPI process certification and a letter of evaluation from the Director of Clinical Training stating that the student is in good standing in the program, is not on probation, and is ready for internship. The Director of Clinical Training will only provide such certification under the following circumstances:

1. The student must have completed the General Examination.

2. The student must have a written dissertation proposal that has been approved by the thesis Supervisory Committee.

3. The student must be in good standing in the program. The Director of Clinical Training will not write a letter for students who are on WARNING or PROBATION status.

4. The student's advisor must notify the Director of Clinical Training (e-mail notification is allowed) that the student is ready for internship (that they know the student has a defended proposal and will complete coursework before the year's end) before they write a letter of recommendation for the internship.

5. The student must be in good standing at the Clinic. Students should make sure that their clinical paperwork (e.g., termination reports, etc.) is in good order prior to applying for internship.

Although not an official requirement, it is **highly** recommended that students have their dissertation data collected and analyzed prior to actually leaving for internship. Ideally, you should also have the dissertation written and defended. Students who leave for internship before gathering and analyzing their data invariably take a longer time to complete

their Ph.D. Completion of the dissertation allows students to devote themselves totally to the rich training opportunities offered by the internship and to accept jobs or postdoctoral appointments that begin immediately after the internship year. Many of our students get job or postdoc offers at their internship settings, and it is unfortunate if they are not in a position to take advantage of such opportunities because they have to finish up their dissertation.

Final Examination/Dissertation Defense

As stated earlier, the APA requires a pre-doctoral internship for a clinical degree. If your Ph.D. is conferred prior to completion of internship, that would go against APA regulations and when it comes time for licensing, you may find yourself ineligible. Please see below for your options in this situation.

FINAL EXAM (Dissertation Defense) BEFORE INTERNSHIP

If you take your final exam (defend your dissertation) before you go on internship, you have only one choice for turning in the final draft to the Graduate School:

You must submit a Petition to the Dean to graduate without being registered. The petition must include a timetable for completion of the internship and submittal of the dissertation. Then apply for on-leave status (Autumn, Winter, Spring only. Summer quarter is free/automatic) to complete your internship. During internship, either you, your advisor, or a trusted friend holds everything—dissertation, signed approval form, and signed warrant—until the final quarter of your internship, or the one after that. Once your internship has been successfully completed, you should get a statement (e-mail or letter) from your internship supervisor, stating that this is the case and have copies sent directly to both the Director of Clinical Training and the Graduate Program Advisor in the Psychology Department. You then return, submit the paperwork to the Graduate School within the appropriate quarter, and get your degree. (Or have that trusted friend submit the paperwork for you in your absence.) Registration when you submit your dissertation is NOT necessary once your petition has been approved.

FINAL EXAM (Dissertation Defense) AFTER INTERNSHIP

If you do not take your final exam (defend your dissertation) before you go on internship, you must be registered for a minimum of two credits in the quarter in which you defend and when the dissertation is submitted, if these two events happen in separate quarters. Register for your final quarter(s) at the minimum of 2 credits in order to return to student status. The per-credit cost will be based on the prevailing resident or non-resident tuition figure and will be your responsibility to cover (unless your advisor has funds and the two of you arranged this in advance).

IMPORTANT: ELECTRONIC DISSERTATION SUBMISSION

The final submission of your dissertation is now an electronic process and completely free (unless you wish to order personal bound copies): http://www.grad.washington.edu/students/etd/info.shtml
Also note that the degree is awarded at the END of the quarter in which it is earned. This becomes crucial when you have a job that begins in September and requires the Ph.D., but your degree is not effective until December! Please check in with the Graduate Program Advisor (jeanny@uw.edu) and get informed about your personal timeline to completion. The DCT (and, in some cases, the Registrar) will also be asked to certify to your job/postdoc site that you have completed all requirements before you can be formally hired.

FUTURE LICENSURE

Even if you go into an academic setting, most of you will probably want to be licensed so that you can do clinical practice or supervision. To prepare yourself for that eventuality, be sure you retain all of your syllabi, for a licensing board may ask you to justify that you have met APA competency requirements (see p. 34). Sometimes, there are issues related to number of credits, for some licensing bodies require 5 *semester* hours to satisfy a DSK area, so you'll need to show that your quarter course was equivalent (generally not hard if you have the syllabus). Scan and keep an electronic copy of all syllabi, reading lists, etc., or at least a hard copy.

The Examination for Professional Practice of Psychology (EPPP)

All states and provinces require a passing score on the EPPP in order to sit for licensure. In the past, this test was taken after the doctorate, as is still the case for the vast majority of applicants. However, it is possible to take the test before the doctorate and the scores will still apply for licensure if you exceed the cut-off score. The dissertation year after the completion of all coursework might be a time to consider preparing for and taking the test.

The ASPPB Credentials Bank

As noted above, we recommend that you make use of the Association of State and Provincial Psychology Boards Credential Bank, a repository of licensure-related information (http://www.asppb.net/i4a/pages/index.cfm?pageid=3463).

The Credentials Bank is the best place to store vital information such as: all your course syllabi; ASPPB EPPP scores; transcripts; letters of recommendation; internship and postdoctoral experience hours; continuing education certificates, CVs, etc. Once archived, this information can be updated, accessed, and submitted to any psychology licensing board, employer, or other agency per your written request. The convenience of the"Bank" helps to reduce potential hassles associated with documenting compliance with licensure criteria, particularly long after one's training and initial licensure, or if you move to a different state. Get license-related letters of recommendation and certifications from internship staff and others when you finish working with them while they still remember vividly how wonderful you are.

ADHERENCE TO PROGRAM REGULATIONS

Students should be familiar with program requirements and regulations to ensure that you are meeting all requirements and milestones. In the event that changes are made in program requirements after the student enters the program, students have the option of meeting the new requirements or complying with the regulations in force when they entered the program. Please consult with your advisor and the Director of Clinical Training to assist you in making decisions in this regard.

APPENDIX F

Excerpts From the Graduate/Faculty Manual

Sexual Offenses

The University is committed to providing its faculty, staff, and students with an environment conducive to the pursuit of knowledge. Conduct constituting a sexual offense, whether forcible or non-forcible, such as rape, assault or sexual harassment, will not be tolerated.

Rape and other forcible or nonforcible sex offenses may result in a variety of disciplinary actions, including suspension or termination from the University. In cases involving an alleged sexual offense, the accuser and the accused are entitled to the same opportunities to have others present during a disciplinary hearing. Both the accuser and accused shall be informed of the outcome of any campus disciplinary proceeding as a result of an alleged sexual assault.

The University of Washington provides educational programs aimed at the prevention of sexual offenses and at reducing the likelihood of faculty, staff, and students becoming victims. The University Police, through its Crime Prevention Unit, offer a variety of programs and services on personal and property protection.

Standards of Conduct

A. The University is a public institution having special responsibility for providing instruction in higher education, for advancing knowledge through scholarship and research, and for providing related services to the community. As a center of learning, the University also has the obligation to maintain conditions which are conducive to freedom of inquiry and expression in the maximum degree compatible with the orderly conduct of its functions. For these purposes the University is governed by regulations and procedures which safeguard its functions, and which at the same time protect the rights and freedoms of all members of the academic community.

B. Admission to the University carries with it the presumption that students will conduct themselves as responsible members of the academic community. Thus, when the student enrolls in the University, the student likewise assumes the obligation to observe standards of conduct which are appropriate to the pursuit of academic goals. Stated in general terms, the student has the obligation to:

1. Maintain high standards of academic and professional honesty and integrity.

2. Respect the rights, privileges, and property of other members of the academic community and visitors to the campus, refraining from actions which would interfere with the University functions or endanger the health, safety, or welfare of other persons.

3. Comply with the rules and regulations of the University and its schools, colleges, and departments.

C. Specific regulations on student activities shall be in accord with these general standards.

Disciplinary Actions

A. Most disciplinary proceedings will be conducted informally between the student and the student's academic dean in matters relating to academic work, and between the student and the Office of Student Affairs in other matters. More formal procedures are provided, however, including an impartial hearing before the University Disciplinary Committee; these procedures may be invoked either by the officer dealing with the case or by the

student involved. In all situations, whether handled formally or informally, basic standards of fairness will be observed in the determination of 1) the truth or falsity of the charges against the student, 2) whether the alleged misconduct is in fact a violation of University standards of conduct, and, if so, 3) what sanctions should be imposed. The criteria for judging student misconduct shall be the general standards of conduct as stated in Section 1.

B. When questions of mental or physical health are raised in conduct cases, the dean, the Office of Student Affairs, or the University Disciplinary Committee may request the student to appear for examination before two physician-consultants designated by the Dean of the School of Medicine. The physician-consultants may call upon the Student Health Center for any other professional assistance they deem necessary. After examining the student, and consulting with the student's personal physician, the physician-consultants shall make a recommendation to the referring agency as to whether the case should be handled as a disciplinary matter or as a case for medical or other treatment. Decisions based upon these recommendations are the responsibility of the referring agency. Such decisions may be appealed.

C. In the case of student conduct which involves an alleged or proven violation of law, the disciplinary authority of the University will not be used to duplicate the function of civil authorities. Disciplinary action may be taken if the conduct also involves a violation of University standards and the interests of the University community are distinct from those of the civil authorities.

D. A student who has been judges to have violated University standards of conduct will be subject to disciplinary sanctions, up to and including dismissal from the University for the most serious offenses. In the case of students who are unmarried minors, such sanctions may be reported to parents or legal guardians at the discretion of the officer or agency taking the action expect that dismissal of a minor will always be reported to the student's parents or legal guardians.

Disciplinary Sanctions

1. Disciplinary Warning: Notice to a student, either orally or in writing, that the student has been in violation of University rules or regulations or has otherwise failed to meet the University's standards of conduct. Such warnings will include the statement that continuation or repetition of the specific conduct involved or other misconduct will normally result in one of the more serious disciplinary actions described below.

2. Reprimand: Formal action censuring a student for violation of University rules or regulations or the failure to meet the University's standard of conduct. Reprimands are always made in writing to the student by the officers or agency taking action, with copies to the Office of Student Affairs. A reprimand will include the statement that continuation or repetition of the specific conduct involved or other misconduct will normally result in one of the more serious disciplinary actions described below.

3. Restitution: An individual student may be required to make restitution for damage or loss to University or other property and for injury to persons. Failure to make arrangements to pay will result in cancellation of the student's registration and will prevent the student from re-registration.

4. Disciplinary Probation: Formal action placing conditions upon the student's continued attendance for violation of University rules or regulations or other failure to meet the University's standards of conduct. The office placing the student on disciplinary probation will specify, in writing, the period of probation and the conditions thereof, such as limiting the student's participation in extra-curricular activities. Disciplinary probation warns the student that any further misconduct will automatically raise the question of dismissal from the University. Disciplinary probation may be for a specified term or for an indefinite period, which may extend to graduation or other termination of the student's enrollment in the University.

5. Dismissal: If a graduate student's performance, or progress, or promise of completion of his or her graduate program is unsatisfactory, it is requested that advice and recommendations concerning the student be transmitted promptly to the Dean of the Graduate School who may send an appropriate letter to the graduate student relating to a change in his or her status.

Procedures for Review of Allegations of Academic and Scientific/Professional Misconduct

These procedures are for review of claims of academic misconduct such as cheating on tests, plagiarism, etc. as it pertains to coursework by psychology graduate students regardless of the department in which the course is housed, and professional/scientific misconduct such as plagiarism, data misrepresentation, violations of confidentiality, etc. Allegations of academic or scientific/professional misconduct by a graduate student in psychology will always be taken seriously. Student misconduct falls into two categories:

1. Allegations of academic misconduct such as first accusation of a small incidence of plagiarism or of sharing of information on course assignments when asked to act individually.

2. Allegations of serious academic misconduct such as blatant or premeditated cheating or extensive, repeated plagiarism by a Psychology Graduate Student or any allegation of scientific/professional misconduct.

Allegations of academic misconduct that fall into the first category will be reviewed by an ad hoc group made up of the course instructor, Psychology Graduate Program Coordinator (Director of Graduate Training), and the student's primary advisor. If the student wishes to petition the decision of this group, the case will be reviewed by the more formal procedures outlined below.

When alleged misconduct falls into the second category, the Graduate program Coordinator (Director of Graduate Training) and the Department Chair will appoint an ad hoc subcommittee of the Graduate Training Committee (GTC) to review the charges. This committee will be composed of three faculty members. The student under review may request that a student representative also be appointed to the committee. The student representative would be selected in consultation with the Graduate Program Coordinator and would be a non-voting member of the committee. GTC members from the student's area of study or who have direct research/training connections with the student whose conduct is under review cannot serve on the ad hoc committee.

Ad hoc committee members will review the evidence of the misconduct and may interview the faculty member(s) making the allegation, the student under review and any others who might have knowledge of the alleged infraction. All discussions and deliberations of the ad hoc committee shall be confidential unless and until there is a determination of misconduct that needs to be shared with others in the department, the Graduate School, or the dean or divisional dean of the College of Arts and Sciences. If the ad hoc committee finds that academic misconduct has occurred, it will determine the appropriate sanction for the behavior. Sanctions for academic misconduct may range from a written warning to the student to assignment of a failing grade on the assignment or in the course in which the transgression occurred. Sanctions for scientific/professional misconduct may range from report of the misconduct to dismissal from the program (following review by the College and by the University's Division of Student Life).

In all cases where fault is determined, a letter will be placed in the student's academic file noting the transgression and action and a copy forwarded to the student's primary advisor/committee chair and the head of the student's area of study. In the case of academic misconduct, the committee may indicate a sunset date for the letter mandating that the letter to be removed from the student's file at some future time point assuming no additional allegations of misconduct are received. Subsequent findings of academic misconduct would result in more serious consequences and could result in termination from the program (following review by the College and by the University's Division of Student Life). Letters indicating findings of scientific/professional misconduct will remain in the students file in perpetuity.

Students who disagree with the outcome of the department review may ask for review of the case by the College of Arts and Sciences Committee on Academic Misconduct:

(http://depts.washington.edu/grading/pdf/StudentInfo.pdf)

and/or the University's Division of Student Life Unit on Community Standards and Student Conduct:

(http://depts.washington.edu/cssc/conductoverview.html)

Student Academic Grievance Procedures

To provide internal mechanisms whereby graduate and undergraduate students at the University of Washington may address problems or grievances which are academic in nature, in an equitable and timely manner, it is the policy of the University that each of the schools and colleges shall develop and provide Student Academic Grievance Procedures.

See: http://www.grad.washington.edu/policies/memoranda/memo33.shtml

Procedures

A. When a question arises concerning an alleged violation by a member of the faculty of a rule or regulation of the University, its schools, colleges or departments, and informal preliminary inquiry appears warranted, such inquiry shall be undertaken by the appropriate chairman, dean, or by a special investigating committee of three faculty members chosen by the Chairman of the Faculty Council on Faculty Affairs and who are not directly involved in the questions being considered. The chairman, dean or special investigating committee shall first fully inform the faculty member of the nature and specific content of the alleged violation and next shall offer to discuss the question with the faculty member and with the party raising the question. The matter may be concluded at this point by the mutual consent of all parties in question.

   Any of the aforementioned parties may request the advice and mediation of the Advisory Committee defined in Section 25.62A.2 of the Faculty Code. The Advisory Committee, when so requested, shall consult privately with that party, may offer confidential advice, and shall attempt to effect a mutually accepted adjustment if possible.

B. If at any time prior to or during the informal inquiry the faculty member requests that formal proceedings be held, these shall be initiated by the Chairman of the above described Committee on Faculty Conduct within one month of the request or the matter shall be dropped. If the chairman, dean, or special investigating committee determines that the alleged violation is of sufficient seriousness to justify formal proceedings, charges shall be submitted to the Chairman of the Committee on Faculty Conduct who must begin proceedings within one month.

C. In the event that formal proceedings are conducted before the Committee on Faculty Conduct, such proceedings shall be in accordance with the principles for hearing procedures provided for the Tenure Committee in the Faculty Code, Section 25-62B, C, D, E, F.1-7, and F.10-13. A verbatim record of the proceedings shall be kept. The cost of such record shall be borne by the University. The Committee shall provide a copy of the proceedings to the faculty member and to the charging authority.

APPENDIX G

Financial Support, Tuition, and Fees

The latest information on financial aid is found in the Department's Graduate Program Manual. Changes that might occur after the printing of that manual and the Clinical Program Manual are communicated to students by the Graduate Program Administrator (Jeanny Mai). Jeanny should be consulted on any financial aid issue that you might encounter during the academic year.

TA AND RA POLICY

TA Assignment Procedures

Many of these procedures are now governed by the union contract between the UW and the graduate students' representative UAW. For details see: <http://www.washington.edu/admin/hr/laborrel/contracts/uaw/addons/>.

1. In the fall of each year, the Psychology Department surveys the courses to be taught in the following year and the grants pending and makes an estimate of the number of TA and RA slots likely to be available. This estimate is used, in conjunction with commitments already made to continuing students, in deciding how many new graduate students will be accepted for the following year. Definite offers of support are not made to new students until the funds for each position are assured.

2. Each quarter, all current graduate students and faculty are asked to state preferences for funding and assistance for the following quarter via Catalyst survey. Preferences for Autumn Quarter arecollected during Summer Quarter. New first year students serving as TAs are automatically assigneda course.

3. Make sure to submit the TA request Catalyst survey by the deadline listed when the quarterly request email is sent.

4. Based on stated preferences, and funding priorities (see Priorities, below), formal appointment offers are made for both TA and RA positions just prior to the beginning of the quarter for which they are effective. It is not possible to make these any further in advance primarily due to the uncertainty of course registration and research funds.

5. *Students on Probation.* If a student is on External Warn, Probation, or Final Probation status with the Graduate School, he or she cannot be a candidate for a TA Fellow or Lead TA position. If a student is on internal warn status, he or she can only be appointed to the Lead TA or TA Fellow positions after consultation with, and approval of, the student's advisor(s) and the Director of Graduate Training. After each meeting of the Graduate Training Committee (GTC), the faculty member in charge of recruiting and assigning the Lead TA and TA Fellow positions will be informed about students who are currently not in good standing (or are in questionable standing) in our program.

SUMMER QUARTER WARNING: The promise of support given to incoming students is for the regular academic year. Summer Quarter operates on a separate budget and is outside of this promise. Therefore, most students have to look elsewhere for summer support. It follows that the TA priority system, being based on the promise of a support letter, does NOT apply to Summer Quarter. The most important criteria in selecting for summer TAs are competence, instructor preference, and student preference.

There are only one-fourth as many Teaching Assistantships available during Summer Quarter as there are during each of the three quarters of the academic year. This does not include several courses taught entirely by senior graduate students. Hence, we can NOT give TAs to all those graduate students who request them for Summer Quarter. You should consult your advisor and the faculty member who heads your area for other possible sources of Summer Quarter financial support.

Graduate students who rely on TAs should, from the beginning of the year, work on alternative sources of summer support. If, for example, you are offered a Research Assistantship that supports you in some but not all of the four quarters, if possible, try to arrange for the RAship during summer quarter as one of those quarters

TA Assignment Priorities

Teaching Assistantship assignments are made near the end of the quarter prior to the actual appointment. This process requires students to complete a Catalyst survey on which they specify their requests for TA positions for the following quarter. TAs are then assigned courses by the Director of Graduate Training in collaboration with the Graduate Program Advisor and graduate student volunteers,according to the following criteria: a) the student's qualifications to teach the course, b) the student'spriority ranking (see below), c) the preferences of the instructor (from among qualified potential TAs) and of the graduate students (from among available courses), and d) the student's demonstrated teaching ability. The overriding consideration in assigning TAs is the quality and enhancement of instruction.

The following priority system is applied in the TA assignment process: Priority I First-year students who were given an explicit promise of support during that year as an inducement to enter the program. These students are top priority for TAs only in the Autumn, Winter, and Spring Quarters of their first year. In Summer Quarter, they are on a par with students in Priority II and III. Only Priority I students are guaranteed a TAship during the academic year. Priority II Second-, Third-, and Fourth-year students who were admitted with explicit promises of support or, who were later placed at this priority level by the faculty in their area or program, and who are not on Probation or Final Probation with the Graduate School. In some cases, Priority III students may be given preference over Priority II students in making TA assignments, e.g., courses requiring special knowledge or skills such as statistics or clinical seminars. Priority III Students who were admitted with no promise of support, students beyond their 4th year of study, and students on Probation or Final Probation.

An internal action, i.e., department watch or warn status, does not affect a student's priority level. As far as possible, student and instructor requests for positions will be matched within the guidelines shown above. Instructors and students are given up to six choices of requests for appointments. If the first choice request is not possible, an attempt is made to provide the second or third choice. As instructors are held responsible for the conduct of courses, every effort is made to provide them with the personnel they request. Any student who is assigned to a class that he or she did not request can contact the Director of Graduate Training to discuss the assignment or request a review of the assignment.

TA Evaluations and Priorities for Future TA Assignments: As the assignment of TAs is primarily to provide undergraduate teaching services, formal evaluation of students in terms of their competence as TAs will be considered in the making of future assignments. All TAs teaching quiz sections **must** be evaluated by the students in their classes. In addition, instructors will be requested to evaluate their TAs each quarter. Evaluations, along with formal letters of appointment for each TA, will be placed in a separate folder for each student and will be made available for review upon request.

Teaching Experience Requirement

Since the Psychology Department has required that students obtain teaching experience if they wish to receive recommendations for teaching jobs, students requesting TA positions who have not previously held such a position will have some priority over students who have been teaching regularly. This, of course, will be weighed with other factors, including the needs of the course in question.

Evening and summer appointments are of two general kinds: assistant to the instructor of the course in large classes or laboratories; or instructor of the course. In the former case, we restrict the level to the payroll rate determined by the student's progress in the program (look for salary levels under Appointment Ranks section, page 59). In the latter instance, we appoint the graduate student at the Pre-doctoral Teaching Associate II regardless of program status. For budgetary reasons, we are limited to a very small number of such positions to cover both kinds of appointments.

Research Assistantships

If a student is requested by the Principal Investigator (PI) and wishes to accept the appointment, that student will be awarded the RA position. This is done because PIs are responsible for the conduct of the research. If the PI does not have a particular request, students are sent by the Director of Graduate Training to interview for the position, based on the same priorities that are stated for assigning Teaching Assistantships. The RAs' responsibilities are to the PI and the respective research project providing the salary (which may or may not coincide with the student's own personal research interests). **These appointments should never be confused with fellowships that allow the student research freedom**.

Fellowships and Traineeships

Fellowships and traineeships which may be under Departmental control are awarded by the Chair, after consultation with appropriate faculty and as dictated by the conditions of the fellowship in question. Graduate students are encouraged to apply for any other advertised fellowship or traineeships for which they are eligible. Watch the Departmental newsletter, or your e-mail, for announcements of awards, internships, etc., being offered by other agencies. See information on-line at: <http://www.lib.washington.edu/gfis>. In many instances, all or part of the student's tuition and fees are paid by the fellowship or training grant. *Questions concerning payment of tuition should be clarified before the onset of the appointment.*

Appointment Ranks

The University has two main types of pay scales for TAs and RAs. They can be found in the general catalog under the graduate school appointment section or see:<http://www.grad.washington.edu/fellow/salaryschedule.htm> for a list of monthly salaries. Below is a summary of our most common appointment ranks

.

TAs RAs Appointment Status:

Predoctoral Teaching or Predoctoral Research Associate I (PDTAI, PDRAI): 1st year and up, until you pass generals

Predoctoral Teaching Predoctoral Research Associate II (PDTAII) OR PDRAII): Ph.C. (Candidate) Status Awarded, i.e., General Exam Passed

Predoctoral Instructor and Predoctoral Researcher to be determined

The Psychology Department petitioned and received permission to pay our students at a higher level than that of other departments on campus. This is called the variable rate scale and can be found at: <http://www.grad.washington.edu/fellow/salaryschedule.htm>. As a result, we now have only two (higher) pay levels. The first level will be paid to all students until such time as they pass their general exam. The second level will be paid to all students who have successfully passed the general exam to attain Ph.C. status. To clarify, the second level grade will begin the quarter the Ph.C. status is awarded by the Graduate School. If you complete your generals during a school break, your Ph.C. will be conferred at the end of the following quarter (that is, your raise won't go into effect for a full quarter). Please keep the quarterly deadlines in mind as you schedule your generals.

Your salary level as an RA is determined by the Principal Investigator (PI) of the grant budget funding your RAship. Factors affecting your salary level include your graduate student classification (see TA appointment ranks above), your duties on the project, and the amount of money available in the grant. Usually, faculty project directors budget sufficient funds to provide for the higher pay levels. You cannot, however, be paid more than your level justifies; you could be paid less. Discuss your salary level with the PI of the grant.

The funding level at which you are hired at the beginning of the quarter is in effect for the entire quarter ofyour appointment. If you become eligible for the second pay level during the quarter, you will not be promoted to the higher salary until your Ph.C. status is awarded and you hold a TA/RA appointment.

Standard Deductions from TA/RA Paychecks

1. Federal Withholding Tax on salary
2. "Medical Aid" (state accident/health insurance termed "Workingman's Compensation" to provide for on-the-job injuries.) This deduction is quite small so it is the least painful of these deductions. In cases of injury during the period of your service appointment, contact the Administrator (G-119), who has the appropriate claim forms.
3. Union Dues: All TA/RAs are obligated to pay union dues. These are automatically deducted for employees upon written authorization by the individual employee. Recognized payroll deduction authorization cards may be submitted to the Employer's Payroll Office. Importantly, students who are being paid hourly rates rather than TA/RA appointments may be eligible to stop making dues payments, but it is the sole responsibility of the employee to file a written notice with the Employer's Payroll Office and also to file written notice with the Union (Washington Federation of State Employees, 1212 Jefferson Street, Suite 300, Olympia, Washington 98501) thirty (30) calendar days prior to the effective day of the month following the 30-day period above. See the union contract for more details.

Standard Appointment Periods

Teaching assistantships, as stated earlier, are made on a quarterly basis only, and have arbitrary payroll dates which do not coincide with the actual instructional period of the quarter. These payroll periods are as follows:

Autumn Sept. 16 - Dec. 15 (3 months)
Winter Dec. 16 - Mar. 15 (3 months)
Spring Mar. 16 - June 15 (3 months)
Summer June 16 - Aug. 15 (TAs) or June 16 - Sept 15 (RAs)

The TA's responsibility is to the course and the instructor to whom he/she is assigned for the entire quarter which the above appointment periods represent, not to exceed 220 hours during the pay period hours and excluding the one week of vacation per payroll period as authorized in the union contract. There is now a provision for vacation which should generally be taken during quarter breaks. This does not carry over into future years.

Research assistantships can be for any period, but usually follow the quarterly dates as in the TA appointments. The standard practice is to make RA appointments for full or half months, although there is no regulation prohibiting the appointment for irregular periods, in which cases payment is computed on a daily basis from the monthly rate. However, the RA, unlike the TA, is expected to be on duty during the actual period of the appointment, not to exceed 220 hours and excluding the one week of vacation per payroll period as authorized in the union contract.
For further information please consult your union contract at
<http://www.washington.edu/admin/hr/laborrel/contracts/uaw/addons/>.

Qualifying for a Tuition Waiver: During Autumn, Winter, and Spring Quarters (the academic year) both RAs and TAs must be employed full time (20 hours per week) and be on the active payroll for at least five of the six pay periods in order to qualify for a tuition waiver. You must also be registered for a minimum of 10 credits per quarter to qualify – see below.

TUITION AND RESIDENCY

Tuition
Current quarterly resident and non-resident tuition and fees can be found at
<http://www.washington.edu/admin/pb/home/opb-tuition.htm>.

The figures for the current academicyear are as follows:

Below is information for the current (**2015-2016**) year. The rates and figures are subject to change. Estimates for 2016-2017 tuition and health insurance have not been released yet. Any changes made are expected to have only a marginal impact on the *total package* amount listed below. A financial offer from the Department of Psychology to a graduate student consists of TA or RA salary, tuition waivers, and health insurance.

» **Salary rate for service appointment as a TA or RA for 9mos (rates for 2015-2016):**

$2,333 per month in salary for a 50% FTE appointment, approximately 20 hours per week; the contract states that ASEs will "not be required to work for more than 220 hours per quarter." Summer quarter funding is not included unless the advisor has the funds to provide RA in summer. We do not guarantee a summer TA.

» **Tuition (rates for 2015-2016)**
Academic year (autumn, winter, spring)

Non-resident, full–time tuition (minimum of 10 credits/quarter; maximum of 18 credits/quarter):

$28,326 total tuition for three quarters
$2,025student fees paid by the student
Balance $26,301 tuition waived

Resident, full–time tuition (minimum of 10 credits/quarter; maximum of 18 credits/quarter):

$16,278 total tuition for three quarters
$1,527 student fees paid by the student
Balance $14,751 tuition waived

» **Health Insurance (2015-2016, 4 qtrs.)**

Information on the Graduate Appointee Insurance Program (GAIP) can be found online. :

http://www.washington.edu/admin/hr/benefits/insure/gaip/index.html

Summer quarter

If the student is enrolled over the summer and is appointed as a TA or RA over the summer, the service appointment salary rate shown above applies. Tuition is waived. The student is responsible for paying the respective student fees for the summer quarter. The minimum load over summer is two credits.

BOTTOM LINE:

Tuition waiver $26,301 for 9–month academic year, non–residents
TA or RA appointment salary $20,997 for 9–month academic year
Health insurance $4,298 student only for 12–month calendar year

Total package **$51,596**

Residency
If you are currently a non-resident who expects to be eligible for resident status after living here for at least one year, *please apply for residency during Spring Quarter of your first year*. This is essential for students appointed as teaching or research assistants during their graduate training. Each year the Department is allocated a limited number of non-

resident tuition waivers, almost half of which go to first year students. If the number of non-resident students with TA/RA support exceeds the number of waivers allotted, some graduate students will be required to pay full non-resident tuition.

To obtain resident status, you must submit a formal application. This process takes time and should be started early. The application is available on-line at <http://depts.washington.edu/registra/forms>. Many criteria must be met (such as registering to vote, obtaining a Washington State driver's license and registering your car.) A list of all the documents needed is available at: the following website: <http://www.washington.edu/students/reg/residency.html>. Residence applications and further information are also available at the Residence Classification Office, 264 Schmitz Hall (phone: 206-543-5932).

Due to restrictions in granting of residency to out of state "students" by the State of Washington, please pay careful attention to the distinction between stating that you reside in Washington solely for school versus with the intent to live in Washington for other purposes.

Payment of Tuition and Fees

One of the eligibility requirements for holding TA/RA positions is full-time registration of a minimum of 10 graduate credits per quarter. Exception: For Summer Quarter only, the minimum is 2 graduate credits. See: Registration Requirements chart on page 11. If you have a student loan you may be required to register for the full 10 credits during the Summer Quarter as well. If you are unsure, please check with Student Fiscal Services in Schmitz 129 and speak with a counselor.<http://f2.washington.edu/fm/sfs/>. Most of the tuition and fees will be automatically paid for any TA or RA who is appointed to a 50% or greater position (i.e., 20 hours or more per week). However, you will receive a bill for certain fees that must be paid by Friday of the third week of the quarter. Failure to pay these fees by the deadline will result in an additional "late payment fee" being assessed to your account. See the Academic Calendar or the General Catalog for deadlines and rates. http://www.washington.edu/students/reg/calendar.html. **EVEN IF YOUR TUITION BILL IS INCORRECT, BE SURE TO PAY THE REQUIRED STUDENT FEES PRIOR TO THE DUE DATE.**

SUMMER EMPLOYMENT AND SUPPLEMENTAL INCOME

The number of summer TA positions available is nearly one fourth of those available during the academic year. It is, therefore, important for graduate students to plan ahead for alternative funding in the form of RA, fellowship, or traineeship appointments, and even to prepare small research grant applications to such on-campus facilities as the Alcohol and Drug Abuse Institute, the Graduate School Research Fund, etc., by contacting their faculty advisors, training grant directors, and, in the case of grant applications, Susan Carpenter-Brandt, the Associate Administrator.

WAGNER TRAVEL GRANTS

Wagner Award travel grants to support clinical students' convention presentations are available through the Department. Simply send Jeanny Mai an e-mail indicating that a presentation has been accepted, the name and location of the convention, and the title and authors of the presentation (first authorship is preferential for funding). Indicate the airfare and lodging costs and other support you have for the trip. The Wagner Committee, chaired by the Director of Clinical Training, will review and authorize the maximum expenditure we can, depending on the number of requests and the current balance in the Wagner Fund. Typically, the allocated amounts are in the $400.00-$500.00 range. When authorized, complete the departmental application form, which can be obtained from Margaret Cheng.