

# *the* Behavior Therapist

## Contents

### Feature

*Timothy R. Tumlin* Ten Things Psychologists Should Know  
When Talking to the Press 69

### Research-Training Link

*Clayton Neighbors and Christine M. Lee*  
A Brief Guide to Manuscript Reviewing 74

### Research-Practice Link

*Thad R. Leffingwell* A Model for Teaching Empirically  
Supported Therapies in a Graduate Course: The Behavior  
Therapy Seminar Series 77

### Institutional Settings

*Jennifer A. Snyder, Anthony Daiuto, Leann Nelson,  
and Janice McStoots* Measuring Motivation for Treatment  
in Adult Psychiatric Inpatients 81

### Book Review

*Reviewed by Stacey B. Daughters & Jon E. Grant*  
Petry, N. P. (2004), *Pathological Gambling: Etiology,  
Comorbidity, and Treatment* 83

### At ABCT

- Find a Therapist 84
- ABCT People 85
- Important Information About Journals On-Line 86

### Classifieds 85

### Feature

## Ten Things Psychologists Should Know When Talking to the Press

Timothy R. Tumlin

Psychologists are experts whose knowledge and skill are of great value to society, not only when it is communicated through personal contact and peer-reviewed publications, but when it is done through the news media. Contact with the news media furthers both the interests of our science and of our practices. When psychologists understand the culture of news, they can better capitalize on potential for extending themselves to the community while observing the limitations that media demands. Listed below are some considerations relating to the press that will help you be heard in ways that will be useful to you and those we undertake to serve.

### 1. You Can Start by Reaching Out

How does one begin? One way is to contact a reporter about a recent story and offer another perspective or new information. Be sure to invite the reporter to call you when the topic arises again. If the perspective you offer is contradictory to what's been written, be sure to offer it as a constructive alternate point of view, pointing to the science to back your position.

Reporters don't like being criticized any more than anyone else—they have to become instant experts on many topics, and so they are open to learning. Let them know you can help them to avoid inaccuracies or mischaracterizations relating to subjects within your area of expertise. Most reporters will be grateful for a new resource on a topic with many facets. Notifying news outlets of your activities, such as a public lecture, through

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press releases is also an appropriate way to make contact. Local newspapers in particular often are willing to print a press release announcing an upcoming talk or significant event.

When writing a release, assume an editor will cut off everything but the first two paragraphs, so all the essential “who, what, when, and where” information should be at the very beginning. Every organization gets many such press releases. You may wish to call to find out the proper recipient for them, whether e-mail is preferred over paper mail, and if there is a reporter or editor who specializes in this topic. However, see suggestion 9 below about the risks of being too aggressive in turning news contacts into marketing.

## 2. Develop Relationships

Good reporters and editors have lists of people in many fields they can turn to for a quote, background information, or ideas. When you develop a relationship with them as someone who is authoritative and reliable, they will seek you out for help and be open to your ideas for stories and commentary. When a puzzled editor gets a press release on too-good-to-be-true “Fudgesicle Therapy,” she may call you to make sure it really is as phony as it sounds. The bottom line is that the rules of networking and good professional relations apply here as well as with colleagues in psychology. All relationships take time to develop; this one will be no different.

## 3. Local Sources Are Often Preferable

Most news media are local, and they look to local resources. While a *New York Times* or ABC News quote will reach millions, if you live in Smallville, Ohio, your practice will likely be better served when you are quoted by the Smallville *Daily Bugle* or the local classic rock radio station’s sole newsmen. The local sources are far less likely to have large budgets, so they’re often grateful for accurate, reliable sources for information. Thus, not only can you approach local journalists more easily, but they may want to cite a local expert rather than someone out of town.

## 4. Clarify the Question

Just as with a clinical referral, don’t be afraid to find out what a reporter or editor is looking for. Is it a full history that starts with Salter or Skinner? Or is it just a couple of lines about shyness? Sometimes you can give it to them quickly once you see where

they are headed, rather than deliver a long lecture covering topics they don’t care about. Don’t give them what they don’t want. It is appropriate to ask what the story is about and what the caller is specifically seeking. We psychologists tend to be long-winded and expansive, while the news media are looking for concise points to be made. Also, as noted in suggestion 7 below, expansiveness can be risky. Remember that if you can state your points succinctly, it is more likely you’ll be quoted as you wish. Therefore, stop and consider a simple declarative sentence when possible. For example, “Cognitive-behavioral therapy has been shown to be as effective as medication in treating conditions such as depression.” This is where it pays to have a moment to collect your thoughts on a topic, as noted in suggestion 6. The reporter will probably be very patient in allowing you to do this, because he is looking for exactly such comments that are easy to include in an article, rather than have to extract them from a lengthy and complex discourse.

## 5. Assess the Reporter

Journalists vary widely in their professionalism and ability to abstract information into news stories that are accurate, reflect the proper tone, and use balance. You will find some to be as perceptive and intelligent as any Ph.D., and then there are those at the other end of the spectrum. While the correlation is far from perfect, journalists in the larger and more respected organizations tend to be more proficient. A journalist with less skill, experience, or time to do a good job may be more likely to get some facts wrong, so you should make sure you make the salient points clearly. On the other hand, the less experienced journalist will likely depend more on what you say, so you can get more of your points across. Some radio stations, weekly newspapers, and small dailies are likely to reprint or read a press release verbatim if it is written well. Don’t expect a reporter to send you a copy of the resulting news story, or to tell you how you will be quoted in it. Large magazines have fact-checkers who call sources to confirm their quotes and other information, and an author of a major, lengthy piece may get back to you to confirm the accuracy of her understanding (for example, an article in the *New Yorker* may take months to write). However, in run-of-the-mill daily journalism, there simply isn’t time to do that. And, as noted in suggestion 10, the author often doesn’t know how the finished product will look, either.

## 6. Take Time If You Need It

If you are called upon to be an expert for a reporter, you may have time to familiarize yourself with the topic. Find out the reporter’s deadlines. Sometimes you’ll be called on a breaking news story with a pressing deadline, but often, information about psychology is not urgent and you can take a few minutes to look something up and call the writer or producer back. As noted below, trying to be an instant expert just to get your name in the paper can cause trouble.

## 7. Anything You Say May Be Repeated, a Million Times

The media disseminate information for two reasons: because it is important and helpful, or because it is entertaining. Try not to be part of the latter, at least not unintentionally. In most instances, you won’t be talking about a controversial area, but nevertheless be aware that you are “on the record” at all times unless you specifically ask to not be. If you are on a politically “hot” topic, such as child sexual abuse or medication effectiveness, your comments may draw sharp public rebuttal from zealous individuals or well-funded corporations using paid consultants with impressive credentials and think-tank surrogates.

Reporters can be as skillful as any therapist in making people feel comfortable speaking their minds, even when it’s not good for them. You may think you’re in a casual conversation or think you’re not being quoted because you are illustrating a point for the reporter’s understanding. If you believe in astrology, are behind on your child support payments, or if you’ve taken antipsychotic medications, don’t bring that up unless you want to see it in the paper or hear it on the radio. The fact that you are a respected health care provider just makes it more likely you will be allowed to entertain rather than inform the readership.

Here’s a personal anecdote: I told a Chicago *Tribune* reporter that, behaviorally speaking, police can be ineffective in enforcing speed limits when they don’t enforce the posted limit and make drivers guess when they will be ticketed. I told him I had once driven past a state policeman with a radar gun at 74 mph in a 55 mph zone and he didn’t flinch because he was waiting for a “real speeder.” Well, the reporter couldn’t resist putting in the story such a profoundly stupid quote from a seemingly respected

*{Continued on p. 74}*

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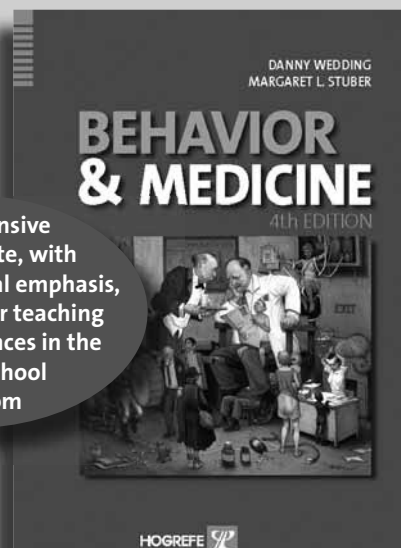
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{Continued from p. 71}

person like a psychologist. Later, the editor of the Sunday *Tribune* editions reprinted it in a section of entertainingly dumb quotes. Let the “expert” beware.

### 8. Don't Overreach

Practicing outside your area of competence is an ethical issue, and it is equally risky to offer the news media opinions about areas in which you are not expert. It may be tempting to overreach when you know it could benefit your clinic, practice, or theoretical orientation. Additionally, a reporter may make the interview feel like an informal conversation and thus elicit an opinion that you're not qualified to give. When in doubt, keep suggestion 7 in mind. You will develop your relationship with a reporter if you can refer her to the right expert.

### 9. Don't Commercialize

Journalists are keenly aware that the power of publicity they have is valuable. The better ones are wary of being hustled for commercial purposes. Reporters are willing to give you publicity in return for your contribution, but within limits. Expect to have included in an article your name,

the city you practice in, and possibly a brief description of your practice, but not your address or telephone number: for example, “Dr. Mary Smith, a psychologist practicing in Smallville, who specializes in treating autistic children.” If you advertise in the reporter's newspaper, or on his station, do not bring that up as a possible inducement to write a story to your benefit. It will have the opposite effect on a professional journalist. If your activities appear to benefit the public, then news outlets are more willing to give you free publicity to promote them. Nonprofit organizations, such as universities, get more help in recruiting research participants and promoting programs.

### 10. You May Not Recognize the Final Product

The information you provide a writer may go through many hands and permutations before it is printed or broadcast. It is often impossible to know how a story shows up on the air or in the paper. It is a ritual among reporters to pick up their morning paper to see what happened to the story they submitted the day before. Sometimes they're as surprised as anyone else. A news editor usually has authority to make changes to the story and decide where it will be placed in the paper. In some cases this is

done long after the reporter has gone home. It is usually up to an anonymous copy editor, not the writer of the article, to write the headlines, picture captions, and other text around the story. In the broadcast field, reporters and producers usually have much more control over the content of their story, but not the placement within the broadcast. You may also find that 5 or 10 minutes of taped interviewing turns into a 5-second snippet on the air.

In sum, it is entirely possible to have excellent connections with the news media in many forms. You can develop relationships with editors and writers, and offer articles of your own that will be given due consideration. However, there are some rules to follow in working effectively with journalists, and some caveats as to what limits are best to keep in mind. The power of the press can spread the benefits we have to offer our community but it also includes some risks and pitfalls for the individual who seeks to use it. I hope these suggestions both forewarn psychologists and offer them potential in working with the news media.

THE AUTHOR is a former reporter and editor for two major newspapers and the Associated Press wire service. ✍

## Research-Training Link

# A Brief Guide to Manuscript Reviewing

Clayton Neighbors and Christine M. Lee, *University of Washington*

The purpose of this article is to provide an overview of manuscript reviewing. This article will be informative for undergraduate and junior graduate students seeking to better understand the process of peer review. This article will be especially useful to senior graduate students, new faculty, and others who have the opportunity to review manuscripts but have not yet had much experience doing so. In addition, we hope this article will provide food for thought for all of those who review manuscripts regularly.

### Why Review Manuscripts?

Reviewing manuscripts requires time and effort for which you receive no financial compensation. So why do it? Presumably, one of the primary reasons many enter “higher education” is the opportunity to

contribute to science. Manuscript reviewing is a real opportunity for you to shape the literature and the direction of science. Manuscript reviews are one place in which paradigmatic battles are fought, and it is your opportunity to help influence the quality of the evidence supporting one camp or another. Reviewing also keeps you informed about what others in the field are doing. It is often difficult to find time to read new journal articles for which there is no external commitment. Committing to a manuscript review ensures that you will contact cutting-edge work and read it carefully.

In pointing out to others what is unclear or how topics might be better organized, we undoubtedly improve the clarity and organization of our own ideas. Thus, manuscript reviewing enhances the likelihood that one's own work will be published because it teaches us how to anticipate the kinds of

things that are important to reviewers. Reviewing also provides you with perspective when reading and responding to reviews of your own work. Completing thoughtful reviews in a timely manner also cultivates good relations with editors, which may improve your chances of getting your own work published. Finally, manuscript reviewing demonstrates service to the field and builds your curriculum vitae. Example vita section:

### EDITORIAL CONSULTATION

Ad hoc reviewer for the following journals:

*Behavior Therapy*  
*Cognitive and Behavioral Practice*  
*Journal of Studies on Alcohol*  
*Psychology of Addictive Behaviors*  
*Psychological Bulletin*  
*Psychological Science*

Requests for assistance in reviewing manuscripts are common. Advisors often use this as a mutually beneficial training tool. Colleagues may ask you to look over a review or they may ask your opinion about a specific aspect of a review (appropriateness of the methodology, whether the authors interpreted the literature in a fair and bal-

anced way, statistics, etc.). Assisting with a review has all of the benefits noted above except, in some cases, recognition (we encourage mentors and editors to acknowledge students who assist in the review process). Helping review a manuscript also has additional benefits. Feedback from a mentor or senior colleague you have assisted should enhance your confidence in reviewing. As a bonus, you may receive some insight into your own reviewing style and obtain specific feedback regarding the issues you identify. Finally, a manuscript review on which more than one person works may well yield a better review. Although assisting with manuscript reviews as a student is not required in most programs, it is a valuable experience and, in many places, opportunities are readily available. Just ask, if someone doesn't ask you first.

### Attitude

We propose that reviewers develop a style and attitude in reviewing that is consistent with motivational interviewing. In our experience, there is a tendency to be overly critical in writing reviews, especially among less experienced reviewers and young professionals who have not received many reviews of their own work. Few things are more discouraging to authors than a review detailing flaws without any practical suggestions for remediation. There are no perfect research studies or papers. We encourage you to conceptualize your role as helping the authors publish their research, whether in the journal you are reviewing for or elsewhere. Keep in mind that the universe in which you publish is smaller than you think and it is a good idea to play nice (think karma). Part of your job as a reviewer is to instruct. Pointing fingers and questioning abilities is unlikely to produce an improved manuscript. We suggest cultivating a certain amount of empathy in reviewing. You may be reviewing the first paper a junior graduate student has ever submitted for publication. Finally, an invitation by an editor to review a manuscript is a complement to you. Treat it as such.

### Strategies for Becoming a Good Reviewer

Becoming a good reviewer involves some time and effort on your part. Writing a review shouldn't be something that you do at the last minute or give just an hour of your attention.

### Keep to the Time Line

Journals typically give reviewers a specific date for turning in their reviews, which ranges from a couple of weeks to a few months, depending on the journal. It is important to avoid turning in your review late. Doing this repeatedly will likely frustrate the editor and reflect poorly on you professionally. More importantly, late reviews are discourteous to the researchers. We know of instances where manuscripts were rejected after being under review for over a year because of slow reviewers. Late reviews are not only unfair to researchers, who might have preferred to submit the paper elsewhere, they also have a detrimental impact on the reputation of the journal.

### Objectivity

You may be "blind" to the identity of the authors in many, but not all, cases. Under some circumstances, even if authors are not listed, you may know who the authors are based on the sample characteristics, or where the research was conducted, especially as you become more familiar with an area of the literature. Regardless of authorship, it is important to write your review as objectively as possible and to maintain con-

fidentiality regarding the manuscript. The main question you should ask yourself is whether you can be objective in reviewing the paper of a person you know. If the answer is yes, review the paper. If no, explain your dilemma briefly to the editor and decline to review the paper as promptly as possible.

Be aware that frequently rejecting offers to review manuscripts will lead to fewer offers in the future. By contrast, if you write helpful reviews, and do so in a timely fashion, you will receive more offers to review (and perhaps more than you'd like). After a few years of good scholarship and contributing helpful reviews, you may be invited to join an editorial board. Be aware that when you accept editorial board membership you are typically committing to reviewing at least four to six manuscripts per year.

### Writing a Review: The Nuts and Bolts

There are probably as many ways to write a review as there are reviewers. The following are suggestions that we have found to be helpful. First, read through the manuscript entirely once. Form some general impressions about the manuscript: Is it

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well written? Does it address important issues of interest to readers of the journal? Then read the manuscript again, taking detailed notes concerning both strengths and weaknesses. In general, you are looking for things that indicate high quality (a thorough literature review, sound methodology, clear results and conclusions). You are also looking for things that require clarification and revision. An exhaustive list of specific issues you might address is beyond the scope of this article, but some specific things you might want to focus on are as follows: How does the manuscript fit with the journal? Is relevant literature cited? Are the aims/hypotheses clearly laid out? Is the sample and procedure adequately described and appropriate to the aims of the study? Are the analyses appropriate? Do the conclusions and discussion follow from the results? Are limitations noted? When you have compiled your notes, it is time to begin writing your review.

### *Length*

Different journals have different forms and/or formats for you to submit your review. Regardless of whether there are forms or not, most journals require that you write a narrative summarizing your impressions of the manuscript. In general, one to two pages is a good rule of thumb. Less than half a page probably indicates a lack of effort, and is less likely to be helpful in improving the quality of the manuscript. Even when publication is recommended with few suggestions for revision, it would be helpful for the editor to know your impression of the strengths of the manuscript. While more detail is better than less detail, reviews in excess of three pages (single-spaced) are probably excessive. For articles that are seriously flawed, it is worth describing the major problems and taking less time and space for minor issues. However, generous reviewers often provide substantial commentary that may be invaluable to young researchers in need of guidance and critical feedback. While the present manuscript may not be publishable, such efforts may be vital for improving future research. As noted above, the tone of the review is critical to whether the recommendations facilitate improvements in the manuscript.

### *Organization*

It is generally a good rule of thumb to begin the review with a summary of the purpose of the manuscript and your overall thoughts about the manuscript, including strengths and weaknesses, novelty, impor-

tance, methodological rigor, and interest level. Summary statements are generally helpful for highlighting key recommendations for the editor and authors. For example: "Overall, the paper is well written and pending clarification of a few issues potentially makes a good contribution to the literature" or "Overall, I think this manuscript has potential, but there are some critical issues that give me pause. I have attempted to provide constructive comments and suggestions that will be helpful in disseminating this research, even if not in XYZ journal."

There are several ways to format a review. One way is to present things in order of importance, having major issues followed by minor issues. By beginning with the primary concerns, the authors know immediately which issues are the most critical to address in a resubmission. A second way to organize your review is to follow the format of the manuscript—beginning with general comments, then moving to the introduction, methods, results, and discussion. A third way to organize would be to use an outline format (A1, A2, B3 . . .), where the review is arranged around themes (e.g., recruitment issues, interpretation of results). Finally, as suggested above, if the paper is fundamentally weak, it is appropriate to focus on more global issues, without too much worry about smaller details. It is helpful to end with a conclusion/summary. Briefly summarize the major points and comment on the importance of the work. Reiterate strengths, especially if you are recommending rejection.

We suggest keeping two goals of a review in mind. First, a review helps give the editor enough information to make a decision about the manuscript for that particular journal. Second, the review is meant to be a guide for the author to revise his or her manuscript and provide suggestions for improving the quality of the article. As such, a review should be written with the goal of helping authors identify the opportunities for modification, new analyses, etc.

### *Examples*

Many new reviewers ask how to write comments that are appropriate and helpful. There are several ways a comment can be written in a positive and helpful way. First, provide clear examples of ways the authors can revise their manuscript. An example of a less helpful comment would be, "The authors did a poor job of reviewing the literature and missed important citations." While this may be true, a more fruitful ap-

proach would be to provide specific examples of important citations and perhaps suggest a few authors that have done important work in the field. Other things to remember: Be cautious about telling people to cite your own work. It's hard to be objective about the importance of your own work. If it's really that critical, another reviewer may suggest it. Tell the authors why incorporating certain ideas would improve the manuscript. Though authors must acknowledge your role as a reviewer, the authors need guidance concerning how to prioritize the feedback of multiple reviewers. Indeed, they are unlikely to be able to incorporate all of the suggestions for improvement they receive. You want to write your review in a way that persuades the authors that your comments will improve the manuscript.

Another example of a less helpful comment: "At present the graphs are misleading and hard to follow. The authors should think of a better way to present their results." It would be more helpful to give the authors specific information concerning how the graphs were misleading and hard to follow. For example, a reviewer might ask, "Were those standard errors or 95% confidence intervals?" Helpful reviewers might even offer a more descriptive title or suggest a line graph instead of a bar graph to show interactions. In summary, the best reviews raise important issues or concerns and make clear, specific recommendations for addressing them.

One way to look at writing reviews is to remember the golden rule: Do unto others as you would have them do unto you. Think about the comments that are most helpful to you when you receive a review of your own work. Have you ever received negative, nonspecific feedback that was discouraging? Avoid such comments. Ultimately, a review should provide specific feedback that renders the manuscript more suitable for publication in that journal or elsewhere. Even if the editor recommends rejection, your efforts have not been wasted. It is important to remember that the authors may benefit from the feedback you provided when submitting to another journal. Good reviews ensure that authors become better scientists and communicators and, ultimately, that high-quality work is published in our journals.

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## A Model for Teaching Empirically Supported Therapies in a Graduate Course: The Behavior Therapy Seminar Series

Thad R. Leffingwell, *Oklahoma State University*

A movement that gained traction with the initial reports on empirically supported psychological procedures by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (1995; Chambless et al., 1998) has continued to gather momentum, as evidenced by a recent policy statement and presidential task force report from the American Psychological Association on evidence-based practice (2005a, 2005b). While controversial, at least in some quarters, acknowledgment of the importance of integrating evidence-based practice seems to be gaining consensus.

Although most of the attention has been directed at the list of empirically supported treatments (ESTs) assembled by the Task Force (Chambless et al., 1998), one of the complementary goals of the committee was to gain an understanding of the current status of training in evidence-based psychological practices among graduate training programs, predoctoral internships, and advanced training for practicing professionals. Early studies evaluating the status of training in ESTs (then called “empirically validated treatments”) revealed that many programs failed to provide even introductory coverage for the vast majority of evidence-based procedures (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). The American Psychological Association added an emphasis on the “empirical basis for all methods involved in psychological practice” to its guidelines for program accreditation (1996, p. 3). Both Crits-Christoph et al. (1995) and the original Task Force report (1995) called on APA site visitors to make training in ESTs a high-priority criteria for accreditation decisions. The original Task Force report also called for increased availability of treatment manuals to facilitate training and dissemination, and a subsequent committee report provided a comprehensive list of all known available manuals describing procedures of treatments on the list of ESTs (Woody & Sanderson, 1998). Calhoun,

Moras, Pilkonis, and Rehm (1998) published a “call to arms” encouraging all scientist-practitioner training programs to redouble their efforts to integrate training in ESTs into their training models. At the predoctoral graduate training program level, they encouraged programs to set the stage for future learning by providing didactics, supervised practice, and modeling in the effective use of ESTs. While generally supporting the idea of enhancing graduate training in ESTs, both Davison (1998) and Ingram, Hayes, and Scott (2000) offer appropriate cautions that training in manualized ESTs may be a necessary, but far from sufficient, component of clinical training programs. Clearly one effect of the EST and evidence-based practice movement has been an increased emphasis upon training and dissemination of empirically supported treatments at all levels, including predoctoral graduate training.

Unfortunately, there is little evidence that these recommendations have been heeded. Although some studies have suggested a slight increase in attention to training in ESTs at the internship level (Hays et al., 2002; Horan & Blanchard, 2001), a recent study of current graduate student trainees suggests that the recommendations and admonitions from the EST movement have had relatively little impact upon current predoctoral graduate training (Karekla, Lundgren, & Forsyth, 2004). An estimated one-third to one-half of students who participated in their survey had little to no exposure to ESTs.

One potential hindrance to the wider integration of training in ESTs in graduate training programs is a lack of models for doing so. A few examples do exist in the current literature. For example, Roberts (1998) describes a training program in clinical child psychology that integrates training in ESTs across the curriculum but provides few details on the pragmatics of how that is accomplished. Cukrowicz et al. (2005) briefly described a policy supporting the use of ESTs in a graduate program training clinic, and provided evidence for im-

proved client outcomes as a result of the policy, but again included few details of the pragmatics of implementation. Finally, Karekla et al. (2004) included in their discussion a brief example of how their graduate program introduces students to EST and empirically oriented approaches to clinical practice via a course called “The Scientist Practitioner,” but again details are thin.

The current article describes one model for providing graduate students of clinical psychology with an introduction to EST and introductory training in a number of specific ESTs in the context of a graduate course in behavior therapy. This training model includes a number of innovative teaching methods, and has been replicated (in whole or in part) at three other Big XII peer institutions with similar graduate training programs.

### The Context

Our clinical psychology doctoral program at Oklahoma State University (OSU) is an empirically oriented scientist-practitioner model training program. Evidence-based practice is an integral part of all course work and practica experiences. Training in ESTs is considered an important part of, but not equivalent to, our larger goal of training in evidence-based practice (Westen, Novotny, & Thompson-Brenner, 2005). Content related to ESTs is included in courses in ethics, clinical research design, systems of psychotherapy, and child diagnostics and treatment. A faculty-supervised practicum is available through an in-house training clinic, with students assigned to vertical teams with both group didactics/supervision and individual supervision. These teams allow faculty to model use of ESTs (not necessarily limited to behavioral therapies, and including evidence-based approaches to assessment) and integration with real-world practice consistent with the goals of evidence-based practice (Calhoun et al., 1998).

The training model described in this article occurs in the context of a graduate course titled Principles of Behavior Therapy—a course typically taken by students in the second semester of their first year. The course includes survey coverage of a broad spectrum of behavioral models of treatment and behavioral techniques using O'Donohue, Fisher, and Hayes (2003) as a required text, as well as many supplementary readings. The course also includes two optional books that include detailed descriptions of a number of ESTs (Barlow,

2001; Kazdin & Weisz, 2003), and students are encouraged to purchase the one that best fits their clinical interests. Course content includes 1 week (2.5 hours of lecture and discussion time) devoted to the history and controversies of the EST movement.

### The Behavior Therapy Seminar Series

The Behavior Therapy Seminar Series (BTSS) is a major part of the course, with about one-quarter of classroom time and 45% of the final course grade devoted to the project. Two students working in teams with the instructor prepare and present 2.5-hour introductory-level workshops on a specific EST of their choosing. Early in the course students are presented with a list of several ESTs, including both adult- and child-focused treatments. The list of possible treatments excludes treatments covered in recent years in the course and excludes nonbehavioral or cognitive-behavioral treatments because of the nature of the course (although students are clearly instructed that nonbehavioral treatments can, and some do, meet definitions of an EST). The content of the workshops is modeled after a beginner-level workshop that might be offered at a national conference, including those offered at the annual meeting of ABCT.

There are a number of objectives of the BTSS as a teaching model, including (a) allowing students an opportunity for in-depth learning about a treatment of particular interest by preparing and presenting their own workshop, (b) allowing students to get a basic introduction to a number of different ESTs as audience members for others' workshops, (c) providing students an opportunity to generate useful secondary-source information about a treatment (critical to evidence-based practice), (d) providing students with a structure and an opportunity to practice critical evalua-

tion of primary source information, (e) providing students with an opportunity to learn from (and learn some of the limits of) treatment manuals (including sometimes learning how frustrating it can be to obtain treatment manuals for some ESTs), and (f) providing students with a supervised opportunity to practice providing training to peers, a skill that may help them effectively disseminate ESTs in their professional careers.

### Workshop Outline and Content

Each live workshop is modeled after a beginner-level clinical workshop such as those found at national and regional professional conferences; it is meant to be an introduction to a treatment and is meant to supplement and enhance, not replace, supervised clinical training. Each workshop includes three components: (a) a theoretical and technical overview in which the theoretical foundation, relevant scientific basis, and techniques typically included in the treatment are described; (b) an empirical overview in which the relevant efficacy and effectiveness data in the literature are summarized, including the strengths and weaknesses of the available literature; and (c) clinical vignettes in which students act out a few scenes depicting important or unique therapeutic skills or interventions included in the treatment.

The instructor, or a guest faculty member with particular expertise in the topic, typically serves as the presenter for the first part of each workshop. Students typically present the empirical overview and vignette parts. Occasionally, students have used creativity to enhance the vignette portion of the workshops. For example, when presenting a treatment typically delivered in a group setting, students may involve the entire class in the role-play vignette, and may plant confederate classmates with prepared

scripts in the audience to illustrate key points. Students have also prepared video clips to demonstrate techniques that are difficult or impossible to demonstrate in the classroom, including bug-in-the-ear therapist coaching of parent-child interactions when presenting a parent training treatment or in vivo exposure when demonstrating treatments for anxiety disorders.

### Literature Coding, Quick-Scan Table, and Treatment Fact Sheet

In addition to developing and presenting the live workshop, the student teams are asked to create two supporting documents that are distributed to the audience. The first is a treatment "fact sheet" that summarizes the nature and expected duration of the treatment, the scientific evidence in support of the treatment, and information regarding alternative evidence-based treatments. This document is written in jargon-free lay language and is intended for a client audience. This document may thus be useful as part of an informed consent process, and forces students to think about the treatment and the scientific literature from the perspective of the client.

The second supporting document is a "quick-scan" table that summarizes the relative strengths and weaknesses of available published studies of the treatment. This table uses *Consumer Reports*-style symbols to indicate relative quality of studies across the domains of design, method, sampling, therapist effects, measurement (dependent variables), and statistical analyses. The table also provides a brief summary of the findings of the study and an opportunity to include brief notes about each study. See Figure 1 for an example of a quick-scan summary table. To allow students to focus on the quality of the content of these documents, students are provided with word-processing templates and are asked to make their table and fact-sheet formats conform to these templates.

Creating the quick-scan summary and preparing the empirical overview portion of the workshop provides students with an intensive opportunity to review and scrutinize the literature regarding their treatment of choice. This skill is also developed in other course work focused on research design and statistical methods, but those skills are supplemented in this course with a lecture on the various qualities of psychotherapy research studies. This particular project focuses upon randomized controlled trials (although it is acknowledged that other research is relevant as well). Students are pro-

Treatment X for Y Disorder

Quick-scan table summarizing empirical findings.

Study	Design	Method	Sample	Therapist Effects	Dependent Variable	Analyses	Results	Comments
Wellington & Herskowitz (1995)	●	●	○	○	○	●	All improved, 3 of 6 lost diagnosis post-tx.	Small, exploratory study using multiple-baseline design. Promising results, but flaws limit confidence without replication.
Seymour & Butz (1997)	●	●	●	⊗	●	●	TX > TAU, 89% improved at post-test	Randomized trial w/ treatment manual, more diverse sample, no information about therapists, immediate post-test only

Note: ● = Excellent, ● = Good, ○ = Fair to Poor, ⊗ = Below minimum standards, ⊖ = no information available

Figure 1. Example of a quick-scan table.

vided with a coding scheme to rate quality across various domains, a method derived from an excellent article on experimental design by Borkovec (1993). Students are given an opportunity to practice this coding scheme with feedback to enhance reliability, and then are asked to compare independent ratings of articles with team partners to reach consensus on the appropriate rating. Although this experience focuses student attention upon evaluating primary sources, students are also encouraged to seek and review secondary sources (book chapters, meta-analyses, practice guidelines, etc.) and to make those sources known to their audience. Therefore, students get an opportunity to develop skills and competencies in finding and using secondary sources as well as in creating a valuable secondary source themselves.

### Multimedia Archiving

The BTSS is offered live only for student peers enrolled in the course. However, the workshops are digitally videotaped and archived on CD for future use by other students and faculty in the program's training clinic who may be interested in the treatments included. See Figure 2 for an example of an archived workshop. Complete CDs, each including all workshops from a given year and all supporting documents, are distributed to all program faculty and participating graduate students, and a copy is added to our training clinic library. When an opportunity to utilize a treatment that has been included in the BTSS arises during training, supervisors and students can use the CDs to glean information about the treatment, review treatment principles or techniques, obtain a client fact sheet, or view models of treatment from the vignettes. Again, the CD is viewed as a useful adjunct to supervised training, not a replacement.

Multimedia archiving has had other admittedly unintended positive consequences. First, the quality of the live presentations is enhanced. This is evidenced by my observation, the observations of other faculty who have viewed the CD, and by student comments about the level of professionalism they devote to preparation, which they attribute to the recordings. Second, the important role for psychologists as not only consumers of evidence but as disseminators is emphasized and modeled. Recently, both state and national organizations have expressed interest in the archived models as potentially useful for the broader profes-

sional community, perhaps as a source of continuing education.

### Evaluation

To achieve the final goal of supervised practice in training, students receive two different aspects of explicit feedback regarding the presentation of their workshops. First, peers provide anonymous feedback on written workshop evaluations completed at the end of the workshop. This process not only provided feedback but models the process of self-evaluation that should be a standard for professional training. Second, students receive detailed verbal and written feedback (including a grade) from the course instructor. Of course, the multimedia archives also provide students with an opportunity for self-evaluation.

### Conclusion

This article described one model of graduate training in ESTs. The BTSS training model provides students with introductory training in a number of ESTs. In the context of our program, we view the BTSS as an important component of training students in evidence-based practice of psychology, but far from sufficient in isolation. Perhaps more important than the content of the BTSS in any given year is exposure to the process of evaluating evidence and learning about a treatment that occurs. The evidence

is always changing, and students will be best prepared for a future of evidence-based practice with a set of skills that allow them to grow and adapt with the evidence.

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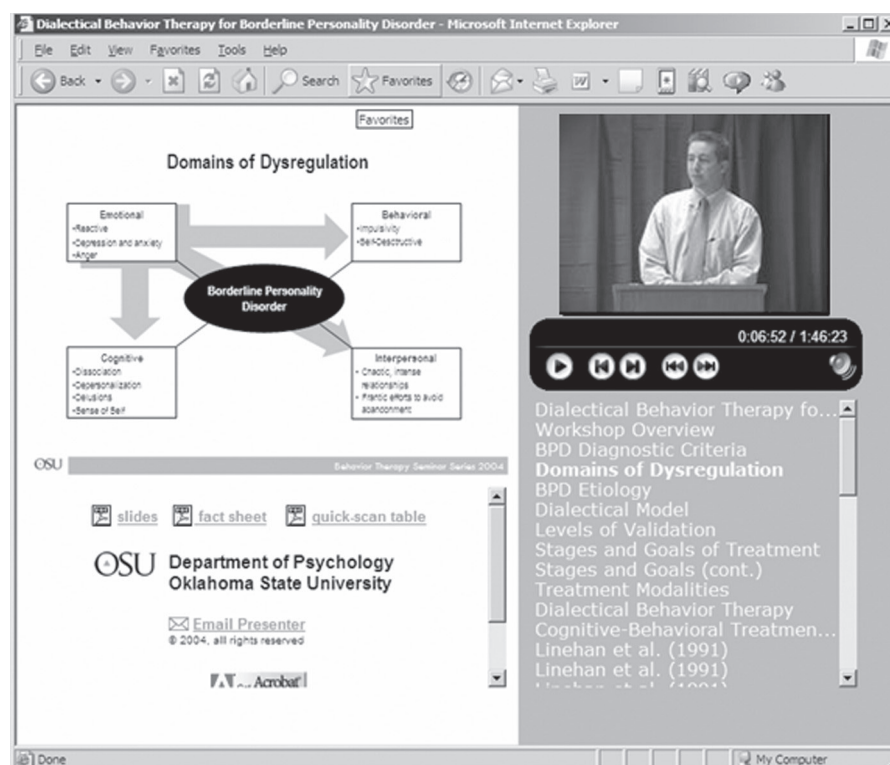


Figure 2. Screen shot of multimedia archived workshops.



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A number of related documents and an example of a multimedia archived workshop can be found at <http://psychology.okstate.edu/faculty/leffingwell/btss/>.

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## CALLS for EDITORS

### ▶ Calling candidates for EDITOR of *Cognitive and Behavioral Practice*

Candidates are sought for Editor-Elect of *Cognitive and Behavioral Practice*, Volumes 16-19. The official term for the Editor is January 1, 2009, to December 31, 2012, but the Editor-Elect should be prepared to begin handling manuscripts approximately 1 year prior.

**Letters of intent** MUST BE RECEIVED  
by July 1, 2006. Vision letters will be required  
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Candidates should send a letter of intent and a copy of their CV to Judy Favell, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008, or via e-mail to [teisler@abct.org](mailto:teisler@abct.org).

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Publications, will provide you with more details on the selection process as well as duties and responsibilities of the Editor. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647-1890.



## Measuring Motivation for Treatment in Adult Psychiatric Inpatients

Jennifer A. Snyder and Anthony Daiuto, *University of North Carolina at Chapel Hill* and *John Umstead Hospital*, and Leann Nelson and Janice McStoots, *John Umstead Hospital*

It is estimated that, over the course of a year, nearly half of the individuals in the United States with serious mental illnesses will be hospitalized in inpatient mental health facilities (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003). For the majority of these individuals, the hospitalization will last 10 to 14 days and the person will be discharged from the institution with the recommendation to continue treatment within his or her community. Yet studies estimate that less than 50% of those discharged from inpatient mental health treatment comply with follow-up recommendations (MacKain, Smith, Wallace, & Kopelowicz 1998). In fact, research as well as anecdotal experience suggests that many of those discharged will be readmitted to the hospital within 30 days due to poor compliance with outpatient treatment recommendations (Haywood et al., 1995). Therefore, it seems that identifying and strengthening the factors related to adherence to outpatient treatment would be a relevant and important goal to focus on during acute brief inpatient psychiatric treatment.

### The Role of Treatment Motivation

One factor that seems to relate to whether or not people engage in outpatient treatment following discharge is their motivation for treatment. It would stand to reason that people who are motivated for treatment and believe that treatment will help them are more likely to engage in treatment and follow through with treatment recommendations. In fact, the Health Beliefs Model (HBM; Becker & Maiman, 1975) suggests that four conditions govern whether people are likely to be compliant with treatment: (a) whether they perceive themselves to be susceptible to the condition; (b) whether they perceive the condition to be serious; (c) whether they perceive that the treatment is likely to be successful; and (d) whether they perceive that they can overcome any barriers to treatment. Research on the HBM has supported that such

attitudes are significantly related to adherence to recommendations for a variety of primary medical conditions, as well as safety recommendations, and that such attitudes can be successfully altered through educational programming. However, no published research to date has assessed the relationship between treatment motivation and adherence to outpatient treatment recommendations, nor to what extent attitudes relevant to motivation for treatment exist in an acute adult inpatient psychiatric population. Furthermore, no published research to date has evaluated whether acute brief inpatient psychiatric treatment is associated with changes in motivation for and attitudes toward treatment.

Given the dearth of research and the number of questions in this area, we desired to begin by attempting to measure treatment motivation as an outcome on our adult inpatient admissions unit at John Umstead Hospital. John Umstead Hospital is one of four state psychiatric hospitals in North Carolina; it encompasses a catchment area of 14 counties in the central northern portion of the state that includes such urban areas as Durham, Winston-Salem, Greensboro, and Chapel Hill, as well as several rural counties. The Adult Admissions Unit is a 120-bed unit that admits people between the ages of 18 and 65 who are a danger to themselves or someone else and are in need of psychiatric treatment. Admitting diagnoses include schizophrenia, schizoaffective disorder, bipolar disorder, major depression, severe personality disorders, and severe substance abuse and dependence, as well as extensive comorbidity of both psychiatric and substance use disorders and Axis I and Axis II disorders. The admission rate fluctuates between 300 and 400 patients a month, and the average length of stay is 7 to 9 days. At least 7% of our patients return to the admissions unit within 30 days, usually because they have stopped taking medication and have become symptomatic. Frequently, patients tell us in a very straightforward fashion that

they do not intend to continue taking medication once they leave the hospital. In many cases, they add that they do not see themselves as having a problem or that they do not believe their medication is helping them. Other times they espouse the intent to remain compliant, but do not follow up with mental health providers and stop taking medication after discharge. Although we provide illness education on the unit, in both individual and group formats, we were unsure whether this increased motivation for treatment. To address whether illness education was effective in increasing motivation for treatment, and possibly treatment adherence, we sought an appropriate measure of treatment motivation.

### Roadblocks in Measuring Motivation for Treatment

We examined several possible measures but found that many existing measures of treatment motivation seemed inappropriate for our population. Often the measures were quite lengthy, with complex two- or three-part questions; open-ended questions; as well as reversed-scored items. Lengthy questionnaires with many items, or with open-ended items, can be inappropriate for an acute inpatient population, as can items that are worded in a confusing or complex manner. People with acute symptoms of severe mental illness are often unable and/or unwilling to complete questionnaires that are lengthy, require extensive writing, or contain difficult or complicated wording. In other research projects on our unit, patients have seemed unable to attend to questionnaires that were longer than one page, and often—even with shorter questionnaires—needed significant help with reading and comprehension of the items. On several occasions patients discontinued participation in the project when they saw the length of the questionnaire to be completed, or when they became frustrated or fatigued as they were completing it. Furthermore, we wanted to use this measure to assess change over time; we wanted a measure that would help us assess the effectiveness of our treatment programming by measuring motivation for treatment upon admission and upon discharge. It seemed necessary, in assessing people over a brief period of time, to have a measure that was relatively short and easy to complete, while still comprehensive, reliable, and valid. We decided to develop a measure of treatment motivation that was both simple enough to be used with our inpatient population and

sensitive enough to measure change over a brief admission.

We developed a theoretical five-factor model that we believed would be useful to measure; these factors were drawn primarily from the HBM, as well as from theoretical considerations of the relevance of social influences. The five factors we hypothesized to be important were: intention to be in treatment; perceived threat of illness; perceived benefits of treatment; perceived costs of treatment; and social influences on compliance. Intention to be in treatment taps whether or not the person expresses a desire to be in treatment or the understanding of the need to be in treatment. Perceived threat of illness is intended to measure a person's general understanding of the severity of his or her illness, as well as the negative impact that the illness can have on his or her life. Perceived benefits of treatment represents whether or not the person expresses the belief that treatment can help him or her to make positive changes in his or her life. Perceived costs of treatment assesses whether the person believes there are reasons to avoid treatment or problems that treatment will create in his or her life. Finally, social influences on compliance taps the degree to which a person believes that others want him or her to be involved in treatment.

### Developing and Refining the Measure<sup>1</sup>

The second author and a graduate research assistant in psychology generated 50 items that were believed to tap these five factors, 10 items per factor. The intent was to identify the 3 or 4 items that most strongly assessed each factor in order to shorten the questionnaire to 15 to 20 items total. As a manipulation check, other members of the research team (representing psychiatry, social work, nursing, recreational therapy, and patient advocacy), who had not been involved in generating the items, indicated which of the five factors they believed each item to tap. The research team discussed any differences that ensued and the wording of these items was changed to more accurately reflect the factor being measured. Each item was phrased as a statement, and the person completing the questionnaire was instructed to circle one of three responses (yes, maybe, or no), depending on the degree to which he or she agreed with the statement. Items were scored as 2, 1, or 0, with higher numbers connoting more of

the factor being measured. Examples of items for each factor are presented below:

#### *Intention to be in treatment*

"I expect to stay involved in treatment."

"I want to get some treatment for my problems."

#### *Perceived threat of illness*

"I am likely to continue to have problems in the future."

"I have a disorder that leads to difficulties in life."

#### *Perceived benefits of treatment*

"Being in treatment can help me."

"Things will get better for me if I work with my doctor."

#### *Perceived costs of treatment*

"I have no interest in getting professional help."

"There are no good reasons to stay involved in treatment."

#### *Social influences on compliance*

"My friends and family want me to get some help."

"Others in my life have suggested I need therapy or medication."

This 50-item questionnaire was administered to all patients currently residing in one of the four inpatient admission wards on the Adult Admissions Unit at John Umstead Hospital. Data were collected in three waves, each approximately 2 to 3 months apart. Two hundred ninety-three questionnaires were administered. Fifty-six questionnaires were not usable due to acute psychosis, language barriers, incomplete data, and other problems. Forty-eight patients refused to complete the questionnaire. This resulted in a total of 189 questionnaires that were suitable for analysis.

### Results

Data gathering appeared consistent across wave and ward, with roughly a third of the sample being collected in each wave and distributed relatively equally across each ward. As a manipulation check, pairs of items with similar content were correlated to assess whether similar items were being endorsed in similar ways. All pairs of items so assessed were significantly correlated.

A principal components analysis yielded four factors that accounted for about 45% of the variance in questionnaire scores. Examination of the items loading on each

factor suggested that the theorized factor structure had been generally supported by the results of the analysis, with the exception that "intention to be in treatment" and "perceived benefits of treatment" appeared to be combined into one factor. The most variance (30%) was accounted for by this combined factor; the other three factors—"social influences on compliance," "perceived threat of illness," and "perceived costs of treatment"—accounted for smaller proportions of the variance (8%, 4%, and 3%, respectively). Correlations between the factors were consistent with theoretical expectations. Intention/benefit, social influences, and perceived threat of illness were all moderately positively correlated (correlations ranged from .70 to .45), while perceived costs of illness was moderately negatively correlated with intention/benefit and social influences (−.34 and −.20) and slightly positively correlated with perceived threat of illness (.11).

For perceived threat of illness, social influences on compliance, and perceived costs of treatment, the four items with the highest loading were chosen. For the combined factor (intention to be in treatment plus perceived benefits of treatment), two items with the highest loading were chosen; two other items were chosen that loaded highly, but appeared to be more theoretically useful than other, more highly loading items. This resulted in a 16-item questionnaire.

We then administered the 16-item questionnaire to all patients currently residing in one of the four admission wards on the Adult Admissions Unit at John Umstead Hospital. A total of 83 questionnaires were administered; eight patients refused to complete the questionnaire. Nine questionnaires could not be used due to incomplete administration, acute psychosis, language barriers, and other problems. This left 66 questionnaires available for analysis. Scores were computed for each factor, with higher scores representing a greater amount of what the factor was hypothesized to be measuring. Correlations between the factors were calculated, and the results were very similar to those obtained in the original factor analysis. Intention to be in treatment/perceived benefits of treatment, social influences on treatment, and perceived threat of illness were significantly positively correlated, and perceived costs of treatment was significantly negatively correlated with intention to be in treatment/perceived benefits of treatment. Perceived costs of treatment did not correlate significantly with social influences on treatment or perceived threat of illness. Internal consistency of the

<sup>1</sup> More detail regarding the method, procedures, and results of the study can be found in Snyder, Daiuto, Nelson, and McStoots (2005).

factors ranged from .59 to .80. Perceived costs of treatment had the lowest internal consistency; the results of the analysis suggested that the items loading on that factor did not correlate very highly with each other, and that there was no practical way to increase internal consistency for this factor. Results suggested that the internal consistency for perceived threat of illness could be improved by dropping one of the items. This item was dropped, resulting in a 15-item final questionnaire, which we named the Daiuto Treatment Questionnaire (DTQ).<sup>2</sup>

### Discussion

We have developed a 15-item questionnaire that can reliably be used to assess motivation for treatment in adult psychiatric patients during a brief inpatient hospitalization. However, further work in the area of validation needs to be done. Specifically, confirmatory factor analyses should be done to assess whether the factor structure found in the current study is consistent across different samples and perhaps different populations or different demographic variables (such as gender, race, and diagnosis). In ad-

dition, research is needed that provides validation of the construct of motivation for treatment, such as studies that link scores on this measure with variables such as insight into mental illness, depression, and hope; as well as outcome variables such as adherence to recommended outpatient treatment or reductions in rates of readmission. Finally, one goal for this measure that was not assessed in the current study was that it would be sensitive to changes taking place over a brief acute inpatient admission. Further research needs to be done to assess whether this measure is a valid and reliable measure of change, as well as how changes in the measure are affected by other variables. For example, obtaining demographic information and data on psychosocial history, psychiatric history, and level of participation in unit psychosocial groups may extend our understanding of how treatment motivation changes over time in particular groups and with particular variables.

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<sup>2</sup>The questionnaire may be obtained from the first author.

### Book Review

## Petry, N. P. (2004). *Pathological Gambling: Etiology, Comorbidity, and Treatment*

Washington, DC: American Psychological Association

Reviewed by Stacey B. Daughters, *University of Maryland*, and Jon E. Grant, *Brown Medical School/Butler Hospital*

The current rise in gambling technology and the expansion of the gambling industry has resulted in more gambling opportunities in the United States than ever before. The public perception and social acceptance of gambling has shifted as well, with more positive interest and attitudes toward gambling facilitating initiation into gambling activities. Accordingly, recent prevalence estimates indicate a large percentage of both adults and adolescents reporting problems with gambling (Derevensky & Gupta, 2000; Shaffer & Hall, 2001). As opportunities and inter-

est increase, so too has the empirical attention to the etiology and treatment of gambling problems. As such, we were eager to review Nancy Petry's *Pathological Gambling: Etiology, Comorbidity, and Treatment*. This book provides a comprehensive resource for professionals in need of a broad overview of the pathological gambling literature. In particular, Dr. Petry provides a wealth of information about the history of pathological gambling, etiology, assessment techniques, research on interventions, and a detailed treatment manual. Although Dr. Petry states that the book is intended for treat-

ment providers, there is a surprisingly strong coverage of the empirical literature with limited emphasis on practical guidance for clinicians. Below, we briefly outline the major topics covered and consider the strengths and limitations of the author's approach.

The book begins with an overview of gambling terminology and prevalence rates across specific populations (i.e., substance abusers, older adults) and types of gambling activities (i.e., horse racing, slot machines). The chapter serves to develop awareness among clinicians concerning the range of individuals that may present to treatment with gambling problems. The author then reviews self-report and interview assessment techniques for making a diagnosis of DSM-IV pathological gambling and determining the severity of gambling problems. Dr. Petry provides a detailed discussion of the advantages and disadvantages of each assessment technique depending on the population, purpose of assessment, length of the battery, and psychometric properties of available instruments. Items from a few assessment measures are provided in tables appearing in the text.



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**Tip:** Check your listing when you change your clocks in the spring and fall!

This book then provides an overview of individual differences among gamblers, including demographics, comorbidity with other psychiatric disorders, and the possible neurobiology and genetics underlying gambling problems. Evidence is provided that problem gambling is associated with male gender, younger age, ethnic minority status, and lower socioeconomic status. Dr. Petry highlights the importance of recognizing the risk of gambling problems for these groups as the current treatment-seeking gambler is middle-aged, married, Caucasian, employed, and has a lower level of education. As such, it is suggested that a subset of problem gamblers are not receiving treatment. Given the disparity between the demographics of treatment seekers and the majority of problem gamblers, it is suggested that treatment development and outreach programs be adapted to better meet the needs of ethnic and racial minority populations. In addition, while the strong relationship between problem gambling and substance abuse is clearly substantiated in the literature and discussed in the book, a review of the relationship of problem gambling with other Axis I and Axis II disorders is also provided. Dr. Petry's discussion highlights the need for additional research assessing how comorbidity affects the onset, persistence, and treatment of problem gambling. Finally, the author presents data supporting the contribution of family factors and biological factors (including molecular genetics) to problem gambling.

A significant portion of the book includes an overview of the theoretical basis and empirical evidence for a variety of treatment approaches including pharmacotherapy, Gamblers Anonymous, recovery without intervention, therapy for families and significant others, psychoanalytic and psychodynamic treatments, early behavioral treatments, cognitive therapy, and brief and motivational interventions. One clear strength of this section is the breadth of coverage, with the sections on recovery without intervention and therapy for families and significant others representing important new avenues for research. Finally, one of the greatest assets of this book is the inclusion of Dr. Petry's cognitive behavioral treatment manual for pathological gambling. The manual is comprehensive, clearly presented, and easy for clinicians to understand and use. It includes forms for tracking your progress, session handouts, homework exercises, and financial planning and handling creditors.

As discussed above, the text provides an excellent review of the empirical literature

regarding the etiology, assessment, and theoretical approaches appropriate to the treatment of pathological gambling. However, the utility of the book for treatment providers would be greatly enhanced had Dr. Petry provided practical guidelines for clinicians concerning why certain treatments might or might not work for specific individuals, how to select treatments, and what obstacles could interfere with treatment success. For example, the Appendix includes Dr. Petry's well-developed cognitive behavioral treatment manual, but readers may be uncertain about who might benefit most from this approach. Moreover, although the manual was developed based upon well-validated work done in the addictions field (Monti et al., 2002), there is no critical discussion of the treatment manual or any clear rationale for why this approach was offered instead of other possible treatment programs. Given the emphasis on research throughout the book, it is surprising that the empirical evidence for the effectiveness of the treatment manual itself is lacking.

Despite the concerns raised above, this text is an outstanding resource for mental health professionals. For those unfamiliar with pathological gambling, this book provides a wealth of information. Even those who have treated gamblers for many years will find new and valuable information in *Petry's Pathological Gambling: Etiology, Comorbidity, and Treatment*.

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**POSTDOCTORAL FELLOWSHIPS IN ALCOHOL ETIOLOGY AND TREATMENT.** The Research Institute on Addictions (RIA), a research component of the University at Buffalo, The State University of New York, has multiple openings for NIAAA-funded postdoctoral fellows in alcohol etiology and treatment. The program provides specialized postdoctoral training

for individuals seeking to pursue a career in alcohol research. The interdisciplinary training program emphasizes two primary areas: (1) etiology and course of alcohol use and misuse and (2) treatment for alcohol use disorders. Fellows develop and pursue research interests under the supervision of faculty preceptors. Seminars on alcohol use disorders, current alcohol research, grant writing, and professional issues and career development are an integral part of the training program. A start date is negotiable. Established in 1970, RIA has a staff of over 180 persons working on over 30 separate research projects. RIA occupies a five-story building, and offers outstanding resources in support of its research endeavors. Visit the RIA Web site at <http://www.ria.buffalo.edu>. Inquiries can be made to either Gerard J. Connors ([connors@ria.buffalo.edu](mailto:connors@ria.buffalo.edu)) or R. Lorraine Collins ([collins@ria.buffalo.edu](mailto:collins@ria.buffalo.edu)), Co-Training Directors. Applicants should forward a vita, representative reprints, letters of reference, and a cover letter describing research interests and training goals to: Alcohol Research Postdoctoral Training Committee, Attn: G. Connors and R. L. Collins, Research Institute on Addictions, 1021 Main St., Buffalo, NY 14203. Applications from minority candidates are particularly welcome. Applicants must be citizens or noncitizen nationals of the U.S. or must have been lawfully admitted for permanent residence. AA/EOE.

## ABCT People

**Kevin D. Arnold, Ph.D.**, proudly announces the birth of Alexandra Kathleen Arnold, born 3/8/06 at 1:49 P.M. She weighed 8 lbs, 4 oz, and was 20.5 inches long.

Long-time member **John W. Bush, Ph.D.**, died on March 12, 2006. Cofounder and Director of the New York Institute for Cognitive and Behavioral Therapies, Dr. Bush was a major advocate of cognitive and behavioral approaches to mental health treatment.

IT'S AN EXCITING TIME

at ABCT; we're celebrating our 40th anniversary! We'd like to honor our members' contributions to the advancement of behavior therapy and cognitive behavior therapy. If you have been an ABCT member for 25 years or more, please take a moment to share your experiences by taking the 40th ANNIVERSARY MEMBERSHIP SURVEY, available on-line at [www.abct.org](http://www.abct.org).



Click on the orange link at the center of our home page: ABCT's MEMBERSHIP SURVEY—CELEBRATING 40 YEARS OF EXCELLENCE. We appreciate your comments. Thank you.

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## Important Information About ABCT Journals On-Line

As we transition to our new publisher, Elsevier, we expect the first issues of *Behavior Therapy* and *Cognitive and Behavioral Practice* for 2006 to be on-line in early April and to appear in print by April 18. In the meantime, back issues and articles in-press are available *now* via ScienceDirect. Here are the links:

*Behavior Therapy*:

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**(and include your contact information)**

**ERRATUM**

In the February issue of *tBT* we identified a photograph on p. 39 as “a grouping of AABT originals.” Since printing the photo, it has come to our attention that although this was an important grouping—perhaps a first meeting or institute of behaviorists—it has nothing to do with AABT/ABCT, and these individuals are not the founding or

original members of the organization. We apologize for this error.

For archival purposes, we are still interested to identify the individuals in the photo. If anyone can recognize faces (one reader believes he recognizes Joseph Wolpe, and perhaps Dorothy Susskind and Nathan Azrin), please contact [sschwartz@abct.org](mailto:sschwartz@abct.org).

—*Managing Editor*





## What'll you have?

\* **How about a “Thought Stopper”?**  
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