

the Behavior Therapist

inside: 19th ANNUAL BOOKSELLING CATALOG

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Open Forum

Employee Assistance Programs: Opportunities for Behavior Therapists

Derek R. Hopko, *University of Tennessee*, and Sandra D. Hopko, *Covenant Behavioral Health Employee Assistance Program*

During the course of informal discussions with colleagues and friends at the most recent AABT conference, we were intrigued to discover that a significant majority of our acquaintances were unfamiliar with the term EAP (Employee Assistance Program). This unawareness was particularly concerning given the increasing prominence of EAPs as a primary context for mental health services and the potential significance of EAPs for behavioral therapy and research (Oher, 1999; Van Den Bergh, 2000). A literature search was conducted using PsycINFO (1967 to the present) to better understand how information on EAPs has been disseminated to behaviorally oriented clinicians. Although over 400 citations made reference to EAPs, not a single record explicitly included the term "behavior therapy" and none of the referenced articles were published in prominent behavioral journals such as *the Behavior Therapist*, *Behavior Therapy*, *Behavior Modification*, or *Cognitive and Behavioral Practice*. Given the many training, practice, and research opportunities available within the context of EAPs, this article briefly highlights the history and functions of EAPs and illustrates how behavior therapists might benefit from increased awareness of these programs and collaboration with EAP personnel.

Employee Assistance Program Services

The development of EAPs began in the late 1930s with the formation of occupational alcohol

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programs. This movement largely was in-
fluenced by the founding of Alcoholics
Anonymous and involved the utilization of
recovering alcoholics to provide assistance
and support to employees with similar
problems. In the course of a decade, a num-
ber of organizations, most notably Eastman
Kodak and du Pont, recognized the poten-
tial benefits of these programs in increasing
work productivity and improving employee
quality of life. Informal assessment prac-
tices and peer intervention slowly came to
be replaced by a more formalized system
that included structured utilization of men-
tal health professionals. The evolution of
EAPs continues, largely as a function of eco-
nomic benefits achieved through decreased
absenteeism and increased productivity. In
fact, companies that utilize EAP services
have a 75% reduction in inpatient sub-
stance abuse treatment costs, report 17%
fewer accidents, 35% reduced turnover,
21% lower absenteeism, and 14% higher
productivity (Rouse, 1995).

The organization of the Association of
Labor and Management Administrators
and Consultants on Alcoholism (AL-
MACA) was formed in 1974 and was re-
named the Employee Assistance
Professionals Association (EAPA) in 1989.
EAPA currently is the primary governing
agency over EAP development and con-
duct, the primary functions of which are to
disseminate and enhance EAP knowledge,
publish program standards to serve as
guidelines for establishing EAPs (EAPA,
1990), and credential employee assistance
professionals through the Employee
Assistance Certification Commission
(Bickerton, 1990). Numerous EAPs have
been established within large businesses
and federal organizations, including the
United States Postal Service and the Federal
Bureau of Investigations (Kurutz, Johnson,
& Sugden, 1996; McNally, 1999). Many
smaller businesses also frequently contract
for EAP services.

The function of EAPs has changed dra-
matically over the years. Early EAPs gener-
ally were sequestered within organizational
structures and functioned on an assess-
ment- and referral-based model (Van Den
Bergh, 2000). Over the past few decades,
EAPs have expanded their focus to encom-
pass case management and intervention
services that include ongoing assessment,
crisis management (e.g., critical incident
stress debriefing), and brief psychotherapy
(Oher, 1999; Summerall, Israel, Brewer, &
Prew, 1999). In this capacity, master- and
doctoral-level EAP clinicians assist employ-
ees with various mental health problems

that include depression, anxiety, substance
abuse and dependence, as well as family and
relationship problems. Among employees
seeking EAP services, as many as 55% to
75% report significant problems with de-
pression and anxiety (Fenrich, 2001;
Poverny & Dodd, 2000) and approximately
40% report significant impairment associ-
ated with alcohol misuse (Thomas &
Johnson, 1994). Perhaps more specific to
the EAP environment as compared with
conventional practice, clinicians also fre-
quently address issues of job stress, organi-
zational layoffs, preretirement planning,
and work addiction (Csiernik, Atkinson,
Cooper, Devereux, & Young, 2001;
Perkins, 2000; Robinson, 1997; Worster,
2000). Importantly, employees who utilize
EAPs generally report moderate to high
levels of satisfaction with patient services
(Leong & Every, 1997; Macdonald, Wells,
Lothian, & Shain, 2000), and there are
strong indications that EAPs allocate top
priority to maintaining ethical and profes-
sional standards (Chima, 1999; Emener &
Hutchison, 1997). The increasing societal
significance of EAP settings as a context for
mental health treatment, the diversity of
patients and problems typically found
within these programs (Chima), and the
paucity of systematic treatment outcome
research conducted in this context make
EAPs an ideal environment in which behav-
iorists may experience unique training op-
portunities, engage in clinical practice, and
conduct socially significant scientific re-
search.

Opportunities for Behaviorists in EAPs

The importance of EAP programs to
behavioral academicians and clinicians has,
for the most part, been unrecognized.
However, there are several reasons acade-
mic training programs, practitioners, and
researchers might benefit from becoming
more aware of these programs and their
functions. First, establishing practicum op-
portunities via communicative efforts with
EAP staff and management may greatly en-
hance clinical training programs. In addi-
tion to increasing the availability of
practicum sites, which is a significant con-
cern in many training programs, students
could be exposed to individuals with a great
breadth of presenting problems, many of
which may be specific to the working en-
vironment. The specificity of these problems
to the EAP context would allow for richer
clinical experiences and enhanced profes-
sional development. Additional educational

opportunities could be provided in EAPs that might differ considerably from those found in more traditional placements in community mental health centers, counseling centers, private practice, and psychiatric hospitals. For example, community outreach frequently is provided by EAP clinicians to educate businesses and organizations about the nature of mental illness, treatment alternatives, and services that can be found within the EAP. Common topics of these presentations include stress management, drug-free workplace, sexual harassment prevention, life/work balance, and EAP program orientation and supervisor training. This networking integrates psychological service and marketing components and facilitates community involvement, valuable experiences that may facilitate the transition from graduate training to long-term employment. Many EAPs also have clinicians involved in a "gatekeeping" process. Although similar in some respects to a case management concept, gatekeeping often involves coordinating insurance authorizations with health maintenance organizations and facilitating referrals to local mental health professionals. These real-world experiences may greatly benefit the novice clinician, particularly those planning to start a career in community practice. Exclusively associated with EAP settings, patients often are assessed and treated subsequent to supervisor referral. These cases frequently involve issues of substance abuse and typically are followed (after initial treatment) in a probationary manner for several years. This situation necessitates ongoing communications between clinician, patient, and supervisor and thus provides some truly unique circumstances in which knowledge and development of ethical behavior is placed at a premium. Under appropriate supervision, these challenging ethical dilemmas would be invaluable to the developing clinician. Finally, given the inadequate internship placements relative to internship applicants, it is quite conceivable that the Association of Psychology Postdoctoral and Internship Centers (APPIC) program could benefit from collaboration with EAPs to establish viable and mutually beneficial internship training settings.

A second potential beneficiary of the EAP movement is the private practice psychologist. EAPs have continued to grow in number and popularity with companies because of their significant economic benefits. EAPs assist with reducing employee turnover, improving the ability of employees to cope with stressful work conditions,



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adjusting to transitions on the job, and increasing job satisfaction (Oher, 1999). They also save money on insurance premiums because the majority of presenting problems are resolved at the EAP without referral to psychologists or psychiatrists (Oher). Accordingly, one may speculate that EAPs will increasingly function as a front-line assessment and treatment context, whereby alternative treatment providers may be sought only when longer-term treatment or specialized services are deemed necessary. If there is merit to this hypothesis, behavioral clinicians would benefit from initiating and maintaining contact with EAPs, communicating the specialized services that they provide, and thereby become an important referral source for EAP practitioners and staff. Indeed, EAP personnel may save time for behavioral practitioners by screening clients most apt to benefit from behavioral therapy and by matching specific presenting problems with specialty areas of practitioners. In addition to serving as valuable referral recipients, behavioral clinicians are uniquely trained to practice in an EAP environment. As most EAPs offer employees a limited number of therapy sessions (typically between 3 and 8), the structured, goal-oriented, time-limited nature of behavioral

therapy would be ideal in effectively and efficiently addressing patients' presenting problems.

A third significant opportunity for behaviorists involves the wealth of research questions to be addressed in the EAP environment. Perhaps most importantly, given the short-term, focused nature of behavioral therapy, treatment outcome studies evaluating the effectiveness of time-limited treatment protocols for depression, anxiety, relationship conflict, substance abuse, and anger management would be highly desirable. Surprisingly, treatment outcome research conducted within EAPs is quite minimal. For those studies that have been done, lack of scientific rigor, unsophisticated methods of data analysis, and case study formats are common (CONSAD Research Program, 1999). Other methodological limitations include the nonexistence of randomized controlled trials, ill-defined treatment protocols, noncomprehensive diagnostic assessment and outcome measurement, and homogeneous patient samples. In the few outcome studies that have been reported, there is some documented success for biofeedback in reducing employee stress (Cherbosque & Italiane, 1999), confrontation and motivational in-

interviewing in reducing drinking frequency and improving job performance (Schneider, Casey, & Kohn, 2000), skill development in facilitating anger management (Bayer, 1998), and modified rational emotive therapy for treating relational problems (Morris, 1992). Internal and external validity of these studies is limited by methodological shortcomings, however, and a more systematic research program clearly is required to assess the potential utility of behavioral therapies within EAPs. Research opportunities also may extend beyond treatment outcome projects. For example, many EAPs accumulate extensive demographic, self-report, and behavioral observation data on employees. Establishing psychometric properties of such measures and the generalizability of commonly used assessment instruments to the EAP setting would be a worthwhile endeavor. Additionally, the EAP environment would provide students with numerous opportunities to formulate important research questions and designs, perhaps extending to thesis and dissertation projects.

In closing, behavior therapists are in a unique position to contribute to the functioning of EAPs as well as benefit from practice and research opportunities available in this setting. This relationship is a symbiotic one, however, as EAPs also could garner benefits from such partnerships. For example, behavioral practitioners, students, and researchers could help to disseminate current knowledge into EAP programs to help counselors stay current with the latest developments in assessment practices and empirically validated treatments, bridging the typically wide gap between research and community clinical practice. EAP personnel also could look toward academicians for guidance in developing research designs to address questions related to program evaluation, epidemiology of psychiatric disorders, and other issues of interest to the EAP. EAPs are an increasingly prominent mode of mental health care. Recognizing these programs and establishing collaborative relationships could benefit both the programs themselves and broaden opportunities for behavioral scientists and practitioners.

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Dependence on Alternative Medicine: Features, Mechanisms, and Treatment Strategies

Shunsuke Kanahara, *Nagasaki Wesleyan University*

Many individuals prefer alternative medicine to conventional, evidence-based medicine (Giddens, 2001). Such individuals hope to (a) provide their own care (Cassileth, 1998/2000), (b) avoid experiencing side effects or malpractice from evidence-based medicine (Bratman, 1997), or (c) enact some kind of miraculous improvement of their problems (Weil, 1995/1998). In the present article, the term "alternative medicine" indicates any therapies, foods, activities, and medications that are not deeply enmeshed in today's evidence-based medicine and in which personal expectations play a more important role than empirical evidence regarding effectiveness. Examples of alternative medicine include acupuncture, herbs, magnetic field therapy, nutritional supplements, homeopathy, therapeutic touch, and so forth (The Burton Goldberg Group, 1994). The variety of alternative medicines that exist around the world is countless. Types of alternative medicine differ from culture to culture. Additionally, some therapies, activities, and medications have been regarded either as alternative medicine or as evidence-based medicine, depending on the period in history in which they exist.

Such stressors as loss, disease, deterioration of appearance, and aging may become incentives for using alternative medicine, and some individuals may become dependent on alternative medicines. Dependence on alternative medicine can be defined as behavior in which individuals spend great amounts of time and money on use and acquisition, and possess an inordinate belief in the medicine. Although Nakamura (2001) stated that 42% of Americans had experienced alternative medicine in 1997 and Giddens (2001) estimated that as many as one in four Britons had consulted an alternative practitioner, because of the scarcity of research data, the number or proportion of individuals dependent on alternative medicine is unknown.

Characteristics

According to Giddens (2001), the typical profile of a user of alternative medicine is a young to middle-aged middle-class female. The illustrative characteristics of those who are dependent on alternative medicine are as follows. Some dependent individuals hesitate to take evidence-based medications or even refuse to visit hospitals; other dependent individuals are comfortable utilizing both alternative and evidence-based medicines (Giddens). Some cling to a particular alternative medicine while others keep changing among a variety of alternative medicines. Some dependent individuals have been criticized for their dependent behavior by nondependent individuals. On the other hand, for other dependent indi-

viduals, even close family members and friends may not know that their significant others are dependent on alternative medicine. Those dependent individuals who are more active may have tried to involve others in using alternative medicine.

Profile of Ms. A

Ms. A is an unemployed 39-year-old single mother with one child. Though her main income is a limited sum of government assistance for low-income individuals, she continues to purchase expensive nutritional supplements and herbal cosmetics. She likes to read magazine articles about new alternative products. As there are a great many of such products, she spends her time looking for better and more interesting ones. She often does this almost all day instead of doing housework or trying to find a job.

Ms. A eats mostly expensive organic foods. She takes citric acid three times a day to enhance her appearance. At the same time, she takes condroitin made from shark bones to prevent backache and several different vitamins, chlorella, and royal jelly to improve her physical condition.

Recently, she has been wearing a necklace made of tourmaline stones, which is

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supposed to improve her health. When she takes a bath, she pours a liquid made from bamboo charcoal into the bath water. This is because she believes that the liquid can smooth her skin. She applies Chinese ointments to her face before sleep. In bed, she uses a magnetic pillow, but she cannot remember the reason why she started using it.

Profile of Mr. B

Mr. B, a 72-year-old male, is retired and lives with his wife. His current concern is tea. He buys and drinks teas that are assumed to contain plenty of vitamins, minerals, and other nutrients that have not even been proven to exist. His purpose in doing this is to avoid senile dementia. He believes that tea made from ginkgo leaves is especially helpful in preventing the disorder. He drinks persimmon and rooibos teas, too. When he goes out, he takes with him a big canteen filled with his tea. Right before it is empty, he rushes back home.

Mr. B bought small globular stones meant to be played with by the fingers. In some cultures, this activity is believed to maintain memory. He does this when he has time for it, and the sound of the stones hitting together are rather noisy. One day, his wife could not help complaining about the noise. He ignored her.

The kitchen utilities in his home are all iron or stainless steel. He has read of the possibility that aluminum may contribute to Alzheimer's disease. Consequently, he exchanged all the aluminum goods for non-aluminum ones. His wife was unsuccessful in stopping this. What he does not do to protect his brain function is to visit a physician specializing in geriatrics in order to obtain advice.

Explanations

Dependence on alternative medicine can be explained through various viewpoints, such as mental health disorders noted in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*; American Psychiatric Association, 1994), and psychological and behavioral mechanisms. The viewpoints shown below are not necessarily exclusive to each other.

DSM Views

Dependence on alternative medicine fits one of the *DSM* viewpoints: obsessive-compulsive disorder with or without poor insight. Some individuals who are dependent may find that their tendencies are annoying to themselves or others and may attempt to suppress such tendencies. They are usually

not successful and become uneasy when not behaving according to their obsessive-compulsive desires.

Second, symptoms from hypochondriasis with or without poor insight (APA, 1994) may be related to the dependence. Hypochondriac individuals are preoccupied with fears of having, or the idea that they might contract, a serious disease. Therefore, they may try to recover from or prevent the disease with the help of any means, including alternative medicine. For example, a hypochondriac may eat excessive amounts of certain mushrooms that are anecdotally said to be beneficial in curing cancer.

Third, it is possible that some individuals dependent on alternative medicines suffer from delusional disorder. A delusion is a belief that is maintained despite argument, data, and sufficient refutation that would otherwise extinguish the belief (Reber, 1995). Dependent individuals may persist in using alternative medicines regardless of the fact that many of such medicines have very weak or no research evidence to support their efficacy.

Finally, alternative-medicine dependence can result in noncompliance with traditional treatment. Individuals who have come to be dependent on alternative medicine tend to lose respect for and interest in evidence-based medicine (Giddens, 2001). Some may visit hospitals but subsequently fail to take the medications prescribed. Usually, doctors do not know about this. Other dependent individuals may decline to visit conventional medical facilities altogether.

Psychological Views

Dependence as discussed in the context of this article is not considered pathological. Rather, it should be seen as more ordinary behavior which is grasped psychologically.

First of all, functional autonomy, an idea introduced by Allport (1937), can be useful in understanding dependence on alternative medicine. This idea indicates that human behaviors can become independent of the needs on which they were originally based (Goranson, 1994): "Allport gave the example of a man who first worked as a sailor just to earn his living, and who then developed a love for sailing that persisted years later, even after he had become wealthy and had no material need to continue sailing" (p. 44). This raises the possibility that motives can function quite independently of any physiological need or drive, as can dependence on alternative medicine.

Second, some dependent individuals tend not to scrutinize the results of the usage of alternative medicine because they do not want to recognize the possibility that their behavior is meaningless. The theory of cognitive dissonance (Festinger, 1957) can be a tool to explain this tendency. The theory points out that humans are motivated to maintain consistency among pairs of relevant cognitions, where a cognition refers to any knowledge or belief about self, behavior, or the environment. Because they hope to continue believing in alternative medicine and in their behaviors regarding the medicine, dependent individuals may ignore the fact that the effect from alternative medicine is less than they had expected.

Finally, although all alternative medicine is not always ineffective, most of them are questionable (Park, 2000/2001). Irrespective of that fact, even questionable alternative medicine can show a positive change. When an inert substance is given instead of a potent drug, this substance is called a placebo. According to Chernow and Vallasi (1993), "Placebo medications are sometimes prescribed when no drug is really needed because they make patients feel well taken care of" (p. 2162). Placebo effects occur when many individuals experience some positive effect from a certain alternative medicine. Interestingly, while Cassileth (1998/2000) introduced outcome studies that indicated that some alternative medicines (e.g., acupuncture or biofeedback) are effective, Sampson (1998) argued the possibility of the placebo effect using acupuncture as an example.

Behavioral Views

In addition to the above psychological explanations, there are more specific behavioral mechanisms working in alternative-medicine dependence. First, the dependence is understood as the consequence of operant conditioning. Reinforcers may be appreciation from others, such as "You look great!" and "You look different," or the user's realization that he or she feels somewhat better than before. Individuals show more inclination to alternative medicine as a result of such reinforcers.

Another reinforcer may be the user's expectation of future improvement. This process is explained through the Premack principle in which a higher-probability behavior serves as a reinforcer for a lower-probability behavior (Spiegler & Guevremont, 1993). For instance, when a person eats rye bread in spite of the fact that the person does not enjoy its taste, he or she

may maintain this behavior because of the expectation that the rye bread will enrich the person's health in the future.

Self-reinforcement (Kratochwill, 1985/1987), which is as efficient as other forms of reinforcement, can also be a possible key factor in understanding the dependence:

Improvement sometimes is simply a result of heightened morale, which enables a person to function better in spite of a medical handicap. People who are "cured" by faith healers and quacks tend to be those who are more accepting than analytical. (Wedding, 1995, p. 439)

Some individuals have self-reinforced in relation to alternative medicine and may have done it too strongly.

Observational learning (Bandura, 1969) may be a way to understand the reason why certain individuals start relying on alternative medicine. Such individuals may have family members, friends, or other models who have positively experienced alternative medicine and have been enthusiastic about it. That is, if an individual is surrounded by those who believe in and actually use horse oil for a burn, the person may show the same behavior when he or she gets burned.

Behavioral Interventions

Modifying dependence on alternative medicine can be difficult because individuals with such dependence are not usually motivated to change their behaviors. Dependent individuals rarely visit therapists. Even if they are in a therapy session, their presenting problems can have nothing to do with the dependence on alternative medicine. As therapy progresses, the dependence may eventually become obvious. Nevertheless, getting the individual to agree to modify his or her behavior can be difficult.

When intervening, target behaviors will be both overt and covert. Cognitive restructuring (Last, 1985/1987) regarding the client's way of thinking, especially his or her way of understanding health or appearance, can be the first step in treatment. For instance, a dependent client may need to realize that deterioration of physical strength as a result of age is a natural event. Another client may need to be challenged regarding his or her tendency to believe in something despite a lack of rational reason to believe it.

Second, reducing the quantity of alternative medicine and/or the amount of hours spent thinking about, looking for, and using alternative medicine can be targeted,

then decreased gradually. For example, a therapist can help the client decrease his or her use of alternative products from 10 to 9 products per day. After the accomplishment of this goal, it can be suggested that the client use 8 products.

Differential reinforcement of other behaviors (Deitz, 1985/1987) can be combined. This technique encourages and reinforces more of the dependent client's acceptable behavior, such as getting enough sleep, avoiding fast food, doing appropriate exercise, or reducing the number of cigarettes. Because these behaviors are healthful, the technique allows the client to feel less distressed when he or she is working on reducing the amount of alternative products or activities.

Finally, exposure (Marshall, 1985/1987) to real stimuli and/or imagined stimuli can be considered. Under this technique, a dependent client is advised to live with fewer or no alternative medicines. For example, a client will try to stay away from any activity related to Ayurveda, contrary to his or her desire. In the beginning, it will be hard for the client to endure this. Gradually, the client will become accustomed to the situation and will realize that his or her life with fewer or no alternative medicines is not necessarily hazardous.

Conclusion

Alternative medicine is generally considered to be harmless, and using the medicine is not regarded as a mental disorder or a problem. However, whether or not the usage of the medicine is considered pathological, research suggests that undesirable consequences can take place in some users under some circumstances (O'Mathna, 1998). For instance, one study found that 48% of transcendental meditation practitioners reported adverse effects from the meditation, such as depression, confusion, and inexplicable outbursts of antisocial behavior, even though meditation is believed to be safe and to have no side effects (Otis, Shapiro, & Walsh, 1984). More generally, use of alternative medicine may compromise one's physical condition. In the case of continued abuse of alternative medicine, the application of evidence-based medicine may be delayed (Jilek, 1993). Furthermore, it is possible that the dependence may lead some individuals to another mental problem like an eating disorder. Dependence on alternative medicine can also be a sign of other dependencies, such as on nicotine, alcohol, or gambling, that are similarly thought serious or life-threatening. Thus,

understanding dependence on alternative medicine and preparing effective treatment regarding this dependence are necessary to assist the individuals concerned.

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Open Forum

Behavior Therapy in Correctional Settings: Fertile Ground or Quicksand?

Stephen E. Wong and Stephanie T. Wong, *Florida International University*

The January issue of *the Behavior Therapist* contained a special series (DeGroot, 2003) on the application of behavior therapy in correctional institutions that should concern us. As noted by Ronan (2003), the number of people incarcerated in this country has increased by 400% since 1970, with the U.S. now imprisoning more of its citizens than supposedly repressive countries such as China or Russia. Curiously, this increase in incarceration has not been associated with changes in crime rates. Inmate populations have grown rapidly since the mid-1980s, but during that same period the U.S. national crime rate has remained relatively flat. The explanation for the growing prison population is in higher arrest and conviction rates for minor crimes, especially nonviolent drug offenses, and lengthier sentencing. These alterations in the criminal justice system have been spurred on by sensationalistic news reports that have disproportionately covered violent crime, resulting in aroused public fear. "Tough on crime" political campaigns have harnessed this fear to advance law enforcement and criminal court policies to produce an ever-expanding prison population (Beiser, 2001; Doyle, 2001; Dyer, 2000).

As this nation's bill for incarceration has risen to \$46 billion annually, private corporations have profited handsomely in constructing and operating prisons and by

providing health care, telephone, and food services in these facilities. Should behavior therapists develop their own niche within this booming industry? If behavior therapists pursue this employment opportunity, they may join ranks with other professions that have become increasingly responsive to market forces rather than moral civic-mindedness or social responsibility (Brint, 1994). In the case of behavior therapists, however, expanding work with the present prison system may actually involve ignoring the ramifications of their own theoretical and scientific principles.

Behavior therapy is grounded in the assumption that human behavior is largely a function of individual learning history and environmental contingencies. Persons who commit crimes presumably could have been prevented from performing these acts by prompting and reinforcing alternative appropriate responses. The finding that two out of three prison inmates were earning less than \$5,000 per year at the time of their arrest (Dyer, 2000) suggests that insufficient reinforcement for appropriate behavior may have been a contributing factor in the performance of a large proportion of criminal acts. The earlier in life appropriate responses were taught and the more consistently they were reinforced, the less likely criminal behavior would have emerged. Such a preventive approach has been recommended for preempting the develop-

ment of mental health problems (Albee, 1998; Task Panel on Prevention, 1984), and it is reasonable to assume that this also applies to criminal behavior. In stark contrast, our criminal justice system's use of imprisonment is an old form of retribution. Its methods are neither based on a science of behavior nor a systematic technology of behavior change, and this is reflected in its poor outcomes (i.e., high rates of criminal recidivism). As one of the series authors notes, prison is primarily for purposes of punishment, not rehabilitation (Spudic, 2003). Hence, prison is for punishment—in behavioral terms, woefully ineffective punishment.

Behavior therapists working in prisons risk not only the loss of their guiding principles but their replacement by the principles and values of the surrounding prison culture. Prisons are institutions whose highest priorities are inmate security and control, and they are not reluctant to use coercive methods to achieve those goals. One series author noted that prison personnel are likely to find behavioral programming more acceptable if it is referred to as "behavioral control" rather than "behavior therapy" (Seegert, 2003). How long will it be before behavior therapists working in prisons become comfortable in this role and see themselves primarily as behavior control experts?

Another, more insidious aspect of prison work could be in bolstering the notion that the prisoners' mental disorders are entirely due to individual defects or pathology rather than the aversive stimulation and deprivation of the prison environment. Prisons are terrifying places in which a person can expect to be intimidated, assaulted, raped, or murdered (Human Rights Watch, 2001). While prisons are structured to provide as little pleasant or rewarding stimulation as possible, even those few desirable events may be withdrawn. Failure to com-

ply with institutional rules can result in solitary confinement and restriction to one phone call and 4 hours of recreation per month (Daniel, Jackson, & Watkins, 2003). In a growing number of maximum-security prisons, inmates may be placed in solitary confinement for years at a time (Good, 2003). Responses to such adverse conditions can include counteraggression, self-injury, bizarre behavior, and suicide attempts (Cox, 2003; Daniel et al., 2003; Seegert, 2003). But under such circumstances, are these behaviors really maladaptive or irrational? Should behavior therapists adopt occupational goals of promoting inmate compliance with and adjustment to inhumane living conditions—in essence, pacifying disturbed inmates and facilitating the smooth operation of these inimical and counterproductive institutions?

Behavior therapists interested in social issues should also consider the growth of prisons within the context of recent political movements and government funding patterns. During the past 2 decades of massive prison growth we have seen simultaneous reductions in state and federal spending on education, mental health programs, and social services. With shrinking state and federal budgets, monies given to one public sector come at the expense of another. Will behavior therapists align themselves with “correctional” facilities instead of educa-

tional, therapeutic, or social support programs that might have obviated the need for those correctional institutions in the first place? Going one step further, will behavior therapists endorse criminal justice and institutions of punishment rather than promoting social justice and the widening of economic opportunity to help prevent crime? These are crucial questions that will define the future values and practice of behavior therapy.

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Open Forum

To Thine Own Self Be True

Frank M. Dattilio, *Harvard Medical School and University of Pennsylvania School of Medicine*

To thine own self be true.” This sage advice has been offered hundreds of thousands of times throughout the centuries since Shakespeare crafted it, and it has always struck a chord with me both personally and professionally. The phrase is also at the heart of CBT, and it has been my experience that most of my colleagues stand by it. However, a study by Gilroy, Carroll, and Murra (2002), which appeared in *Professional Psychology: Research and Practice*, really threw me for a loop. The study involved a random sampling of 1,000 psychologists throughout the United States. The names were drawn from APA’s Division 17 (Counseling Psychology).

The primary objective of the study was to poll psychologists as to whether or not they have ever experienced depression during their professional careers. More than 60% of the psychologists who responded reported experiencing depression, most of which consisted of dysthymia. Fifty-three percent of those admitting to depression contended that they primarily employ cognitive-behavioral interventions in their work as therapists. But what shocked me is that 40% of those individuals who professed to be cognitive-behavioral therapists also stated that they chose psychodynamic therapy for their own treatment. The second most popular modality sought by the group was gestalt therapy, which consti-

tuted 19%, with a mere 12% selecting CBT for the treatment of their own depression. The remaining percentage (29%) sought other alternatives such as pharmacotherapy.

The results seem incongruous for a group of individuals notorious for touting empirically validated treatments, and initially, I was hard-pressed to explain the phenomenon. The decision is particularly odd in light of the strong empirical evidence for the use of CBT with depression, not to mention the other rationales that support it as a treatment of choice, including time frame, efficacy, cost factors, and so forth. I began looking for some palatable explanations.

First, with any empirical study, there is, of course, always the possibility that the data may be flawed. I found myself rooting for this alternative. Possible flaws with the sampling process in particular may have erroneously designated certain subjects in the study as being pure cognitive-behavioral therapists when, in fact, they were not. It could be that those who identified themselves as using cognitive-behavioral techniques were “hybrid therapists,” who actually use a mix of techniques. Perhaps if

the sample had been drawn from a more homogeneous list, such as members from AABT or IACP, the results would probably have been much different.

Barring this explanation, what else might account for so many cognitive-behavioral therapists turning to a treatment modality that has almost no empirical support? Could the answer have something to do with immunity? In other words, perhaps some cognitive-behavioral therapists think that because they espouse one modality in their work with patients, they themselves are immune to its benefits. This may not be such an uncommon schema among therapists, particularly those who use a particular modality over a long period of time. I must say, though, that I have always found that most psychodynamic psychotherapists submit to psychodynamic therapy for their own treatment. In fact, many are required to be in psychodynamic therapy themselves during their training. But back to cognitive-behavioral therapists: Why psychodynamic therapy over any others?

Another explanation might be that many cognitive-behavioral therapists work collaboratively, and the world may seem small when it comes to reaching out for help themselves. Enlisting the aid of a colleague may not be comfortable. While this would contradict one of the main tenets of CBT,

distorted thinking is a plausible explanation. Add to this that many therapists think that they can fix their own problems. Armed with self-help manuals and the intensive training that cognitive-behavioral therapists undergo, self-help may appear to be a viable alternative.

The most unsettling explanation is, of course, that some cognitive-behavioral therapists may actually still believe that the only type of treatment capable of getting beneath the surface and to the deeper roots of an issue is long-term dynamic psychotherapy. Some have regarded CBT as the "therapy for the masses" as opposed to the "insightful." This is particularly disturbing because such an underlying belief suggests a basic distrust in the effectiveness of what we do. This and the previous explanation may be said to fall in the category of cognitive distortion—ironically, the types of distortions we try to rid clients of during the course of our work. So, why have some of us fallen victim to the same distortions that we attempt to change in others? Perhaps it's simply human nature. The fact that we engage in repetitious interventions as cognitive-behavioral therapists, conducting treatment on a daily basis, may have a watering-down effect on our perception of the potency of CBT for ourselves. While I would like to think that the data were

flawed, it is more likely that something else is at work. The results of Gilroy et al.'s (2002) study beg the question: Why do some of us not practice what we preach? Obviously, the percentages don't bode well for our profession or the field of CBT. Imagine how our clients would feel reading about the study.

So, maybe we need to ask ourselves the Gilroy question: If I were to require treatment for depression, which modality would I seek? Further, if the answer is something other than CBT, then we need to consider seriously what it means about our own practice and choice of modalities.

Obviously, this is only one small study, and more research is needed in this area in order to get to the truth. But if we are dedicated to promoting our profession and the efficacy of what we do, we need to look seriously at why there seems to be some discrepancy between what is preached and what is practiced.

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Lighter Side

A Modest Proposal for a New Diagnostic Classification: Intrinsic Motivation Deficit Disorder (IMDD)

David Reitman, *Nova Southeastern University*

With the publication of *DSM-IV-TR* (APA, 2000), it is apparent that preparation of the much-anticipated *DSM-V* can't be far behind. Although behavior therapists once shunned the categorical taxonomic approach (see Follette, Houts, & Hayes, 1992; Krasner, 1992), only limited resistance remains (Scotti, Morris, McNeil, & Hawkins, 1996). So, whether conceived in the spirit of "if you can't beat 'em, join 'em" or simply to ensure that behavior therapists have a larger role in refining future *DSMs* than enhancing the reliability of existing *DSM* symptom profiles, I offer a compelling new disorder for your consideration. This disorder, Intrinsic Motivation Deficit Disorder (IMDD™), has

been known only to those few brave researchers and journalists who have dared to question the wisdom of contingent reinforcement (see Deci, 1995; Kohn, 1993). Mental health professionals previously frustrated in their attempts to identify enough cases of ADHD or ODD to keep their practices afloat will welcome this common and easily diagnosed condition as a focus of clinical attention.

Although treatment studies are practically nonexistent, the condition will most certainly respond to Reitman Therapy™, which has proven 87% effective in cases uncomplicated by messy comorbidities and uncooperative family members. Indeed, certified Reitman Therapists™ are currently

training practitioners across the nation in this revolutionary treatment for this previously unknown and underdiagnosed condition. We at Reitman Therapy™ are very excited about the prospects for continued association with AABT. We feel that we have something unique to offer today's mental health professional. While others offer only an untested therapy, we offer both an untested therapy and an untested diagnostic entity! For more information, please point your browser to <http://www.thehellwithscience.showmethemoney.com>.

Diagnostic Features. The essential feature of IMDD™ is a persistent pattern of craving for tangible rewards that is more frequent and severe than is observed in individuals at a comparable level of development and socioeconomic status (Criterion A). Some symptoms of the craving for tangibles that cause impairment must have been present before 7 years of age (Criterion B). Some impairment must have been observed in at least two settings (e.g., home and school) (Criterion C). There must be clear evidence of interference with social, academic, or occupational functioning (Criterion D). The disturbance does not

occur exclusively in the context of other annoying behavioral patterns such as those characteristic of children diagnosed with ADHD or ODD or as a result of a severely impoverished upbringing (Criterion E).

The disorder primarily manifests itself when the individual is asked or required to engage in nonrevenue-generating activities such as exercise and social interaction with persons other than business associates. In the most extreme cases the individual will scarcely raise a finger unless there is a clear incentive. Such individuals may be regarded by family, peers, and coworkers as narcissistic, materialistic, greedy, opportunistic, superficial, or spoiled brats. These individuals are often observed in adulthood driving BMW or Mercedes-Benz convertibles with bumper stickers proclaiming HE WHO DIES WITH THE MOST TOYS WINS OR WINNING ISN'T EVERYTHING, IT'S THE ONLY THING. Symptoms usually worsen in the absence of tangible reinforcement but will improve rapidly with their delivery. Unfortunately, improvements are generally short-lived, and individuals with IMDD™ can develop an insatiable appetite for material goods.

Associated Features. The associated features of the disorder include low frustration tolerance, temper outbursts, bossiness, excessive and frequent insistence that demands be met immediately, mood lability, demoralization, rejection by peers, and low self-esteem. Academic achievement is devalued, unless explicitly connected to an occupation with an anticipated annual compensation of over \$100,000. The individual will strongly resent evaluation and frequently present an air of "entitlement."

Associated Laboratory Findings. Although many laboratory analogues have been proposed (e.g., intrinsic motivation studies), no study to date has clearly established that contingent reward can cause IMDD.

Associated Physical Examination Findings and General Medical Conditions. No specific physical features are associated with IMDD™, although obesity may develop secondary to the consumption of candy, sodas, and Big Macs. In adulthood, the individual may develop acute hypertension as a result of investing heavily in the stock market and real estate.

Specific Culture, Age, and Gender Features. IMDD™ is a disorder known to occur in various cultures, especially those that closely emulate the United States. It is difficult to establish this diagnosis in preverbal children, although children who are "bribed" for toileting may be particularly at risk. In contrast, older children with

IMDD™ are easily identified by their characteristic aversion to situations in which material rewards or access to the family automobile are unavailable. As children mature, symptoms become less conspicuous as the absence of intrinsic motivation becomes the rule rather than the exception. No significant gender differences have been observed, but they are likely to emerge in one of several studies planned as part of a large, multisite, collaborative investigation costing several million dollars (with an author list rivaling the board of trustees of a large urban bank).

Prevalence and Course. IMDD™ is nonexistent at birth. It is believed that the ubiquity of tangible reward erodes intrinsic motivation increasingly throughout childhood and adolescence. As far as can be told, only two individuals, Edward Deci and Alfie Kohn, do not suffer from this disorder.

Familial Pattern. Since almost all parents suffer from IMDD™, they almost invariably transmit the disorder to their children through the adoption of token economies and consistent use of tangible reward. Though the specific mechanism of transmission is unknown, recent genetic studies show an abnormality on the long-arm of chromosome 1040, with sufferers persistently deemphasizing their material wealth. Symptoms appear to worsen seasonally and are acute in mid-April of each year.

Differential Diagnosis. The craving for material goods is to be distinguished from the impulsive spending that may arise as part of a manic episode. Many associated features, such as the air of entitlement and attachment to material things, may also be present in some forms of personality disorder, though most individuals diagnosed with borderline personality disorder display greater concern for social reinforcers (especially praise). Differential diagnosis for antisocial personality disorder will require an assessment of associated features of aggression. Persons with IMDD™ are known to become aggressive only during stock market crashes, fender benders, and especially during divorce settlements. Major depression may occur after long periods of tangible deprivation. In women, IMDD™ should be distinguished from a rare condition involving shoe hoarding, known as Imelda's Syndrome.

DIAGNOSTIC CRITERIA

A. Six or more of the following symptoms of extrinsic motivation have persisted for at least 6 months to a degree that is maladaptive and inconsistent with develop-

mental level: (1) Often makes statements such as, "What will you give me if I clean up my room?" (2) often fails to follow through on schoolwork or duties in the workplace unless followed by the delivery of currency (preferably in unmarked bills); (3) often bargains or negotiates to exact highest possible price for such routine acts as making beds or, for an adult with a partner, for performing such duties as intercourse, or taking the children to Sunday school; (4) nonverbal behavior often gives the impression of disinterest (e.g., eyes averted) unless there appears to be a clear indication of imminent material reward; (5) reads *Fortune*, *Money*, or *Forbes* on more days than not; (6) spends more time counting assets than counting blessings; (7) frequently asks (in school setting), "Is this going to be on the test?" or "Do we really have to know this?"

B. Some symptoms of extrinsic motivation that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of significant impairment in social, academic, or occupational functioning.

E. The disturbance does not occur exclusively in the context of other annoying behavioral patterns such as those characteristic of children diagnosed with ADHD or ODD or as a result of a severely privileged upbringing.

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*Gretchen Kelbaugh and Centre for Addiction and Mental Health;
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Dr. Lori Haskell

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First Stage Trauma Treatment: A Guide for Mental Health Professionals Working With Women

Dr. Lori Haskell

This book provides a conceptual framework and useful techniques for therapists working with women experiencing post-traumatic stress disorder.

PUB. DATE: 2003
LIST PRICE: \$34.95 (CAN)
SHIPPING: 15% outside Canada

Brief Couple Therapy: Group and Individual Couple Treatment for Addiction and Related Mental Health Concerns

*Gloria Chaim, Sharon Armstrong, Joanne Shenfeld, Colleen Kelly,
and Selina Li*

This manual is a tool for therapists and counsellors working in substance use settings who would like to augment their practice by seeing couples.

PUB. DATE: 2003
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Eden Institute Curriculum Series

David L. Holmes, Ed.D., et al.

Five-volume series of teaching programs and strategies for individuals with autism.

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LIST PRICE: \$580
MEMBER PRICE: \$522
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Autism Through the Lifespan: The Eden Model

David L. Holmes, Ed.D.

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Choice, Behavioural Economics and Addiction

Edited by R. E. Vuchinich and N. Heather

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MEMBER PRICE: US \$75.00
www.elsevier.com/locate/isbn/0080440568

Origins of Phobias and Anxiety Disorders: Why More Women Than Men?

Edited by Michelle G. Craske

ISBN: 0-08-044032-0
PUB. DATE: 2003
LIST PRICE: US \$80.00
MEMBER PRICE: US \$57.00
www.elsevier.com/locate/isbn/0080440320

Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment, and Treatment

Edited by Randy O. Frost and Gail Steketee

This volume assembles nearly all of the major investigators responsible for the development of cognitive therapy (and theory) for OCD, as well as other major researchers in the field, to write about cognitive phenomenology, assessment, treatment, and theory related to OCD. ISBN: 0-08-043410-X
PUB. DATE: May 2002
LIST PRICE: US \$94.00
MEMBER PRICE: US \$70.50
www.elsevier.com/locate/isbn/008043410X

Handbook of Conceptualization and Treatment of Child Psychopathology

Edited by Helen Orvaschel, Jan Faust, and Michel Hersen

This handbook includes contributions from outstanding scholars active in both the science and practice of child and adolescent treatment. ISBN: 0-08-043362-6
PUB. DATE: 2001
LIST PRICE: US \$81.50
MEMBER PRICE: US \$61.00
www.elsevier.com/locate/isbn/0080433626

Innovations in Adolescent Substance Abuse Interventions

Edited by Eric F. Wagner and Holly B. Waldron

This volume provides a single reference source for empirically tested approaches to assessing, preventing, and treating

adolescent substance abuse problems. It includes 16 chapters from leaders in the field. ISBN: 0-08-043577-7

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MEMBER PRICE: US \$56.25
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Integrated Behavioral Healthcare

Cummings

This book provides a roadmap of the emerging directions integrated behavioral healthcare is taking and lays out the steps the mental health professional needs to take to adapt to the new system of healthcare. ISBN: 0-12-198761-2

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Clinician's Guide to Adult ADHD

Edited by Goldstein and Ellison

This book is devoted to the treatment of adult ADHD, presenting a comprehensive review of the existing literature, a practical set of clinical guidelines, and the observations and insights of professionals on the research and the clinical treatment of this condition. ISBN: 0-12-287049-2

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Therapist's Guide to Substance Abuse Intervention

Johnson

Presenting information in easy to read outline form, the guide identifies how to assess, diagnose, and treat substance abuse or substance dependence. ISBN: 0-12-387581-1

PUB. DATE: 2003
LIST PRICE: \$49.95
MEMBER PRICE: \$37.95
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Therapist's Guide to Clinical Intervention (2nd Edition)

Johnson

This practical, hands-on handbook outlines treatment goals and objectives for each type of psychopathology as defined by the diagnostic and statistical manual by the American Psychiatric Association, identifies skill-building resources, and provides samples of all major professional forms. ISBN: 0-12-386588-3

PUB. DATE: August 2003
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Therapist's Guide to Learning and Attention Disorders

Edited by Fine and Kotkin

Provides clinicians a blueprint for treatment of children and adolescents with learning and attention disorders. ISBN: 0-12-256430-8

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LIST PRICE: \$65.00
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A Guide to Starting Psychotherapy Groups

Edited by Price

This book assists psychologists, social workers, psychiatrists, nurse clinicians, pastoral counselors, school and college counselors and other trained therapists in the process of forming and maintaining groups. ISBN: 0-12-564745-X

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Effective Brief Therapies

Edited by Hersen and Biaggio

This book is devoted to facilitating the understanding of strategies for approaching cases, conducting viable assessments, and implementing contemporary therapies. ISBN: 0-12-343530-7

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OCD: The War Inside

Mark Pancer and David Hoffert

Explores the causes and possible treatments for Obsessive-Compulsive Disorder, through the painful and occasionally funny stories of four children and adults with OCD.

PUB. DATE: 2002

LIST PRICE: \$229.00

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Bad Hair Life

Jennifer Raikes

This vivid documentary is a personal exploration of trichotillomania, or compulsive hair-pulling, and of the social context that makes it such a secret epidemic.

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Inside Out: Stories of Bulimia

Michelle Blair

Bulimia can affect women and men from all walks of life, and it kills nearly 20 percent of its victims every year. This moving documentary profiles individuals and families affected by this eating disorder.

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Coping With Stress Through Picture Rehearsal: A How-to Manual for Working With Individuals With Autism and Developmental Disabilities

June Groden, Ph.D., Patricia LeVasseur, M.Ed., Amy Diller, M.S., and Joseph Cautela, Ph.D.

This book was written as a guide to provide a model for using picture rehearsal to reduce stress in this population.

PUB. DATE: October 2002

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Schema Therapy: A Practitioner's Guide

Jeffrey E. Young, Janet S. Klosko, and Marjorie E. Weisbaaer

This book—written by the model's developer and two of its leading practitioners—is the first major text for clinicians wishing to learn and use the popular schema therapy approach.

PUB. DATE: April 2003

LIST PRICE: \$45.00

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Biofeedback: A Practitioner's Guide (3rd Edition)

Edited by Mark S. Schwartz and Frank Andrasik

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**Cognitive-Behavioral Treatment of Obesity:
A Clinician's Guide**

Zafra Cooper, Christopher G. Fairburn, and Deborah M. Hawker

This book presents the first cognitive-behavioral treatment manual for obesity, delineating an innovative therapeutic model currently being evaluated in controlled research at Oxford University. The approach is specifically designed to overcome a major weakness of existing therapies: post-treatment weight regain.

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**Cognitive Therapy With Children and Adolescents:
A Casebook for Clinical Practice (2nd Edition)**

Edited by Mark A. Reinecke and Frank M. Dattilio

This important casebook presents empirically supported interventions for a wide range of child and adolescent problems. Leading cognitive-behavioral therapists demonstrate assessment and treatment approaches that have been carefully adapted—or specially designed—to meet the needs of young clients.

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**Integrated Treatment for Dual Disorders: A Guide
to Effective Practice**

*Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake,
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Grounded in decades of influential research, this comprehensive clinical handbook provides virtually everything needed to plan, deliver, and evaluate integrated treatment for dual disorders. Presented are clear guidelines for developing programs, performing state-of-the-art assessments, and implementing a wide range of individual, group, and family interventions. Designed in a convenient large-size format with lay-flat binding for ease of photocopying, the volume contains all needed assessment forms, treatment planning materials, and client handouts, most with permission to reproduce.

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**Authoritative Guide to Self-Help Resources in
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John C. Norcross, John W. Santrock, Linda F. Campbell, Thomas P. Smith, Robert Sommer, and Edward L. Zuckerman

Keeping pace with the ever-changing world of self-help, the revised and expanded edition of this indispensable reference helps consumers and professionals distinguish high-quality self-help resources from those that are misleading, inaccurate, or even harmful. The volume is organized around 36 fre-

quently encountered clinical problems and life challenges, with entirely new chapters covering posttraumatic stress disorder, obsessive-compulsive disorder, youth violence, borderline personality disorder, bipolar disorder, and suicide.

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**The Paper Office: Forms, Guidelines, and Resources
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Science and Pseudoscience in Clinical Psychology

*Edited by Scott O. Lilienfeld, Steven Jay Lynn,
and Jeffrey M. Lohr*

This is the first major text designed to help professionals and students evaluate the merits of popular yet controversial practices in clinical psychology, differentiating those that can stand up to the rigors of science from those that cannot.

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**Addiction and Change: How Addictions Develop and
Addicted People Recover**

Carlo C. DiClemente

From Carlo DiClemente, codeveloper of the transtheoretical model, this book offers a panoramic view of the entire continuum of addictive behavior change. Illuminated is the common path that individuals travel as they establish and reinforce new patterns of behavior, whether they are developing an addiction or struggling to free themselves from one, and regardless of the specific addictive behavior.

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**Treatment Planning in Psychotherapy: Taking the
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*Sheila R. Woody, Jerusba Detweiler-Bedell, Bethany A. Teachman,
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This book provides clinicians of any theoretical orientation with a framework for evidence-based work. The innovative treatment planning method presented is known as PACC

(Planning and Assessment in Clinical Care). Illustrated with a wealth of case examples, the book shows how to use PACC to conceptualize the distinct phases of therapy, identify specific aims for each phase, develop a measurement plan for those aims, specify the intervention strategies to be used, assess and document progress toward goals, and conduct regular, collaborative progress reviews with clients.

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Evidence-Based Psychotherapies for Children and Adolescents

Edited by Alan E. Kazdin and John R. Weisz

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Kalyna Z. Bezchlibnyk-Butler, J. Joel Jeffries (Editors)

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Clinical Handbook of Psychotropic Drugs (Child and Adolescent Version)

Kalyna Z. Bezchlibnyk-Butler, Adil S. Virani (Editors)

The latest information is summarized in charts and bulleted lists for each class of psychotropic drug used in children and adolescents.

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Alcohol Consumption and Alcohol-Related Problems in Germany

Gerhard Bübringer et al.

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Diego De Leo, Unni Bille-Brabe, Ad JFM Kerkhof (Editors)

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Suicide and Euthanasia in Older Adults:

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Cognitive Therapy With Schizophrenic Patients: The Evolution of a New Treatment Approach

Marco C. G. Merlo, Carlo Perris, Hans D. Brenner (Editors)

The evolution of cognitive-based therapies for schizophrenia is changing psychiatric treatment of schizophrenia. This book describes the state of the art.

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Suicidal Behavior in Europe: Results from the WHO/EURO Multicenter Study of Suicidal Behavior

Armin Schidtko, Unni Bille-Brabe, Diego De Leo, Ad JFM Kerkhof (Editors)

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Saul D. Raw, *Weill Medical College of Cornell University*

Doctors' Suit Against Health Care Companies Allowed to Proceed

The New York Times reports that a panel of federal appeals judges in Atlanta rejected a request from several managed care companies to stop a proposed class-action suit filed against them on behalf of 600,000 physicians. The managed care companies had argued that the doctors' claims needed to be decided by arbitration and not by the courts.

Lawyers for the doctors were reportedly planning to ask the United States Court of Appeals for the 11th Circuit to lift the order that had up to now stalled the litigation. As had previously been reported in this column, the plaintiffs in the case alleged that the insurance companies had "violated contracts and defrauded doctors in violation of the federal Racketeer Influenced and Corrupt Organizations Act, known as RICO; the Employee Retirement Income Security Act; and state laws." A separate lawsuit was filed on behalf of "millions" of subscribers.

Archie Lamb, a lawyer for the plaintiffs, was planning to ask the court to require that the insurance companies make available business records that he stated would support the plaintiffs' position. A spokesperson for the California Medical Association, which joined in the suit, stated that the doctors were "pleased that the circuit court will allow us to continue with the lawsuit."

The general counsel for the American Association of Health Plans called the ruling a "victory for the health plans." She noted that the lawsuits would end up in a "procedural morass" on account of doctors having different types of contracts with the insurance companies.

The companies involved in the suit include Aetna, Cigna, Humana, United Healthcare, Wellpoint Health Networks, Health Net, Prudential, Pacificare, and Coventry Health Care of Georgia.

U.S. Judge Rules Bipolar Disorder Is a Physical Illness

The Wall Street Journal reports a story in which a person named Jane Pitt had to quit her job 7 years ago as an employment attorney at the Federal National Mortgage

Association after she was diagnosed with bipolar disorder. Ms. Pitt received part of her salary for 2 years under a long-term disability policy. The payments then stopped. The agency's disability policy provided benefits to people up to age 65 for physical disabilities but only provided 24 months of coverage for disabilities resulting from mental illness. This disparity in coverage was said to be typical of those of many employers.

In February 2002, however, a federal court ruled that Ms. Pitt's illness could be considered physical and that she was entitled to full disability benefits. The presiding judge in the case "cited statements by physicians that [her] disorder was visible on brain scans, was characterized by chemical imbalances in the brain, and might have genetic causes."

The ruling was said to have caused a stir in employment law circles, even though efforts by workers to challenge differential benefits for physical and mental illnesses under the Americans With Disabilities Act had not previously been successful. The article notes that maintaining distinctions between the two types of disorders was becoming increasingly difficult as research blurred the lines between them.

The trial court ruling is not binding on other courts, but the ruling was expected to encourage other similar suits, according to an attorney specializing in employment law. Employers and insurers were said to be alarmed by the trend, according to Stephen Bokart, general counsel for the U.S. Chamber of Commerce. He warned that if the distinctions were not maintained, employers would have increasing difficulty offering disability insurance.

Ronald Cooper, an attorney who represents insurers, noted that the underlying problem is that the costs for mental health-related benefits are hard to control. "These are very difficult things to diagnose and treat in a way that's predictable."

Ms. Pitt's lawsuit alleged that mental health disability caps violate the disabilities act. The judge in the case had to determine if bipolar disorder was clearly a mental illness under the policy definitions of the disability insurer, Unum. An Unum physician noted that the disorder was contained in *DSM-IV* and a psychologist employed by Unum asserted that bipolar disorder was a

mental illness because it was "characterized by a cognitive, emotional, or behavioral abnormality."

The judge was not convinced by this argument as he noted that even *DSM-IV* "posits that the distinction between mental disorders and physical illnesses is a false one." He further noted that problems such as Alzheimer's disease and anorexia nervosa are brain based, but are commonly seen as "physical" illnesses.

Drug Companies Challenge Longstanding European Ban on Consumer Drug Advertising

The Wall Street Journal reports that the French-German company, Aventis SA, spent approximately \$89 million in 2001 to publicize its allergy drug Allegra, but in Europe, decisions of the European Union ban prescription drug advertising and even prevent Aventis from mentioning Allegra on its Web site or in its brochures.

These regulations, in effect for many years, help to control health-care costs, which are heavily subsidized in European countries. Drug makers are arguing that such restrictions unfairly limit patients' access to information and hence limit their access to medications that may be clinically useful. AstraZeneca PLC is the producer of the drug Prilosec, which is used for the treatment of ulcers. Although the drug had \$6 billion worth of sales worldwide, the United States contributed two-thirds of that total, with Europe contributing one-third, despite the United States having a smaller population.

The European Commission is now considering allowing drug companies to market treatments for AIDS, diabetes, and respiratory disorders on their corporate Web sites and in brochures requested by consumers. The overall rubric is that the consumer must request the information.

Though falling far short of American direct-style marketing, the proposal reflects pressures on European governments, as well as the fact that much of the information is already available to the European consumer on American and other Web sites. The article notes that this can sometimes create confusion because medications are given different names and sometimes available in different dosages depending on the country.

Both consumer groups and European officials assert that relaxing drug advertising regulations will simply raise advertising budgets and drug prices without having any significant effect on the health of

Europeans. European governments typically set some price controls on drugs, and prices are typically 40% to 60% lower than in the U.S.

Charles Medwar, director of the group Social Audit, a consumer interest group in London, is skeptical about the benefits of advertising. He notes that the total health care cost per person, a significant part of which is made up of drug prescriptions, was \$3,724 in the U.S. as opposed to \$1,660 in Europe (year 2000). He maintains that consumers can already learn about available medications through the media and through patient organizations. Finnish allergist Erkka Valorvirta states (referring to drug advertising), "It doesn't help patients seek out the best treatment . . . ; it usually just happens to be the most expensive."

John Patterson, a senior marketing executive at AstraZeneca, notes that direct-to-consumer marketing is something of a two-edged sword. "It's expensive, and you end up in a spiral of costs because everyone is doing it." He maintains that such advertising is often useful, as it may prompt consumers to make an appointment to see a doctor and seek treatment in situations in which they might not ordinarily do so.

Study Reveals Americans More Willing to Seek Out Treatment for Depression in the United States

Psychiatric News, citing a study that appeared in the *Journal of the American Medical Association*, reveals a threefold increase in outpatient treatment for depression in the decade 1987 to 1997. In 1987, 0.7%, or 1.76 million people, sought treatment while in 1997, 2.3%, or 6.33 million people, sought treatment. Of those treated for depression, 44.6% were prescribed a psychotropic medication in 1987 as opposed to 79.4% in 1997.

The study collected information from surveys done for the Federal Agency for Healthcare Research and Quality. In both studies, participants were asked to record "medical events" in a diary. Events could include such things as visits to physicians. These diary entries were later discussed with respondents in face-to-face interviews. Tens of thousands of households were reportedly polled for these studies, which were designed to determine health-care utilization and sources of funding.

Other findings revealed that the overall percentage of patients receiving psychotherapy for depression declined from 71% to 60% during this period, while the

percentage of those being treated by a physician increased from 69% to 87.3%.

The study concludes that "these changes coincided with the advent of better-tolerated antidepressants, increased penetration of managed care, and the development of rapid and efficient procedures for diagnosing depression in clinical practice."

More on the Evidence-Based Practice Debate

An article in *NASW News* discusses a number of research reports that suggest that treatment effects reported in outcome literature are less dependent on treatment technique than on a number of other factors. According to James Drisko, Associate Professor of Social Work at Smith College, the social work profession would be better off informing the public that those who participate in therapy do better than those who do not. He also believes that the researchers' time would be better spent studying therapeutic common factors, such as empathy and acceptance, as well as the agency and client contexts within which service delivery occurs.

Drisko maintains that 25 years of increasingly sophisticated meta-analytic studies reveal that "differences across therapies are not particularly significant or meaningful." He believes that, although studies comparing psychotherapies sometimes show differences, meta-analyses, which factor out various biases and methodological problems, reveal outcomes that are the same or similar. The article notes that there is controversy as to whether meta-analyses really reveal no significant differences between therapies.

Citing the work of Michael Lambert of Brigham Young University, Drisko maintains that 40% of outcome variance can be attributed to factors outside the therapy itself, such as client context (neighborhood and family, peer, social, workplace and spiritual supports) and the client as common factor (intelligence, motivation, trust, resilience, etc.). Thirty percent of the variance, according to Lambert, comes from the therapeutic relationship while only 15% of outcome variance comes from therapy techniques that are "unique to a specific treatment." Lambert attributes the other 15% of variance to the placebo effect, including hope and expectancy that clients bring to the therapeutic encounter.

According to Drisko, the results of these meta-analytic studies have several strong implications for the field of social work. It is more important that the overall efficacy of

psychotherapy, rather than the type of therapy, be the basis for discussions of mental health policy and funding. Meta-analyses show an effect size of 0.8 for psychotherapy, a result said to be stronger than for many service programs and many medical treatments. "It isn't the common notion out there in the world that therapy works. We have become very critical of professionals, but empirical evidence shows that therapy works. Since social workers do more of this work than other professions combined, that's what we ought to be promoting."

By contrast, William Reid, professor of social work at the State University of New York at Albany, believes that when studies are searched by problem and population, different interventions show different results. In his study of 42 meta-analyses, 31 reported different treatment effects between interventions.

"Given the weight of the evidence, it may make sense to consider differential effects or the lack thereof in respect to specific problems, population and intervention match-ups rather than to refer to a general tie-score effect. . . ." According to Reid, "Determining whether or not comparisons between intervention methods yield genuine differences in effectiveness will always be a daunting task, and one that will frequently yield null results."

Kathleen Millstein, associate professor of social work at Simmons College, believes that evidence-based practice may miss relationship issues critical to client improvement. "Controlled studies take away the heart of social work—the relationship piece. It doesn't work unless you have a good relationship."

Criticism of New Mexico Decision on Prescription Privileges for Psychologists: More Dispassionate Views From Another Psychiatrist

In response to pending legislation in New Mexico that would give prescription privileges to psychologists, two highly critical letters, both from physicians, appeared in *The Wall Street Journal*. One was from Joseph J. Zealberg, M.D., clinical professor of psychiatry at the Medical University of South Carolina and former president of the American Association for Emergency Psychiatry. His letter, in its entirety, follows:

As a proponent of high-quality patient care, I am writing regarding New Mexico's pending legislation that would allow psychologists to prescribe psychiatric medications.

Such an idea is myopic and pernicious. After receiving my medical degree, I began psychiatric residency training in 1981. In the past two decades, I've practiced in all types of settings—rural Appalachia, urban research centers, in hospitals, outpatient clinics, community settings and in emergency rooms. I've evaluated thousands of patients.

Treatment of the nervous system requires the most sophisticated forms of medical expertise. Patients often take numerous medications for concomitant medical or neurological syndromes. Alcohol and drug abuse often complicate their clinical histories. One medication can have profound effects on another. Worsening angina pectoris may mimic panic disorder. Hyperthyroidism can be mistaken for mania. Confusional states caused by medical illness or drug toxicity can be misconstrued as severe depression or dementia. In spite of their medical training, even general physicians can miss such differential causes of behavioral change. Psychopharmacologic medications can affect not only the brain, but also the circulatory system, the liver's biochemical pathways, the body's complex gastrointestinal system, and other critical organ networks. Non-physicians have no business ordering medications that may affect the body's most complicated organ—the brain.

Psychiatric syndromes are complicated by high levels of morbidity and mortality. Let's not compound these terrible problems by devising inferior solutions. Incentives should be in place to attract outstanding psychiatrists to rural areas. Government and state-sponsored scholarship programs should be in place to assist in this endeavor.

Another point of view is provided in an interview with Ali Hashmi, M.D., in *The National Psychologist*. Dr. Hashmi works in a community mental health center in Jonesboro, Arkansas, a city of about 55,000. Dr. Hashmi views the controversy as essentially economic. "It's amusing that the whole argument is couched in philosophical, moralistic terms. Nobody seems to be willing to acknowledge that this is primarily, or at least largely, an economic issue," according to Hashmi. He adds, "There is a pervasive fear in psychiatric circles that if nonphysicians are given prescribing privileges the rates of reimbursement, salaries, and earnings of psychiatrists would be driven down accordingly. Conversely, the other camp doesn't want to admit that getting prescription privileges would boost their income since prescribing is much less labor and time intensive than therapy. It

guarantees a steadier income stream than therapy," he adds.

Hashmi believes that because of economic and political factors pushing prescription privileges forward, it is inevitable that these privileges will one day be granted in one state, and he predicts a domino effect in other states. He thinks that psychiatry should be open to "physician extender" models, such as those already in effect in physician assistant and nurse practitioner practice.

Hashmi maintains that psychologists and psychiatrists are fighting "over a larger piece of an ever-shrinking pie." He notes that "almost all health insurance companies have 'carved out' their mental health services to 'for-profit' behavioral health companies which slice off, 30, 40, 50% of member premiums for 'overhead,' meaning that for every dollar paid into the plan, half goes into the company's pocket, not for health care. At the same time, access to psychologists and psychiatrists alike is more restricted than ever. That is the fight we should all be fighting."

Psychological Needs of Hepatitis-C Patients

A paper in *Issues in Interdisciplinary Care* describes support groups for patients receiving combination therapy for Hepatitis C, a disease which is said to affect 4 million people in the United States. The combination of physical, psychological, social, and cognitive side effects of the disease and its treatment poses major challenges to patients, friends, and family.

The treatment of choice for many of these patients is alpha interferon in combination with ribavirin, an antiviral therapy. Interferon side effects include flulike symptoms, hair loss, fatigue, and depressed white blood count. The author notes that although she has observed mild to severe psychological, social, and cognitive difficulties in patients undergoing combination therapy, she has also attended physician conferences in which these side effects were described as "minimal." Significant areas of dysfunction for combination therapy patients include activities of daily living, work, social relationships, and marriage.

Support groups, led by professionals or "facilitators," are essentially psychoeducational in form and focus on decreasing isolation, encouraging sharing of feelings and coping strategies, and disseminating the best available information about the disease and its treatment in order to help patients make the most informed treatment choices.

Stress management techniques are said to be another important component.

Report on Racial Disparities in Access to Health Care Available On-Line

A study recently published by the Institute of Medicine documents racial and ethnic disparities in access to health care, even when patients have access to the same insurance. This study is available in its entirety in a fully searchable version on the World Wide Web (<http://books.nap.edu/books/030908265X/html>). The study received a great deal of media attention, including a front-page article in *The New York Times*.

The report, which examined both medical and psychiatric care, is said to reveal both overt and covert factors that interfere with equal access to medical care.

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What's in a Name? Everything!

Kenneth D. Salzwedel, *Private Practice, Whitewater, WI*

I don't think the name of AABT should be changed. To do so would give voice to those who do not have a behavioral orientation. There are other organizations and SIGs they can join if they wish. I find it very curious that these individuals want to belong to a behavioral organization. Maybe we should ask them sometime. Already, many of the behavioral journals are devoting more and more space to "cognitive" work. This strikes me as being totally unwarranted.

I looked over the most recent issues of *Behavior Modification*, *Behavior Therapy*, the *Journal of Applied Behavior Analysis*, and the premier clinical journal, the *Journal of Consulting and Clinical Psychology*, to determine the extent of there being a "cognitive" emphasis in the articles that were printed. In *Behavior Modification*, there were 7 articles in the issue. Of these, 4 were cognitive in orientation and none of them were behav-

ioral. The remaining 3 articles were of a research nature that would be a better fit in the *Journal of Consulting and Clinical Psychology*. In *Behavior Therapy*, there were 8 articles: 4 cognitive, 1 behavioral. The remaining 3 were of a research nature or were impossible to classify. Of course, the secondary title of *Behavior Therapy*, "An International Journal Devoted to the Application of Behavioral and Cognitive Sciences to Clinical Problems," suggests that "cognitive" articles are okay. Fortunately, we still have the *Journal of Applied Behavior Analysis*. A recent issue of this publication contains 12 articles, all of which are behavioral. Finally, 5 articles appeared in an issue of the *Journal of Consulting and Clinical Psychology*, all of which were cognitive in orientation.

The basic point of this discussion is to indicate that a behavioral article is difficult to find, even when the term "behavior" is in the journal's name. We do not need to change our name to ensure that others may have a place to hang their hats. The hatrack is already filled with their cognitive hats.

Let's keep advancing behavior therapy, not cognitive therapy. Skinner would roll over in his grave if he noted how cognition has intruded into behaviorism. ✍

Yes, You Can Call Yourself a Real Doctor

Barry A. Bass, *Towson University*

Frank M. Dattilio (2003) will be heartened to learn that all his worry about not being a "real doctor" was for naught. I'm pleased to inform him that contrary to popular opinion, it is the physicians who have "stolen" that title from the scholars and academics. From at least the early Middle Ages, the honorific title of doctor had been reserved for men of great learning. It was not until the 18th century that medical schools began the now accepted practice of referring to their graduates as doctor. As noted in *The Wall Street Journal*, it appears that it was "jealous[y]" of the respect shown to scholars by the title

doctor" that was responsible for the change in how one was to address physicians (Sherman, 1995). So, Dr. Dattilio, it is not too late to disabuse your son of his mistaken notion and to point out to him that it is the Ph.D.s of the world, and not the physicians, that are truly the "real doctors."

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Reno Re-Revisited

Barbara Parry, *Private Practice, Las Vegas, NV*

I read with dismay the article in January's *the Behavior Therapist* (Steffen, 2003) recapping the Reno convention. I am a private practitioner and I pay for absolutely everything by myself. The Reno Convention was the only affordable one AABT has ever put on. I lived in Stockton, CA, prior to moving to Las Vegas, and I could not afford to go to the one in San Francisco due to the cost of staying there and the drive times.

I am appalled that people were appalled at the "casino atmosphere." The Hilton actually allows convention participants to enter their convention area without ever getting into the gambling area. I am so very sorry that you will not use a casino-based hotel again. Can you give me the statistics on the number of people who went to the conference who complained of the casino venue versus the number of people who went who did not complain? I would like to know what statistic you are basing this decision on. Please count me as a non-complainer.

As the conventions tend to be expensive and in far-away places for me, I am really saddened that I probably will never again attend an AABT conference. Price does matter. Los Angeles, Portland, Honolulu, San Diego, Palm Springs, Seattle, Victoria, BC, Banff, Canada, Anchorage, Chicago, Phoenix, Sedonia, Flagstaff, Albuquerque, Taos, Boulder, and Denver are all pretty expensive places, both to get to and to stay in. I will be very interested in seeing if your attendance statistics go down again for West Coast conventions when you have to select an expensive venue.

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Response to Bobicz and Richard (2003)

Barbara O. Rothbaum, *Emory University School of Medicine*

I take issue with some of the conclusions reached by Bobicz and Richard (2003) in their recent *tBT* article "The Virtual Therapist: Behavior Therapy in a Digital Age." Some of their conclusions fail to recognize the extent of the research conducted on the therapeutic use of virtual reality. They criticize the field on a number of issues that have been addressed but were not included in their brief review. For example:

- "Most studies are either case studies or include small samples (. . . 5 to 20 participants . . .)" (p. 267)

Response: In Rothbaum, Hodges, Smith, Lee, and Price (2000), there were 45 treatment completers. This study has now been replicated with 75 treatment completers.

- "... with inconclusive or absent follow-up data" (p. 267)

Response: In Rothbaum et al. (2000), data were presented on participants 6 months after completing treatment; in Rothbaum, Hodges, Anderson, Price, & Smith (2002), follow-up data were gathered 12 months after treatment.

- "It is the rare study that compares VR exposure to its in vivo cousin" (p. 267)

Response: The Rothbaum et al. (2000) study compared virtual reality exposure therapy to standard exposure therapy to a wait-list control group.

- "Treatment outcome is often measured using questionnaires rather than by observing more meaningful behavioral activities" (p. 267)

Response: In the studies listed below, participants were rated on a BAT of an actual airplane flight and rated for their ability or avoidance to fly on real airplanes. In our work on social phobia, we have pre- and posttreatment BATs of speeches delivered in front of live audiences (Anderson, Rothbaum, & Hodges, in press).

- "Computer-based . . . could be enhanced by the use of digitized video" (p. 268).

Response: Not only do we currently do this, we hold a patent on it!

I think it was slightly sloppy not to include the very relevant studies below that were readily available. A list of publications is available at www.virtuallybetter.com.

References

- Anderson, P. L., Rothbaum, B. O., & Hodges, L. (2001). Virtual reality: Using the virtual world to improve quality of life in the real world. *Bulletin of the Menninger Clinic Supplement*, 65, 4-17.
- Anderson, P., Rothbaum, B. O., & Hodges, L. F. (in press). Virtual reality exposure in the treatment of social anxiety: Two case reports. *Cognitive and Behavioral Practice*.
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- Rothbaum, B. O., Hodges, L., Anderson, P. L., Price, L. & Smith, S. (2002). 12-month follow-up of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology*, 70, 428-432.
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In Response to Dr. Rothbaum's Critique

David C. S. Richard, *Eastern Michigan University*

Dr. Rothbaum (2003; see above) brings up a number of interesting points, and I am grateful for the opportunity to address them. I am sure that she and her colleagues would agree that when we say "most studies are either case studies or include small samples," we mean exactly that. We are not speaking exclusively of her research. VR studies reported to date, as a whole, have been intriguing and well conceived. However, the majority include small sample sizes with all the attendant power issues. The 2002 follow-up paper she references was published after we submitted our manuscript to *the Behavior Therapist*, and I concur that the follow-up data are of interest. However, we can not be held responsible for papers that were not available at the time we wrote our manu-

script. Indeed, we note in the review that our remarks would be outdated by the time the article went to press. Despite the impression Dr. Rothbaum leaves in her letter, our remarks (like those you will find in all review papers) were general summaries of the field and were not specifically directed at her research. Indeed, her comment regarding the overreliance on questionnaire data seems odd given that the study we cited (i.e., Carlin et al., 1997) had nothing to do with her research. The fact that one researcher or one group of researchers employs sound methods does not mean the field as a whole does. Thus, we stand by our review and look forward to the fine work Dr. Rothbaum and her colleagues will undoubtedly contribute in the years to come. I applaud her pioneering work and look forward to reading of future developments.

Reference

- Rothbaum, B. O. (2003). Response to Bobicz and Richard (2003). *the Behavior Therapist*, 26, 326. ✍

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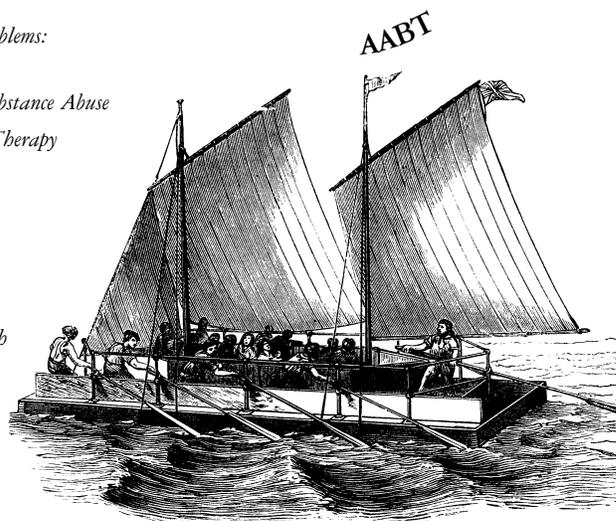
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