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Contents

ACCESS AND EQUITY

When the Glass Ceiling Is Made of Concrete: What Causes the Progressive Nature of the "Leaky Pipeline" in Academia?

Julia M. Hormes, *University at Albany, State University of New York*

NOBEL LAUREATE Tim Hunt's much discussed and highly controversial 2015 comments about his "trouble with girls" in the laboratory renewed doubts about the extent to which overt sexism in science has truly been eradicated.[1] The account by two female researchers who were told by an anonymous reviewer that their work could be improved by involving men as co-authors is another recent example of seemingly persistent discrimination against women in academia.[2] Animated panel discussions at the 2014 and 2015 meetings of the Association for Behavioral and Cognitive Therapies (Conelea et al., 2015; Sockol et al., 2014) gave voice to widespread frustration with the challenges women face in pursuing traditional academic careers, resulting in the pattern of disproportionately frequent dropout of women in science and research that is often referred to as the

[1] See http://www.nytimes.com/2015/06/12/world/europe/tim-hunt-nobel-laureate-resigns-sexist-women-female-scientists.html for one example of news coverage of this story.

[2] See http://www.washingtonpost.com/news/speaking-of-science/wp/2015/04/30/sexism-in-science-peer-editor-tells-female-researchers-their-study-needs-a-male-author/ for one example of news coverage of this story.

[continued on p. 305]

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▶ *Erratum*

In the October issue of *the Behavior Therapist* (Vol. 39, issue 7, p. 226), we incorrectly identified one of the founders of ABCT in a photo caption. The corrected caption is below:

left to right: Andrew Salter, Leonard Krasner, Martin Gittelman, Joseph Wolpe, Edward Dengrove, Dorothy Susskind, Joseph Cautela, Arnold Lazarus, Cyril Franks

INSTRUCTIONS *for* AUTHORS

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

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"leaky pipeline" (Etzkowitz & Ranga, 2011; Gasser & Shaffer, 2014; Goulden, Mason, & Frasch, 2011; Leeman, Dubach, & Boes, 2010). Perhaps most important, these recent discussions reveal the many unanswered questions about the causes of the "leaky pipeline" and, in turn, effective ways to repair it.

Much has been said on the topic of women in academia in recent years and adding meaningfully to this debate is undoubtedly a challenge. The goal of this article is not to present a comprehensive overview of the literature on this subject, which has been provided elsewhere (Blickenstaff, 2005; Gasser & Shaffer, 2014). I will instead attempt to address the relative dearth of research that specifically focuses on the challenges female faculty face midway into a traditional academic career and suggest some solutions. The question I want to address is simple: Do women who wish to pursue a traditional academic career, are as qualified as their male colleagues, and put in the same amount of effort towards their professional pursuits have equal opportunities for long-term success in academia? If not, then what is getting in their way?

Why Focus on Female Faculty Midcareer?

Much of the writing on the experiences of women in academia has focused primarily on early career stages, including women's representation in graduate programs and their likelihood of earning doctoral degrees in various fields. At least on the surface there appears to be substantial progress: according to the National Center for Education Statistics, 51.4% of doctoral degree recipients in 2011 were women, a number that is projected to increase to 53.6% by 2022.[3] Women represent the majority of Ph.D. recipients in several of the social and life sciences, including psychology (Goulden et al., 2011): Between 2003 and 2013, the number of women earning doctoral degrees in psychology increased by 16.3% (compared to a 4.0% decrease in the number of men earning doctorates in psychology across that same time period).

Digging a bit deeper, however, things no longer look quite as rosy: overall, women remain underrepresented in the STEM fields (i.e., science, technology, engineering, and mathematics; Blickenstaff, 2005), and while women's representation in STEM fields—specifically at the Ph.D. level—increased for several years, it peaked at 28% in 2009 and has been declining ever since, a trend that is expected to continue over the next few years (Miller & Wai, 2015). Interestingly, women drop out of scientific degree programs at significantly greater rates than their male counterparts, even if they are equally or better prepared to achieve success (Blickenstaff, 2005). Studies suggest that women in postdoctoral positions report markedly lower confidence regarding their prospects of successfully securing a principal investigator position and obtaining tenure, compared to their male colleagues, in spite of a lack of significant gender differences in self-assessments of professional skills (Martinez et al., 2007). Unfortunately, the available data largely support this pessimistic outlook, with women who obtain a doctoral degree in the sciences being significantly less likely than men to move on to traditional academic positions (Committee on Gender Differences in the Careers of Science, Engineering, and Mathematics Faculty, Committee on Women in Science, Engineering, and Medicine, & Committee on National Statistics, 2009).

But the trouble only starts here. Overall, women are significantly more likely than men to drop out of careers in science both temporarily (e.g., due to family circumstances) and permanently (i.e., for a true career change), both in the U.S. and Europe (Blickenstaff, 2005; Corley, Bozeman, & Gaughan, 2003; Gasser & Shaffer, 2014; Martinez et al., 2007; Wolfinger, Mason, & Goulden, 2008). The leakage along the STEM pipeline has been referred to as being both persistent and progressive, meaning that significantly fewer women than men remain in STEM careers the further along the pipeline we go (Blickenstaff, 2005; Cronin & Roger, 1999). This pattern is glaringly apparent in the social sciences, where women represented over 50% of doctoral degrees earned between 1991 and 2001, but make up just over 40% of assistant professors, around 35% of associate professors, and 20% of full professors in the field (Mayer & Tikka, 2008). In psychology, women's relative representation similarly decreases incrementally in the transition from assistant to associate to full professor (Sockol, McGinn, & Newman, 2016).[4]

Looking more closely at the pattern of dropout of women researchers, it appears that women face significantly more obstacles to advancement at each stage of promotion, compared to their male colleagues. Women are more likely than men to leave academia prior to obtaining tenure (Goulden et al., 2011), and 21% less likely than men to be awarded tenure (Wolfinger et al., 2008), even if they have comparable credentials (Bonawitz & Andel, 2009). As a result, only 48% of female full-time faculty members are tenured, compared to 68% of their male colleagues (Wolfinger et al., 2008). For reasons that I will attempt to explore in more detail below, women are also significantly more likely than men to never enter the tenure track in the first place, instead accepting "off ladder" academic appointments, for example as instructors and visiting or part-time faculty (Bonawitz & Andel, 2009; Stack, 2004).

Women across all academic fields are significantly less likely than men to be promoted to full professor and make up only about a quarter of faculty at this career stage (Misra, Lundquist, Holmes, & Agiomavritis, 2011; Wolfinger et al., 2008). Remarkably, the percentage of female full professors in psychology nearly tripled between 1985 and 2013; however, at 34% it remains significantly below the number of men represented at this career stage.[5] Given that women have been earning doctoral degrees at rates comparable to men for several decades now, we can no longer attribute these discrepancies simply to a delay in this cohort of women reaching more advanced career stages. If women do achieve promotion to full professor, it takes them on average 1 to 3.5 years longer to get there, compared to their male colleagues (Buch, Huet, Rorrer, & Roberson, 2011; Misra et al., 2011). The absence of women at the full professor level, in turn, results in a lack of representation of women in institutional leadership and other influential, decision-making positions (Buch et al., 2011). Women's disadvantages when it comes to being promoted to senior positions remain significant even when controlling for their graduate institution, year in which they earned their graduate degree, field of study, race, and quality and quantity of published research (Corley et al., 2003). Gender differences are therefore not simply due to men being more qualified or

[3] Data accessed at https://nces.ed.gov/programs/digest/d12/tables/dt12_310.asp on July 24, 2015.

[4] http://www.apa.org/monitor/2014/10/datapoint.aspx, accessed on August 10, 2015.

[5] http://www.apa.org/monitor/2014/10/datapoint.aspx, accessed on August 10, 2015.

productive, but appear to be due to other obstacles that disproportionately affect women (Misra et al., 2011).

So the question is: What exactly are these obstacles? A 2005 review of 30 years of literature on the subject of women in academia identifies a long (and, at times, controversial) list of potential causes of unequal representation of women specifically in the STEM fields, including biological differences between men and women, girls' lack of academic preparation for a degree and career in science, a lack of positive early experiences with science, an absence of female role models in science and engineering, and science curricula and pedagogy that favors male students (Blickenstaff, 2005). Aside from lacking empirical support in many cases, it is quite striking that none of the hypotheses put forth in this review account specifically for women dropping out of academia well into their career, a point in time at which they have already proven their interest, motivation, and skill. Similarly, many of the proposed solutions (e.g., ensuring equal access to classroom resources, eliminating sexist language in printed teaching materials, increasing depth and reducing breadth in introductory courses) do not offer a remedy for keeping women from leaving academia at more advanced stages in their professional development. In an attempt to explain the progressive nature of the "leaky pipeline," I will explore evidence in favor of two hypotheses to explain the disproportionate numbers of women dropping out of academia at later career stages, implicating (a) the role of family formation versus (b) unfavorable institutional culture and practices.

The Impact of Family Formation

"*Irrespective of marriage and children, women remain less likely to get tenure and less likely to get promoted to full professor*." (Wolfinger et al., 2008)

One of the most common explanations offered to account for the "leaky pipeline" are cultural pressures on women to conform to traditional gender roles, leaving them to face competing demands of a career and responsibilities as spouses and mothers (Wolfinger et al., 2008). In spite of seemingly offering greater flexibility than most careers, conflict between personal and professional obligations is intensified in academia, where any boundaries between "the office" and home are blurry and work is largely open-ended, resulting in long hours and significant psychological strain (Hogan, Hogan, Hodgins, Kinman, & Bunting, 2015; Misra, Lundquist, & Templer, 2012). A growing body of research suggests that women experience greater work-life conflict compared to men (Catano et al., 2010), especially if they are mothers (Tausig & Fenwick, 2001). But does greater conflict necessarily translate into lowered productivity?

Perhaps surprisingly, marriage appears to impact women academics more favorably than men, with married women generally being as productive or more productive than their single counterparts, while unmarried men in academia tend to report the lowest rates of research productivity (Fox, 2005). Marriage increases both men and women's chances of promotion to full professor by 23% (Wolfinger et al., 2008). Gender was found to be largely unrelated to research productivity in the social sciences, unless women had very young (i.e., preschool age) children, in which case their research productivity was somewhat lower (Stack, 2004). Studies suggest that married women in the sciences overall tend to publish more than their single counterparts even when they had children (Fox, 2005), though they are significantly less likely to have their work funded by federal grants or contracts, compared to their single or childless colleagues (Goulden et al., 2011). When controlling for structural factors, such as characteristics of the home academic institution; individual characteristics, such as organizational ability; and the presence of competing demands, for example from administrative roles, researchers concluded that "children are not a strong predictor of productivity, but the influences that they do have followed a gendered pattern," a trend that appears largely attributable to gendered norms regarding child-rearing responsibilities, which continue to place a larger proportion of the burden on women (Stack, 2004).

In spite of what could at best be described as weak relationships between marriage, motherhood, and research productivity, in particular in the social sciences, women are significantly less likely to pursue and be hired for tenure-track positions if they are married or have children, as opposed to men, who benefit in their job search from having a family (Ginther & Kahn, 2006; Misra et al., 2012; Wolfinger et al., 2008). In fact, women in the sciences who are married with young children are 35% less likely to enter a tenure-track job, and 27% less likely to earn tenure, compared to married men with young children (Goulden et al., 2011). Women who have children within 5 years of obtaining their doctorate degree are especially unlikely to be awarded tenure (Mason & Goulden, 2002).

Taken together, these data suggest that the stereotype of women distracted from their professional pursuits by familial obligations is persistent, in spite of an absence of compelling empirical evidence to support it. There is, however, data to suggest that these perceptions adversely impact women in academia, who are significantly more likely to either delay marriage and motherhood or to not to get married or have children at all, compared to their male colleagues or women in other professions (Blickenstaff, 2005; Bonawitz & Andel, 2009; Fox, 2005; Goulden et al., 2011). The anticipation of major conflicts between career aspirations and the desire to form a family makes some women reluctant to pursue an academic career in the first place (Martinez et al., 2007); among those who do, a striking 38% report regretting not having had more children (including those who never had any children), compared to only 11% of male academics.[6]

The Role of Institutional Culture and Practices

"*In academia, the proverbial glass ceiling hindering women's professional progress is not made of glass at all. It is made of concrete*." (Bonawitz & Andel, 2009)

A growing body of research suggests that the underrepresentation of women in academia is due to a complex set of institutional and other structural factors that interact to selectively filter out women along the pipeline (Blickenstaff, 2005; DiPrete & Eirich, 2006). Unequal treatment of women is no longer overt (Blickenstaff, 2005); instead, "most women scientists are discriminated against in a series of small events that contribute to a significant cumulative disadvantage for career advancement within academe" (Corley et al., 2003). Thus, the glass ceiling has not been shattered; instead, it appears to simply have been raised further towards the top of the ivory tower (Misra et al., 2011).

Many subtle forms of discrimination against women in the academy, such as low perceived authority and credibility, snide comments, or exclusion from departmen-

[6] http://chronicle.com/article/The-Pyramid-Problem/126614/

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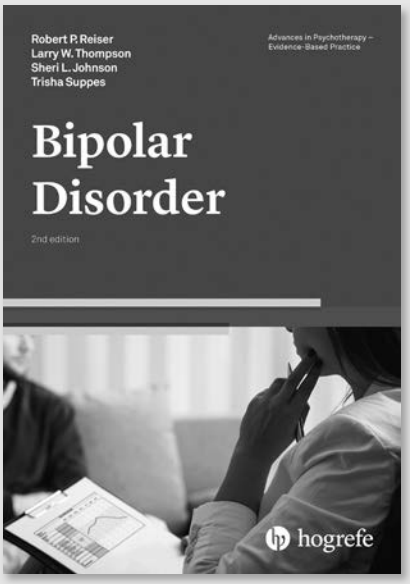

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tal and other institutional decision-making, can be difficult to quantify, but nevertheless take a significant emotional toll (Gardner, 2013; Hirshfield & Joseph, 2012). Discrimination against women scientists when it comes to the recognition of their work in the form of promotions and salary increases, on the other hand, has been widely documented in the literature (Corley et al., 2003). Striking data reported by the Association of American Colleges and Universities suggests that the average salary for female full-time faculty in 2009–2010 was 81% of that for men, the exact same that it was in 1975–1976![7] Female faculty are also more likely to have their research trivialized (Gardner, 2013). Such lack of recognition may discourage women from putting efforts towards research, publication, and attempts to secure external funding.

Discrepancies between male and female academics in research productivity, in particular in publication records, are often cited as the main reason why women are less likely to be tenured (Wolfinger et al., 2008). For example, female faculty (either tenured or in tenure-track positions) at doctoral-granting academic institutions were found to produce an average of 8.9 papers in a 3-year period, compared to 11.4 for their male colleagues (Fox, 2005). However, data also suggest that women's publications are often of higher quality than those of their male colleagues, as reflected in overall higher citation counts (Cummins, 2005), a fact that tends to not weigh as heavily in decisions about tenure and promotion.

Literature increasingly suggests that women experience unequal treatment in multiple areas related to their involvement in research, teaching, and service, including the relative time they spend on activities related to each domain: while most studies find few to no differences in total work hours between male and female academics, women consistently report spending significantly more time—either by choice or out of necessity—on service and teaching, compared to men, who spend significantly more time on research (Gardner, 2013; Misra et al., 2012). In the following I will highlight three areas of inequity, resulting in reduced chances for women to achieve tenure and promotion, and accounting at least in part for the progressive nature of the "leaky pipeline": disparities in grant funding, service obligations, and teaching evaluations.

Discrepancies in Grant Funding

Significant gender disparities in grant funding, a major factor in decisions about tenure and promotion, especially at R1 institutions, have been widely documented (Goulden et al., 2011). For example, female applicants receive on average only 63% of the grant money awarded to male applicants by the National Institutes of Health (NIH), a major source of funding for research in psychology (Hosek et al., 2005). Women are especially underrepresented among recipients of large-scale NIH grants, representing only 13% of recipients of the top 1% of awards made. These figures control for age, academic degree, institution, grant type, institute, and application year (Hosek et al., 2005).[8]

Interestingly, the pattern of grant funding awarded to women parallels the "leaky pipeline" of their overall career trajectory: women receive a significantly larger proportion of NIH and National Science Foundation (NSF) predoctoral fellowships, compared to postdoctoral fellowships and faculty research grants, which are predominantly awarded to men (Goulden et al., 2011). While there are no significant differences between men and women in the likelihood of receiving a grant prior to completion of graduate training, or in the average latency of first grant obtained, the median size of the first grant awarded to men is significantly greater than funding obtained by women in their first successful application (Corley et al., 2003). Across the course of their careers, men are awarded almost twice as many grants as their female counterparts (Corley et al., 2003), and grants awarded to male faculty continue to be larger and of longer duration than awards made to women (Etzkowitz & Ranga, 2011).

Women make up around a quarter of grant applicants to NIH and NSF (Hosek et al., 2005), and in 2007, they represented 25% and 23% of recipients of competitive faculty grants awarded by the two agencies, respectively (Goulden et al., 2011). It is thus tempting to conclude that discrepancies are simply due to women not applying for grants to the same extent as their male counterparts. Indeed, compared to their male colleagues, women researchers have been shown to apply for fewer grants, to request smaller amounts, and to be significantly less likely than men to reapply for NIH and NSF grants (regardless of the outcome of the first application) within 2 years of their initial submission (Etzkowitz & Ranga, 2011; Goulden et al., 2011). This discrepancy could be due to women being inherently less motivated or productive (though data cited earlier should serve to refute this hypothesis), or more likely to be discouraged by criticism or rejection. But there is also the very real possibility that women face significantly more competing professional demands than men that prevent them from dedicating sufficient time to activities that will directly advance their research, and, as a result, their career.

Inequity in Expectations for Service Participation

Demands on junior faculty preparing for tenure review are significant and routinely include multiple new course preps, high expectations for research productivity, including publications and grant funding, and long hours put towards building a laboratory and recruiting and supervising graduate and undergraduate students. While most universities explicitly state that they seek to protect junior faculty from extensive service obligations, data suggest that these protections may not extend equally to men and women. Instead, studies fairly consistently show that female professors at all stages of their careers are disproportionately burdened with service obligations (McLaughlin Mitchell & Hesli, 2013). Discrepancies in service obligations appear to specifically disadvantage women at the associate level, who were found to engage in markedly more service work than their male colleagues at the same career stage, as well as the male and female full professors in their departments (Misra et al., 2012).

Gendered norms continue to put disproportionately more women in service roles that are generally devalued, such as serving as undergraduate advisors (Misra et al., 2011), while men are more likely to be asked to fill highly respected positions, for example as department and committee chairs or directors of academic programs (McLaughlin Mitchell & Hesli, 2013). An unfortunate consequence of the underrepresentation of women in many academic fields is that they are disproportionately involved in "token" service—for example,

[7] http://archive.aacu.org/ocww/volume39_1/feature.cfm?section=2, accessed August 10, 2015.

[8] No comparable gender biases were detected in the pattern of grants funded by the National Science Foundation or the United States Department of Agriculture.

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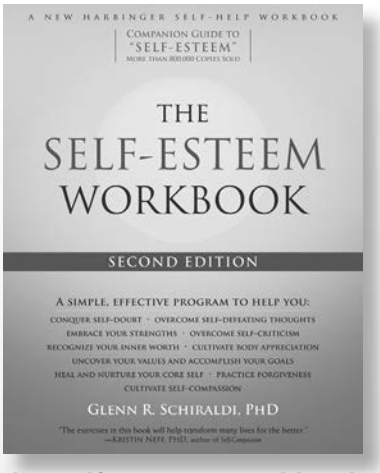

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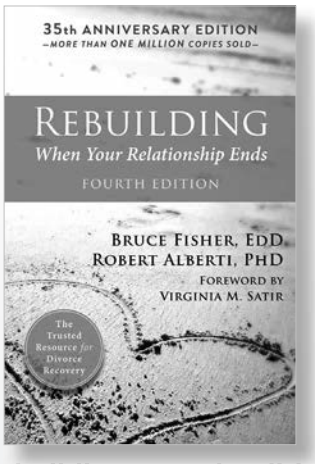

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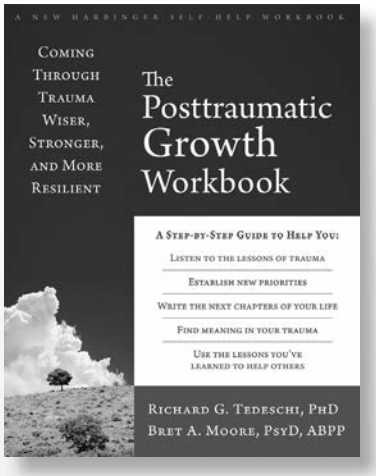

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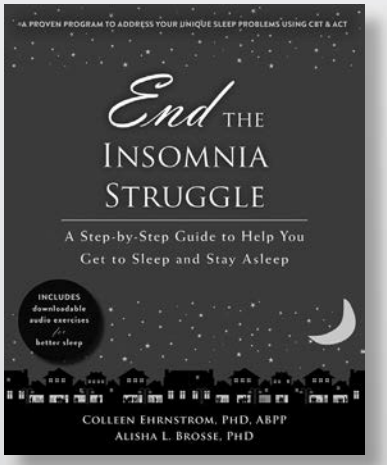

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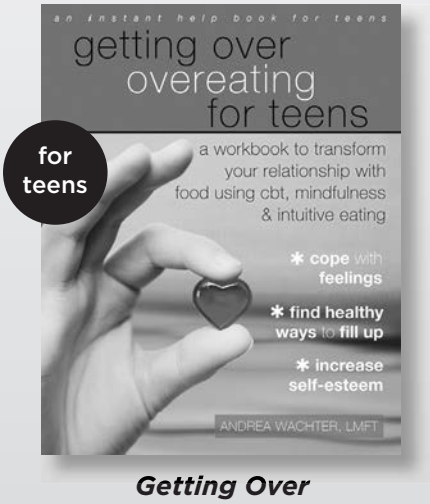

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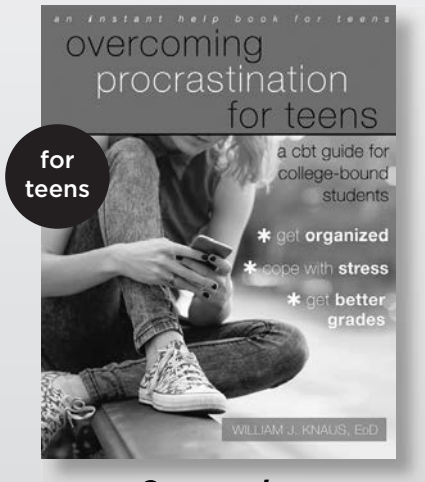

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by being asked to serve on committees simply in order to represent the "female perspective" and assure diversity, a fate that is shared—often to an even greater extent—by ethnic and racial minority faculty (Delapp & Williams, 2015; Hirshfield & Joseph, 2012; McLaughlin Mitchell & Hesli). The types of service activities women typically take on are thus both more time-consuming and less respected, especially when it comes to decisions about tenure and promotion (McLaughlin Mitchell & Hesli). Women are not only asked more frequently to take on service obligations, but may also be punished more severely if they turn down requests for service participation: men who refuse such requests are seen as assertive, women risk being branded as uncooperative.

Biases in Teaching Evaluations

Women, on average, are assigned heavier teaching loads and consequently spend more time on teaching-related activities (Gardner, 2013). In addition, evidence suggests that the evaluation of women's efforts in the classroom is subject to significant biases, putting them at a disadvantage in decisions about tenure and promotion in the absence of actual deficits in their skills and abilities as instructors. A 2015 study cleverly circumvented the potential influence of actual gender differences in teaching style or effectiveness on student evaluations by comparing students' ratings of instructors in four sections of an online course, two taught by a male instructor and two led by a female instructor. Students in two of the sections were given incorrect information about the identity of their instructor, allowing the researchers to compare the influence of actual versus perceived instructor gender on student evaluations (MacNell, Driscoll, & Hunt, 2015). There were no significant differences in *actual* performance between the male and female instructor (as illustrated by comparisons of ratings from the two sections actually taught by a female versus male instructors). A comparison by *perceived* gender identities of the instructors, however, revealed striking discrepancies, with students who believed they were taught by a female instructor (even though only half of them actually were) assigning their instructor significantly lower overall ratings and scores on items assessing "professionalism, promptness, fairness, respectfulness, enthusiasm, [and] giving praise" (MacNell et al., 2015). For example, both male and female instructors posted grades after 2 days, resulting in a mean rating of 4.35/5 on "promptness" for the (perceived) male instructor, compared to a rating of 3.55/5 for the female instructor. Similarly, the female instructor was rated as 3.50/5 on "fairness" in assigning grades, compared to a 4.26/5 rating for the male instructor, even though both used the same grading rubric and there were no significant differences in the average grades for each of the sections (MacNell et al.). The study authors concluded that "the combination of higher expectations and lower automatic credibility translates into very real differences in student ratings of female versus male instructors." Male instructors are almost automatically perceived as credible, professional, and effective experts, while their female colleagues are primarily expected to excel in the interpersonal domain (though they are not actually rewarded with higher ratings when they exhibit traits such as being "caring," "helpful," or "respectful"; MacNell et al.).

Where Do We Go From Here?

"*Research on institutional values and norms points to gender inequalities in academia which are deeply rooted in the academic culture itself, its symbolic practices, and career constructions.*"
(Leeman et al., 2010)

Policy Changes

An increase in awareness of more or less subtle biases in the treatment of female faculty is certainly a first step towards remedying the issue. But are there more concrete steps we can take to implement fundamental change? The "leaky pipeline" is by no means unique to academia, and similar patterns of women disproportionately dropping out of careers before reaching the top of the ladder can be observed in the business world, where women currently enter the workforce at about the same rate as men, but occupy only a small fraction of leadership positions (Cabrera, 2009). Many of the steps that have been suggested as remedies for this inequity—including flextime or the ability to telecommunicate (Cabrera, 2009)—are already inherent in the "academic lifestyle" and unlikely to remedy female academics' disadvantages.

An example of a policy change that seems like it should be highly effective in promoting women in academia—especially if one does believe in family formation as an obstacle to career advancement—is the implementation of more generous paid parental leave. The U.S. remains one of a very small minority of countries in the world that does not mandate paid parental leave (though academia is generally considered to offer some of the more progressive, family-responsive maternity leave policies). While research suggests a positive link between the availability of maternity leave and women's advancement into senior positions in the business world (Cabrera, 2009), it is worth noting that women are no more equally represented in tenure-track academic positions in countries with more liberal leave policies (i.e., Finland and Sweden), compared to the U.S. (Mayer & Tikka, 2008). This suggests that changes in family policies may have limited effectiveness in increasing female representation in the academy (Mayer & Tikka). Given the unforgiving "lock-step structure" of academia, reentry into a research career following extended leave times is difficult and it is no surprise that early interruptions or short-term absences predict women leaving careers in science altogether later on (Corley et al., 2003; Goulden et al., 2011).

Many of the current public policies aiming to promote women scientists (such as tenure-clock extensions or on-campus child care) are thought to have been largely ineffective, in part because they are often not informed by longitudinal research data or policy analysis (Corley et al., 2003; Goulden et al., 2011). Indeed, it has been suggested that the obvious disparity between formal organizational policies designed to promote equity and the reality of unfair treatment of women can cause an uncomfortable state of cognitive dissonance in female faculty (Kjeldal, Rindfleish, & Sheridan, 2005). Furthermore, many of the policies that have been put into place in recent years specifically attempt to improve the situation of women with families. Single, childless women remain a largely understudied group who are thought to be at a significant disadvantage, facing the same obstacles as women with families, without being able to benefit from many of the policies designed to promote female faculty (Cummins, 2005).

Bonawitz and Andel (2009) offer a number of concrete steps women can implement in order to enhance their chances of obtaining tenure and promotion, and specifically encourage women to turn down "extraneous and gendered" requests for service unlikely to be highly valued in favor of professional service within national societies or as part of the editorial or review staff of professional

journals. They note that active collaboration with other women and the availability of mentors who represent the interests of junior women faculty can make it easier to actively fight unequal treatment such as inequities in service expectations (Bonawitz & Andel).

As described earlier, research points to the presence of a real and marked gender bias in student evaluations of teaching that puts female faculty at a significant disadvantage, even when they actually perform as well or better than their male colleagues in the classroom. Until we develop more objective assessments of teaching effectiveness, active efforts need to be made to account for this inequality in teaching evaluations as women come up for tenure review and promotion (MacNell et al., 2015). In light of studies to suggest that women prefer a teaching style that involves less lecturing and more discussion and is thus more suitable to smaller classroom settings (Centra & Gaubatz, 2000), equity in teaching assignments is another important step towards leveling the playing field for women in decisions about tenure and promotion.

Addressing inequity in grant funding is an especially complex challenge and requires active efforts on the part of both academic institutions and funding agencies. The need for a centralized database maintaining records of scoring and funding decisions, along with demographic information on principal investigators in identifying and combatting systematic bias against women, has been highlighted in recent writing on the subject (Hosek et al., 2005). Universities can actively support female faculty by providing truly protected time to be devoted towards the development of competitive grant applications. The importance of accessing professional networks in competing successfully for funding cannot be overstated, and senior colleagues can provide active support and mentorship to female faculty by serving as consultants and collaborators on grant applications.

Finally, it has been suggested that women's difficulties in obtaining promotion to full professor are in part due to the lack of specific criteria for promotion at this stage of their career (relative to expectations for obtaining tenure, which are often more explicitly stated), which opens the door for subtle discrimination that is difficult to identify, and even harder to combat (Fox & Colatrella, 2006). Indeed, women are significantly more likely than their male colleagues to agree that criteria for promotion to full professor at their institution are unclear, and markedly less likely to report having received guidance from their chairperson while going through the promotion process (Buch et al., 2011). There is thus a clear need for more transparency when it comes to expectations for promotion beyond the tenure review stage (Buch et al.).

Implementing Cultural Change

Formal policies and procedures designed to promote gender equity in academia can only be successful if they are accompanied by a change in informal practices and organizational culture (Kjeldal et al., 2005). In other words, we need to challenge the status quo in the academy. Linear progression through a series of predetermined steps, adherence to fairly rigid sequential deadlines, and a willingness to be "geographically flexible" have tradition-

ally been a requirement in the pursuit of an academic career, forcing aspiring faculty to move multiple times over the course of their careers to start graduate school, match for internship, move on to a postdoctoral position, and accept a first tenure track appointment (Etzkowitz & Ranga, 2011; Goulden et al., 2011; Wolfinger et al., 2008). In order to be successful, women must adhere to this antiquated and largely male model of professional success, often at a high cost to their personal lives. It is difficult to remain flexible, especially when others, such as a spouse, children, or aging parents, are increasingly involved and affected by such decisions. Women in particular may be likely to pass on opportunities that would advance their career in favor of jobs that are convenient, rather than optimal, in order to be able to stay put in one place (Leeman et al., 2010; Wolfinger et al.). That, in turn, may lead to greater career dissatisfaction down the road, increasing the risk of them dropping out of academia altogether. The data largely support this assumption: compared to women, men in intramural postdoctoral positions at the NIH are twice as likely to indicate that they expect their partner or spouse to make sacrifices to their career in order to facilitate their professional development (Martinez et al., 2007). Women in academia are significantly more likely than their male counterparts to have spouses or partners with doctorates and working in science and research, leaving them more likely to face the "two-body problem" and thus at increased risk of abandoning a traditional academic career in favor of their partner's professional development (Corley et al., 2003; Fox, 2005; Wolfinger et al.). Interestingly, the requirement to move geographically as one moves up the career ladder is somewhat unique to the U.S., with at least some European countries more routinely promoting Ph.D.s within the institution where they received their doctorate degree (Mayer & Tikka, 2008), thereby providing a template of how things could be done differently to better accommodate women in academia.

The successful pursuit of an academic career is a social process that is heavily dependent on the recognition, integration, and promotion of junior faculty by their more senior colleagues (Leeman et al., 2010). For example, collaboration in publishing has been shown to significantly strengthen female graduate students' chances on the academic job market following graduation (Corley et al., 2003). Research suggests that women are disproportionately excluded from the scientific discourse, especially when it comes to more informal communications, thereby limiting their ability to network and build social capital, and leaving them at a disadvantage when it comes to opportunities for career advancement (Etzkowitz & Ranga, 2011). Thus, one of the most important solutions to the problems described here is for women pursuing a career in academia to have access to (and be encouraged to make use of) mentors who serve both as role models and advocates on their behalf. Research consistently shows that female doctoral students are especially discouraged by the lack of role models of women who successfully combine work and family. The need for mentoring remains critical as women advance through the pipeline, with one study reporting that only about 12% of women at the associate level have access to a mentor, but over 70% stated a desire for continued guidance (Buch et al., 2011).

The underrepresentation of women in many academic fields has been described as a sort of self-fulfilling prophecy: low numbers of female faculty signal to women applicants that they are not welcome or unlikely to succeed, thereby maintaining low numbers (Blickenstaff, 2005). The importance of having women who are succeeding in academic careers to serve as role models, actively mentoring and supporting those more junior, cannot be overstated. However, after arguing that they are already disproportionally burdened by "token" service obligations that do not directly advance their careers, it feels hypocritical to place the onus of plugging the "leaky pipeline" primarily on women themselves. Recent research indeed suggests that many female professors resent the automatic expectation that they serve as mentors to female students, simply because of gender concordance (Hirshfield & Joseph, 2012).

Until more women are represented in associate and full professorships, much of the burden of plugging the "leaky pipeline" thus falls to our male faculty. It is imperative that men step up to the plate to take on a more active role in supervising, mentoring, and promoting female trainees and junior colleagues. Unfortunately, there appears to be much room for improvement: Male principal investigators at the top of their field in the life sciences are currently significantly less likely to employ and train women than men (Sheltzer & Smith, 2014). It is tempting to assume that this is simply due to a lack of qualified female applicants, but data instead point to a clear bias against hiring women. For example, in a study of faculty in biology, physics, and chemistry, a (fictitious) female undergraduate applicant for a laboratory manager position was rated to be significantly less competent and offered a significantly lower starting salary and less career mentoring, compared to a male applicant with identical application materials and credentials (Moss-Racusin, Dovidio, Brescoll, Graham, & Handelsman, 2012). Interestingly, female raters exhibited the same bias as their male colleagues, suggesting that women in academia may be equally guilty of perpetuating cultural stereotypes about women's relatively lower science competence (Moss-Racusin et al., 2012). It has been suggested that a more formalized (or perhaps even centralized) application process for graduate school and postdoctoral positions (akin to the "match" process used to place students in predoctoral internships) may be a first step in increasing transparency and thereby alleviating bias against women at all stages of professional development (Sheltzer & Smith).

Final Thoughts

To conclude, I want to make sure to note that there are problems with the metaphor of the "leaky pipeline," which seems to imply that the "drops" exiting the pipeline should automatically be considered failures when there is in fact relatively little known about what happens to women who leave traditional academia for alternative career paths (Etzkowitz & Ranga, 2011). It has been suggested that the term "vanish box" more accurately captures the idea that women leaving academic careers often reappear to effectively apply their skills and talents in novel contexts (Etzkowitz & Ranga).

Finally, I want to emphasize the critical role of professional societies in paving the way for equal opportunities for women in academia. Organizations like ABCT have and continue to make invaluable contributions to this cause by providing comprehensive data on the status of women in academia, promoting women into leadership positions, and offering opportunities for professional networking and access to mentors and role models. The significant and encouraging progress that women have made as members and leaders of ABCT has been described recently (Sockol et al., 2016). My hope is that the data presented here will add to the conversation about the challenges female faculty face at

all career stages, and that ABCT and *the Behavior Therapist* will continue to provide a forum to raise awareness and foster discussion of this important issue.

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Putting Our Multicultural Training Into Practice: Assessing Social Anxiety Disorder in Sexual Minorities*

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MULTICULTURALISM HAS BECOME increasingly important in behavioral health services and a focus in training programs. Various models have been developed to define multicultural competency (Newell et al., 2010; Sue, 1997) and numerous professional associations have issued guidelines for research, practice, and training (e.g., American Psychological Association, 2003). Many of these proposals follow Sue's (1991) model that multicultural competence includes *attitudes and beliefs*, *knowledge*, and *skills* for working with cultural groups different from one's own. We recently extended Sue's model to identify the choice points for clinical psychology programs that wish to include multicultural competency for sexual minorities in their training program (Hope & Chappell, 2015). In that paper, we described the importance of infusing multiculturalism across the curriculum, including in practice and research training. In this paper, we will illustrate how we have put those recommendations into practice in our lab.

One aspect of good multicultural awareness is to consider whether standard assessment procedures are a good cultural fit with a given client or research participant. For example, Chapman and colleagues (Chapman, DeLapp, & Williams, 2013a, 2013b) have identified how individuals from non-White ethnic backgrounds may score differently on measures of social anxiety that affect assessment and treatment plans. Their work highlights the need to consider whether the development of the tool or procedure included individuals who share our clients' or participants' experiences and cultural identities. Using our multicultural knowledge, we can consider whether a measure may yield inaccurate data because of a poor cultural fit. We can identify obstacles that may lead to disengagement from the assessment process (e.g., Croizet et al., 2004), leading to poorer outcomes. The idiographic tradition in behavior therapy and behavioral analysis is very compatible with good multicultural practice. The emphasis on precise measurement of the behavior of interest in a specific context should automatically include cultural considerations. However, even a quick perusal of the ABCT convention program or treatment manuals produced by ABCT members reveals that many of us rely on nomothetic assessment procedures as well.

Typically, nomothetic assessment procedures, such as self-report and interview measures, have undergone extensive development and validation, leading us to use them without looking at specific items or scoring procedures. For self-report measures, in particular, it is easy to administer and score them without examining responses to specific items or checking whether they are appropriate for the client or research participant. Many clinics and laboratories now administer and score questionnaires electronically, making it even less likely that specific items will be reviewed. An example of how this can be problematic is the use of some self-report measures for social anxiety with sexual minorities.

For many years, we and many other clinicians and researchers have administered measures of social anxiety that include items that assume heterosexuality and a binary gender, making them inappropriate for individuals who identify as lesbian, gay, bisexual, or transgender/gender nonconfirming. For example, the Interaction Anxiousness Scale (Leary, 1983) asks participants to rate the phrase "I often feel nervous when talking to an attractive member of the opposite sex." The Social Avoidance and Distress Scale (Watson & Friend, 1969) asks participants if "I am usually at ease when talking to someone of the opposite sex." Over the years, we have handled this issue in various ways, including just ignoring it, telling the client to switch it to same-sex if that was who they would date, or altering the wording to be more inclusive for a particular client or study. Other researchers have made similar informal changes (e.g., Pachankis & Goldfried, 2006). However, as our multicultural awareness grew in our lab, we came to understand that these language issues were more important than our modest attempts had addressed.

Items referring to *opposite sex* in measures of social anxiety are problematic for at least three reasons. First, the *opposite sex* language reflects *heterocentrism*, a cultural perspective that assumes all members of a society are heterosexual (Herek, 2006). Heterocentrism risks alienating sexual minorities in clinical and research settings and is inconsistent with professional guidelines and clinical competencies that recommend that clinicians and researchers not assume the gender identity or sexual orientation of clients (American Counseling Association, 2014; American Psychological Association, 2011). Furthermore, in the widely used *Publication Manual of the American Psychological Association* (American Psychological Association, 2010), researchers are urged to avoid using biased language in scientific writing and "perpetuating demeaning attitudes and biased assumptions about people in their writing" (pp. 70–71).

Second, the *opposite sex* language is problematic because it fails to accurately measure the experience of sexual minorities and lacks specificity for heterosexuals (Weiss et al., 2013). The wording for items related to dating may not detect anxiety in dating situations if one's desired dating partners are always or sometimes individuals of the same gender. For heterosexual individuals, mentioning *opposite sex* may or may not automatically assess for dating anxiety, depending upon whether the item is interpreted as potential romantic partners or simply a class of people who share a certain characteristic.

Finally, *opposite sex* is problematic because of the binary assumptions about gender. Contemporary conceptualizations of gender are more nuanced (Muehlenhard & Peterson, 2011). Also, individuals who identify as transgender may be unsure how to respond—does it mean "opposite" to the sex one was assigned at birth, different from the preferred gender one enacts in public or private, or does it refer to perceived gender of the other person, regardless of their biological sex?

*We appreciate the suggestion of the title from an anonymous reviewer.

We started addressing the problem in language in measures of social anxiety a few years ago. Weiss et al. (2013) systematically tested a variety of alternative wordings for the Interaction Anxiousness Scale (IAS; Leary, 1983), Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969), Social Interaction and Anxiety Scale (SIAS; Mattick & Clarke, 1998), and the Social Phobia and Anxiety Inventory (SPAI; Turner, Beidel, Dancu, & Stanley, 1989). In short, semantically and statistically equivalent alternatives were identified and recommended for use for all of these measures, except the SPAI for which no satisfactory alternative could be identified among the options tested in this first study. This required us to step back and consider other options and conduct a second study.

The SPAI is widely used, with over 500 citations in the *Social Sciences Citation Index* as of 2016. It can be particularly useful in clinical settings because of the large number of specific situations it assesses. Seventeen of the items ask participants to rate the level of anxiety evoked in different situations for specific groups of people. One of the groups is opposite sex. Weiss and colleagues (2013) tested *people I'm attracted to*, *people I could date*, *attractive people*, and *potential romantic partners* and found no clear indication of which alternative could best replace *opposite sex.* In the absence of clear findings, *attractive people* was recommended based on statistical arguments even though it appeared to change the original intention of the authors.

As we considered other options to test, we tried to balance our multicultural knowledge of best practices with sexual minorities and our desire to accurately assess anxiety in a given situation. Our goal was to identify items that would be appropriate for everyone, regardless of sexual orientation or gender identity. We were looking for as much precision as possible so that the situation being rated would be clearly defined and not open to interpretation for the respondent. Below we will briefly describe a small online study to find a statistic and semantic equivalent alternative to the wording of *opposite sex*. In the full study, we compared opposite sex to various combinations that included *same sex*, *another gender*, and *same gender*. For brevity, we will only describe the best option—changing *opposite sex* to *another gender* and adding *same gender*.

Method

Participants

Following data cleaning described below, 280 participants (183 women, 87 men, 4 transgender, 4 gender queer or gender fluid, and 1 agender) were included in this study. On average, participants were 36.41 years old (*SD* = 12.80). Most participants self-identified as European American (*N* = 197 or 70.4%). Other ethnicities included African American (*N* = 23 or 8.2%), Asian American/Pacific Islander (*N* = 19; 6.8%), Hispanic (*N* = 17 or 6.1%), Native American/Alaskan Native (*N* = 7, 2.5%), and Mixed Ethnicity (*N* = 14 or 5.0%). Seventeen (6.1%) participants selected "other" for race/ethnicity. Most participants identified as heterosexual (*N* = 189 or 67.5%), with 42 (15.0%) identifying as bisexual and 35 (12.5%) as lesbian or gay. Eleven participants (3.9%) choose "other" as their response or declined to answer.

Social Phobia and Anxiety Inventory

The Social Phobia and Anxiety Inventory (Turner et al., 1989) is a 45-item self-report measure of an individual's fears of negative evaluation in various settings and with various groups of people. The SPAI also measures other aspects of anxiety including physiological symptoms. Questions 9 through 25 ask participants to rate their fears about specific situations for specific groups of people. For example, Item 15 asks participants to rate their fears of discussing intimate feelings with strangers, authority figures, members of the opposite sex, and people in general. The problematic wording of *opposite sex* is present only in Items 9 through 25. Participants rate their fears on a 7-point Likert-type scale from *never* to *always*. The SPAI has two subscales—social phobia and agoraphobia—the social phobia scale is the focus of this study. In the present study, participants rated their fears with two additional groups for questions 9 through 25: *another gender* and *same gender*. These items were presented in a fixed order (i.e., strangers, authority figures, people in general, opposite sex, same gender, and another gender), as is typical for the SPAI.

Procedure

The Amazon Mechanical Turk system was used to recruit participants with the requirements set for participants in the United States and age 21 years or older. After providing informed consent, participants completed the SPAI including alternate wording, another measure of social anxiety not reported here for brevity, and provided their demographic information. They were debriefed, thanked for their time, and offered a code to place into the Mechanical Turk system to receive compensation. Participants received $0.10–$1.00 compensation for participating, with no difference in data quality depending upon the amount of compensation received (all *p*'s > .05). The average time to complete the online survey was 12 minutes and 43 seconds. This study was approved by the University Institutional Review Board.

Data Cleaning

There were a total of 487 responses to the survey. To help ensure that participants were providing valid responses, two validity checks were included. At the one-half mark and three-fourths mark in the survey, participants were instructed to select a particular response. Participants who did not pass these two validity checks, failed to complete the questionnaire, or provided duplicate responses identified by IP address were removed from the dataset (*N* = 207). The final sample size of usable responses was 280.

Results

Our full analyses compared various combinations of the changes in wording, including just changing *opposite sex* to *another gender* and just adding same sex as an option with *opposite sex*. Most changes yielded similar results and a full description of those analyses are available from the second author. For the purposes here, we will report only the analyses that included *another gender* and *same gender*, as this is our recommended updated wording.

Individual Item Analyses

The first series of analyses compared the original wording of *opposite sex* to *another gender* to test whether this updated language could be used. Then *opposite sex* was compared to *same gender* to determine whether inclusion of *same gender* added useful information not captured by the original wording. A series of 3 (Wording Option) × 2 (Sexual Orientation: Heterosexual vs. Sexual Minority) ANOVAs compared the wording of *opposite sex* vs. *another gender* and *same gender* in 17 applicable items. Select comparisons are shown in Table 1. Overall, there were no items that were statistically different when comparing *opposite sex* to *another gender*. However, there was a significant interaction of sexual orientation on Item 18 (*I feel*

anxious when approaching and/or initiating a conversation with…), which demonstrated that including *another gender* reduces scores slightly for sexual minorities. There were no other significant interactions for sexual orientation on the comparisons between *opposite sex* vs. *another gender*. Finally, the comparison between *opposite sex* vs. *same gender* also revealed only two main effect differences, with ratings being lower for *same gender*. These items were 19 (*I feel anxious when drinking [any type of beverage] and/or eating in front of…*) and 20 (*I feel anxious when having to interact for longer than a few minutes with…*). Sexual orientation interacted with the comparison between *opposite sex* vs. *same gender* on Items 9, 11, 12, 14, 15, 18, 20, 23 (p's < .05). In general, these interactions followed a similar pattern—for heterosexuals, ratings of *opposite sex* were higher than for *same gender,* but for sexual minorities, ratings of *opposite sex* were lower than for *same gender*. Items 15 and 23 in Table 1 illustrates this expected pattern.

Social Phobia Subscale Analyses

Mean comparisons. The social phobia subscale scores of the SPAI were calculated comparing the alternate wording options to the original opposite sex. A 3 (Wording Option) × 2 (Sexual Orientation: Heterosexual vs. Sexual Minority) ANOVA was conducted for each wording pair. As shown in Table 2, the main effect of just substituting *another gender* for *opposite sex* did not change the total subscale score, $F(1, 243) = 0.50$, $p = .478$, and there was no interaction between wording and sexual orientation, $F(1, 243) = .01$, $p = .91$. There was a significant main effect for sexual orientation, $F(1, 243) = 9.60$, $p = .002$, showing that sexual minorities reported greater social anxiety than heterosexuals, regardless of specific wording (see Table 2). The correlation on the social phobia subscales between original wording and a revised version with another gender/same gender was very high ($r = .99$).

Internal reliability. Internal reliability was excellent on the original items of the SPAI ($\alpha = .98$) and with the revised wording *another gender* and *same gender*, $\alpha = .97$.

Discussion

We sought to further explore alternate wording in the SPAI to update the language for contemporary standards for clinical and research measures by eliminating heterocentric wording and binary gender assumptions. These results suggest that changing *opposite sex* to *another gender* and adding a *same gender* option meets these goals without sacrificing the psychometric properties of this established measure. This modest change also allows for the assessment of dating anxiety, an important component of social anxiety, in all individuals regardless of sexual orientation. Adding the *same gender* option also increases the clinical information available in all of the items because it allows assessment of anxiety in all of the situations with variations of gender groupings. The addition of the *same gender* alternative appears to decrease total scores by approximately 1 point, which, in this particular sample, was

Table 1. SPAI Means, Standard Deviations, and Mean Differences of Alternate Wording Compared to Original Wording

Item#	Item	*M* (*SD*)			F_{Total}	$F_{Interaction}$
		Heterosexual	*Sexual Minority*	*Total*		
15	*I feel anxious when discussing intimate feelings with*					
	Opposite sex (Original Wording)	4.44 (1.86)	4.42 (1.99)	4.44 (1.90)		
	Another Gender	4.48 (1.82)[b]	4.41 (1.99)[b]	4.45 (1.87)	.08	.11
	Same Gender	4.21 (1.85)[a]	4.63 (1.96)[b]	4.34 (1.89)	.03	6.93**
17	*I feel anxious when talking about business with*					
	Opposite sex	3.10 (1.71)	3.52 (1.81)	3.24 (1.75)		
	Another Gender	3.10 (1.71)[b]	3.51 (1.86)[b]	3.23 (1.77)	.12	.02
	Same Gender	3.06 (1.68)[b]	3.53 (1.85)[b]	3.21 (1.75)	.08	.28
22	*I feel anxious when speaking in front of*					
	Opposite sex	4.00 (1.93)	4.32 (1.96)	4.10 (1.95)		
	Another Gender	3.98 (1.95)[b]	4.31 (1.96)[b]	4.09 (1.95)	.36	.01
	Same Gender	3.88 (1.90)[a]	4.28 (1.93)[b]	4.00 (1.91)	3.37	.72
23	*I feel anxious when being criticized or rejected by*					
	Opposite sex	4.54 (1.88)	4.76 (2.11)	4.61 (1.95)		
	Another Gender	4.46 (1.94)[b]	4.82 (2.05)[b]	4.57 (1.98)	.08	3.30
	Same Gender	4.32 (1.92)[a]	4.95 (1.99)[a]	4.51 (1.96)	.08	10.05**

Note. Original items are in italics. $N = 270$ - 276 due to missing data. Heterosexual $n = 184$-189 due to missing data. Sexual minority $n = 84$-88 due to missing data. * < .05 ** < .01; [a] indicates a statistical difference between opposite sex and the alternate wording within sexual orientation at the $p < .05$ level. [b] indicates no statistical difference between opposite sex and the alternate wording for that sexual orientation.

statistically significant. However, such a modest change is unlikely to be of clinical importance with the benefits outweighing the costs.

It was surprising that overall scores on the SPAI decreased when assessment included a potential romantic partner for sexual minorities. However, it appears to be an artifact from how the scores are calculated for Items 9 through 25. For these 17 items, the fear ratings are averaged across the four target groups, and adding a fifth group with a value below the mean decreases the average rating. Although many sexual minorities tended to rate *same gender* as more anxiety provoking than *another gender*, the value of *same gender* tended to be below the mean of strangers, authority figures, and people in general. Thus, adding *same gender* as a fifth item decreased the score slightly.

Our sample of sexual minorities allowed an initial examination of the revised items. Although individuals who identify as gay and lesbian are more likely to be diagnosed with social anxiety disorder and tend to score higher on self-report measures of social anxiety (Meidlinger & Hope, 2014), the large differences between sexual minority and heterosexual participants on the SPAI were surprising.

There are some limitations in the present study that should be acknowledged. First, the Mechanical Turk workers may represent a unique population and limit the generalizability of these results. However, Buhrmester and colleagues (2011) have shown that the Mechanical Turk workers provide useful and valid data that generalizes to other samples. A second limitation is the relatively small sample size of sexual minorities and gender diverse individuals. We were unable to examine potential differences among sexual minorities. Little is known about social anxiety in individuals who identify as transgender or gender nonconforming, and this would be a fruitful topic for future research, including understanding the assessment of social anxiety in these populations.

Our recommendation to change items on an established measure such as the SPAI is not made lightly. Nor are the original authors to be faulted for failing to live up to multicultural standards that would not exist until three decades later. As our lab has broadened and deepened our understanding of the experiences of sexual and gender minorities, we find ourselves looking at our clinical and research tools with a new lens. We are also consciously choosing to collect data whenever possible, rather than just making modifications and hoping it is fine as we did in the past. In our experience with the SPAI across two studies, our perseverance has yielded a result that adds greater precision. Adding the *same gender* option highlights the importance (or lack thereof) of gender in the SPAI situations, a dimension that may be important when designing exposures (Hope, 1993).

Carefully developing assessment and treatment tools that fit the experiences of our clients and research participants exemplifies our ABCT mission statement, which commits us to "… the advancement of scientific approaches to the understanding and improvement of human functioning…" (abct.org). We know that many training programs and labs among the ABCT membership are integrating multicultural training and practice into their day-to-day work. The goal of this paper was to provide one example of how relatively simply data collection can move beyond ad hoc adaptations to better evidence-based work.

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Table 2. SPAI Social Phobia Subscale Means, Standard Deviations, and Mean Differences of Alternate Wording Compared to Original Wording

Wording Options	Heterosexual M (*SD*)	Sexual Minority *M* (*SD*)	Total *M* (*SD*)
Opposite Sex (Original Wording)	83.26 (44.57)	101.76 (42.96)	89.92 (45.01)
Another Gender and Same Gender	82.27 (44.29)	100.68 (42.98)	88.92 (44.84)

Note. $N = 247$ due to missing data. SPAI = Social Phobia and Anxiety Inventory.

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INSTITUTIONAL SETTINGS

Multidisciplinary and Multi-Setting CBT Peer Group Supervision

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SUPERVISION HAS BEEN a long-standing hallmark of clinical training in cognitive behavioral therapy (CBT). Traditionally, clinicians receive training and supervision, often in the form of individual supervision, as part of their academic requirements in graduate and professional training programs. There are also options to receive specific training and certification in treatments after graduation as well as voluntary or mandatory continuing education experiences once a clinician is licensed to practice. Beyond these options, however, the working clinician is often left alone to practice independently, without many outlets for continued supervision. Workload demands and financial limitations can leave the working clinician without convenient, accessible, and affordable ways of gaining new skills, and/or maintaining and even improving skills. Additional ongoing training and supervision is often accomplished outside of the clinician's actual clinical environment, with the individual clinician going elsewhere independently of his or her clinical colleagues and context. Moreover, many of CBT's best teaching and training programs with certification do not address the longitudinal growth, continued competence, and potential for therapeutic drift of working clinicians postcertification. Spurred by the recent recommendations of the Association for Behavioral and Cognitive Therapy Dissemination and Implementation Science Special Interest Group's Training Workgroup (Park, Guan, Kanuri, Stirman, & Chorpita, 2016), this paper offers an example of a CBT peer group supervision that developed organically within a large psychiatric services setting to enhance the skills of working clinicians.

CBT Peer Group Supervision at NewYork-Presbyterian Hospital Westchester Division

The CBT Peer Group Supervision at New York-Presbyterian Hospital (NYPH) Westchester Division was created in 2011, originally to address ongoing training and supervision needs subsequent to a CBT training among the staff working in the psychotic disorders inpatient and day programs at the hospital. The concept was developed as a Social Work Department Advanced Clinician project by one of the authors (O. D-B.), with the other author (V.W.) serving as a mentor. The project quickly expanded its scope and purpose beyond the psychotic disorders program to include the support and growth of CBT practice throughout the hospital. The basic structure was to hold a voluntary monthly meeting to review CBT concepts and techniques. The group is open to clinicians and

trainees of all disciplines throughout the hospital. Group members represent clinicians working in inpatient, day program, partial hospital program, outpatient, and private/faculty practice settings. The structure of the group itself follows the traditional format of a CBT group (Table 1).

O. D-B. serves as the facilitator for the group. The main focus of each group takes the form of supervision, teaching, or case consultation. The topics are identified and developed in collaboration with group members and are wide-ranging, according to interest and need. Instruction and supervision occur using a variety of modes, including didactics, role-plays, modeling, readings, and videos. Peers are strongly encouraged to be familiar with two basic CBT texts: *Cognitive Behavior Therapy* by Beck (2011) and *Learning Cognitive-Behavior Therapy* by Wright, Basco, and Thase (2006). There is a mix of experienced CBT clinicians, seasoned clinicians who are not as familiar with CBT, and early-career clinicians and trainees who have varying experience with CBT. More experienced CBT clinicians are able to reinforce their own skills-set and pass on knowledge to peers, while less-experienced clinicians are able to learn, ask questions, and practice CBT techniques in a supportive setting. At the end of every group, verbal feedback is elicited from group members.

The diversity of clinical presentations and treatment formats with which the group members work creates a rich basis for understanding and exploring the use and adaptation of CBT (Table 2). In the four years of its existence, the CBT Peer Group Supervision has welcomed clinicians and trainees from each of the six clinical disciplines within the hospital (i.e., social work, psychology, psychiatry, psychosocial rehabilitation, nursing, and pastoral care). Main topics covered in the supervision include case conceptualization, Socratic questioning, guided discovery, homework, agenda-setting, dysfunctional thought records, family integration into individual therapy, maladaptive assumptions, core beliefs, and group therapy. In addition to particular CBT skills, the application of those skills to particular cases and populations has been a staple of how group members use the group supervision. Whenever possible, we have referenced the manuals associated with the empirically supported treatments relevant to the cases presented in supervision (e.g., *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*—Barlow et al., 2011; *Cognitive Therapy of Schizophrenia*—Kingdon & Turkington, 2008; *Problem-Solving Therapy*—Nezu, Nezu, & D'Zurilla, 2013). Cases discussed in the supervision have involved diagnoses of GAD, PTSD, psychosis, medical problems, depression, substance abuse and dependence, ADHD, personality disorders, and cognitive impairment. Furthermore, the demographics of the cases reflect the hospital's catchment area: New York City and its greater metropolitan region. The group has discussed cases of ages ranging from children to older adults, ethnic and cultural diversity, languages other than English, and varied socioeconomic statuses.

Table 1. CBT Peer Group Supervision Monthly Meeting Structure

1. Agenda setting
2. Bridge to last session
3. Review of homework
4. Introduction of a concept or application of a particular skill
5. Discussion
6. Identification of opportunities to use the concept or skill in future with patients or with oneself
7. Eliciting feedback on the group including suggestions for future topics

Peer Group Supervision Case Example

The following is an example of a peer group supervision session and discussion of a particular case.

Initial Structuring of Peer Group Supervision (5 minutes)

- Agenda setting: The case presentation was selected prior to the group meeting, with the clinician supervisee preparing a particular case for discussion.
- Bridge to last session: Review of CBT model for depression.
- Review of homework: Brief review of and answering of questions regarding the assigned reading: Chand & Grossberg (2013).

Case Presentation (5 minutes)

A case was presented by a social worker with novice-level CBT experience. This clinician requested guidance from the group on challenges she was experiencing engaging a 70-year-old, White, widowed woman, with a 20-year history of major depression, currently hospitalized on a geriatric psychiatry inpatient unit. This was patient's first psychiatric hospitalization due to severe neuro-vegetative symptoms of depression and suicidal ideation with a plan to overdose on her medications. The patient had been in long-term treatment with a private psychiatrist, with limited response to medication trials and electroconvulsive therapy. The clinician identified feeling anxious, frustrated, and hopeless in the context of the patient's rejection of her discharge plan, and she was uncertain how to apply CBT to this situation. The clinician also identified that she herself was experiencing maladaptive automatic thoughts that she is professionally inefficient and inadequate. She verbalized feeling embarrassed and thinking, "I should be able to figure this out by now."

Questions from the clinician for group discussion:

1. The patient is refusing to cooperate with discharge planning. How can I apply CBT in this setting with this patient to help facilitate an effective discharge from the unit?
2. How can I cope with my own thoughts and feelings regarding this case?

Prioritize Supervisee's Problems (20 minutes)

The case was conceptualized on two levels: the patient's problems and how to improve them and the clinician's challenges and how to remedy them by teaching skills.

- Based upon the clinician's problem engaging the patient in discharge planning, the group decided to first focus on helping her conceptualize the case according to CBT theory.
- Peers worked together with the clinician to begin a Cognitive Conceptualization Diagram (CCD; Beck, 1995). This CCD version was selected because it is from the recommended reading for the PGS and peers were most familiar with it. The CCD helps to rapidly determine patients' key problematic situations, cognitions, and coping strategies. The CCD also serves to guide cross-sectional treatment planning. Working with the clinician supervisee, peers hypothesized the meanings of the patient's cognitively distorted negative automatic thoughts and the impact they were having upon her current functioning.

Discussion and Problem Solving (20 minutes)

- Guided discovery was used by the peers to explore how the patient was influenc-

ing the clinician's own cognitions, feelings, and behaviors (i.e., beliefs about herself that were being activated by the patient and inpatient unit work). The clinician worked on a Dysfunctional Thought Record (Table 3).

- A role-play was employed for the clinician to practice teaching the patient about the cognitive model for depression. Peers provided supportive feedback about her skill performance.
- Based upon immediate feedback on the role-play, peers suggested strategies for clinician to conduct cognitive interventions to challenge her own "should" rules and beliefs, such as thought records and writing a case conceptualization diagram on herself.

Homework (5 minutes)

Peers collaboratively decided upon new homework, which was to read articles suggested by a peer with expertise treating older adults with CBT. Also, the clinician supervisee agreed to do a Dysfunctional Thought Record on her thought "I should have 100% efficiency discharging my patients." Additionally, she planned to compose and read coping cards with adaptive responses to her maladaptive self-appraisals. Peers agreed to reinforce their learning by practicing using the CCD with their patients and/or on themselves.

Outcome (5 minutes)

The presenting clinician summarized what she had learned in the meeting and described how she would apply it. She gave feedback that she felt relieved and had gained perspective on her relationship with the patient and her role as a clinician on the inpatient unit. She said this form of supervision serves as an adjunct to the unit-based supervision she receives and helped normalize what she has been experiencing. Other group members stated that they concurred with her points. She agreed to report on the outcome of this case and her reactions to it at the next meeting.

Peer Group Supervision Acceptability and Feasibility

The peer group supervision strives to be useful and convenient for members. The number of meetings held has fluctuated from year to year and attendance has varied, although a core group of clinicians and trainees attend the majority of meetings. Holding the supervision monthly does not create a time burden on the busy clinician and offering the meeting during the typical lunch hour within the hospital (12–1:00 P.M.) allows for minimal disruptions to clinical schedules and duties. Snacks are often provided and group members are free to bring their lunches. The meetings of the supervision are announced in advance on hospital-wide listserv and group members can sign up for automatic electronic calendar reminders. Group members may receive institutional continuing education credits for attending the supervision. All of these aspects help to make participation and attendance as easy as possible for group members and to encourage consideration of the supervision as a way of enhancing one's professional skills and identity. Anecdotally, the authors are aware of some members pursuing advanced CBT trainings at conferences and organizations outside of the hospital. When group members continue their learning and growth as CBT therapists, they bring back to the supervision useful information and valued contributions to everyone's education.

The NYPH Westchester CBT Peer Group Supervision Model and ABCT Training Recommendations

At the beginning of 2016, the ABCT Dissemination and Implementation Science Special Interest Group Training Workgroup published general recommendations to help advance the circulation of CBT (Park et al., 2016). The workgroup underscored the need for clinicians within community-based service settings to be adequately trained in evidence-based treatments (EBT). In comparing the NYPH Westchester Division CBT peer group supervision with the recommendations, we found that the current model incorporates many elements of the major recommendations. We also identified areas in which the peer supervision group could be adjusted to more adequately meet the recommendations.

"Conceptualize Training as Professional Development and Support"

"Trainers can help to establish a culture of learning orientation, openness, enrichment, and a willingness to try new things in the pursuit of professional excellence" (Park et al., 2016). The primary goal of the peer group supervision is to advance psychiatric care through the provision of CBT training and supervision to multidisciplinary clinical staff who provide CBT either as the primary mode of treatment or as an adjunct to other treatments (e.g., medications). The second goal is to fuse knowledge and skills to address the needs of patients with severe, acute, and chronic mental illness. An additional goal was to enhance and encourage collaboration among members of treatment teams throughout the hospital. These goals and the peer group supervision effort is an active and naturally occurring support structure to help the clinicians at the hos-

Table 2. Diversity of Patient Characteristics and Topics Discussed in CBT Peer Group Supervision

Behavioral Health Inpatient and Outpatient Patient Populations Discussed	
Adults	**Children and Adolescents**
Bipolar Disorder	Acute stress reaction
Comorbid medical illness	Attention Deficit Hyperactivity Disorder
Eating Disorders	Conduct Disorder
Generalized Anxiety Disorder	Mood Disorders
Geriatrics	Reactive attachment disorder of childhood
Group Cognitive Behavioral Therapy	Sexual Identity
Obsessional Compulsive Behavior	Suicidal ideations
Panic Disorder	
Personality Disorders	
Post-Traumatic Stress Disorder	
Psychosis	
Sexual Identity	
Substance Use	
Suicidal ideations	
Trichotillomania	

Table 3. Dysfunctional Thought Record

Directions: When you notice your mood getting worse, ask yourself, "What's going through my mind right now?" and as soon as possible jot down the thought or mental image in the Automatic Thought column.

Situation	Automatic Thought(s)	Emotion(s)	Adaptive response	Outcome
1. What actual event or stream of thoughts, or daydreams or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad/anxious/angry/ etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions at the bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you believe each automatic thought? 2. What emotions(s) do you feel now? How intense (0-100%) is the emotion? 3. What will you do (or did you do)?
My patient is rejecting my help to discharge plan with her. Patient is refusing to return to her own apartment and says she only wants to live with her daughter, but her daughter refuses to take her in.	I should have 100% efficiency discharging my patients (100%) I'm inefficient (75%) I should be able to figure this out by now (90%) Patient is making me look inadequate (90%) I'm letting my Team down because we won't meet our target for discharges (100%)	Anxious 80% Frustrated 80% Hopeless 40% Ashamed 50%	1. Should rules 2. Magnification 3. Labeling 4. Personalization It's unrealistic to have 100% efficacy with discharges, there are unforeseen variables. (100%) The patient is uncooperative because she is severely depressed and unable to problem-solve effectively at this time. (100%) I am part of a treatment team; I am not solely responsible for discharges. (50%) Due to the patient's symptoms of depression, she is experiencing cognitive distortions and believes her daughter is rejecting her (All or Nothing thinking). I'm having similar cognitive distortions triggered by the patient's rejection of my plan. (100%)	1. 5% 2. 5% 3. 5% 4. 10% 5. 10% Anxious (20%) Frustrated (20%) Hopeless (0%) I will meet with patient and educate her about the CBT model for depression. I can review her CCD and use guided discovery to help her understand the impact her symptoms are having upon her life. I can use the cognitive continuum to illustrate this to her. I can try to engage daughter as a Care Partner to develop a discharge plan that could help their relationship.
			I am capable of doing my job (90%). This case can be an opportunity to practice my CBT skills to help my patient realize this is not true, and that her daughter wants her to recover. (100%)	

pital grow and maintain their knowledge and practice of CBT.

"Meet Clinicians Where They Are in Terms of Their Current Needs and Strengths"

The peer group supervision personalizes and adapts CBT training and supervision to be responsive to the needs of the individual clinicians within the group. As in the case example, group members may be novice CBT practitioners; others may have decades' worth of CBT experience. The diversity of the patients seen within the hospital setting also allows group members to share insights and modifications of CBT techniques adapted for one clinical setting or psychiatric disorder and help a supervisee apply these to a case in a different setting or with a different problem.

The recommendations call for developmentally sensitive and flexible training models as well as for allowing clinicians to contribute to training design. The NYPH peer group supervision is attuned to the clinicians' varying levels of CBT knowledge and time schedules. The supervision is flexible in its open attendance policy, provision of opportunities to follow up missed sessions with questions, emails disseminating articles and presentations, and support of the growth of each clinician. Spontaneous requests for supervision and direct elicitation of feedback on each supervision meeting encourages "bidirectional learning" and motivates attendance and participation. Park et al. also raise the point that there are different needs regarding CBT: "Certain clinicians may not be interested in becoming an expert in CBT, but instead may be looking for tools to integrate into their practice." The peer group supervision has welcomed anyone interested in learning more about CBT, even if this is not one's primary psychotherapeutic orientation. That the peer group supervision has included representatives of all six clinical disciplines (i.e., social work, psychology, psychosocial rehabilitation, nursing, pastoral care, and psychiatry), as well as trainees of various levels from these disciplines, demonstrates that the peer group supervision can be accessed and used by a range of community and academic partners.

"Utilize Active Training Strategies"

The use of active training strategies is crucial to the learning and dissemination of CBT. Rather than simply lecturing on CBT principles, the NYPH peer group supervision consistently involves active training strategies. The aforementioned supervision case example illustrates the peer group's use of collaborative and active work on developing a case conceptualization diagram as well as the use of role-play with the supervisee. This example also incorporated self-practice of skills and self-reflection, such as completing a dysfunctional thought record. Other desirable and recommended elements of training and supervision, such as modeling and behavioral rehearsal, are also present in the peer group supervision. In these ways, active training strategies are at the core of the peer group supervision, increasing the likelihood of clinicians acquiring skills and implementing them (Bearman et al., 2013). The collaboration and interactive nature of the peer group supervision is in line with the Park et al. recommendations, which stipulate that "The clinicians in the room are experts in working with the clinic's targeted population, in understanding the needs of the clinic, and their fellow clinicians, and in their own areas of study." In affording the peer group clinicians the opportunity to present their cases for peer consultation, instruction and feedback, the peer group supervision promotes peer interaction and collaboration, leading to active clinical problem-solving of challenging treatment cases.

"Remember That Training Is an Ongoing Process"

Although the NYPH peer group supervision exists for all interested clinicians within the hospital, the fact that it has been running for a number of years is testament to the idea that for any clinician, there is no endpoint to what can be learned. Peer group supervision allows both the novice and the expert to exchange knowledge and to feel supported when challenges arise in treating patients. For the less experienced clinician, ". . . ongoing support is critical to influencing clinicians' adoption and competency in using new treatments" (Beidas, Edmunds, Marcus, & Kendall, 2012). For the more experienced clinician, the ability to offer support in the form of supervision to others in the field is a way for CBT to be disseminated in an efficient way. The peer group supervision model blends supervision from within the behavioral health institution with the peer coaching model. This model is used in peer-to-peer education, where "peer-to-peer networks provide discussion and feedback of a program's use" (Lyon, Stirman, Kerns, & Bruns, 2011) and employ "the existing workforce to provided ongoing support" (Park et al., 2016).

The Park et al. recommendations emphasize the need for awareness of the organization and context in training and supervision of CBT. In the present example of peer group supervision, NYPH as an institution endorses and supports the use of evidence-based treatments and has a history of incorporating CBT into its inpatient, outpatient, and partial hospital settings. Characteristics of CBT (e.g., time-limited, goal-oriented, structured) provide a good fit with NYPH Westchester Division's short-term length-of-stay model and emphasis on multidisciplinary teamwork in treating patients. That the peer group supervision was a pilot project developed with the support and interest of the Social Work Department demonstrates how such supervision groups can be encouraged by the organization itself. Other practical matters when considering contextual fit are cost and disruption to clinical care. The NYPH Westchester Peer Group Supervision has no overhead fees associated with it and the supervision is free to all interested clinical staff. The supervision takes place on the grounds of the institution, facilitating attendance and minimizing disruption to the work day and clinical duties.

"Acknowledge and Speak to Difference in Clientele"

The peer group supervision focuses on the supervision needs of the participants who present cases and ask questions about adapting CBT to real patients they see in their settings. Because of the diverse patient population seen throughout the service settings of NYPH Westchester Division, the peer group supervision tailors handouts, worksheets, complex case presentations, and client role-plays during supervision to the hospital's client population. Guidance in supervision is provided for "adapting the EBT protocol due to culture, comorbidity and emergent life events" (Park et al., 2016). These efforts are supported by circulating articles via the group supervision's email list and are open for discussion during supervision. Didactic lectures and their notes are disseminated via email to group members. Modeling by trainers and via video recordings provides an opportunity for clinicians to see what treatment looks like in action and with particular patients. Thus, the peer group supervision includes understanding and seeking out knowledge for work with patients from various backgrounds and to

sensitively adapt CBT to effectively treat them.

"Think About Treatment Fidelity Early and Often"

This final recommendation from the ABCT Training Workgroup is one that the peer group supervision at NYPH Westchester Division is certainly interested in but is not currently implementing in a formal manner. Although the supervision involves practice of general CBT skills, we have not provided formal, intensive training in any one particular empirically supported and manualized CBT treatment. The infrequency and modest scope of the group supervision meetings preclude this, although peers are pointed towards manuals, studies, and key readings on specific interventions relevant to their cases and clinical settings. Rather than providing concentrated training to manuals, the peer group supervision is used in two ways: (a) to educate and inform peers about the existence of empirically supported CBT treatments and where peers may access training and (b) to nurture and reinforce adherence to empirically supported treatments once peers have received the formal training and are independently applying these protocols in their clinical work.

Because the peer supervision group does not train to a particular manualized intervention, assessing treatment fidelity is an important challenge for the supervision model. The voluntary nature of participation in the supervision is one aspect that departs from more traditional training models. The infrequency of the supervision meetings and the inability to implement measurement or even direct observation of peers' clinical work highlights a limitation of this model of supervision and ongoing training. There may be ways of enhancing treatment fidelity, such as partnering peers to be in touch with and coach one another in the interims between peer group supervision meetings. Another idea is to have peers use fidelity measures (e.g., Cognitive Therapy Rating Scale; Young & Beck, 1980), either when providing supervision on a case presented to the group or when practicing skills within supervision. We currently are considering implementing a more formal self-assessment of CBT knowledge and skills within the peer group. Without a formal structure beyond the supervision group meeting itself, there are certainly barriers to monitoring treatment fidelity beyond clinicians' self-report.

Conclusion

There can be barriers to clinicians learning, maintaining, and refining their CBT skill sets without dedicated and convenient opportunities to do so in their work settings. Peer group supervision is one way in which the real needs of clinicians can be met in an ongoing and supportive manner. While by no means the only way in which to conduct such supervision, the NYPH Westchester CBT Peer Group Supervision is an example of how peers within a clinical care environment have organically grown a mechanism in which to offer to one another continual training in and commitment to CBT standards and practice. With the new recommendations from ABCT, we hope we can continue to grow to meet the needs of clinicians and to enhance how CBT is used to treat the patients who walk through the doors of NYPH Westchester.

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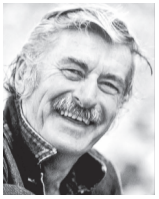
OBITUARY

Remembering Gerald Roy Patterson: 1926–2016

John Wills Lloyd, *University of Virginia*



GERALD ROY PATTERSON, internationally renowned scientist and psychologist who helped to define the applied and research basis for parent management training and developed a theory of coercive interactions based on negative reinforcement, died 22 August 2016 in Eugene, Oregon.

Born in Lakota, North Dakota, on 26 July 1926, Patterson was considered by many to be among the architects of contemporary family psychology, particularly for his contributions to the scientific understanding of parent-child and marital relations. In addition, however, those who knew "Jerry" knew that he also embraced life closely, engaging in many outdoors activities, enjoying fine dining, and gathering with friends.

After serving in the Army in the Pacific theater in World War II, Patterson returned to the north woods of the upper Midwest and began postsecondary studies at Northland College in Ashland, Wisconsin, and then Gustavus Adolphus in St. Peters, Minnesota. Ultimately, he earned bachelor's and master's degrees in psychology from the University of Oregon. He then matriculated at the University of Minnesota, where he earned a Ph.D. in 1956, defending a dissertation entitled "A Tentative Approach to the Classification of Children's Behavior Problems."

Over 50 years later, the University of Minnesota recognized Patterson's contributions by awarding him its Outstanding Achievement Award. The Minnesota award is one among many Patterson received during his lifetime. The American Psychological Association (APA) and groups within it recognized him repeatedly. He received the Distinguished Scientific Award for the Applications of Psychology from the APA, itself; the G. Stanley Hall Award and the Urie Bronfenbrenner Award for Lifetime Contribution to Developmental Psychology in the Service of Science and Society from the APA's Developmental Psychology, Division 7; the Distinguished Scientist Award from the APA's Section III, Division 12; the Distinguished Professional Contribution Award from the APA's Section I, Division 12. Other awards include the James McKeen Cattell Fellow Award from the American Psychological Society; the Presidential Award from the Society for Prevention Research; the Award for Distinguished Scientific Contributions to Developmental Psychology from the Society for Research in Child Development; the Cumulative Contribution to Research in Family Therapy Award from the American Association for Marriage and Family Therapy; and the Distinguished Contributions to Family Therapy award from the American Family Therapy Association.

Patterson's relationship with the Association for Behavioral and Cognitive Therapies (ABCT) was particularly close. From 1971–1972, he served as the organization's sixth president. His pioneering work in developing interventions for parenting children with noncompliant and aggressive behavior helped lead to the formation of the Parenting and Families Special Interest Group in the ABCT (Khanna, 2006) and contributed to his receipt of the Trailblazer Award from the ABCT's Parenting and Families SIG.

The reasons for Patterson receiving such substantial recognition are many, but they reduce to a few major themes. He and his colleagues considered it sensible to study social aggression (or conduct problems) in children by closely examining the interactions between children and others—particularly their parents—in their natural environments. Using intensive observations of these interactions, they were able to identify basic psychological mechanisms (especially negative reinforcement) that led to the development of coercive family processes (Patterson, 1982). Operating from this understanding, Patterson and his colleagues were able to develop and refine a successful method for teaching parents how to manage the behavior of their socially aggressive children by, essentially, learning to manage their own parenting behavior. Having a stable way to examine coercive family processes and a powerful program for changing them allowed the Parent Management Training Oregon (PMTO) group then to examine other contributors (e.g., marital relations, maternal depression, child abuse, stress, etc.) to difficulty in family processes in a systematic and thorough manner.

In a talk delivered upon receipt of the ABCT Parenting and Families SIG award, Patterson (2005) provided a compelling but succinct summary of the "The Next Generation of PMTO Models" that was reprinted in the pages of *the Behavior Therapist*. In fewer than 5,000 words, Patterson summarized, integrated, and contextualized more than 40 years of research that ranged across clinical, observational, and theoretical work.

In that work, Patterson and his colleagues insisted on employing strong scientific methods throughout. He was, he said, as much concerned with the methods employed to study phenomena as he was concerned with what he learned from the studies; if he couldn't trust the methods, then he couldn't trust the findings. Although he was a capable designer of studies and data analyst, Patterson collaborated with measurement experts and other methodologists, as well. He regularly engaged in detailed discussions about not just the theoretical aspects of scientific problems but also how different analyses might lead to different conclusions. His attention to such matters enhanced the strength of his contributions.

Patterson documented his work in hundreds of articles, chapters, and books, often collaborating with the late John B. Reid, Thomas Dishion, Patti Chamberlain, and many others. Chief among his collaborators was his wife, Marion Forgatch. Many of the books (e.g., Patterson, Reid, & Dishion, 1992; *Antisocial Boys*) were resources for scholars, but other books (e.g., Patterson & Gullion, 1968; *Living With Children*) were widely distributed because they clearly explained important principles to general audiences.

According to his own reports (http://geraldrpatterson.com), Jerry grew up in the northern woods and lakes and had a great love of the outdoors. I remember him joking about catching fish from a canoe, cutting them open to examine the contents of their stomachs, conducting a quick analysis of variance, and then choosing which flies to use for his next casts accordingly. When I first got to know him in the mid-1970s, he and Marion were preparing to complete a solo hike through part of the north slope of Alaska. A bush pilot dropped them inside the Arctic Circle and they trekked south across the Brooks

Range before the area was opened for oil drilling and the Arctic pipeline. They returned with magnificent pictures of wilderness accompanied by superb stories of wearing bells on their packs (to warn bears of their approach) and "tussocking" across the tundra.

Implementation Sciences International published an obituary (http://isii.net/PATTERSON-OBIT.pdf) and is raising funds to support the Jerry Patterson Coercion Chautauqua, a scientific discussion about the role negative reinforcement plays in coercion theory. Many of Patterson's colleagues are continuing his work at the Oregon Social Learning Center.

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AT ABCT

Monthly Mental Health Topics: A New Initiative From the Clinical Directory and Referral Issues Committee

Laura A. Payne, *David Geffen School of Medicine at UCLA*

Robert Schachter, *Mount Sinai School of Medicine*

HELLO FROM THE CURRENT (LAP) and former (RS) chairs of the Clinical Directory and Referral Issues Committee! Our committee's mission is to help ABCT members develop and maintain successful clinical practices. One particular way to help members achieve this is via the Find a CBT Therapist clinical directory (www.find-cbt.org). Here, potential patients or clients can locate a CBT therapist in or around any area of the United States. This directory includes all full members of ABCT that have chosen to have their information included. One feature for those members who wish to benefit from greater exposure in the directory is the "Expanded Listing." For a small fee, this allows for a larger presentation in the directory search results, including a picture, a description of your practice, and additional details, such as which insurances you accept. Another focus of the committee is to provide you with materials that can help you market your skills and services. For this, we offer a range of FAQ sheets on the website.

More recently, we have implemented a new initiative to help build practices—the Monthly Mental Health Topic. Each month, we have selected a monthly mental health topic to focus on and promote awareness of throughout the designated month for marketing purposes. This began with our first month, in March 2016, which was Women's Health month. In April, we focused on Children's Mental Health, May was focused on Cancer, June addressed Veterans' Mental Health and PTSD, and July highlighted Lesbian, Gay, Bisexual, Transgender, Queer/Questionning (LGBTQ). In August, we focused on Pain Management. Other topics for the remainder of 2016 include Suicide Prevention, Obsessive-Compulsive Disorder, Ethnic/Racial Minorities Mental Health, and Depression/Grief/Traumatic Grief. As part of the focus of each month, we are coordinating with relevant Special Interest Groups (SIGs) and other ABCT members to develop fact sheets and videos pertaining to the mental health topic. All fact sheets and videos are made available on the ABCT website and ABCT YouTube channel.

We have had a fantastic group of individuals providing information on various topics, from female sexual pain disorders to veterans' mental health to treatment strategies in children with autism spectrum disorders, and we are always looking for new people to help us create fact sheets and videos! If you have an idea or would like to provide information about a topic you are interested in, send an email to Laura Payne at LPayne@mednet.ucla.edu. Please don't hesitate to volunteer! Also, keep looking out for one of our new initiatives—the CBT Pioneers Project, where our committee members will be interviewing various ABCT members who have been pioneers in the development of CBT!

Our goal is to help you build your practice. If there are any ideas you have about what more you would like to see, please let us know.

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call for Continuing Education Sessions

Submission deadline:
February 1, 2017

51st Annual Convention
November 16–19, 2017
San Diego

Submissions will now be accepted through the online submission portal, which will open on Wednesday, November 2, 2016.

Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

Workshops & Mini Workshops

Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. **Mini Workshops** address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. *When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.*

For more information or to answer any questions before you submit your abstract, contact **Lauren Weinstock, *Workshop Committee Chair***
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

For more information or to answer any questions before you submit your abstract, contact **Christina Bosseau, *Institute Committee Chair***
institutes@abct.org

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday. Please limit to no more than 2 presenters.

For more information or to answer any questions before you submit your abstract, contact **Sarah Kertz, *Master Clinician Seminar Committee Chair***
masterclinicianseminars@abct.org

2017

Call *for* Award Nominations

to be presented at the 51st Annual Convention in San Diego

The ABCT Awards and Recognition Committee, chaired by Katherine J. W. Baucom, Ph.D., of the University of Utah, is pleased to announce the 2016 awards program. Nominations are requested in all categories listed below. **Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below**. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, and Marsha Linehan. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Recent recipients of this award include Alan E. Kazdin, David H. Barlow, Terence M. Keane, Thomas Borkovec, Steven D. Hollon, and Michelle Craske. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Research" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, and the Charleston Consortium Psychology Internship Training Program. Please complete the on-line nomination form at www.abct.org/awards. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Training Program" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.
Nomination deadline: March 1, 2017

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent recipients of this award include Mark S. Bauer, Vikram Patel, Benedict Carey, and Patrick J. Kennedy. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Distinguished Friend to BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.
Nomination deadline: March 1, 2017

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize to support travel to the ABCT Annual Meeting and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: 1) Candidates must be active members of ABCT, 2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care.

Applicants should submit: Nominating Cover Letter, CV, Personal Statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to Awards.ABCT@gmail.com. Include candidate's last name and "Albano Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Anne Marie Albano Early Career Award, 305 Seventh Ave., New York, NY 10001.

This award is made possible by a generous donation to ABCT. A family who benefitted from CBT and knows of Dr. Albano's work expressed wanting to see others benefit from CBT and CBT-trained therapists

Nomination Deadline: March 1, 2017

Student Dissertation Awards

- Virginia A. Roswell Student Dissertation Award ($1,000) • Leonard Krasner Student Dissertation Award ($1,000)
- John R. Z. Abela Student Dissertation Award ($500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2016 . Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to awards.abct@gmail.com. Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

President's New Researcher Award

ABCT's 2016–2017 President, Gail Steketee, Ph.D., invites submissions for the 39th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. **For complete instructions, visit http://www.abct.org/Awards/**

Submission deadline: August 1, 2017

Nominations for the following award are solicited from members of the ABCT governance:

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 1, 2016

the Behavior Therapist
Association for Behavioral
and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org
ADDRESS SERVICE REQUESTED

Nominate the Next Candidates for ABCT Office

I nominate the following individuals:

PRESIDENT-ELECT (2017–2018)

_____

_____

REPRESENTATIVE-AT-LARGE (2017–2020)
Liaison to Membership Issues Coordinator

_____

_____

_____

NAME (printed)

SIGNATURE (required)

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Candidates for the position of President-Elect shall ensure that during his/her term as President–Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.
Electioneering is prohibited on the ABCT List Serve and Facebook page.

Please complete, sign, and send form to: **David Pantalone, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001** (fax: 212-647-1865); or email the signed form to membership@abct.org. Subject line: NOMINATIONS
(Note: only full members, fellows, and new member professionals may nominate.)