

the Behavior Therapist

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Research Forum

Internet-Mediated Research: Beware of Bots

*Kayla R. Prince, Abby R. Litovsky,
and Dara G. Friedman-Wheeler,
Goucher College*

Internet-mediated research (IMR) is growing in popularity due to its accessibility and the large number of participants it can attract. IMR has many advantages over in-person data collection, including increased efficiency and the ability to reach a wider audience (Naglieri et al., 2004). Daily diary studies, in particular, benefit from the use of the Internet, as Web surveys are often time-stamped, allowing researchers to check when entries were completed (Gunthert & Wenzel, 2012). However, our own experience conducting IMR suggests that there may be a need for specific measures to ensure the integrity of the data collected online. We launched an Internet-mediated daily diary study this summer and were quickly inundated with suspicious-looking data.

In June 2011, we advertised our study on craigslist. We had a few responses to our survey, but in order to attract more participants, we added mention of available incentives (gift cards to Amazon.com) to the subject line of the craigslist ad the following day. By 4:48 p.m., our participant count had reached 11 people, and the members of our research team were emailing each other in excitement. Two hours later, that number rose to 34. At this point, we started to get a little nervous because of the amount of work involved in the day-to-day operations of the study, which was in direct proportion to the number of new participants (e.g., setting up reminders to be sent to participants to invite them

[continued on p. 87]

to complete the daily-diary portion of the study). Another 2 hours later, we had 80 participants. We started discussing taking the study down once the number hit 100 participants, and that happened much more quickly than we had anticipated. Panic mode kicked in. We took our ad off craigslist and deleted our welcome page, a basic Web-page setup to connect participants to the actual survey form. The next morning, we discovered that deleting the welcome page was not sufficient to keep participants out of the study, as we had data from over 350 “participants.”

The majority of these responses were suspect. The time spent in the study was very brief (often under 2 minutes) and the data often did not make sense (responses to open-ended questions were often skeletal and followed set patterns, such as frequent use of the word “quarreled,” consistently misspelled). It became apparent that we were victims of form-completion bots.

Bots

Form-completion bots can take two forms. The term originally referred to a class of computer programs that generate automated responses to Web survey forms (Kobayashi & Takeda, 2000). In addition, the term “human spam bots” is now being used to refer to people who repeatedly complete and submit forms (or perform other interactive Web activities) on behalf of someone else (Chapman, 2009). Presumably, these human bots are paid small amounts of money by a third party for each form submission, while the third party ultimately receives the study incentive. Distinguishing bot-generated responses from real responses required us to become detectives and involved many hours of labor and database customization. For example, while often these “participants” completed the survey quickly and gave brief, patterned answers to open-ended questions, it was rarely possible to determine definitively that bots had generated these responses. Making this determination, however, is critical for protecting the integrity of the data and for respecting the rights of human participants completing the study in good faith – we wanted to ensure we paid our real participants and did not incorrectly assume them to be bots. Yet we also needed to feel confident that our results were based on legitimate data, or we would potentially be writing articles about how bots cope with stressful events.

Among the criteria we used to try to distinguish legitimate responses from bot-generated responses were:

- Time spent in the survey.
- Giving impossible answers to specific items in the survey: for example, one item asked participants where they had learned of the study. Answer choices included places where recruitment was not yet taking place; many suspected bots selected these sources.
- Specific patterns of responses to an open-ended question about the “most bothersome event” that occurred that day: for example, many suspected bots generated repetitive answers (across days and across supposed-participants) that included the phrase “my boss blame me.” Many responses also were simply “no” or “none.”
- Suspicious email addresses, such as rkasldhfnsmkflwerkjlweuirp@gmail.com (fictitious example).

In approaching this dilemma, we consulted with members of our college’s IT department to learn more about how bots may operate and about how to identify them and, ultimately, exclude them from our study. We also sought the advice of the chair of our IRB and of college counsel, so as to be sure we were minimizing the risk of infringing on the rights of legitimate participants (i.e., if we decided not to send a gift card to a given email address, on the grounds that it was likely associated with a bot and then received a complaint from that email address). Finally, we attempted to consult with other Internet researchers (emailing them after finding their studies listed online), but it happened that our emails often ended up informing them about bots, as they had not previously been aware of their existence. With the assistance of our database designer, we were able to use Microsoft Access to sort through the data with respect to the above criteria, helping us to distinguish between real and automated responses. We ultimately retained responses from only 20 of the initial 350 participants. Several full days were spent poring over the data to make these determinations.

Suggestions for Researchers

It stands to reason that people are most often tempted to employ bots (human or automated) to complete surveys when they learn of an appealing incentive (in our case, an Amazon.com gift card). In addition, we

learned that several online survey hosts prohibit their users from advertising their studies on craigslist (where we had initially posted our study), on the premise that this site is often mined by those using bots to try to get incentives. If researchers do choose to use craigslist, we recommend that incentives not be mentioned in the subject line of the ad (or potentially anywhere in the ad), and the data should be checked frequently, especially immediately following the launch of the study. Generally speaking, it may be preferable to recruit participants via websites that are less likely to be visited by those whose primary motivation is making money (e.g., Hanover University’s “Psychological Research on the Net”; <http://psych.hanover.edu/research/exponnet.html>), and that incentives not be mentioned in the initial listing (but rather described when a reader clicks to seek more information about the study). This strategy might yield fewer initial responses, but hopefully these responses will be from real people who are motivated for reasons other than monetary incentives. It should also be noted that incentives may not be required at all: many participants seem willing to complete one-time online questionnaires for free. Not offering an incentive at all might then solve this problem entirely.

When incentives are used, researchers should work with their IRBs to adapt consent forms to reserve the right to not pay participants whose data look suspicious, thus protecting themselves if the people behind the bots should complain about not having received the incentive. Our initial incentive structure involved payment for all participants: a \$5 gift card for those who completed the baseline assessment and fewer than 6 daily diary assessments, and \$25 or \$30 gift cards for those who completed 6 or 7 days, respectively. In addition to stating explicitly that we reserved the right not to pay participants whose responses resembled those generated by bots,¹ we revised our incentive strategy to involve a drawing for a \$25 gift card for those who did baseline plus fewer than 6 daily diary assessments, thus reinforcing the expectation among participants that they would not all be paid, and potentially saving us money in the event that hundreds of responses should come in that we could not definitively attribute to bots.

The use of “required” questions may also help to eliminate some bots. Ethically, we

¹All of these revisions were approved by our IRB before they were implemented.



Figure 1. CAPTCHA-like text.

prefer not requiring questions of respondents, as we believe participants should have the right not to answer any question they don't want to answer. However, in our first wave of recruitment, many of the suspected bots left the open-ended item, "Please describe the most bothersome problem of the day," blank or entered "no" or "none" as a response. Our solution to this dilemma was to require the question (form-creation software allows for this and often places an asterisk [*] next to questions that are required) and to mention under the question that "no" and "none" were not acceptable responses. To lessen the ethical concerns associated with this decision, we mentioned in the consent form that participants who wished not to share their most bothersome event could enter text such as, "I prefer not to share the description of the event but will answer the follow-up questions with this event in mind" in the required field.

Researchers may also want to include questions with impossible (or highly unlikely) answer choices. We ended up including a question of this nature ("Where did you learn about the study?") inadvertently, as we did not begin recruiting through all venues at the same time. Impossible answers to this question proved very helpful in sorting out real participants' data from bot-generated responses.

Finally, and perhaps most importantly, numerous IT consultants suggested to us that the most effective way to keep automated programs from submitting responses

to Web forms is through the use of CAPTCHAs (Completely Automated Public Turing Tests to tell Computers and Humans Apart), questions that require users to interpret distorted text (see Figure 1), a task that (at present) automated systems do not do well. These CAPTCHAs are freely available (www.captcha.net) but are not compatible with all Web-survey software. Researchers concerned about automated responses to Web forms may want to employ Web-survey software that allows the use of CAPTCHAs. Unfortunately, CAPTCHAs do not exclude human bots; other measures need to be used to filter out spam produced by humans.

Despite the many challenges we experienced, we continue to be enthusiastic about the many advantages of Internet-mediated research: we don't have to be available to run our participants (who sometimes participate in the middle of the night), there is no potential for data-entry errors on the part of the research team, as participants effectively enter their own data, and we have easy access to a broad variety of populations (as opposed to just those who can easily come into our lab; Naglieri et al. 2004). In fall 2011, we relaunched our study using Formstack as a platform and listed it only on the Hanover University website, the Social Psychology Network's "Online Social Psychology Studies" page (<http://www.socialpsychology.org/expts.htm>), and on craigslist with no mention of the incentive. The Formstack software includes CAPTCHA capability, and, to our knowledge, we have no automated bots among our new respondents (we continue to use the other strategies described above to exclude data produced by human bots). Internet-mediated research has many advantages, and the risk of bots can be minimized through careful planning and the use of CAPTCHAs. We believe the benefits of

this medium greatly outweigh the costs associated with automated responses.

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Address correspondence to Dara G. Friedman-Wheeler, Ph.D., Department of Psychology, HS 113, Goucher College, 1021 Dulany Valley Rd., Towson, MD 21204; darafw@goucher.edu.

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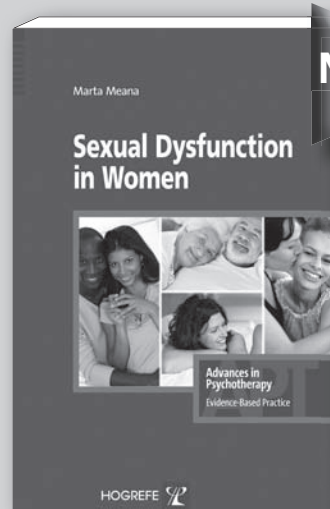
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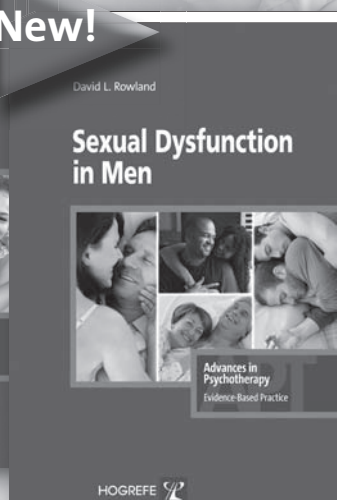
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Use of Therapist Self-Disclosure and Self-Involving Statements

James W. Sturges, *California State Polytechnic University, Pomona*

Responding with irritation, the patient ("Carol") dismissed most of what I had to say with words that sounded entirely reasonable but left me feeling thwarted, impatient, and increasingly frustrated. Finally, I told her that I was beginning to feel quite irritated myself, adding that I usually had the feeling here that the two of us were on the same side, as I suspected she did, but that somehow our conversation today seemed to have turned adversarial.... Before long Carol was engaged in a rather troubling consideration of the ways our interaction mirrored that with her husband, with whom at times she felt irresistibly drawn to pick a fight. (Wallin, 2007, pp. 123-124)

Therapist self-disclosure (SD) of personal life experiences or information and therapist self-involving statements (SI; an aspect of "immediacy"; the use of the immediate situation) in psychotherapy comprise only a small percent of therapist interventions (Hill et al., 1988; Hill & Knox, 2001).¹ However, SD and SI are used with the majority of clients (Peterson, 2002) by therapists across theoretical orientations (Carew, 2009; Henretty & Levitt, 2010) and can be important tools. SD/SI is ethical when it is helpful and not harmful or exploitive (Peterson).

SD/SI can be a way to build or repair the therapeutic alliance as well as address client motivation. It can model relationship skills and allow clients to practice appropriate responding. It can underscore the effectiveness of specific coping strategies. Used carefully and with specific therapeutic goals in mind, SD/SI should be a part of your repertoire.

Risks of SD/SI

There is a need for caution in that some clients have reported negative reactions, for example, perceptions that the therapist's

own issues could preclude adequate treatment (Hanson, 2005). Exploitive or harmful SD/SI often involves information that is troublesome to clients in some way or has the potential to essentially reverse the roles of therapist and client (Barnett, 2011; Peterson, 2002).

The therapeutic relationship should be developed before using very much SD/SI, and it should be avoided when clients are weak (Gelso & Palma, 2011). Therapists should be especially cautious about turning attention to themselves when clients are in crisis. Well-intentioned therapists might be tempted to share their own experiences with people who are grieving, for example, but probably should not. Although the goal may be to offer coping strategies or information (e.g., that pain lessens over time), the grieving person may feel compelled (though unprepared) to provide sympathy to the helper. There are other ways to convey that we are present and that we "get it."

Depending on their understanding of psychotherapy, clients may have the expectation that SD/SI be very limited and occur in the context of a great deal of careful listening. SD/SI that is too intense has the potential to be overwhelming (McCarthy Veach, 2011). Disclosures should be chosen with specific therapeutic goals in mind, and worded constructively. Therapist comments, especially disclosures, can be perceived as insensitive when they dominate the session or disregard the need to listen to clients well. Clients may be sensitive to competition for time to talk and reveal, may experience boredom in session when the therapist speaks, or may react negatively to flaws revealed about the therapist (Audet & Everall, 2010). For example, disclosure of unconventional belief systems could alienate an otherwise engaged client, who may then question the therapist's judgment in general.

Constantine and Kwan (2003) pointed out that although mutual discussion of racial identity and values can be beneficial with clients of a different ethnicity than the therapist, therapists who lack cross-cultural knowledge may overcompensate for racial

differences by overemphasizing similar experiences, or mentioning having friends of color. Constantine and Kwan also noted evidence that self-disclosing therapists may be viewed as having less expertise by people from cultures that emphasize formal roles.

Use of personal examples (e.g., of the therapist's use of coping strategies) can create a negative impression and distract from client issues. There are often other ways of teaching and practicing skills that do not involve personal storytelling on the part of the therapist, even though those approaches work well in self-help groups. When the therapist's qualifications partly rest on having experienced substance abuse, sharing the patient's sexual orientation, or other considerations, mention of those facts does not necessitate more detailed disclosures.

Benefits of SD/SI

It is clear that there are often benefits of SD/SI (Henretty & Levitt, 2010; Peterson, 2002). Barrett and Berman (2001) evaluated the benefits of SD/SI on psychotherapy outcome in a randomized clinical trial at a university outpatient clinic. Levels of SD/SI were manipulated such that therapists either increased or restricted their use of SD/SI. Relevant SD/SI was made in response to client self-disclosures. SD/SI was related to the topic of the client disclosure, and attempts were made to make it similar in language and tone. SD/SI did not seem to increase client self-disclosure, but it was associated with self-reported improved symptom reduction and greater liking for the therapists. One recent comprehensive review that included therapy analog studies (Henretty & Levitt, 2010) found inconsistent but beneficial effects of SD/SI on client symptoms and perceptions of symptoms.

Beneficial SD may include provision of self-related examples in cognitive therapy. It can also include provision of relevant therapist characteristics during the informed consent process. Beneficial SI can involve carefully and purposefully discussing immediate reactions to the client within the therapy session (Peterson, 2002). It seems that the benefits of SD/SI are not linear, however, but are likely better represented by a curve that levels off, or even an inverted U-shaped function, in which SD/SI is useful only in small amounts (Gelso & Palma, 2011; Henretty & Levitt, 2010; Hill & Knox, 2002).

Gelso and Palma (2011) concluded that appropriate and limited SD/SI strengthens the relationship between therapist and

¹ For detailed definitions of SD/SI, see Gelso and Palma (2011), McCarthy Veach (2011), and Zur (2011).

client, and that the therapeutic relationship is also the key mediator of benefits from SD/SI. Some types of self-disclosure are appropriate at the beginning of therapy: to explain the therapeutic approaches to be used or to show appropriate qualifications and characteristics of the therapist. Similarly, some SD may help with the transition away from treatment roles at termination. Henretty and Levitt (2010) noted that therapists who used SD/SI were perceived by clients as warmer. SD/SI was associated with clients being more willing to return to therapy and refer others to therapy.

An argument can be made for the necessity of at least minimal disclosure to fulfill the expectations of a normal interaction held by children (or adults with low intellectual functioning), as well as to model communication in therapy. Children usually do not ask for much information, and therapists tend to answer their basic personal questions, such as whether the therapist is a parent (Capobianco & Farber, 2005; Gaines, 2003). It is often useful to discuss common interests when building rapport with children. And although it is problematic to expect egocentric adolescents to consider your experiences highly similar to

theirs, there can be the need to provide enough information to teens to differentiate you from other authority figures (Gaines). These are some of many situations in which rapport is strengthened through judicious self-disclosure.

SD/SI that is sensitive and relevant can model relationship skills for clients. In particular, it can be used to address clinically relevant behaviors that occur in session. Tsai, Plummer, Kanter, Newring, and Kohlenberg (2010) mentioned examples in which SD/SI opens discussion of a client's avoidance of closeness with the therapist, or when clients are invited to compare cognitive distortions to therapist perceptions. Tsai et al. (2010) further suggested that clients' responses to SD/SI can provide opportunities to reinforce improvements in clinically relevant behaviors. They tested this with a carefully worded email disclosure of a therapist's mother's death, finding that in some cases it led to positive developments in treatment.

We can use the therapy session to shape more appropriate client behavior, keeping in mind ways to promote generalization, such as through homework exercises. For example, a client who has demonstrated

caring responses in therapy might be asked to notice the ways in which this was a positive experience, and to look for opportunities to try this outside of therapy. Similarly, clients who respond nondefensively to therapist feedback might be encouraged to practice similar ways of responding when criticized at home.

For some clients, SD demonstrates a willingness to take risks, which may then be reciprocated. This may be relevant, for example, when the therapist is of a different ethnicity than the client (Constantine & Kwan, 2003), and the therapist makes a gesture of openness.

Differential Benefits of SI

Although SD in response to relevant material introduced by clients can be supportive (Hill, 1989; Knox, Hess, & Peterson, 1997), it is important to note that SI may be more beneficial. Henretty and Levitt's (2010) review suggested that "self-involving statements elicited more positive responses from clients in action and in ratings of their perceptions of the therapist than self-disclosing statements" (p. 68). Therapists using SI may be seen as more ex-



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pert than those using SD (McCarthy, 1979; McCarthy & Betz, 1978) and more attractive, if the SI is positive (McCarthy; Watkins & Schneider, 1989). Watkins and Schneider suggested that at least in the initial interview, clients may be distracted by SD, but positive (reinforcing) SI may increase the likelihood they will return. In his group therapy text, Yalom with Leszcz (2005) wrote, "I am advocating that therapists relate authentically to clients in the here-and-now of the therapy hour, not that they reveal their past and present in a detailed manner..." (p. 223).

Even when good rapport and trust enhance client motivation to participate in therapy, clients are often ambivalent about adaptive behavior change. Cognitive approaches such as motivational interviewing (Miller & Rollnick, 2002) address this by asking clients to explicitly consider their reasons for and against change. Goldfried, Burckell, and Eubanks-Carter (2003) suggested that the therapist can effectively incorporate SI in addressing motivation fairly directly, and used this example: "I am concerned about your welfare, and I seriously doubt that you can ever have a happy life while you remain in this relationship.... My second concern is that I seem to be more concerned than you are." In the context of a strong therapeutic relationship, this is an intervention that emanates from caring concern (arguably an essential component of any intervention).

SI can be especially important in repairing breaches of rapport. For example, negative feedback from a client deserves a response, and that response may often involve SI. Yalom and Leszcz (2005) advocated thoughtful ("not disinhibited") statements such as, "You're right. There are times when I feel irritated with you, but at no time do I want to impede your growth..." (p. 223). SI should be used in the service of the therapeutic relationship and for the client's benefit.

Goldfried et al. (2003) wrote of the benefits of conveying positive views of clients who view themselves too negatively, and providing an accepting but honest reaction to clients' alienating behaviors. In their Acceptance and Commitment Therapy for anxiety, Eifert and Forsyth (2005) mentioned the use of relevant personal examples and here-and-now reactions in their discussion of therapist competencies. They advocated judicious use of SI in some contexts when it "illustrates a therapeutic point" (p. 111), such as, "I am experiencing sadness in response to what you just said ..." (p. 112). McCarthy Veach (2011), who carefully dis-

tinguished between SI and SD, found that "self-involving statements may enhance clinician genuineness, likability, and trustworthiness... and they can decrease client anxiety" (p. 351).

McCarthy Veach (2011) emphasized the importance of truthfulness and self-knowledge—knowing your own reactions and considering in advance how much to reveal. Self-knowledge can also help you filter statements that might reflect your own issues more than the client's (Yalom & Leszcz, 2005). Obviously, SD/SI should be relevant to the therapeutic goals. McCarthy Veach, as well as Knox and Hill (2003), recommended returning the focus to the client after a disclosure. This can be done with a question, for example, such as, "I really admire how you have handled this situation. How do you feel about your efforts?"

Conclusions

Therapist SD involves sharing information about your extra-therapy self, whereas SI reveal your responses to the immediate therapy experience. When well-chosen for the client's benefit and well-timed, carefully worded and limited-information disclosures (SD) can enhance the therapeutic alliance and client motivation, and can convey important concepts and skills. However, in most situations, therapeutic goals can be achieved without sharing personal experiences. Reasons to self-disclose should be considered ahead of time.

The most benefit may come from sharing your honest reality-based reactions in therapy (SI) when you see that it can help your client, when that client has the capacity to benefit, and when the therapy relationship is strong enough to sustain it. Disclosing your positive reactions, in particular, can reinforce client progress. It should be concise, for client benefit, and return focus to the client. It can contribute to a genuine and respectful relationship with clients. In the context of empathy and caring, it can be an effective intervention.

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Correspondence to James Sturges, Ph.D.,
Department of Psychology and Sociology,
California State Polytechnic University,
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Pseudoscience in Scientific Clothing: A Response to McFall's "Psychological Clinical Science Accreditation: FAQs and Facts"

Frank L. Gardner, *Kean University*

The recent article by McFall (2012), which appeared in *the Behavior Therapist's* special issue "Graduate Training in Evidence-Based Approaches," makes the case for professional psychology to systematically prepare psychologists for the appropriate use of evidence-based approaches in their clinical work, and presents a case for an exclusionary accreditation system as an alternative to the current, widely accepted APA accreditation system, in which only programs training clinical scientists and offering a Ph.D. degree would qualify. It was suggested that this new system would "... increase the quality and quantity of clinical scientists making significant contributions to improving public health" (p. 11). The author of the present response paper is in general agreement with the fundamental issues presented by McFall, notably: (a) the importance of training clinical psychologists who are grounded in the necessary bidirectional relationship between science and practice in professional psychology, and (b) the importance of the development and dissemination of evidence-based practice within clinical psychology. However, while McFall suggests that the barrier in advancing these fundamental objectives lies primarily with doctoral programs whose primary emphasis is on "... preparing graduates for service delivery roles" (p. 11), his previous writings clarify that this is a catchphrase for Psy.D. programs. For example, a recent paper by Baker, McFall, and Shoham (2008) stated the opinion that "substantial evidence shows that many clinical psychology doctoral training programs, especially Psy.D. and for-profit programs, do not uphold high standards for graduate admission, have high student-faculty ratios, deemphasize science in their training, and produce students who fail to apply or generate scientific knowledge" (p. 9). I find McFall's rather clear implication that the barrier in advancing these fundamental objectives lies primarily in the training of professional psychologists within Psy.D. programs to be

logically flawed, and propose that it consists of pseudoscientific presentation of data of questionable relevance. Furthermore, his proposed solution of a new "clinical science"-based accreditation system is similarly logically flawed, and ultimately would likely increase, rather than decrease, the science-practice divide that was so eloquently described.

It is clear that the new Psychological Clinical Science Accreditation System (PCSAS), which is actually McFall's only direct suggestion to the field to enhance evidence-based practice of professional psychology, would overemphasize scientific production within doctoral programs (their faculty and their graduates) with minimal emphasis on clinical training, in much the same way that the current accreditation system is criticized for overemphasizing clinical training at the expense of an appropriate emphasis on science. McFall describes the example of medical training in which practitioners are taught to appreciate, depend upon, and ultimately utilize clinical research, yet suggests that somehow in the field of psychology, practitioners must be "clinical scientists" to appropriately practice. Clearly, the front-line physicians trained in the current medical model of education are not medical-scientists, nor are they or should they be trained as such. Conspicuously absent in McFall's (2012) discussion is the logic or rationale for the fact that this proposed new accreditation system would not permit any clinical Psy.D. program to achieve, or even apply for, such recognition, despite the fact that Psy.D.s constitute an increasingly high percentage of licensed psychologists nationwide, and the fact that numerous Psy.D. programs are truly exemplary in their preparation of both scientists and practitioners. This latter fact is given disingenuous lip service in the brief mention that "... comparisons between degrees use these labels only as imperfect proxies for underlying variables of interest. Not all Psy.D. programs are alike . . ." (p. 13).

The larger question, of course, is how could this new accreditation system possibly address the stated problem of a lack of consistent application of science-driven practice as previously described by McFall (2012)? It would seem rather logical to conclude that any real solution to this problem requires that the training of all psychologists be addressed, especially considering that half of all psychologists are being trained in Psy.D. programs. It is suggested herein that there is nothing in McFall's paper that leads to a greater adoption of science-informed practice by all psychologists. I assert that while McFall suggests that "some" Psy.D. programs are acceptable in his eyes, none of these programs, and in fact no Psy.D. program at all, no matter how it was designed, could apply for PCSAS accreditation. This leads to the inescapable conclusion that the issue is not quality but the degree itself. Therefore, how could his proposed "solution" do anything but continue and even further extend this issue?

Pseudoscience can be described as a position that is presented in a manner suggestive of science, when in fact, sound scientific methods are not used and data appear relevant but in fact lack a credible relationship to the claim. It is argued herein that the core positions presented in McFall (2012) unfortunately fulfill this definition. Consistent with the pseudoscientific core of his paper, McFall subscribes to unsubstantiated overgeneralizations and uniformity myths about practitioner training. McFall presents data regarding program size, tuition/assistance, GRE scores, acceptance rates, etc., in order to draw the seemingly empirical conclusion that clinical science-oriented Ph.D. programs turn out better clinical practitioners. However, as with any pseudoscientific enterprise, McFall's treatise presents data providing the impression of science without clear and directly related empirical evidence. While his data regarding admissions information, student numbers, and the like are generally accurate, McFall makes an empirically unfounded leap in the assumptions and conclusions he reaches regarding this information. Is there empirical evidence that Ph.D. graduates from PCSAS-accredited programs have better clinical outcomes, or have lower percentages of ethical violations, or practice in greater percentages in underserved areas of this nation, than graduates of Psy.D. or even non-PCSAS-accredited Ph.D. programs? Of course not. These data do not exist, and with the absence of these findings, any suggestion that the "data" McFall presents has any relationship to clinical and/or public

health outcomes is premature at best and pseudoscientific at worst. Likewise, while McFall could have pointed to differences in the Examination for the Professional Practice of Psychology (EPPP; ASPPB, 2012) scores between Ph.D. and Psy.D. graduates, it should be noted that there are no data whatsoever to suggest that EPPP scores are themselves related to clinical competencies and/or outcomes.

Rather, if there is a true interest in furthering the cause of an enhanced evidence-based practice of clinical psychology, any new accreditation system (or modification of the current system, for that matter) should focus on correcting the science-practice divide that has resulted in a dearth of scientifically informed practitioners of professional psychology, and not on the establishment of what would essentially be accredited doctoral programs of research.

The solution to the problem of how to increase the utilization of evidence-based practice within professional psychology is a strong and consistent advocacy of appropriate doctoral training, including training in critical thinking and the scientific method,

sound and diverse clinical competencies and experiences, and an acceptance of the reality that science informs practice and in turn practice informs science, in all doctoral programs, regardless of their degree type. Psy.D. programs that provide just this type of education and training absolutely exist (Block-Lerner, McClure, Gardner, & Wolanin, in press), and any suggestion or unstated implication to the contrary is incorrect and irresponsible.

Finally, McFall's (2012) article provides little by way of practical solutions to thorny issues, such as insuring: (a) adequate preparation of all doctoral-level psychologists to be both producers and consumers of basic and clinical research; (b) that evidence-based practice is given necessary attention within doctoral training; and (c) that internship sites are held to the same standards in these regards as are doctoral programs themselves. While McFall admirably desires a better training of clinical psychologists, the focus on training clinical scientists would serve to enhance and codify the very problem that he identifies by further segmenting the field.

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Correspondence to Frank L. Gardner, Ph.D., Department of Advanced Studies in Psychology, Kean University, 1000 Morris Avenue, Union, NJ 07083; fgardner@kean.edu

Video Review

Brief Behavioral Activation Treatment for Depression: Mental Health Professional Training Video (2012)

MacDonald, M. (Producer), & Selzer, L. (Director)
Behavior Works (49:25 minutes)

Reviewed by Kevin Young, *George Mason University*, Erica Fener, *Medical University of South Carolina*, and Ron Acierno, *Private Practice, Washington, DC*

The last 15 years have evidenced a resurgence of behavioral treatments for depression (see Ferster, 1973, and Lewinsohn, 1974, for early behavioral approaches), beginning with a seminal paper by Neil Jacobson (1996) indicating that the behavioral components of cognitive behavior therapy (CBT), referred to as behavioral activation, performed as well as the full CBT package in treating depression. In line with this work, a growing body of research provides strong support for several versions of behavioral activation (for reviews see

Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011; Hopko, Lejuez, Ruggerio, & Eifert, 2003). The most concise and straightforward version was developed by Lejuez, Hopko, and Hopko (2001), which they referred to as the Brief Behavioral Activation Treatment for Depression (BATD). In addition to publicly available training manuals, they have developed a 50-minute training video produced by Behavior Works (MacDonald & Selzer, 2012; for more about the video and access to the most recent BATD manual, visit

www.behaviorworkslc.com). This review provides an overview of the video and highlights the key aspects of it as a training tool for therapists of varying expertise and theoretical orientations.

The training video is presented by Dr. Lejuez, one of the co-developers of the approach, who presents with a clear yet expressive style. From the start, Dr. Lejuez distills the essential components of BATD and its application into an excellent resource for therapists at all levels. Like BATD itself, the video is purposefully focused, and offers a session-by-session application of key intervention strategies. While based on his treatment manual, the video is far more compelling in that Dr. Lejuez himself is offering examples and explanations of all treatment components, and his presentation is animated, to say the least. Dr. Lejuez describes each essential aspect of the treatment along with corresponding rationales and excellent examples of implementation. We were very impressed with the fact that a graduate-level therapist watching this 50-minute video was able to immediately implement the intervention. This is because, in addition to general concepts and theories, Dr. Lejuez has divided the video according to major milestones to be accomplished each session. It is, in fact, a video manual.

With respect to the specifics of the video: Dr. Lejuez opens with an introduction designed to ensure that clinicians from various perspectives and levels of training all begin on the same page with at least a basic understanding of depression. Following this, Dr. Lejuez establishes a clear and simplified dichotomy, comprised of those treatment approaches that address the distinction between targeting thoughts and feelings directly vs. those that focus on behavior change. This simplified dichotomy leads nicely into a brief overview of BATD and a quick description of its key treatment components.

Following the introduction, Dr. Lejuez outlines exactly what a 10-session BATD treatment plan might look like for a hypothetical depressed client. Specifically, in this section, Dr. Lejuez describes the importance of explaining the treatment rationale to the client during the first session, drawing specific attention to the structure and support that BATD will provide. Dr. Lejuez then introduces and details the first BATD tool that will be used regularly within treatment sessions: behavioral monitoring. Next follow the details of what will take place during the second session of treatment. This includes a mock review of a daily monitoring form completed by a depressed client, as well as an interpretation of the clinical significance of the form's contents. He emphasizes the importance of carefully reviewing monitoring and how taking the time to review these forms can act as a foundation for the subsequent BATD sessions. Following this review, Dr. Lejuez introduces the Life Areas, Values, and Activities (LAVA) form, and explains their contents and purpose. This important section, taking a value-driven approach to guide activation efforts, is what sets effective BATD apart from simply assigning a schedule of activities to clients. Additionally, Dr. Lejuez describes various questions that a clinician can ask a client in order to elicit information related to each of these areas. Finally, Dr. Lejuez concludes this section of the video with a metaphor entitled "Going to Pittsburgh," which demonstrates clearly the relationship between first determining a client's values (final destination), and then determining the individual activities (directions) needed to live in line with these values. Again, simplicity and patience are emphasized, as well as the importance of monitoring activities outside of the therapeutic session.

With the rationale and framework of BATD having been explored thoroughly in the previous sections of the video, the remaining sections focus primarily on the

unique contents that will be added in future sessions. For example, in the third session of BATD, the activity selection and ranking form is introduced. The goal of this form, explained from the therapist's perspective, is to identify exactly what you are able to work on right now with the client, and which activities you will be working toward. The fourth session identifies the way that continued behavioral monitoring can start to foster awareness within a client, and describes the idiosyncratic process of activity planning for clients with various levels of ability. The utility of assessing barriers to activity completion is also broached as a way to obtain valuable clinical information. Session 5 marks the introduction of contracts as (a) a straightforward way to identify the activities that a client wanted to do but was not able to, and (b) to help the client create a supportive environment outside of the session to facilitate completion of activities in the future. In Sessions 6 through 9 of this hypothetical 10-session treatment plan, key concepts mentioned previously are reviewed with the client. Finally, in line with the emphasis of BATD on the continuation of treatment outside of the therapist's office, Session 10 involves the discussion of what is to happen once therapy concludes.

As one caveat worthy of mention, the video does not include role-play clips to supplement the training material. Although role-plays would certainly be a useful teaching tool under certain circumstances, the material presented, including the section on barriers, is full of clear and clinically meaningful examples that address most of the potential benefits of role-plays. Of note, we contacted Behavior Works and they indicated that the video was limited to didactic material and examples to ensure it could be shown in a 1-hour time slot; however, they also indicated they are currently developing short role-play clips to accompany the video that will be available on their website in the near future.

Overall, we liked this translation of a written manual into its video counterpart. At a practical level, the short duration and professional presentation greatly enhance the utility of the video. We highly recommend this training video for anyone interested in using BATD, but because it is rooted in the basics of behavioral approaches of depression, we believe it really can be useful for providing behavior therapy approaches to depression more generally. Finally, the depth of the examples makes it useful for therapists of varying degrees of experience, from those trying to grasp the

basics of behavioral approaches to more seasoned behavior therapists looking to understand the nuances of this particular approach.

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Correspondence to Ronald Acierno, Ph.D., Medical University of South Carolina, 67 President Street, Msc 861 2nd Floor - Iop South, Charleston, SC 29425; acierno@musc.edu

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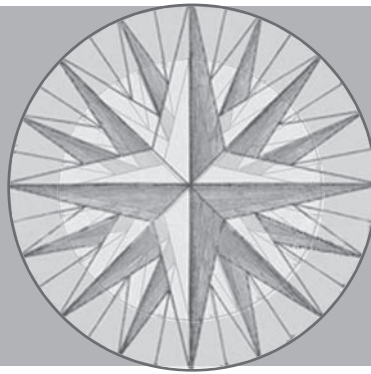
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Much in the way that the Food and Drug Administration (FDA) provides physicians with a method for giving feedback on their experiences in using empirically supported drugs in clinical practice, the Society of Clinical Psychology (Division 12 of the American Psychological Association) and Division 29 (Psychotherapy) of the American Psychological Association, have created a mechanism whereby practicing therapists can report on their clinical experiences using empirically supported treatments (ESTs). In essence, this collaborative initiative on Building a Two-Way Bridge Between Research and Practice has established a procedure for practicing therapists to disseminate their clinical experiences. This is not only an opportunity for clinicians to share their experiences with other therapists, but can also offer clinically based information that researchers may use to investigate ways of improving treatment.

This collaborative initiative has already completed surveys of practicing clinicians on the use of CBT to treat panic, social anxiety, and general anxiety disorder, and these findings will be published shortly. We are now conducting clinical surveys on the use of CBT to treat (1) obsessive compulsive disorder (OCD) and (2) posttraumatic stress disorder (PTSD), and would very much appreciate your input. Each should take between 10 and 15 minutes to complete, which you can do online at:

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Cohen, J., 1990,
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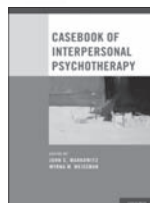
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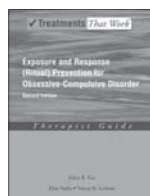


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these sessions the patient will be gradually exposed to situations and places that trigger his or her OCD symptoms. The goal is that over time the OCD sufferer comes to realize that the things he or she fears will not necessarily occur if the rituals are not performed.

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