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ABCT Facebook page relaunch: March 1

ABCT has over 2,000 FB friends and half are *not* ABCT members. Our new page will appear in news feeds with exciting new content.
Check our existing group for further instruction.
If you have content to share, please post!

—Josh Magee, Ph.D,
Committee on Social Networking Media Chair

President's Message

DSM-5 vs. ABCT?

Stefan G. Hofmann, *Boston University*

Some time ago, ABCT was invited to endorse by co-signing an Open Letter (http://www.ipetitions.com/petition/dsm5/) concerning the Task Force of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5). The letter was generated by a 14-member Executive Committee of the American Psychological Association's Division 32, Society for Humanistic Psychology. David Elkins, President of Division 32, was named as the primary contact person. This committee contacted ABCT, as well as many other organizations and divisions of the American Psychological Association, inviting us to join "this historic effort" by co-signing the letter in order to "provide the most unified response possible from American psychologists as a scientific and professional community." ABCT considered co-signing the letter, discussed the letter during the November 2011 Board meeting, and decided not to sign it. Now that the DSM-5 process is wrapping up, and after some time has passed for the dust to settle, I would like to share with our members the reasons why (from my point of view) ABCT decided not to co-sign this letter.

In order to provide an accurate presentation of the issue, I will need to give a brief summary of the letter and additional background information on the DSM-5 development process. Before I continue, I should note that I am an advisor to the DSM-5 Anxiety Disorders Sub–Work Group. In this role, I have assisted with literature reviews (I was a co-author on two of them), and I have been taking part in many biweekly

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
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- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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hourly conference calls organized by Michelle Craske, one of our members.

The DSM-5 maintained a web page, www.dsm5.org, during the development process that invited anybody to comment on any changes and proposals. On various occasions, the work group had been going through these comments, no matter how insignificant or self-serving, in great detail. It is surprising how few comments were submitted in light of the importance of the topic. Given the high degree of transparency, I was surprised that the authors of the Open Letter chose not to share their concerns with the DSM-5 development committee. The Open Letter implies that the DSM-5 is being written primarily by psychiatrists, with little input from other mental health professionals. For example, the letter states that "American psychologists are some of the foremost researchers and clinical practitioners who utilize the manual and, as such, active involvement is preferable to silence during the revision process. . . ." The letter further encourages psychologists and psychiatrists "to join together in developing a more scientifically based and clinically sound approach to the conceptualization of psychological distress." As is apparent from the list of advisors and members noted earlier, and in contrast to what was said in the Open Letter, psychologists are very well represented, at least for the Anxiety Disorders Work Group.

In the overview paragraph, the letter summarizes the authors' concerns "about the lowering of diagnostic thresholds for multiple disorder categories, about the introduction of disorders that may lead to inappropriate medical treatment of vulnerable populations, and about specific proposals that appear to lack empirical grounding." Furthermore, the authors

> . . . question the proposed changes to the definition(s) of mental disorder that deemphasize sociocultural variation while placing more emphasis on biological theory. In light of the growing empirical evidence that neurobiology does not fully account for the emergence of mental distress, as well as new longitudinal studies revealing long-term hazards of standard neurobiological (psychotropic) treatment, [the authors] believe that these changes pose substantial risks to patients/clients, practitioners, and the mental health professions in general.

The letter concludes that "it is time for psychiatry and psychology collaboratively to explore the possibility of developing an alternative approach to the conceptualization of emotional distress." After a list of concerns, the authors of this letter express

> . . . serious reservations about the proposed content of the future DSM-5, as [they] believe that the new proposals pose the risk of exacerbating longstanding problems with the current system [because] clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation.

The authors of the letter voice a need for "a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience and the fact that strongly evidenced causal factors include psychosocial factors such as poverty, unemployment and trauma." An ideal empirical system for classification would not be based on past theory but rather would "begin from the bottom up—starting with specific experiences, problems or 'symptoms' or 'complaints.'"

This analysis stands in stark contrast to my personal experience with the DSM and also the stated guidelines for changes. In fact, the guidelines recognize that the current DSM criteria have been criticized by clinicians for not capturing the clinical complexities of many of their patients. The new guidelines were created to "improve the usefulness for classifying and diagnosing mental disorders based on our current knowledge and predictions of where the science might be heading." In earlier versions of the DSM, there has been no intention to abandon the categorical system. Problems with the current categorical system were examined by the DSM-5 work groups and study groups with the goal of improving the system (e.g., improving reliability, avoiding "overdiagnosis" and NOS diagnoses, etc.). At the beginning of the DSM-5 revision process, four principles were laid out: (a) the DSM is a manual to be used by clinicians, and changes must be implementable in routine practices; (b) the recommendations have to be guided by empirical evidence; (c) if possible, continuity with previous editions should be maintained; and (d) there will be no a priori constraints on the degree of change between DSM-IV and DSM-5.

In general, the empirical evidence for any change introduced in DSM-5 has to be proportional to the magnitude of the change. In other words, the larger and more significant the change, the stronger the required level of empirical support should be. The amount of evidence needed for a change also depends on the magnitude of the problem with the existing criteria or definitions in that the more problematic the area or the diagnosis, the more compelling the rationale for change.

The criteria further list two broad criteria in evaluating a DSM-IV category for potential deletion. The first criterion is the clinical utility of the syndrome in terms of the magnitude of adverse effects on patients that would arise from the deletion of the syndrome (e.g., frequency of use, importance in making treatment decisions, role in stimulating the development of clinical programs). The second criterion relates to the overall quality of information about the validity of the category (e.g., there are very few studies that have examined their validity or studies suggest poor validity). Thus, the prime candidates for deletion from the DSM are those categories that have (a) low clinical utility and (b) minimal evidence for validity.

The proposed criteria changes are made on the basis of the literature reviews and secondary data analyses that document the clinical validity of such changes. Similarly, addition of a new diagnosis or the decision to delete a diagnosis is based on evidence and clear rationales. For some changes, DSM field trials have been conducted to provide a "first line" check on the clinical utility and feasibility of the changes (e.g., changes to existing diagnostic categories and proposed new diagnoses) along with reliability.

The DSM process is far from perfect. As an advisor, there have been times when the decision process was less evidence-based than I preferred. Furthermore, personal preferences and individual research topics at times colored and perhaps even determined the conversations. There have also been occasions when I felt extremely frustrated with the process, especially when we ended up at the same point after many months of discussions or when it seemed that some people were trying to push their personal agendas. However, I do not believe that this is unique to the DSM-5. Any diverse group charged with a highly complex and high-stake task probably encounters similar problems. It is not a perfect system, but I can assure you that there is no secret psychiatry-mafia or Big Pharma plot at work. The DSM-5 work group members and advisors are simply trying to come one step closer to solving one of psychiatry's toughest problems: how to define and classify mental dis-

orders. The controversy around the DSM not only centers around the assessment of mental disorders (dimensional vs. categorical) and their assumed etiology (brain disorders vs. learned behaviors), but it also reflects some fundamental, philosophical differences in the definition of what a mental disorder actually is. As its predecessors, the DSM-5 is far from perfect. However, until there is a better, alternative system for making sense of the heterogeneity of psychological problems, it continues to be the best tool that we have. And it is important that ABCT plays a role in it.

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Clinical Forum

Cognitive Behavioral Therapy for Weight Management

Julie C. Michael, ***Allegheny General Hospital, Pittsburgh, and University of Pittsburgh***

Katherine A. Belendiuk, Anne Marie Kuchera, and Dana L. Rofey, ***University of Pittsburgh***

The prevalence of overweight and obesity is an increasing health problem in the United States. Currently, it is estimated that 31.8% of children and adolescents (Ogden, Carroll, Kit, & Flegal, 2012) and 68.8% of adults are overweight or obese (Flegal, Carroll, Kit, & Ogden, 2012). Obesity in children and adolescents is problematic because it results in physical health risks such as cardiovascular abnormalities, insulin resistance, abnormal glucose tolerance, and chronic inflammation (Dietz, 1998; Ford et al., 2001; Freedman, Dietz, Srinivasan, & Berenson, 1999) as well as psychological health risks such as depressive symptoms for girls (Erickson, Robinson, Haydel, & Killen, 2000; Needham & Crosnoe, 2005) and non-Hispanic White youth (Goodman & Must, 2011). Obesity in childhood and adolescence also increases the risk of psychosocial stressors. For example, overweight and obese youth have an increased risk of bullying by peers (Janssen, Craig, Boyce, & Pickett, 2004) and being subject to negative bias by peers (Kraig & Keel, 2001; Latner & Stunkard, 2003; Neumark-Sztainer et al., 2002), teachers (Bauer, Yang, & Austin, 2004; Neumark-Szatainer, Story, & Harris, 1999), and family members (Crandall, 1991; Neumark-Sztainer et al., 2002). An additional risk of childhood obesity is that children with increased Body Mass Index (BMI) often become obese adults (Serdula et al., 1993; Singh, Mulder, Twisk, van Mechelen, & Chinapaw, 2008; Whitaker, Wright, Pepe, Seidel, & Dietz, 1997). In adulthood, obesity continues to be associated with numerous physical and psychological health risks, such as diabetes (Malnick & Knobler, 2006), cardiovascular disease (Malnick & Knobler; Wilson, D'Agostino, Sullivan, Parise, & Kannel, 2002), certain forms of cancer (Bianchini, Kaaks, & Vainio, 2002), mortality (Adams et al., 2006; Malnick & Knobler), and depression and anxiety (Strine et al., 2008). On a larger scale, the financial demands of treating obesity and the comorbid health sequelae are also a growing economic concern (Thompson & Wolf, 2001; Withrow & Alter, 2011). In light of increasing physical and psychological health risks and the inherent economic burden, effective weight management interventions are needed to prevent and treat obesity. This article will provide a brief overview of weight management treatment options for youth and adults. Subsequently, the majority of this article will focus on CBT strategies for weight management as well as special considerations and future directions in the field.

Brief Overview of Weight Management Strategies for Youth and Adults

Lifestyle intervention is the primary treatment for youth and adults who are overweight or obese. For pediatric populations, overweight is defined as having a BMI that is in the 85th to 94th percentile and obesity as having a BMI in the 95th percentile or above (Barlow, 2007; Centers for Disease Control and Prevention [CDC], 2012). When considering weight management for children and adolescents, prevention is of primary importance. For young children who are overweight, weight maintenance is commonly encouraged because of growth that occurs during early ages, and weight loss is typically the intended goal for older children and adolescents. For adults, the National Heart, Lung, and Blood Institute (NHLBI) and The Obesity Society (formerly NAASO) recommended lifestyle interventions that include modification in diet, increases in physical activity, and behavior therapy for those with a BMI of $\geq$ 30.0 kg/m^2 or those with a BMI $\geq$ 25.0 kg/m^2 with comorbid health complications (NHLBI & NAASO, 2000). If lifestyle intervention alone is deemed ineffective for adolescents or adults, additional weight

management methods such as pharmacotherapy (e.g., FDA-approved orlistat for those 12 years or older) or bariatric surgery may be recommended. Individuals who use pharmacotherapy or undergo bariatric surgery typically need to consider the pros and cons of the route taken along with the possible improvements in medical comorbidities. For youth, pharmacotherapy and bariatric surgery for weight management is typically considered with caution due to a lack of research on long-term outcomes (Catoira, Nagel, DiGirolamo, & Gonzalez, 2010; Treadwell, Sun, & Schoelles, 2008; see NIH TeenLabs, PI: Inge). In sum, the use of lifestyle intervention has been the most empirically supported for the treatment of overweight, obesity, and co-occurring medical comorbidity as a method of reducing body weight while minimizing side effects.

CBT Approach to Weight Management

CBT is an effective, widely used, and empirically supported lifestyle intervention for weight management in youth and adults. In general, CBT techniques are used to identify and modify maladaptive thoughts and behaviors associated with an unhealthy, obesogenic lifestyle. Within the CBT framework for obesity, there are key behavioral and cognitive skills that can be useful while working with patients. Select behavioral and cognitive strategies (adapted from Rofey, Blake, & Phillips, 2011) are described in detail below.

Behavioral Strategies

Dietary guidelines. According to the Dietary Guidelines for Americans from the U.S. Departments of Agriculture (USDA) and Health and Human Services (USDHHS), recommended caloric intake varies based on age, gender, and energy expenditure from physical activity (USDA & USDHHS, 2010). Daily recommendations range from 1,000 to 2,000 calories for children, 1,400 to 3,200 calories for older adolescents, 1,600 to 2,400 calories for adult women, and 2,000 to 3,000 calories for adult men (USDA & USDHHS). Within each calorie range, the low end of the range is suggested for sedentary individuals, and the higher end is recommended for those who are physically active, in addition to taking into consideration other health-related information. For weight loss of 0.5 kg to 1 kg (approximately 1 to 2 pounds) per week, it is recommended that children, adolescents, and adults aim to achieve a reduction of 500 calories per day through single or combined modification of dietary intake and energy expenditure from physical activity. While calorie intake most directly affects weight, it is also important for individuals to maintain a balanced diet. The USDHHS and Institute of Medicine recommend that individuals follow a diet that is within the Acceptable Macronutrient Distribution Ranges for carbohydrates, fat, and protein. For children and adolescents, carbohydrates should be 45% to 65% of total calories, fat should be 25% to 35% of total calories, and protein should be 10% to 30% of total calories. For adults, carbohydrate recommendations are similar, fat should be 20% to 35% of total calories, and protein should be 10% to 35% of total calories (Institute of Medicine, 2002; USDA & USDHHS). Consistent with a CBT approach, patients are recommended to gradually make adjustments to calorie and macronutrient intake in order to achieve their desired weight loss and maintenance goals. If patients have medical comorbidities, special considerations of dietary changes are recommended in consultation with the patient's physician.

Physical activity. Physical activity refers to any bodily movement produced by skeletal muscles that expends energy (Caspersen, Powell, & Christenson, 1985). The USDHHS as well as the American College of Sports Medicine (ACSM) and the American Heart Association (AHA) recommended that children and adolescents participate in 60 minutes or more of daily moderate- to vigorous-intensity physical activity in order to achieve health benefits. Individuals of all ages are recommended to participate in strength-building activities (Haskell et al., 2007; USDHHS, 2008) and children are especially encouraged to participate in bone-strengthening activities (USDHHS). In order for adults to achieve health benefits, at least 150 minutes/week of moderate-intensity physical activity is recommended (Haskell et al.; USDHHS). ACSM/AHA guidelines recommend at least 60 minutes of vigorous physical activity for adults, whereas the USDHHS recommends at least 75 to 150 minutes/week of vigorous physical activity. Both the USDHHS and ACSM/AHA guidelines note that activity may also be completed by a combination of both intensity and duration levels for adults (Haskell et al.; USDHHS).

Patients are encouraged to make gradual increases in physical activity in order to meet recommended levels, with the overarching goal of reducing inactivity. Physical activity for adults should be accumulated in at least 10-minute bouts within national recommendations in order to achieve health benefits (Haskell et al., 2007; USDHHS, 2008). Depending on a person's weight management goal, physical activity levels may be tailored to the individual with higher duration and intensity associated with greater energy expenditure. With regard to weight management, patients have been shown to have similar reductions in body weight irrespective of the intensity (i.e., either moderate or vigorous) and duration (i.e., either short or long) of regular exercise (Jakicic, Marcus, Gallagher, Napolitano, & Lang, 2003). With regard to weight management, patients are reminded that physical activity alone may lead to modest weight loss outcomes unless performed in conjunction with reduced caloric intake (e.g., Wing, Venditti, Jakicic, Polley, & Lang, 1998).

Self-monitoring. Self-monitoring is a skill in behavioral weight management programs that includes tracking both dietary intake and physical activity expenditure. Patients are typically asked to use a food and activity tracker in order to record daily food consumed with accompanying nutritional information as well as physical activity duration and intensity. Self-monitoring is a useful CBT tool because it encourages patients to have an accurate portrayal of their baseline ratings and allows them to objectively monitor change over time. Patients are suggested to provide as much information as possible in their weekly reports, yet abbreviated self-monitoring approaches have been shown to be similarly effective for weight loss (Helsel, Jakicic, & Otto, 2007). Additionally, recent use of self-monitoring technology has been shown to be effective for weight loss outcomes and may promote adherence to self-monitoring (Burke et al., 2011).

Goal setting. Setting goals is an important component of weight management in order to achieve success and overcome challenges. In coordination with the therapist, patients are encouraged to set short-term, reasonable weight loss goals. On average, typical behavioral interventions result in a reduction of 5% to 9% of body weight over a 6-month period (e.g., Franz et al., 2007). However, overweight and obese individuals have been shown to initiate treatment with desired weight losses that are, on average, two to three times greater than this range (Dutton, Perri, Dancer-Brown, Goble, & Van Vessem, 2010; Foster, Wadden, Phelan, Sarwer, & Swain-Sanderson, 2001; Foster, Wadden, Vogt, & Brewer, 1997; Jeffery, Wing, & Mayer, 1998; O'Neil, Smith, Foster, & Anderson, 2000). Several studies

have shown that greater weight loss expectations are associated with less weight loss (Dalle Grave et al., 2005; Teixiera et al., 2004), yet other research has shown that unrealistic goal setting may be unrelated to weight loss outcomes (Fabricatore et al., 2007; White, Masheb, Rothschild, Burke-Martindale, & Grilo, 2007), or may even encourage weight loss (Linde, Jeffery, Levy, Pronk, & Boyle, 2005). In light of mixed findings in the literature and in accordance with a CBT approach, patients are encouraged to set short-term, specific, achievable goals that can be monitored over time.

Stimulus control. Stimulus control includes modifying a person's environment in order to promote behaviors consistent with the desired weight management goals. Based on the idea that eating behavior is influenced by food cues (Cullen et al., 2003; Kratt, Reynolds, & Shewchuk, 2000), patients are recommended to increase the amount and availability of healthy foods in their environment while decreasing the amount of and availability of unhealthy foods. For example, home grocery delivery has been shown to be one way for participants to change healthy food environments and potentially minimize high-fat "impulse" purchases (Gorin, Raynor, Niemeier, & Wing, 2007). In regard to physical activity, patients are encouraged to consider behaviors that will increase their likelihood of being active. For example, patients may be encouraged to leave their sneakers in a high-traffic area in order to increase visibility and serve as a cue to become physically active. Stimulus control has been shown to be an effective component for decreasing sedentary behavior in the context of a weight loss. Specifically, research by Epstein, Paluch, Kilanowski, and Raynor (2004) showed that a family-based stimulus control intervention involving restructuring the home environment and setting limits related to sedentary activity showed equal and significant effectiveness in promoting reductions in BMI as compared to a treatment involving behavioral reinforcement.

Relaxation training. Relaxation training may also be helpful for individuals as part of a CBT intervention. Diaphragmatic breathing, guided imagery, and progressive muscle relaxation are relaxation strategies that may be taught to patients in order to manage negative affect and subsequently aid in making healthy lifestyle choices. In an acute situation, use of relaxation strategies is intended to directly reduce negative affect while indirectly enabling patients to elucidate negative thoughts related to the situation. Additionally, patients are encouraged to practice relaxation at home as it may be effective in lowering baseline levels of negative affect.

One way to work on barriers around eating, physical activity, and thinking is by using your problem-solving skills. Consider your challenges and work through the STEPS.

Five S-T-E-P-S to Problem-Solving

S STAY CALM AND SAY WHAT THE PROBLEM IS

_____

T THINK OF SOLUTIONS

1. _____ 3. _____
2. 4.

E EXAMINE EACH ONE [WHAT GOOD AND BAD THINGS MIGHT HAPPEN IF YOU DID THIS?]

1. GOOD: BAD:
2. _____ GOOD: _____ BAD: _____
3. _____ GOOD: _____ BAD: _____
4. _____ GOOD: _____ BAD: _____

P PICK ONE AND TRY IT OUT [WHICH ONE?]

_____

S SEE IF IT WORKED [IF IT WORKED, GREAT! IF IT DID NOT WORK, THEN GO BACK TO YOUR LIST OF SOLUTIONS AND TRY ANOTHER ONE.]

Fig. 1. **Problem Solving S-T-E-P-S.** Reproduced with permission from the protocol of Primary and Secondary Control Enhancement Therapy-Physical Illness (Szigethy et al., 2007).

Behavioral activation. Behavioral activation, which includes spending time completing pleasurable activities on a regular basis, has been shown to result in positive mood improvements (Erickson & Hellerstein, 2011; Gros & Haren, 2011). For weight management, therapists may want to recommend "experiments" in which the patient attempts to engage in a certain healthy behavior during the week. Prior to attempting a new behavior, the therapist and patient may discuss cognitive, emotional, or logistical barriers to completion of the intended experiment. At the next session, the therapist and patient should review the expected barriers from the previous week as compared with the actual barriers to completion. Behavioral activation serves the dual function of improving mood and promoting an increase in activity levels. While the USDHHS has specific guidelines for weekly physical activity, a more global goal is to "avoid inactivity" (USDHHS, 2008). Thus, even if patients find meeting national recommendations for physical activity to be challenging, encouragement to engage in any amount of activity is preferable over sedentary behavior.

Homework assignments. Therapists trained in CBT utilize structured, comprehensive, and manualized sessions that typically include a brief mood update, a bridge from the previous session, agenda setting, review of homework, discussion of agenda issues, setting new homework, periodic summaries, and a final summary and feedback (J. Beck, 1995). The implementation and use of homework assignments has been shown to enhance therapy outcomes as compared to modalities that do not utilize homework assignments (Kazantzis, Whittington, & Dattilio, 2010). Because CBT encourages practice between sessions, the intention of homework assignments is to have patients try new strategies in their daily lives in order to determine the individual effectiveness of a proposed change. Examples of homework assignments include tracking the relationship between mood and eating or exercise behavior, increasing daily water consumption, or practicing relaxation strategies.

Cognitive Strategies

Problem solving. Within an intervention, patients are encouraged to identify specific problem areas that present challenges to achieving their intended goals. Together with the therapist, patients are asked to identify a problem area, generate solutions, and evaluate the consequences of each solution (see Figure 1). Problem areas may include planning ahead for activity, eating out, managing negative emotions in specific situations, or negotiating desired social support with a partner. Regardless of the type of problem presented, patients are encouraged to work collaboratively with the therapist to develop an individualized plan to meet their needs. The addition of problem-solving strategies to a weight-loss intervention is believed to contribute directly to weight loss as well as treatment adherence (Murawski et al., 2009).

Cognitive restructuring. Cognitive restructuring is a critical component of CBT that includes identifying and challenging maladaptive cognitions related to a person's weight management goals. Patients may have certain thoughts or beliefs specifically related to weight management that serve as barriers to meeting their goals. J. Beck (2007) labeled potentially sabotaging cognitions as "permission-giving" ideas, which may serve as justification for overeating or inactivity. For example, one may think, "I'm on vacation" or "I'm celebrating," which would grant permission to allow a patient to indulge in sabotaging eating or activity behaviors.

In order to intervene with "permission giving" or other unhelpful thoughts, patients are trained to identify negative thought patterns by writing down thoughts when they notice themselves experiencing negative affect. Together with the therapist, the patient is taught to self-monitor patterns of negative or self-defeating thinking (see Figure 2, Emotional Eating Resource). Therapists may choose to use a thought record, which has space to write down a situation, thoughts and emotions related to the situation, and alternative thought and emotion responses (J. Beck, 1995). Clinicians may also utilize worksheets specifically tailored to link thoughts and emotions with maladaptive health behaviors (see Figure 3, Food/Mood Chart). Once patients are adequately able to identify negative thoughts, they are asked to challenge these thoughts by examining the evidence and utility of each thought. Patients are then encouraged to consider alternate neutral or positive thoughts to counter their negative thinking. Socratic questioning by the therapist may be useful for having patients challenge assumptions and maladaptive thoughts as well as generating alternatives. For example, the therapist may ask, "What is your understanding of why it was difficult to achieve your physical activity goals this week?" By the end of the weight management intervention, participants are expected to be able to generate and implement alternative thoughts to minimize maladaptive thinking.

Relapse prevention. Relapse prevention is a CBT strategy that is typically used in addiction-oriented models to anticipate "slips," or lapses in one's intended behavior change. Lapses are presented as realistic possibilities, and patients are encouraged to think about how to prevent lapses from becoming a relapse, or a return to the previous undesired behavior. In the weight management context, patients are encouraged to anticipate "slips" in their behavior consistent with weight management goals.

Considerations and Future Directions for CBT and Weight Management

Childhood Weight Management

Research has demonstrated that weight management interventions for children and adolescents have positive health implications and result in improved weight loss outcomes (Wilfley, Kolko, & Kass, 2011). The involvement of parents is crucial for promoting weight loss in children and adolescents. Specifically, parents are able to utilize behavioral reinforcement strategies and rewards in the context of making behavioral changes with their children, which has been shown to produce positive outcomes (Epstein, McKenzie, Valoski, Klein, & Wing, 1994; Israel, Stolmaker, & Andrian, 1985). Research has shown that whether parents actively choose to join children in their weight loss efforts or if parents choose to commit to assisting children with the child's efforts, similar positive weight loss outcomes are likely (Israel, Stolmaker, Sharp, Silverman, & Simon, 1984). Additionally, parental readiness to change weight control behaviors, but not adolescent readiness to change, has been preliminarily shown to be predictive of adolescent weight change (Jakubowski et al., in press). While parents are important to facilitate weight loss behaviors in youth, a review by McLean, Griffin, Toney, and Hardeman (2003) suggests that beneficial weight loss outcomes were seen when greater numbers of behavior change strategies are taught to both parents and children. Age and developmental considerations should inform treatment recommendations for how to also tailor programs to children and adolescents. In addition, complementary strategies such as the use of technology-based approaches may be useful. For example, the use of text messages via mobile phone has been shown to be a feasible way to improve adherence to healthy behaviors for adolescents (Woolford, Clark, Strecher, & Resnicow, 2010).

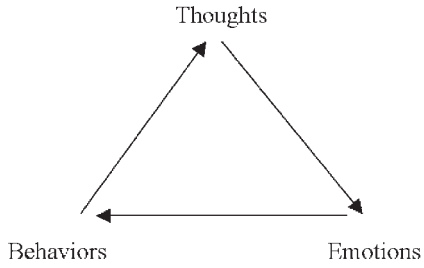
Weight Management for Older Adults

Older adults have unique considerations for weight management due to the physical effects of aging and the likelihood of comorbid medical issues. First, use of BMI as a clinical tool may be confounded by loss of muscle mass and decreasing height over time (Han, Tajar, & Lean, 2011). Sarcopenia, the loss of muscle mass with aging, and reduction in muscle strength is a concern for older adults (Doherty, 2001; Gallagher et al., 2000). Specifically, individuals who are both sarcopenic and obese have been shown to have reduced physical function than nonobese counterparts with sarcopenia (Baumgartner et al., 2004; Villareal, Banks, Siener, Sinacore, & Klein, 2004). In terms of weight loss interventions, there is mixed evidence regarding weight loss and health outcomes in older adults. An "obesity paradox" has been suggested for older individuals because of some evidence that obese individuals have a lower risk of mortality than nonobese individuals (Logue & Sattar, 2010). However, a review by Han et al. (2011) suggests that unintentional weight loss in the elderly is the result of comorbidities such as cancers or heart or lung disease, which may explain the paradoxical effects of lean weight on mortality. Clinical trials such as the Diabetes Prevention Program and Look AHEAD provide promising evidence that intentional weight loss in older adults is possible, safe, and associated with a reduction in health risks (Crandall et al., 2006; Knowler et al., 2002; Look AHEAD Research Group, 2010). Continual follow-up of the Look AHEAD trial may provide further insight about weight management in older adults. In sum, careful consideration of the risks and benefits of weight management is recommended for older adults seeking weight management. Further information evaluating the risks and benefits of weight management in older adults can be found in a publication by The National Heart, Lung and Blood Institute (NIH & NHLBI, 1998).

CBT and Weight Maintenance

Weight maintenance has been shown to be increasingly challenging, with the modal response being successful weight loss after 6 months followed by subsequent weight gain. However, promising outcomes for behaviors that promote weight maintenance have been shown from the National Weight

Because our thoughts, emotions and behaviors are connected, negative thinking and self-talk can lead to emotional eating. It can also lead to lower self-confidence, feelings of hopelessness, and isolation from others. To learn more about how your thoughts affect you and your health, check out the Lifestyle Lesson on positive thinking.



How our thoughts, emotions, and behaviors are connected:

Negatives Bring Us Down

Negative thought	Negative emotion	Negative behavior
I look terrible.	*Sadness*	*I'm not going out tonight. Emotional eating.*
I'll never pass the test anyway.	*Hopelessness*	*I'm not studying. Emotional eating.*

Positives Bring Us Up

Positive thought	Positive emotion	Positive behavior
My friends like me.	*Happiness*	*I'm going out with my friends.*
I can do well if I try.	*Confidence*	*I'm going to study for the test and do my best.*

Fig. 2. **Emotional Eating Resource: Thoughts, Emotions, and Eating.** From Weight Management and Wellness Center, Children's Hospital of Pittsburgh of UPMC; Adapted from principles of cognitive therapy (Beck, 1976; Beck, 2007).

Control Registry, a database of "individuals who have intentionally lost at least 10% of their body weight and kept it off at least one year" (Wing & Phelan, 2005). Those who are successful at weight maintenance consistently report a higher frequency of six strategies: (a) eating a low-calorie, low-fat diet; (b) engaging in high levels of physical activity; (c) weighing themselves frequently; (d) consuming breakfast daily; (e) maintaining a consistent eating pattern across weekdays, weekends, and holidays; and (f) catching "slips" before they turn into larger regains (Wing & Phelan). Research has shown that cognitive and behavioral aspects of participating in physical activity may be different for those who are able to maintain weight loss and those who are not (Riebe et al., 2005). Thus, additional research is needed in order to examine CBT interventions specifically for weight maintenance.

Broad-Based Behavioral Strategies in the Community

Changes in the future of weight management are dependent on a variety of entities, including international organizations, the private sector, civil society, health professionals, and individuals (Gortmaker et al., 2011). Within the many areas for intervention, one consideration is the promotion and reinforcement of healthy lifestyle choices within work and school environments. In a review by Anderson et al. (2009), worksite nutrition and physical activity interventions were shown to achieve modest weight reductions. Interestingly, most interventions targeted individual-based approaches, and fewer programs made modifications to the work environment. For children and adolescents, school-based interventions, particularly those in large cohorts, have also had limited effectiveness for weight management (Katz, O'Connell, Njike, Yeh, & Nawaz, 2008; Kropski, Keckley, & Jensen, 2008). Results from the HEALTHY study, a 3-year school-based lifestyle intervention for middle-school students, showed that intervention and control groups showed no significant difference in weight loss by the end of the intervention. However, the intervention group had improvements in secondary weight-related outcomes such as prevalence of obesity, BMI standard scores, percentage of students with waist circumference above the 90th percentile, and fasting insulin levels as compared to the control group (HEALTHY Study Group, 2010). Increased environmental changes and soci-

etal regulations will likely facilitate the promotion of weight management behaviors. A review by Sallis and Glanz (2009) provides useful suggestions for the development of healthier activity and eating environments such as more "walkable" neighborhoods to promote activity and societal regulations to regulate community food environments. Finally, it is also necessary to consider the cost-effectiveness of intensive weight management programs. Behavioral weight loss interventions may be expensive, and identifying predictors of success will likely be beneficial for researchers and clinicians. There is promising initial research that inexpensive lifestyle interventions are effective in preventing future health risks and associated costs (Hersey et al., 2011). Further research is needed to evaluate the costs of implementing behavioral interventions with the risk-reducing health benefits and subsequent reduction in medical costs.

Summary

Weight management is an increasing health concern for youth and adults. In light of research supporting the use of lifestyle modification, CBT is an effective, empirically supported treatment for weight management. Select behavioral and cognitive strategies may be helpful for tailoring CBT to modifying weight-related behaviors. Special considerations for weight management such as age, developmental considerations, and medical comorbidities need to be considered across the lifespan. Future research on weight maintenance and broad-based behavioral strategies will be useful in tailoring effective weight management interventions.

Situation/Time of day	**What I ate, or felt like eating/Approximate amount**	**Thoughts/Feelings**	**Hunger Level** (Scale of 1 – 5)
(Example: Home from rowing practice and watching TV.)	(Example: Ate wheat thins out of the bag.)	(Examples: Out of control. Angry at myself for eating.)	Rate hunger before and after eating. 1 = very hungry; 2 = hungry; 3 neutral (not hungry or full); 4 = stomach full – feel just right; 5 = stuffed – I ate too much

Fig. 3. **Food/Mood Chart.** Source: Weight Management and Wellness Center, Children's Hospital of Pittsburgh of UPMC; Adapted from principles of cognitive therapy (Beck, 1976).

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The Academic Job Market: Advice From the Front Lines

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By the time you receive your Ph.D. in clinical psychology, you have already cleared a number of impressive hurdles. The exciting (and intimidating) fact is that, in many respects, all of those hurdles were cleared in the interest of overcoming this next one: the job market. While there are many job opportunities for individuals with a Ph.D. in clinical psychology, the current article provides advice that is most relevant to those who are (or expect to be) applying for a position in academia at the level of assistant professor.

We were excited to have the opportunity in *the Behavior Therapist* to share resources for applying to academic jobs in psychology, and to provide practical information and advice based on our own recent experiences. We note that this article is not intended to be a comprehensive list of advice, or an always-applicable reference for applying to academic positions. Rather, what follows is a reflection of our shared knowledge from our recent experiences on the academic job market, discussions with colleagues—representing a number of institutions including Binghamton University, Brown University, Rutgers University, the University of Texas at Austin, and the University of Virginia—and our involvement on academic search committees. In the interest of providing a context for our experience, two of us (TTW and EMC) applied broadly to a range of settings, and two of us (CAS and ESS) applied narrowly to small liberal arts/teaching-focused colleges.

Types of Academic Jobs

Though somewhat oversimplified, the primary settings for academic jobs are research-focused institutions (RFI) with graduate programs in clinical psychology, teaching-focused colleges (TFC), and academic medical centers (AMC).[1] We acknowledge that the distinction between RFI and TFC positions blurs in some instances, such as in TFC settings that hold high expectations for faculty scholarship or RFI settings in which teaching performance is a strong component of the tenure review. Thus, we use this distinction only as a general guideline as it pertains to differences in the application/interview process.

In general, the expectations for faculty vary as a function of type of setting. Both research and teaching are important elements in the tenure requirements at RFIs, but teaching often takes a secondary focus. Teaching requirements typically range from a 1:1 load (i.e., 1 course in the fall semester and 1 in the spring) to a 2:2. Of note, teaching at an RFI often includes clinical supervision, and these institutions will likely be interested in what you can offer in this area (e.g., experience with specific therapeutic interventions or clinical populations). TFC tenure requirements focus more heavily on quality of teaching (with loads typically ranging from 2:2 to 4:4), though they often expect professors to maintain an active research program.

When deciding to which type of academic job you might apply, you should consider your fit with each of these types of positions based on your background and relative interest in research and teaching. Indeed, the few empirical studies to investigate factors leading to successfully attaining an academic job found that search committees place highest emphasis on the fit between the candidate's research and teaching experiences and the needs of the department (Landrum & Clump, 2004; Sheehan, McDevitt, & Ross, 1998). Specifically, RFIs place more emphasis on research fit and productivity and less emphasis on teaching experience than TFCs (Nalbone, 2011).

Prepare Early for an Academic Job

As early in your career as possible, you should start to obtain the experiences that will make you most competitive for an academic job. Thus, independent teaching would be particularly helpful for TFC jobs, whereas the number and quality of publications from independent research are critical for RFI jobs. However, an exclusive focus on one domain will be to your disadvantage, as TFCs often expect applicants to maintain an active research program and RFIs want applicants to demonstrate some facility with teaching. Put simply: *publish and gain independent teaching experience throughout your graduate training*. If independent teaching opportunities are not offered within your graduate training program it will be important to seek out other prospects for teaching, such as guest lecturing for classes in your department or adjunct/lecturer positions at other institutions. Additionally, be aware that you will likely have opportunities to acquire adjunct or lecturer positions during a postdoctoral fellowship. It has been our experience that you do not need many independently taught courses to be successful on the market (our applications ranged from 1 to 3 courses), and at RFIs in particular, teaching an independent course may not be critical.

If your department is hiring new faculty while you are in graduate school, make sure to attend the job talks of the applicants, student-applicant luncheons, teaching demos, etc. Take note of the applicants and talks that were particularly compelling and what made them so. Also, ask your mentor or other faculty in the department if they are willing to discuss the qualities the department is looking for in an applicant and what has helped or hurt applicants' success.

Resources in the Academic Job Hunt

There are two types of resources you may find helpful: resources for finding academic job postings and resources for tips and advice on applications, job talks, and the like. The two best resources for academic job postings in psychology are the employment ads on the websites for the American Psychological Association (APA; http://jobs.psyccareers.com/jobs) and Association for Psychological Science (APS; http://www.psychologicalscience.org/index.php/employment). A psychology jobs wiki (http://psychjobsearch.wikidot.com) also

[1] We have limited experience applying to AMC faculty positions and thus refrain from offering specific advice for these job applications. Though much of the broad advice below will be applicable to AMC jobs, there are unique aspects to these positions that are not addressed here.

provides regularly updated information about job listings. This wiki can be particularly useful (albeit stressful) because it is updated by users when they have been offered interviews. You may also find postings through the Association for Behavioral and Cognitive Therapies or Society for a Science of Clinical Psychology list-serves.

Regarding the application process, there is compelling information in a broad academic wiki: http://academicjobs.wikia.com/wiki/Academic_Jobs_Wiki. Of note, this wiki includes a list of institutions where people have had memorable application/interview experiences (see "Universities to Fear" and "Universities to Love"). In addition, theprofessorisin.com, a recently established blog, and www.facultydiversity.org, an online mentoring community, both provide valuable information devoted to the academic job search, preparation of application materials, and the interview process. Finally, there are existing articles and chapters that focus on applying to academic jobs in psychology (e.g., Darley & Zanna, 2003; Huang-Pollock & Mikami, 2007; Snyder, 2003).

The Application Process

The annual cycle of postings for academic job positions typically begins in late August or early September. Most jobs will be posted by the end of October, but the process may continue through January or February. The jobs posted in August/September typically have deadlines in early to mid-November, though some may be as early as the end of September or beginning of October. Though cliché, we feel compelled to point out that you are likely to underestimate how time-consuming the application process is. Having well-organized and targeted materials for each position, preparing for interviews, and interviewing are all incredibly time-intensive. We estimate that applications require 10 to 20 hours/week over the course of several weeks, although this varies considerably depending on the number of applications you are submitting. It is important to recognize that your productivity in other domains will be compromised in the months during which you are applying for jobs. However, to reduce the time burden, you can start preparing most of these materials in advance to jobs being posted (e.g., update your CV, develop research and teaching philosophy statements).

Deciding Where to Apply

As we noted above, fit between your interests and the needs of the department is an important factor contributing to the success of your application. However, it is in your best interest to apply broadly rather than too narrowly given that you may never be sure exactly what the search committee is looking for. For example, one of us received an interview for a position that was advertised as "child-focused," despite the absence of a child-focused program of research. The department chair later mentioned that the overall quality of the applicant's research was substantially more important to the search committee than having a child-focused research program. That said, some other searches will be much less likely to consider applicants who do not possess the qualities listed in the job posting. Thus, you will need to weigh the opportunity cost associated with preparing and sending a given application (i.e., time spent working on that application rather than other applications or other things important to you) against the likelihood and value of obtaining an interview or offer for that particular job.

Other important factors to consider when applying to academic jobs include whether you will be able to pursue your research agenda in that setting, feasibility of securing external funding at that institution, and how well your academic record aligns with an assistant professorship at that institution. To this end, it can be beneficial to evaluate the CVs of junior faculty at that institution or similar institutions, which are typically posted on the department's website (e.g., How many publications are typical? Do faculty have external funding and how much? Have most of the faculty completed postdoctoral training?). For institutions that value research productivity, it will be important that your record demonstrates the ability to lead independent research, which is typically reflected by multiple first-author publications and/or procurement of grants. Additionally, teaching institutions will want to see independently taught courses with strong student evaluations. In short, your fit with the institution, and your ability to articulate this in your cover letter, will be most important in determining whether you are ultimately successful in your application (Landrum & Clump, 2004; Sheehan et al., 1998).

Applying to "Open" Searches

Some job postings will advertise that it is for an "open" position rather than for a professor at a specific level (assistant, associate, or full). Many assistant-level applicants wonder whether they should apply for these open positions. The consensus advice from colleagues on search committees for these open positions is to apply if the job is very desirable to you and/or if your background makes you a particularly good fit for the position, but be aware that you may be at a disadvantage compared to the other applicants with more established research programs.

Application Materials

The materials requested as part of your application are meant to provide a reflection of your academic record, and specifically to provide information to the committee regarding your potential match with the department's needs (e.g., ability to successfully teach needed coursework and conduct publishable/fundable research in this setting). To this end, the typical application materials include a cover letter, CV, research statement, teaching statement, reprints/preprints, and three letters of recommendation. Across settings, your CV, cover letter, and recommendations are likely to be weighted heavily. The relative importance of the research statement, teaching statement, and reprints are likely to vary depending on the setting. Further, TFC postings will also often request a teaching portfolio. Most postings will request all of these materials, but some may not require one or more of these. *You should send exactly the materials that have been requested*. Our specific advice for each of the materials follows.

Cover Letter

Your cover letter should be 1 to 2 pages in length. Letters that exceed 2 pages run the risk that search committee members will lose interest. Do not underestimate the importance of this component of your application. The cover letter is your chance to introduce yourself to the search committee and is likely the first piece of your application that committee members and other faculty will read. *The two main goals of the cover letter are (a) to promote yourself and (b) to emphasize your fit with the job*.

Many psychology job applicants indicate that they find self-promotion difficult. We recommend being achievement-focused in your cover letter to effectively self-promote without sounding arrogant. For example, "In recognition of my independent research, I was awarded the X Award for Research Excellence and the results have

been published in well-regarded journals such as *Journal Y* and *Journal Z*," is an achievement-focused, fact-based statement that highlights the accomplishments of the applicant.

The cover letter is also your opportunity to make explicit that you have researched the institution, the department, and the position. Be clear why you are interested in this position (e.g., if you were a student at a similar TFC, considering pointing that out here), and briefly describe what your plans (e.g., research program) would be for the appointment. Attention to detail is important; your cover letter should be composed on letterhead and formatted in a formal business/academic letter style with appropriate margins, font, and font size.

Research Statement

The research statement is typically 2 to 3 pages and should outline your research program with an emphasis on how your research fits together to provide a coherent body of work. You can mention publications that resulted from your research program, as well as any research awards or grants you have received. You will also want to provide information about the direction you plan to take your research program in the future.

When applying to institutions that emphasize teaching or that have limited resources (either because of department size, location, or some other limiting factor), it will be important to identify in your research statement how your program of research will be successful within the given institution. For example, if a number of your publications include functional magnetic resonance imaging (fMRI) and the setting does not provide access to fMRI facilities, your proposed workaround for this issue should be clear. In addition, when applying to TFCs, be sure to note how your research program will (a) provide training opportunities for undergraduate students, (b) be successful in a setting without graduate students, and (c) succeed with potentially limited access to clinical populations.

Teaching Statement

A typical teaching statement is 1 to 2 pages. This statement should emphasize how what you have done has contributed to your philosophy of teaching. Assume that everyone who is applying to this position (a) loves teaching, (b) thinks teaching is important, and (c) uses multimedia to illustrate difficult concepts. This statement should convey enthusiasm for teaching, mention the classes you have taught, and list the classes you would be excited to teach (including those listed in the job posting, if qualified to teach them). Set your statement apart by conveying enthusiasm with concrete examples of creative teaching strategies rather than flowery language. Of note, the previously mentioned blog has a focused entry on this topic (theprofessorisin.com; see Kelsky, 2011).

Teaching Portfolio

The teaching portfolio is intended to provide a summary of the data you have collected demonstrating your teaching competency. Unless more specific information about the required components is included, the portfolio is comprised of a teaching statement (see above), a sample syllabus, course demographic information (i.e., what you have taught, where, when, enrollment numbers, etc.), and a summary of student evaluations. Ideally, you should provide a sample syllabus for a course you have taught that is also one of the courses the institution has identified in the job posting. However, providing a syllabus for a course that is not listed in the job posting is likely preferable to creating a "fake" syllabus. In terms of summarizing teaching data (sometimes referred to as "Evidence of Teaching Excellence"), provide summary ratings in either tables or figures, and select key qualitative statements students have provided about your course(s). Where possible, provide department or college means for comparison. You should prioritize student feedback from classes in which you were the instructor of record; however, if necessary, it is acceptable to include data from classes in which you were the instructor for a lab section to a larger course or a teaching assistant.

Curriculum Vitae

At the point in your career when you are applying for an academic job, you should already have the content and general format of your CV prepared. Therefore, our primary advice is to focus on improving the professional appearance of your CV and eliminating material that specifically points to your "junior" status, such as being a student member of professional organizations.

Reprints/Preprints

Most postings will ask for 3 or 4 reprints/preprints of your scholarly work. The guidelines about what to send are relatively intuitive: articles on which you are the lead/sole author will be the most compelling evidence of your ability to generate independent research. You will also want to prioritize articles from peer-reviewed journals with higher impact factors over journals with lower impact factors or those that are not peer reviewed. Finally, if possible, send the official journal preprint/reprint PDF file rather than a text document as the former appears more "authentic" than the latter.

Letters of Recommendation

Most postings will request three letters of recommendation. Letters of recommendation have been rated as the most important factor when evaluating a job applicant's materials (Sheehan et al., 1998). As with the letters of recommendation you requested for graduate school and internship, you should choose letter writers who know you well and will write *unfailingly positive* letters for you. You should provide letter writers with a draft of your cover letter and/or other materials and identify to your writers the strengths you would like emphasized in your letter. You should choose writers who can address the strengths that are most relevant for the position to which you are applying. For example, if you are applying to an RFI, your writers should address your potential as an independent researcher.

Research indicates that lack of a letter from your primary advisor may be a cause for concern for search committees (Landrum & Clump, 2004). If you do not feel comfortable requesting a letter from your primary advisor, you should consider how to address this issue. One potential approach is to ask your letter writers to identify the extenuating circumstances that have led to you being unable to request a letter from your advisor and to include information in the letter to allay any concerns about your academic dedication or interpersonal skills. It is probably best not to address this issue in your cover letter.

Telephone Interviews

Many institutions conduct preliminary phone interviews before deciding whom to invite for on-campus interviews. These phone interviews can take place anywhere from 2 weeks to a month or more after the submission deadline. Some committees conduct telephone interviews only with the 3 to 5 applicants whom they are planning on inviting to interview on campus, whereas others may conduct telephone interviews with 8 to 12 applicants in order to

narrow down promising candidates to the 3 to 5 who will be invited for on-campus interviews.

Committees use telephone interviews to assess the applicants' social skills, interest and enthusiasm for the position, and fit with the job posting and the department in terms of research and/or teaching. These interviews typically last 15 to 30 minutes. Some questions to expect in a telephone interview include:

- What interested you in applying to our program/department/university?
- What courses would you be interested in teaching?
- How would you implement your research at this college/university?

RFIs may ask specific questions about your research to better understand your research program. TFCs may ask you to describe the structure of a course you would like to teach and the assignments you would include in such a course.

On-Campus Interviews

Search committees will invite 3 to 5 candidates to interview on-campus. At this point—congratulations!—you are on the (very) short list of candidates, and the department has decided to invest in you as a potential hire. In addition to our advice below, you may find helpful tips on the interview process in an article by Miller and colleagues (2007). Also, keep in mind that on-campus interviews are, in addition to an evaluation of you, opportunities for you to evaluate the department and faculty to determine if this is the right position for you.

Interview with out-of-department faculty. If you are invited for an interview, you may be asked if there is anyone outside of the department with whom you would like to meet during your on-campus interview. We have received some mixed advice on how to respond to this. Some argued that you should always say yes to such a request as it shows enthusiasm and interest for the job. Others have stated that the decision to interview with someone outside the department is genuinely optional and will not negatively impact your chances if you decline. If you do decide to interview with someone outside the department, make sure that the meeting makes sense in the context of your teaching or research interests.

Preparing for the interview. In preparing for your interview, take time to learn about the department and the faculty. Make a special note of any faculty with whom you have mutual research and/or teaching interests or with whom you could collaborate. You may not be expected to know everyone's names and research interests in detail when you come to interview, but you will be expected to be familiar with the department and the faculty research programs. It will also provide you with material to talk about on the interview.

You will want to be prepared to answer numerous questions about your research, teaching, and many other topics. A small sample of questions and statements you should be prepared to answer includes:

- Tell me about your research.
- Why are you interested in a job here?
- What would you like to teach?
- What are your thoughts about living here?
- What are some future directions of your research?
- How would you describe your mentorship/teaching style?
- What questions do you have for me?

In response to the last question, you absolutely want to have many questions and statements prepared that will help you to learn more about the department and whether it will be a good fit for you. Some you might consider are:

- What is it like to be an assistant professor in the department?
- I would like to learn about tenure expectations/requirements.
- What are service expectations for junior faculty?
- Where is the department headed over the next 10 years?
- What is the relationship between the department and the college/university?
- What is the student body like?
- How does the department support graduate students?
- How does the department decide which faculty can recruit graduate students?
- What is it like to live here? Where do faculty live? What is the cost of living like here? What is it like in the summer? Which are the good school districts?

Some questions will be more appropriate in some circumstances than others, and you should feel free to ask the same questions in each of your interviews to gauge the consistency of the responses.

Details of the interview process. The actual on-campus interview will typically take place over 1 or 2 days. The department should pay for or reimburse your transportation, lodging, and meals during your interview process. You will likely meet with most, or all, of the faculty in the department and thus will have little downtime. The interview process can be mentally and physically exhausting due to the full schedule and the need for the candidate to be "on" during the process. Therefore, you should take advantage of any breaks you do have to use the restroom, eat, drink water, etc.

Expect to eat your meals with faculty members or students. These meals are absolutely a part of the interview process and give the faculty a chance to see and talk with you in a less formal context. You may be offered alcohol at dinner and many people wonder if it is appropriate to have a drink in this situation. The consensus advice on this issue is that it is fine to have one drink with the meal but feel free to decline. In addition to meeting with faculty, you will meet with graduate and/or undergraduate students. You should consider meetings with students a formal part of the interview process, as search committees often contain at least one student. In addition, feedback from students is taken seriously. If you are arrogant or dismissive of the students, expect this to reduce your chances of being hired.

At your meals and more informal meetings, be prepared to converse about something *other than* being a clinical psychologist at this institution. This kind of small talk comes more or less easily to different people. Assuming that you may be somewhat anxious, it is a good idea to think a bit ahead of time of topics that you are comfortable discussing. In general, given the evaluative nature of these meetings, it is safest to avoid controversial topics. One strategy is to do some informal research on "safe" topics to bring up prior to the interview. For example, reading interesting news stories online or in the city's local newspaper may provide conversation options if discussion gets dry. Also, to make these meetings less interview-like, engage in conversation about your interviewers' interests rather than simply answering questions about yourself.

You will likely meet with the dean or associate dean (or both) of the college in which the department is housed. In most settings, the dean is the person officially hiring you, giving him or her "veto power" over the hiring decision (though this power is rarely used at most institutions). Be prepared to discuss the general focus of your research program and its implications. This also is an opportunity to ask broader questions about the standing of the psychology department within the college and the dean's vision for the college over the next 5 to 10 years.

You will also have an exit interview with the department head/chair. The chair will review tenure expectations (if not already discussed) and may also discuss estimates for salary and startup funds. It is not appropriate to negotiate at this point; you will negotiate if you receive a formal offer. If you have not already done so, you should ask to see the office and lab space that would be yours if you were offered the job.

Your performance in interviews with faculty, especially faculty on the search committee, and in your job talk (see below) is typically the most important criteria in the final evaluation of candidates (Sheehan et al., 1998). Thus, your behavior during the interview and job talk is of considerable import. As such, *we recommend maintaining an enthusiastic but professional attitude throughout the interview process*. This communicates both a positive interpersonal demeanor and an interest in the program and the faculty. Remember, the search committee is choosing someone who will be a colleague in the department for several years. They want to choose someone who is both engaging and collegial.

The job talk. The job talk is a 45- to 60-minute presentation on your program of research. You should ask for specific details regarding the job talk when you are invited to interview. For example, ask how long the talk is expected to be and whether this includes time for questions. The goal of the job talk is not to present your latest research findings, or an exhaustive list of all your studies. Rather, you want to demonstrate your program of work and tell a story about how your research projects fit together in a coherent way. It is important to know that this segment of the interview is oftentimes simultaneously an evaluation of your research program *and* your teaching abilities.

Depending on the complexity of your research, you should present between one and three studies in this talk. Assume that your audience will consist of faculty in your area of expertise, faculty outside your area, graduate and/or undergraduate students, and possibly faculty from other departments. As such, you will want to present your talk in a manner that is comprehensible to a broad audience. That said, don't "dumb down" your talk. Rather, present more background or introduction to your research and reduce jargon that is particular to your area or field of study. For example, at a TFC there may not be another clinical psychologist in the audience, and thus a more detailed overview of the clinical profile/public health relevance of your research is warranted. Use good presentation skills; limit text on your slides and consider the aesthetics of your presentation. Consider removing slides that only present statistics and instead use figures or tables. You will also want to spend a substantial portion of your talk (the last 5 to 10 minutes) discussing future directions of your research; this lets the search committee know that you have a vision for the future of your research program. In general, but especially at TFCs, it is useful to outline the role that students will play in your research program and how your research will fit into the (geographical, academic) context of the department.

You will want to practice your job talk several times. Keep in mind that it may be particularly valuable to practice the talk in front of people who are not clinical psychologists. Also, we suggest you "overpractice" the first 5 minutes of your talk. This is the time when you will likely be the most nervous, and extensive practice with this section will help you perform well despite any early anxiety. Make sure to keep to the time limit on your talk and leave time for questions. Resist the temptation to go over the time limit, as staying within the designated time shows professionalism and courtesy for your audience.

Many people are nervous about the question-and-answer period at the end of the talk, which ranges from 5 to 30 minutes. Answer questions openly and honestly and avoid becoming defensive in response to any questions. Prepare for questions that seem likely based on your practice talks. As with the interviews, be enthusiastic and engaging in your talk. Consider this the unique opportunity to talk about work that you love with a bright and captive audience!

You should wear a suit on the day of your job talk. Many people wonder if they should wear a suit for the second day of interviews and, if so, if they should have a second suit. We recommend wearing a suit on the second day because it is better to dress too formally than too casually in interview situations. If you do not have a second suit and do not want to buy one, it is fine to simply wear a different shirt/blouse (and necktie, for men) with the suit from the first day.

Teaching demonstration/guest lecture. Many TFCs will ask candidates to present a guest lecture or teaching demonstration (often referred to as a "chalk talk"). These sometimes occur as separately scheduled talks or occur as a guest lecture in a standing class. Typically you have the freedom to decide what to lecture on (though the topic may be a specific request such as a classroom lecture informed by your research). We suggest you select a topic that is a teaching strength, as teaching outside of your expertise risks putting you at a disadvantage compared to other applicants who do teach on their specialty area. Further, if it is appropriate to the topic and you have time, consider varying from lecture format (e.g., a brief group exercise or multimedia component), but use these judiciously. For example, one of us (CAS) has expertise in the anxiety disorders and cognitive behavioral therapy. Her classroom lecture, "How Learning Theory Has Informed Treatment of the Anxiety Disorders," included an activity in which students developed treatment hierarchies for case examples. Another of us (TTW) has a background in depression research and taught a classroom lecture on "How the Diagnosis of Depression Impacts Depression Research," which included an interactive group exercise where students attempted to determine if case examples met criteria for major depressive disorder.

Case conference presentation. You may be asked to give a "case conference" to the clinical area only, which focuses on your treatment or assessment of a specific client. Case conferences are a much rarer component of the interview process; thus, there are fewer guidelines and recommendations for presenting an effective case conference. If you are asked to give a case conference, we encourage you to ask the search committee chair about anything specific the department would like to see included in this presentation (e.g., a therapy vs. an assessment case). In general, the goal of these presentations is not to demonstrate a particularly successful case, but instead to highlight your intervention and/or assessment plan, specific therapeutic techniques, challenges confronted, and your theoretical framework. This gives the department the opportunity to get to know your clinical style and to gauge what you might be able to offer in terms of clinical training, supervision, and graduate course work.

After the interview. It is customary to send an email of thanks to the search committee chair as soon as you return home from the interview. You might also consider sending emails to other faculty, especially those with whom you had dinner or lunch, and the administrator of the department if you interacted frequently with him or her. This is another opportunity to express your enthusiasm about the position, the department, and the institution. The waiting game then begins. If you happened to be the final candidate on campus, you could receive an offer within a few days of your visit. However, it is common to not receive an offer until a few

weeks after your visit. During your interview, you can ask the chair what the time line is for a decision on the position to give you a sense for when you should hear from the department.

Negotiating an Offer

During negotiations, keep in mind that you are not directly negotiating with the chair/head of the department (although it does feel that way, as they are the person with whom you are speaking/emailing). In fact, the chair acts as the go-between for you and the dean of the college. Thus, do not feel self-conscious about being polite yet firm in your emails to your future colleague. The chair has a vested interest in negotiating a contract that provides the resources that you need to be a productive and successful member of the department. However, the chair is also concerned with perceptions of fairness in the department and may not want an incoming hire to have a much higher salary or more extensive lab space than current professors.

Negotiations are expected, so don't be averse to negotiate anything in the initial offer. Many people think of negotiating starting salary, but almost anything is on the table during negotiations. Here are some things to consider negotiating: startup funds, teaching course-load reductions (especially in the first 1 to 2 years), money for conference travel, summer funding for students, the official start date of your position (consider when your current position ends and whether there will be a gap in salary, health benefits, etc.), lab space, furniture for your office, and clinical licensure fees. Negotiating for a higher starting salary can be very beneficial in the long run because your raises will likely be dependent on your starting salary. However, this also makes institutions reluctant to increase starting salary much, so they will often look for other ways to improve the offer. In negotiations, it is often useful to provide comparative data in order to leverage the best position for yourself. For example, salary numbers across institutions are publicly available via the American Association of University Professors (AAUP). Websites such as glassdoor.com and salary.com may also provide comparables for you to use in negotiations. Your goal throughout this process should be to ensure that you will have the resources necessary to be successful in your scholarship, teaching, and service as you enter into the tenure track. Do not lose sight of this! Finally, make sure that any negotiated items are included in the final written contract as this prevents any future misunderstandings about what was agreed upon during negotiations.

After you have officially agreed on a contract with an institution, you should call or e-mail the department chair at other institutions where you know you are being actively considered as a potential candidate. In our experience, this has been a brief and collegial conversation. Keep in mind that other institutions will be grateful to you for not using their time and resources if you will not consider a potential offer.

Special Circumstances

Applying and interviewing while pregnant. Applying for tenure-track positions—a challenge under the best of circumstances—can become even more daunting when this process intersects with personal life events. One issue that has received little empirical attention, but which one of us (EMC) experienced firsthand, is applying while pregnant.

First, it is critical to consider not only the extent to which pregnancy will impact your ability to undergo the rigorous application and interview process, but also whether it is the right time to move and begin a position with a new baby. Simply put: the stress of applying while pregnant must be factored into the potential costs and benefits of applying versus deferring your application. Once you make the decision to apply, it is important to consider the time frame during which you feel comfortable to fly or drive to an interview. Of course, this may change both as you experience what it is like to interview while pregnant, and as you move toward the later stages of pregnancy and/or postdelivery.

More than anything, effective communication is critical when contending with a personal issue that affects the interview process. Following the maxim that it is best to wait to introduce potential bias, we advise against disclosing information about the pregnancy in the initial application materials or during the phone interview stage. Similar to any personal characteristic (e.g., one's marital status), it is not necessary to ever disclose this information, and search committee members cannot legally ask you about it unless you have already offered this information. Personally, once offered a campus interview, I (EMC) chose to e-mail the chair of the committee because I was visibly pregnant.[2] It is also important to communicate any special needs (greater bathroom breaks, extra snacks, etc.). That said, while search committees will likely be gracious and accommodating of your needs, do not expect to receive special treatment.

Academic partner. Having a partner who is also an academic (the so-called "two body problem") is very common and comes with unique challenges when applying for an academic position (see Schiebinger, Henderson, & Gilmartin, 2008). In this section we draw from personal experience (EMC), in addition to the input from various colleagues who have successfully navigated this issue in acquiring academic jobs in psychology departments.

Our advice is to think about this issue early when you are preparing to apply for academic jobs. Some questions that you and your partner might consider are:

- Does it make sense for both of you to apply to the same positions or at the same institution? Are you both at the same point in your career?
- If you both cannot apply to the same institution, are there other opportunities in the area for your partner?
- Are you willing to take a job if your partner does not get a job in the area?

Advice that was consistent across colleagues was that it is not a good idea to discuss your partner during initial application materials or during the phone interview stage. Additionally, if you both are psychologists, it is likely beneficial if both the applicant and partner apply for the same position even if the department is advertising for only one hire. During negotiations this will allow the applicant to make a case that the partner was genuinely interested in the job, department, etc.

There were mixed opinions on whether an applicant should bring up the academic partner issue before negotiations. Some argued that this could put an applicant at a competitive disadvantage if it is revealed before negotiations. Others felt that it was better to raise the issue ahead of time, particularly if the department seemed like they might be receptive to it (e.g., if you happen to interview with faculty who are part of a

[2]Given that my window to interview was very constrained, I also sent carefully worded e-mails to several institutions following a phone interview but prior to being offered a campus interview. In the e-mail, I explained that while I was very enthusiastic about the institution, I could not interview after X date. This gave the schools the information they needed if they were interested in inviting me for a campus interview.

dual academic couple). Finally, some cautioned that it is difficult not to discuss one's partner during the many hours spent interviewing, which can lead (even inadvertently) to a discussion about your partner's job. If you do decide to raise the issue, we suggest that you have a plan to help assuage possible concerns (e.g., "Part of why I'm so excited about this position is because the geographical area has so many potential universities/opportunities/etc. for my partner").

We recommend preparing a firm statement for negotiations regarding your partner—for example, "I am very excited about this offer; but, in order for me to be able to accept this job, I need to have plans for my partner." Something to keep in mind is that, once an offer has been extended, it cannot be retracted because of the requests you make in negotiations. Therefore, don't be afraid to be polite but firm in negotiating for your partner. Also, don't make the mistake of only negotiating a position for your partner and losing sight of the fact that you are negotiating for your position as well.

There is substantial variability in institutions' willingness and ability to negotiate on this issue. The general consensus is that, if a department really wants you, they will try to make some kind of accommodation for your partner, though it may not be a fully satisfying position. For example, a department may be able to offer a visiting professor position that is not guaranteed to turn into a tenure-track appointment.

Final Thoughts

The process of applying for academic jobs can be long and stressful, but it is also an exciting phase in redefining yourself as an independent professional. Hopefully, this article will be helpful for those of you preparing to enter the academic job market and for those of you planning on doing so in the future. We acknowledge that this is by no means an exhaustive list of helpful advice for the academic job application process, but we have covered a number of issues and included a substantial amount of advice that we either (a) received before we went on the job market and found helpful or (b) wished we had received before starting the process. We also think that the advice contained herein is helpful and not iatrogenic, but you should discuss our suggestions with your advisor and/or colleagues to determine their relevance to your particular situation. Good luck!

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Sheehan, E. P., McDevitt, T. M., & Ross, H. C. (1998). Looking for a job as a psychology professor? Factors affecting applicant success. *Teaching of Psychology, 25*(1), 8-11.

Snyder, C. R. (2003). Preparing for a position in clinical psychology: Part 2 – the application, interview, and negotiation stages for obtaining a position in clinical psychology. *The Clinical Psychologist, 56*(1), 19-25.

. . .

We would like to thank our advisors and colleagues for their instrumental guidance and support, especially Nancy Barnett, Cynthia Battle, Christopher Beevers, Meredith Coles, Ed Craighead, Brandon Gibb, Ivan Miller, and Bethany Teachman.

Correspondence to Tony T. Wells, Oklahoma State University, Department of Psychology, 116 N. Murray, Stillwater, OK 74079; tony.wells@okstate.edu

Appendix

Potentially useful resources mentioned in this article.

Finding Academic Job Postings

American Psychological Association:
http://jobs.psyccareers.com/jobs

Association for Psychological Science:
http://www.psychologicalscience.org/index.php/employment

The Chronicle of Higher Education:
http://chronicle.com/section/Jobs/61/

Inside Higher Ed:
http://careers.insidehighered.com

Psychology Job Wiki:
http://psychjobsearch.wikidot.com

Applying to Academic Jobs

Darley, J. M., & Zanna, M. P. (2003). The hiring process in academia. In J. Darley, M. Zanna, & H. Roediger, (Eds.), *The compleat academic: A career guide* (2nd ed.). Washington, DC: American Psychological Association.

Huang-Pollock, C. L., & Mikami, A. Y. (2007). The academic job search: Time line, tips, and tactics. *the Behavior Therapist, 30*(5), 104–108.

Miller, D. N., Blom-Hoffman, J., Chafouleas, S. M., Riley-Tillman, T. C., & Volpe, R. J. (2007). Navigating a successful academic career in psychology: Tips and recommendations for graduate students. *Graduate Student Journal of Psychology, 9*, 49-55.

Snyder, C. R. (2003). Preparing for a position in clinical psychology: Part 2, The application, interview, and negotiation stages for obtaining a position in clinical psychology. *The Clinical Psychologist, 56*(1), 19-25.

http://academicjobs.wikia.com/wiki/Academic_Jobs_Wiki

www.theprofessorisin.com

www.facultydiversity.org

Academic Salaries (for Negotiation Purposes)

AAUP faculty compensation survey: http://www.aaup.org/AAUP/comm/rep/Z/

www.glassdoor.com

www.salary.com

At ABCT

Minutes of the Annual Meeting of Members

Saturday, November 17, 2012, National Harbor, Maryland

Call to Order

President Klepac welcomed members to the 46th Annual Meeting of Members. Notice of the meeting had been sent to all members in September.

Minutes

Secretary-Treasurer Davis asked for any comments or corrections on the minutes from last year's meeting. M/S/U: The November 12, 2011, minutes were unanimously accepted as distributed.

Expressions of Gratitude

President Klepac thanked Deb Hope for the wonderful job she has done as Past President and noted that Dean McKay is rotating off as Representative-at-Large and joining us as President-Elect. He thanked Kristene Doyle for the superb job she's done as Membership Issues Coordinator. President Klepac remarked that there are literally hundreds of people serving in the association. He thanked Catharine P. MacLaren, 2009-2012 Clinical Directory and Referral Issues Committee Chair; Carl V. Indovina, 2009-2012 List Serve Committee Chair; Daniel L. Hoffman, 2009-2012 Social Networking Media Committee Chair; Todd A. Smitherman, 2009-2012 Committee on Student Members Chair; Kristalyn Salters-Pedneault, Academic Training Committee Chair; Michael P. Twohig, Research Facilitation Committee Chair; David A. F. Haaga, 2009-2012 Publications Committee Coordinator; Maureen Whittal, *Cognitive and Behavioral Practice* Editor, Volumes 16–19; N. Bradley Schmidt, 2009-2012 Media Production Committee Chair.

President Klepac reported that he was very pleased with the content and expanse of this year's convention. He gave a heartfelt thanks to Jeff Goodie, 2012 Program Chair; and all the committee chairs and committee members who put the program together. He noted his appreciation to Jillian Shipherd, 2009–2012 Workshops Committee Chair.

Thanks were extended to the stellar group of reviewers who helped Dr. Goodie put the 2012 program together, including Lauren Alloy, Drew Anderson, Margaret Andover, Karla Anhalt, David Atkins, Abbie Beacham, J. Gayle Beck, Rinad Beidas, Kathryn Bell, Jennifer Block-Lerner, Thomas Bradbury, Timothy Brown, Steven Bruce, Andrew Busch, Will Canu, Cheryl Carmin, Anil Chacko, Eunice Chen, Mari Clements, Rebecca Cobb, Dennis Combs, Michael Coons, James Cordova, Ronda Dearing, Thilo Deckersbach, Patricia DiBartolo, Ida Dickie, David DiLillo, Linda Dimeff, Brian Doss, Laura Dreer, Jill Ehrenreich-May, Miriam Ehrensaft, Susan Evans, Todd Farchione, Christopher Flessner, Dara Friedman-Wheeler, Patti Fritz, Richard Gallagher, Scott Gaynor, Jeffrey Goodie, Cameron Gordon, Kim Gratz, Amie Grills Taquechel, Shelby Harris, Stacey Hart, Trevor Hart, Sarah Hayes-Skelton, James Herbert, Amy Herschell, Marjan Holloway, Flora Hoodin, Matthew Jarrett, Barbara Kamholz, Kathryn Kanzler, Robert Kern, Jacqueline Kloss, Kelly Koerner, Jennifer Langhinrichsen-Rohling, Robert LaRue, Robert Leahy, Penny Leisring, Cara Lewis, Gabrielle Liverant, Aaron Lyon, Sarah Markowitz, Kelly McClure, Lata McGinn, Carmen McLean, Daniel McNeil, John McQuaid, Elizabeth Meadows, Douglas Mennin, Terri Messman-Moore, Alicia Meuret, Robert Meyers, Catherine Michas, Alec Miller, Damon Mitchell, John Mitchell, Nathanael Mitchell, Todd Moore, James Murphy, Taryn Myers, Brad Nakamura, Douglas Nangle, Lisa Napolitano, Tara Neavins, Karl Nelson, Timothy Nelson, Roisin O'Connor, Phyllis Ohr, Bunmi Olatunji, Camilo Ortiz, John Pachankis, David Pantalone, Sandra Pimentel, Donna Posluszny, Holly Ramsawh, Sheila Rauch, Simon Rego, Lorie Ritschel, Shireen Rizvi, Patricia Robinson, Ronald Rogge, Kelly Rohan, George Ronan, Kenneth Ruggiero, Steven Sayers, Brad Schmidt, Kathleen Sexton-Radek, Jedidiah Siev, Sandra Sigmon, Monica Skewes, Moria Smoski, Jennifer Snyder, Susan Sprich, Gregory Stuart, Mary Sullivan, Sharon Sung, Raymond Tafrate, Dennis Tirch, Kimberli Treadwell, George Tremblay, Matthew Tull, Cynthia Turk, Lisa Uebelacker, Risa Weisberg, Robert Weiss, Adam Weissman, Amy Wenzel, Chad Wetterneck, Shannon Whiltsey Stirman, Bradley White, Kamila White, Monnica Williams, Douglas Woods, Jerome Yoman, Claudia Zayfert, and Michael Zvolensky.

The Local Arrangements Committee did a great job setting things up and making us feel welcome. The President thanked chairs Jennifer Bodart and Kathryn Kanzler and committee members Kent Corso, Meghan Corse, Heidi Daniels, Melissa Decker, Leigh Johnson, Nevia Pavletic, Matthew Sacks, and Robin Toblin.

Appointments

The President listed the new appointments to leadership positions: David DiLillo, 2012-2015 Membership Issues Coordinator; Danielle Maack, 2012-2015 Student Membership Committee Chair; Robert Schachter, 2012-2015 Clinical Directory and Referral Issues Committee Chair; Joshua Magee, 2012-2015 Social Networking Media Committee Chair; Anne Marie Albano, 2012-2015 Publications Committee Coordinator; Justin Weeks, 2013 Program Committee Chair; Kevin Chapman, 2013 Associate Program/2014 Program Chair; Kirsten Haman, 2013 Local Arrangements Committee Chair; David Atkins, 2013-2016 AMASS Committee Chair; Barbara Kamholz, 2012-2015 Workshop Committee Chair; Kim Gratz, 2012-2015 Research Facilitation Committee Chair; Gabrielle Itta Liverant, 2012-2015 Academic Training Committee Chair; and Ariel J. Lang, 2012-2015 Affiliations and Specializations Committee Chair.

Finance Committee Report

Denise Davis expressed her enjoyment in the job of Secretary-Treasurer and explained the Finance Committee's functions: to protect the fiscal health of ABCT; track income, expenses, and projections; evaluate requests for special projects that require funding; review personnel recommendations; monitor investment portfolio management; ensure property maintenance of our permanent headquarters; and serve as liaison to development activities.

She noted that the current Finance Committee is comprised of the Secretary-Treasurer and two appointed members, Mike Petronko and Christopher Mosunic, plus the President-Elect (Stefan Hofmann this past year, to be followed by Dean McKay in the coming year), and ABCT's Executive Director, Mary Jane Eimer, as an ex officio member.

Secretary-Treasurer Davis reported that for fiscal 2012, the year just ended, we pro-

ject a gross income of $1,742,481, with gross expenses of $1,472,435, giving ABCT a net excess revenue of $270,040. Of this net revenue, 39% comes from the convention, and 30% each from publications and membership, with another 1% from other sources. These percentages fluctuate somewhat year to year, but remain within a similar range. She noted these are projections and we will know the final numbers for fiscal 2012 after our accounting firm has conducted the annual audit. The projected expenses for 2013 flow as follows: convention at $364,843; publications at $299,238; membership at $28,195, and the rest at $1,184,522, totaling $1,889,448 in overall projected operating expenses. We are projecting modest surpluses for 2013 and 2014, with a possible deficit in 2015.

We use a conservative-income strategy for our short-term investments that stresses high liquidity plus blue-chip fixed income instruments. This is used for General Operating Funds; our Capital Expense Fund, which is currently at $180,000, and our Special Project Funds, currently at $143,766. For our long-term investments, we use a moderately conservative strategy in which we aim to preserve capital and generate moderate growth. Our returns this year have generated 5.10%. Our total endowment of $1,064,493 includes Named Award Funds of $40,834 and Fund the Future at $1,023,659.

Within development, donations are up modestly. We see our development's purpose to support our mission; and our updated policy eternalizes new funds. There will be more to happen in 2013 with a new student travel award and the creation of a Development Committee.

Concerning ABCT's general financial health, we are fiscally sound. We pass yearly independent audits, follow accepted accounting principles, and comply with all state and federal regulations. Our budget is transparent and there is no structural deficit in the 2013-14 budget. Staff time and task allocations are congruent with our stated goals. Lots of people have worked hard to get us here—kudos to all!

Coordinators' Reports

Academic and Professional Issues

Kamila White, Academic and Professional Issues Coordinator, reported that the Academic Training Committee, under Chair Kristi Salters-Pedneault, completed the Teach CBT portal on the ABCT website. The committee will maintain and update this section with additional teaching resources, syllabi, demonstrations, and assignments for instructors of CBT courses, as needed. They are also looking at adding video resources and demonstrations. She thanked Dr. Salters-Pedneault for her service and introduced Gabrielle Liverant, the incoming chairperson for the Academic Training Committee.

Shireen Rizvi, chair of the Committee on Awards and Recognition, hosted the award ceremony for the 2012 award recipients. Congratulations to Alan E. Kazdin, Career/Lifetime Achievement; Patricia A. Resick, Outstanding Contributions by an Individual for Educational/Training Activities; Michael Gelder, Distinguished Friend to Behavior Therapy; Mitchell J. Prinstein, Outstanding Mentor; for Outstanding Service to ABCT, Laura E. Dreer, Carl V. Indovina, and Lynn McFarr; Caroline Oppenheimer, Virginia A. Roswell Student Dissertation Award; Johanna Thompson-Hollands, Leonard Krasner Student Dissertation Award; and Amanda S. Morrison, John R. Z. Abela Dissertation Award. The coordinator also noted that the committee discussed the relative absence of awards for mid-career members and included this as a priority for the upcoming year. She reminded everyone that the 2013 Call for Nominees is posted on our website and appears in the winter issue of *tBT*. The deadline for nominations ends March 1. Members are strongly encouraged to nominate colleagues and friends.

The Committee on Affiliations and Specializations, under Chair George Ronan, has worked with the Inter-Organizational Task Force on Cognitive-Behavioral Psychology Doctoral Education, developing a report that has been published in *Behavior Therapy* and elsewhere. The coordinator welcomed incoming Chair Ariel Lang.

The Committee on International Associates, under Chair Anne Marie Albano, has developed a new page on the website. It highlights the World Congress Committee (WCC) in Behavioural and Cognitive Therapies, including a link for the next World Congress, to be held in Lima, Peru, in 2013.

The Committee on Research Facilitation, under Chair Michael Twohig, has finalized the policies and procedures for IRB-approved surveys to be posted on our list serve and/or Facebook page (as a means to assist student members with their research). Kim Gratz is the incoming chairperson for the committee.

The Committee on Self-Help Book Recommendations, chaired by R. Trent Codd, presented four books to the Board for approval. The committee is working on refining the preamble and review procedures and criteria for self-help books.

Convention and Continuing Education

Sandy Pimentel, Coordinator of Convention and Continuing Education, reported that we had 3,412 convention registrants as of Saturday morning and a record number of program submissions. New features this year include the ScholarOne app and a Workshop-PLUS option of postconvention follow-up consultation sessions for a limited number of workshops.

The coordinator expressed appreciation of Program Chair Jeff Goodie for his conscientiousness and of Stephanie Schwartz, our Managing Editor, for the design of the convention logo and book. She also singled out Jennifer Bodart and Kathryn Kanzler for their help in the fabulous local arrangements at our National Harbor Convention.

In the transition to convention planning for next year, Jillian Shipherd is stepping down as Workshop Chair and Barb Kamholz is taking over. Risa Weisberg will continue to organize the Institutes offerings. To ensure a smooth transition for AMASS, David Atkins will work with Scott Compton over the coming year.

The Continuing Education Committee, headed by Muniya Khanna, has developed three new CE webinars. These were first showcased live, then added to our website as streaming videos. This greatly exceeded the original goal of hosting one webinar, and Kelly Koerner's assistance was acknowledged as instrumental in the success of this launch. The target for next year is 6 webinars. The coordinator thanked Lisa Yarde and David Teisler for their help in establishing the webinar access on our website.

The coordinator expressed excitement about upcoming conventions in Nashville, then Philadelphia, Chicago, and ABCT's 50th anniversary in New York City. She ruefully noted her namesake hurricane that impacted the Central Office immediately prior to the convention, and offered heartfelt thanks to all the staff who kept going even without power to insure all systems were "go" for this year's annual convention!

Membership Issues

David DiLillo, incoming coordinator, presented on behalf of the Coordinator of Membership Issues, Kristene Doyle, who

was presenting on a membership panel during this time slot.

He noted that Membership and Student Membership Committees continue their priorities of retention and recruitment of members. As of October 26, 2012, ABCT was ahead of where we were exactly 1 year ago, for current members, former members rejoining, members change of status, and new members for 2013.

The Membership Committee, chaired by Jon Grayson, is contacting nonmember authors who have accepted manuscripts in our journals. They are investigating whether there are an adequate number of clinically focused offerings at our conventions, as this could directly impact the attendance at conventions as well as membership. He also noted that a membership panel, "Career Possibilities After You've Completed Graduate School," is being given at this convention.

The Student Membership Committee, chaired by Todd Smitherman, has been very productive this year. This committee is evaluating the potential use of monthly student emails, student calendars, and postcard mailings to expand upon recruitment and retention. The committee has made noteworthy progress in increasing its visibility on the website as well as providing additional student resources online. The Student Membership Committee published an article on the benefits of student membership in the September issue of *tBT*, and developed a dictionary of commonly used ABCT abbreviations, acronyms, and slang that is available on the website. The Student Membership Committee will continue to organize student-focused *tBT* articles, and is developing a series of podcasts aimed for students in which members described memorable experiences they had as students in ABCT. Dr. DiLillo thanked Todd Smitherman for his commitment as chair and introduced Danielle Mack as incoming chair.

The Clinical Directory and Referral Issues Committee plans to add photographs to clinical directory listings in 2013, and reports that the Find-a-Therapist (FAT) Directory now includes a search by radius of ZIP code, making FAT much more user-friendly. Incoming Chair Bob Schachter is exploring various avenues to add value to the expanded listing for its clinical members. For example, this may include more polished format for the listings, and more practice-related information for clinicians such as marketing ideas and practical tools (e.g., office document templates). The incoming Membership Coordinator thanked Catharine MacLaren for her service as Clinical Directory and Referral Issues Committee Chair.

Our Special Interest Groups continue to be a strong feature of the association. There are 37 Special Interest Groups (SIGs) participating in the SIG expo, presenting 293 posters. One new SIG has been added (Clinical Psychology at Liberal Arts Colleges SIG-in-formation) and 2 SIGs have changed their names: Autism Spectrum and Developmental Disorders SIG, formerly the Developmental Disabilities SIG; and Trauma and PTSD SIG, formerly Disaster and Trauma SIG.

The Social Networking and Media (SNM) Committee continues to make diverse postings on Facebook. The SNM Committee has identified several areas of concern. Two primary concerns addressed by the committee are inappropriate posts and low traffic to the ABCT Facebook page. Inappropriate posts are being addressed through ongoing moderation and reminders to follow the rules and regulations. The committee is dealing with low traffic by providing more diversified and regular content and suggests revisiting new group/organization page formats to push into news feeds. The committee continues to reach out to students and professionals focused on psychology as well as careers in mental health. The committee continues to offer publicly accessible content as a resource for psychological issues in the media as a means of increasing public awareness. The incoming Membership Issues Coordinator thanked Dan Hoffman for his commitment to ABCT. He will be succeeded by Josh Magee as committee chair.

The incoming coordinator noted that the List Serve Committee continues to do a good job monitoring online postings. He also said that feedback on the moderator manual that Carl created has been positive. Moderators say it is easy to follow and user-friendly. He thanked Carl Indovina for his tireless work and time as List Serve Moderator and as chair of the committee.

The Leadership and Elections Committee continues to develop a leadership development program for mid-level career members. The committee contacted participants who attended ABCT's first leadership seminar at last year's convention to inquire how they have incorporated the seminar information into their activities this year. President-Elect Dean McKay, Coordinator Kristene Doyle, Chair Ray DiGiuseppe, and Executive Director Mary Jane Eimer will participate in a panel discussion on leadership in ABCT this Sunday.

Dr. DiLillo noted that the 2013 Call for Nominations appears on our website, in *tBT*, and on the back page of the program addendum. Calling attention to the February 1, 2013, deadline for nominations, he encouraged everyone to think of colleagues who would be interested in governance, including ourselves, and to become active in the nomination process.

On behalf of Membership Issues Coordinator Doyle, Dr. DiLillo offered a special thank you to Carl Indovina (List Serve), Todd Smitherman (Student Membership), Dan Hoffman (Social Networking Media), and Catharine MacLaren (Clinical Directory and Referral Issues) for their service to membership. Coordinator Doyle hopes their involvement in ABCT governance continues in various capacities. She also sent thanks to Jon Grayson, Ray DiGiuseppe, Kathyrn Roecklein, and their committee members for their work in membership throughout the year. Coordinator Doyle extended her gratitude to members of the Board and to Bob Klepac, Deb Hope, and Frank Andrasik for their leadership and support throughout her tenure as Membership Issues Coordinator. She proclaimed that ABCT is in great hands with incoming Coordinator David DiLillo. Finally, she expressed a hearfelt thank-you to members of the ABCT Central Office—Mary Jane, Mary Ellen, David, Lisa, Tonya, Stephanie, Keith, and Damaris—whose tireless efforts do not go unnoticed. She truly enjoyed her time as coordinator and appreciates the good friends that she made along the way.

Publications Committee

David Haaga, Publications Coordinator, noted that it has been a very good year for ABCT publications. Our contract with Elsevier garnered additional royalties from our journals, so we made some money. Susan White and her Public Education and Media Dissemination Committee has been busy, adding podcasts to our website in which members discuss how their work affects the treatment of various disorders. Web Editor Carmen McLean and her associate editors are immersed in a redesign of the website with the expectation that it will be even easier to find what you're looking for. Maureen Whittal is completing her tenure as editor of *C&BP*, during which she initiated videos (embedded in online articles) demonstrating clinical techniques as well as improving the impact factor to 1.372, which is incredible for a clinical journal. Incoming editor Steve Safren is already han-

dling manuscripts. At *BT*, Tom Ollendick is entering the final year of his tenure, where he is handling a record number of submissions, and incoming editor-elect Michelle Newman is already set with her editorial team. Kate Gunthert is doing well at *tBT*, and is several issues ahead of schedule, which is a big deal. The coordinator was happy to announce that Brett Deacon is the editor-elect for *tBT*.

Discussion is under way with Oxford University Press about developing a series of clinician guides. Details of this project should be provided at the next meeting. The coordinator expressed pleasure in handing the gavel off to Anne Marie Albano, who inherits a committee well served by its editors and chairs. He offered his thanks to David Teisler, who remains calm while getting things done, and to the at-large committee members, Carolyn Becker-Black, Dara Friedman-Wheeler, and Kami White.

Executive Director's Report

The Executive Director noted that our organization is fiscally sound, healthy, and vital. She expressed pride in the efforts of our staff during Hurricane Sandy. Notably, those without electricity used the office as home base. Staff who had power worked remotely because there was no transportation within, much less into, the city. She extended thanks to Keith Alger, the first person many members hear when they call and who is handling membership at the convention, and to Damaris Williams, who handles our bookkeeping. Tonya Childers and Lisa Yarde are professional and graceful under stress as they handle registration at the convention. Stephanie Schwartz applies her editorial and graphic eye to our journals, printed materials, and website. Finally, the Executive Director feels that she could not go wrong with Mary Ellen Brown and David Teisler as her right and left hands.

An organization of this size and complexity takes partnership. You can see some of the measures of success at the convention and in our products. This year is no different: we added three webinars, the ScholarOne mobile app, added bandwidth to keep pace with growing demands on our communications, switched from an outdated tape backup system to cloud technology while retaining internal redundancy, earned ABCT an award-winning website by winning the 2012 NYSAE CyberAward (thanks to the submission by our Director of Communications and the work of our web editors, committees, and staff), and our accounting firm continues to give us high marks during our annual audit for being fiscally sound, in compliance with all state and federal regulations, and points out we are well managed.

The stability the association enjoys in staff allows us to get things done. We are paying attention to technology, and, as you've seen with the journals, are often on the cutting edge. For our friends outside the states, you can now visit the international associates page on our website so you can find one another. The Executive Director invited all members to feel encouraged to stop by their professional home if their travels bring them to the Big Apple.

President's Report

President Klepac thanked the membership for allowing him to serve and thanked the various committees and coordinators for great work this year. He said that it has been rewarding working with the Board of Directors. He offered many thanks to the Central Office and said that he couldn't imagine working without them, especially Mary Jane, Mary Ellen, and David.

Transition of Officers

Dean McKay becomes President-Elect and Sabine Wilhelm becomes Representative-at-Large and liaison to Convention and Education Issues. Karen Schmaling becomes the 2013-2016 Secretary-Treasurer, to succeed next November. President Klepac expressed pleasure to present the new President, Stefan Hofmann.

Incoming President's Report

President Hofmann noted that he is happy to serve his professional family. He thanked the Central Office, and asked all the staff to stand up to warm round of applause.

Adjournment

There being no further business, the meeting was adjourned at 1:07 P.M. Eastern Standard Time.

—Respectfully submitted,
Denise D. Davis, Ph.D.
Secretary-Treasurer 2011–2013

online

47th Annual Convention
ABSTRACT SUBMISSION
http://www.abct.org

in-press

Randomized Clinical Trial Comparing Affect Regulation and Supportive Group Therapies for Victimization-Related PTSD With Incarcerated Women

"The findings suggest that relatively brief group therapies teaching affect-regulation skills or facilitating experiential self-expression may benefit incarcerated women with PTSD. Although women in TARGET groups overall viewed themselves as achieving only small gains in affect regulation, they did report greater increases in the ability to forgive those who had caused harm than women in SGT groups. . . . ."

Ford et al., *BehaviorTherapy*
in press
doi:10.1016/j.beth.2012.10.003

archive

"...the grasping of the object..."

Wolpe, J., 1982
The Practice of Behavior Therapy,
Third Edition (p. 21)

Call for Papers on next page of this issue

47th Annual Convention | Nashville

Preparing to Submit an Abstract

ABCT will once again be using the ScholarOne abstract submission system. The step-by-step instructions are easily accessed from the ABCT home page. As you prepare your submission, please keep in mind:

• ***Presentation type:*** Please see the two right-hand columns on this page for descriptions of the various presentation types.

• ***Number of presenters/papers***: For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

• ***Title***: Be succinct.

• ***Authors/Presenters***: Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are **current member**; **lapsed member** or **nonmember**; **postbaccalaureate**; **student member**; **student nonmember**; **new professional**; **emeritus**.

• ***Affiliations***: The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.

• ***Key Words***: Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword "military" is already on the list and should be used rather than adding the word "Army." Do *not* list *behavior therapy*, *cognitive therapy*, or *cognitive behavior therapy*.

• ***Goals***: For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the goals of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."

Overall: Ask a colleague to proof your abstract for inconsistencies or typos.

Understanding the ABCT Convention

The ABCT Convention is designed for practitioners, students, scholars, and scientists who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions and Ticketed Events.

GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. General session types include:

Invited Addresses. Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.

Spotlight Research Presentations. This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Symposia. Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. A total of 5 or 6 presenters is preferable, and no more than 8 are allowed.

Panel Discussions and Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. A total of 5 or 6 presenters is preferable, and no more than 8 are allowed.

Poster Sessions. One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

Clinical Grand Rounds. Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings. More than 35 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee.

Clinical Intervention Training. One- and 2-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

Institutes. Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, there is generally one offered on Thursday and one offered on Sunday morning. They are 4 hours long and limited to 40 attendees.

ABCT's 47th Annual Convention

CALL *for* PAPERS

PROGRAM CHAIR:
Justin W. Weeks, Ph.D.

Cognitive and Behavioral Therapies: ***Harnessing Synergy Among Multidisciplinary Sciences***

Cognitive and behavioral therapies (CBT) are grounded in empiricism and the scientist-practitioner model. Given its overarching scientific emphasis, it is not surprising that numerous and multifaceted methodologies have proven useful for both measuring and conceptualizing the changes that CBT can yield for patients. However, utilizing diverse methodologies to evaluate CBT-related outcomes represents only one direction of effect. As a scientific discipline, CBT also stands to inform independent disciplines in valuable ways.

Fusion is the process by which two or more objects join together, or "fuse," to form a single object. Under the proper conditions, the fusion of two objects can result in harnessed energy. Evidence abounds that such conditions are readily achievable when it comes to fusing CBT and related scientific disciplines.

The theme of this year's conference is "CBT and Harnessing Synergy Among Multidisciplinary Sciences." The conference will focus on presentations that highlight the integration of a broad range of methodologies, including some disciplines that do not traditionally interface directly with health care. For example, how can we better fuse CBT research with neuroscience; genetics; biology; social sciences; anthropology; linguistics; and other allied disciplines? What more can we learn from these different disciplines and, of equal importance, what can these other disciplines learn from researchers of empirically supported treatments?

We encourage submissions that seek and provide opportunities for an interdisciplinary cross-fostering dialogue, with the goals of fully harnessing knowledge pertaining to CBT and its associated applications and exploring ways in which evidence-based practices can be informed by and, in turn, directly inform related sciences. To this end, submissions focusing on potential synergies between CBT research and the other sciences will receive special consideration. Given the theme focus, representation in disciplines that have been underrepresented in past meetings is welcome.

Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters.

Information about the conference and for submitting abstracts will be on ABCT's website, www.abct.org, after January 1, 2013. The online submission portal will open in early February.

November 21–24, 2013 | Nashville

DEADLINE FOR SUBMISSION:
March 1, 2013

the Behavior Therapist
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