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Key Questions/ Chapter Outline	Core Concepts	Psychology Matters
13.1 What Is Therapy? Entering Therapy The Therapeutic Alliance and the Goals of Therapy Therapy in Historical and Cultural Context	• Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.	**Paraprofessionals Do Therapy, Too** Some studies show that the therapist's level of training is not the main factor in therapeutic effectiveness.
13.2 How Do Psychologists Treat Psychological Disorders? Insight Therapies Behavior Therapies Cognitive–Behavioral Therapy: A Synthesis Evaluating the Psychological Therapies	• Psychologists employ two main forms of treatment, the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).	**Where Do Most People Get Help?** A lot of therapy is done by friends, hairdressers, and bartenders.
13.3 How Is the Biomedical Approach Used to Treat Psychological Disorders? Drug Therapy Other Medical Therapies for Psychological Disorders Hospitalization and the Alternatives	• Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.	**What Sort of Therapy Would You Recommend?** There is a wide range of therapeutic possibilities to discuss with a friend who asks for your recommendation.
13.4 How Do the Psychological Therapies and Biomedical Therapies Compare? Depression: Psychological versus Medical Treatment Anxiety Disorders: Psychological versus Medical Treatment Schizophrenia: Psychological versus Medical Treatment "The Worried Well": Not Everyone Needs Drugs	• While a combination of psychological and medical therapies is better than either one alone for treating some (but not all) mental disorders, most people who suffer from unspecified "problems in living" are best served by psychological treatment alone.	**Using Psychology to Learn Psychology** Consider the ways in which therapy is like your college experience.

Critical Thinking Applied: Evidence-Based Practice

chapter 13 therapies for psychological disorders

Off and on, Derek had felt tired and unhappy for months, and he knew it was affecting not only his work but the relationship with his partner. Michele, a coworker and friend, tactfully suggested he seek professional help, but Derek was unsure where to turn. As many people do, he asked for a recommendation from another friend, who he knew had sought therapy three years ago. And that is how he ended up, a little apprehensively, at Dr. Sturm's office.

She was easy to talk to, it turned out, and it didn't take long for both of them to agree that Derek was depressed. After some more conversation about the nature of depression, Dr. Sturm said, "We have several treatment alternatives." She added, "The one in which I am trained is cognitive-behavioral therapy, which approaches depression as a learned problem to be treated by changing the way a person thinks about life events and interpersonal relationships. If we take that route, we will explore what is happening at work and at home that might trigger depressive episodes. I would also give you 'homework' every week—assignments designed to help you build on your strengths, rather than focusing on your weaknesses." "Just like school," she added with a little laugh.

"As a second option," she said, "I could refer you to a colleague who does psychodynamic therapy. If you choose that approach, you and Dr. Ewing would explore your past, looking for events that may have pushed you down the path to the feelings you are experiencing now. Essentially it would be a treatment aimed at bringing some unpleasant parts of your unconscious mind into the light of day.

"The other thing I could do is to arrange to get you some medication that has been proven effective in treating depression. It would probably be one of those antidepressants, like Prozac, that you have seen advertised in magazines and on TV. The problem there is that it takes several weeks for them to have an effect. And, besides, I'm not sure they really treat the problems that keep making you feel depressed."

"Oh, yes," she added, "There are some additional medical options, such as electroconvulsive therapy—people often call it 'shock treatment,' but I don't think it is indicated in your case."

"Just hearing that makes me feel better," Derek sighed. "So, the choice is between drugs and psychological therapy?"

"Or perhaps a combination of the two," replied Dr. Sturm.

"How do I decide?"

PROBLEM: What is the best treatment for Derek's depression: psychological therapy, drug therapy, or both? More broadly, the problem is this: How do we decide among the available therapies for any of the mental disorders?

Despite the diversity of approaches that Dr. Sturm and her colleagues bring to their work, the overwhelming majority of people who enter **therapy** receive significant help. Not everyone becomes a success case, of course. Some people wait too long, until their problems become intractable. Some do not end up with the right sort of therapy for their problems. And, unfortunately, many people who could benefit from therapy do not have access to it because of financial constraints. Still, the development of a wide range of effective therapies is one of the success stories in modern psychology.

In this next-to-last chapter of our journey together through psychology, we begin an overview of therapy by considering what therapy is, who seeks it, what sorts of problems they bring to it, and who administers it. Here we will also see how therapeutic practices have been influenced by history and culture. In the second section of the chapter, we will consider the major types of psychological treatments currently used and how well they work. Then we will look at medical treatments for mental disorders, including drug therapy, hospitalization, psychosurgery, and "shock treatment." In the final parts of the chapter, we will take a critical look at two of the major unresolved issues in the field of therapy, the question of drugs versus psychotherapy and the divisive problem of restricting therapy to demonstrably effective techniques.

As you read through this chapter, we hope you will weigh the advantages and disadvantages of each therapy. Keep in mind, too, that you may sometime be asked by a friend or relative to use what you, like Derek, have learned here to recommend an appropriate therapy. It's even possible that you may sometime need to select a therapist for yourself.

Therapy A general term for any treatment process; in psychology and psychiatry, therapy refers to a variety of psychological and biomedical techniques aimed at dealing with mental disorders or coping with problems of living.

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13.1 KEY QUESTION WHAT IS THERAPY?

When you think of "therapy," chances are that a stereotype pops into mind, absorbed from countless cartoons and movies: a "neurotic" patient lying on the analyst's couch, with a bearded therapist sitting by the patient's head, scribbling notes and making interpretations. In fact, this is a scene from classic Freudian psychoanalysis, which is a rarity today, although it dominated the first half of the 20th century.

The reality of modern therapy differs from the old stereotype on several counts. First, most therapists don't have their patients (or *clients*) lie on a couch. Second, people now seek therapeutic help for a wide range of problems besides the serious *DSM-IV* disorders. People also go to counselors or therapists for help in making difficult choices, dealing with academic problems, and coping with losses or unhappy relationships. And here's a third way in which the popular image of therapy is mistaken: Some forms of therapy now involve as much action as they do talk and interpretation—as you will see shortly.

At first, the therapeutic menu may appear to offer a bewildering list of choices, involving talk and interpretation, behavior modification, drugs, and, in some cases, even "shock treatment," or brain surgery. No matter what form therapy takes, however, there is one constant, as our Core Concept suggests:

Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.

core concept

In this chapter, as we examine a sample from the therapeutic universe, we will see that each form of therapy is based on different assumptions about mental disorder. Yet all involve relationships designed to change a person's functioning in some way. Let's begin our exploration of therapy by looking at the variety of people who enter treatment and the problems they bring with them to the therapeutic relationship.

Entering Therapy

Why would you go into therapy? Why would anyone? Most often, people enter therapy when they have a problem that they are unable to resolve by themselves. They may seek therapy on their own initiative, or they may be advised to do so by family, friends, a physician, or a coworker.

Obviously, you don't have to be declared "crazy" to enter therapy. But you may be called either a "patient" or a "client." Practitioners who take a biological or medical-model approach to treatment commonly use the term *patient*, while the term *client* is usually used by professionals who think of psychological disorders not as mental *illnesses* but as *problems in living* (Rogers, 1951; Szasz, 1961).

CONNECTION • CHAPTER 12
The *medical model* assumes that mental disorders are similar to physical diseases.

Access to therapy can be affected by several factors. People who have money or adequate health insurance can get therapy easily. For the poor, especially poor ethnic minorities, economic obstacles block access to professional mental health care (Bower, 1998d; Nemecek, 1999). Another problem can be lack of qualified therapists. In many communities, it is still much easier to get help for physical health problems than for psychological problems. Even the nature of a person's psychological problems can interfere with getting help. An individual with agoraphobia, for example, finds it hard, even impossible, to leave home to seek therapy. Similarly, paranoid persons may not seek help because they don't trust mental health professionals. Obviously, many problems remain to be solved before all those who need therapy can get it.

The Therapeutic Alliance and the Goals of Therapy

Sometimes you only need to talk out a problem with a sympathetic friend or family member, perhaps to "hear yourself think" or to receive reassurance that you are still worthwhile or likeable. But friends and family not only lack the training to deal with difficult mental problems; they also have needs and agendas of their own that can interfere with helping you. In fact, they may sometimes be part of the problem. For many reasons, then, it may be appropriate to seek the help of a professionally trained therapist. You might also want professional help if you wish to keep your problems and concerns confidential. In all these ways, a professional relationship with a therapist differs from friendship or kinship.

What Are the Components of Therapy? In nearly all forms of therapy there is some sort of *relationship,* or **therapeutic alliance,** between the therapist and the patient/client seeking assistance—as our Core Concept indicates. (We must admit that there are computer-therapy programs, where the idea of a "relationship" is stretching the point.) Trust is one of the essential ingredients of a good therapeutic alliance. You and your therapist must be able to work together as allies, on the same side and toward the same goals, joining forces to cope with and solve the problems that have brought you to therapy (Horvath & Luborsky, 1993). And, as clinicians have become more aware of gender and ethnic diversity among their clientele, research has shown that the most effective therapists are those who can connect with people in the context of their own culture and native language (Griner & Smith, 2006).

In addition to the relationship between therapist and client, the therapy process typically involves the following steps:

1. *Identifying the problem.* This may mean merely agreeing on a simple description of circumstances or feelings to be changed, or, in the case of a *DSM-IV* disorder, this step may lead to a formal diagnosis about what is wrong.
2. *Identifying the cause of the problem or the conditions that maintain the problem.* In some forms of therapy, this involves searching the past, especially childhood, for the source of the patient's or client's discomfort. Alternatively, other forms of therapy emphasize the present causes—that is, the conditions that are keeping the problem alive.
3. *Deciding on and carrying out some form of treatment.* This step requires selecting a specific type of therapy designed to minimize or eliminate the troublesome symptoms. The exact treatment will depend on the problem and on the therapist's orientation and training.

Who Does Therapy? Although more people seek out therapy now than in the past, they usually turn to trained mental health professionals only when their psychological problems become severe or persist for extended periods. And when they do, they usually turn to one of seven main types of professional helpers: counseling psychologists, clinical psychologists, psychiatrists, psychoanalysts, psychiatric nurse practitioners, clinical (psychiatric) social workers, or pastoral counselors. The differences among these specialties are detailed in Table 13.1. As you examine that table, note that each specialty has its own area of expertise. For example, in most states the only therapists who are licensed to prescribe drugs are physicians (including psychiatrists) and psychiatric nurse practitioners.

Currently, through their professional organizations, clinical psychologists are seeking to obtain prescription privileges. Past APA President Robert Sternberg (2003) made the following argument:

> Psychologists, like other professionals, once viewed physical and psychological disorders as relatively distinct. No longer. We now know that physical and psychological symptoms are highly interactive. Some practicing psychol-

Therapeutic alliance The relationship between the therapist and the client, with both parties working together to help the client deal with psychological or behavioral issues.

TABLE 13.1 Types of Mental Health Care Professionals

Professional title	Specialty and common work settings	Credentials and qualifications
Counseling psychologist	Provides help in dealing with the common problems of normal living, such as relationship problems, child rearing, occupational choice, and school problems. Typically counselors work in schools, clinics, or other institutions.	Depends on the state: typically at least a master's in counseling, but more commonly a PhD (Doctor of Philosophy), EdD (Doctor of Education), or PsyD (Doctor of Psychology)
Clinical psychologist	Trained primarily to work with those who have more severe disorders, but may also work with clients having less severe problems. Usually in private practice or employed by mental health agencies or by hospitals. Not typically licensed to prescribe drugs.	Usually required to hold PhD or PsyD; often an internship and state certification required.
Psychiatrist	A specialty of medicine; deals with severe mental problems—most often by prescribing drugs. May be in private practice or employed by clinics or mental hospitals.	MD (Doctor of Medicine); may be required to be certified by medical specialty board
Psychoanalyst	Practitioners of Freudian therapy. Usually in private practice.	MD (some practitioners have doctorates in psychology, but most are psychiatrists who have taken additional training in psychoanalysis).
Psychiatric nurse practitioner	A nursing specialty; licensed to prescribe drugs for mental disorders. May work in private practice or in clinics and hospitals	Requires RN (Registered Nurse) credential, plus special training in treating mental disorders and prescribing drugs.
Clinical or psychiatric social worker	Social workers with a specialty in dealing with mental disorders, especially from the viewpoint of the social and environmental context of the problem.	MSW (Master of Social Work)
Pastoral counselor	A member of a religious order or ministry who specializes in treatment of psychological disorders. Combines spiritual guidance with practical counseling.	Varies

> ogists may believe, therefore, that to treat the whole person, they need to supplement psychotherapy with medications. Indeed, the biopsychosocial model adopted by many psychologists is consistent with an integration of kinds of treatments. (p. 5)

Already, a few military psychologists have undergone training that allows them to prescribe drugs for mental disorders to military personnel (Dittmann, 2004). And in 2002, New Mexico became the first state to grant prescription privileges to civilian psychologists who have completed a rigorous training program, including 850 hours of course work and supervised internship (Dittmann, 2003). Similar legislation has been introduced in more than a dozen other states. Nevertheless, prescription privileges for psychologists remain a highly political issue, hotly contested by the medical profession (Clay, 1998). Surprising, even some clinical psychologists oppose prescription privileges, fearing that psychology will "sell its soul" to serve a public that demands drug therapy. Said former APA President, George Albee (2006):

> The current drive for people who are in practice to become drug prescribers is a matter of survival. Society has been sold the fallacy that mental/emotional disorders are all brain diseases that must be treated with drugs. The only way for psychology practitioners to survive is to embrace this invalid nonsense. (p. 3)

In this painting from the 1730s, we see the chaos of a cell in the London hospital St. Mary of Bethlehem. Here, the upper classes have paid to see the horrors, the fiddler who entertains, and the mental patients chained, tortured, and dehumanized. The chaos of Bethlehem eventually became synonymous with the corruption of its name—Bedlam.

Whether you agree with Sternberg or Albee, it appears that the era of prescription privileges for properly trained psychologists is coming. It remains to be seen how that will change the face of psychology.

Therapy in Historical and Cultural Context

How you deal with mental disorder depends on how you *think* about mental disorder. If you believe, for example, that mental problems are *diseases,* you will treat them differently from another person who believes they indicate a flaw in one's character or a sign of influence by evil spirits. The way society has treated people with mental disorders has always depended on its prevailing beliefs.

History of Therapy As we saw in the previous chapter, people in medieval Europe interpreted mental disorder as the work of devils and demons. In that context, then, the job of the "therapist" was to perform an exorcism or to "beat the devil" out of the disordered person—to make the body an inhospitable place for a spirit or demon. In more recent times, however, reformers have urged that the mentally ill be placed in institutions called asylums, where they could be shielded from the stresses of the world—and from the brutal "therapies" that had been all too customary. Unfortunately, the ideal of the insane asylums was not often realized.

One of the most infamous of the asylums was also one of the first: Bethlehem Hospital in London, where for a few pence on the weekend sightseers could go to observe the inmates, who often put on a wild and noisy "show" for the curious audience. As a result, "Bedlam," the shortened term Londoners used for "Bethlehem," became a word used to describe any noisy, chaotic place.

In most asylums, inmates received, at best, only custodial care. At worst, they were neglected or put in cruel restraints, such as cages and straightjackets. Some even continued to receive beatings, cold showers, and other forms of abuse. It's not hard to guess that such treatment rarely produced improvement in people suffering from psychological disorders.

Modern Approaches to Therapy Modern mental health professionals have abandoned the old demon model and frankly abusive treatments in favor of therapies based on psychological and biological theories of mind and behavior. Yet, as we will see, even modern professionals disagree on the exact causes and the most appropriate treatments—a state of the art that gives us a wide variety of therapies from which to choose. To help you get an overview of this cluttered therapeutic landscape, here is a preview of things to come.

The **psychological therapies** are often collectively called simply *psychotherapy.*[1] They focus on changing disordered thoughts, feelings, and behavior

Psychological therapy Therapy based on psychological principles (rather than on the biomedical approach); often called "psychotherapy."

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[1]No sharp distinction exists between counseling and psychotherapy, although in practice *counseling* usually refers to a shorter process, more likely to be focused on a specific problem, while *psychotherapy* generally involves a longer-term and wider-ranging exploration of issues.

using psychological techniques (rather than biomedical interventions). And they come in two main forms. One, called *insight therapy,* focuses on helping people understand their problems and change their thoughts, motives, or feelings. The other, known as *behavior therapy,* focuses primarily on behavior change. More recently, a combination of the two, *cognitive–behavioral therapy,* has been developed.

In contrast with psychotherapy, the **biomedical therapies** focus on treating mental problems by changing the underlying biology of the brain, using a variety of drugs, including antidepressants, tranquilizers, and stimulants. Occasionally the brain may be treated directly with electromagnetic stimulation or even surgery. Sometimes, therapists use a combination approach, involving both drugs and psychotherapy.

Disorder and Therapy in a Cultural Context Ways of thinking about and treating mental disorder vary widely across cultures (Matsumoto, 1996). People in individualistic Western cultures (that is, from Europe and North America) generally regard psychological disorders to be the result of disease processes, abnormal genetics, distorted thinking, unhealthy environments, or stressors. But collectivist cultures often have quite different perspectives (Triandis, 1990; Zaman, 1992). Asian societies may regard mental disorder as a disconnect between the person and the group. Likewise, many Africans believe that mental disorder results when an individual becomes estranged from nature and from the community, including the community of ancestral spirits (Nobles, 1976; Sow, 1977). In such cultures, treating mentally disturbed individuals by removing them from society is unthinkable. Instead, healing takes place in a social context, emphasizing a distressed person's beliefs, family, work, and life environment. An African use of group support in therapy has developed into a procedure called "network therapy," where a patient's entire network of relatives, coworkers, and friends becomes involved in the treatment (Lambo, 1978).

In many places around the world, the treatments of both mental and physical problems are also bound up with religion and the supernatural—much as in medieval Europe—although their treatments are not usually so harsh. Had Derek been in such a culture, he would undoubtedly have received treatment from a sorcerer or *shaman* who was assumed to have special mystical powers. His therapy would have involved ceremonies and rituals that bring emotional intensity and meaning into the healing process. Combined with the use of symbols, these rituals connect the individual sufferer, the shaman, and the society to supernatural forces to be won over in the battle against madness (Devereux, 1981; Wallace, 1959).

PSYCHOLOGYMATTERS

Paraprofessionals Do Therapy, Too

Does the best therapy always require a highly trained (and expensive) professional? Or can **paraprofessionals—** persons who may have received on-the-job training, in place of graduate training and certification—be effective therapists? If you are seeking treatment, these questions are important because hospitals, clinics, and agencies are increasingly turning to paraprofessionals as a cost-cutting measure: Those who lack full professional credentials can be hired at a fraction of the cost of those with professional degrees. They are often called "aides" or "counselors" (although many counselors do have professional credentials).

Surprisingly, a review of the literature has found no substantial differences in the effectiveness of the two groups across a wide spectrum of psychological problems (Christensen & Jacobson, 1994). This is good news in the sense that the need for mental health services is far greater than the number of professional therapists can possibly provide. And, because paraprofessional therapists can be

Biomedical therapy Treatment that focuses on altering the brain, especially with drugs, psychosurgery, or electroconvulsive therapy.

Paraprofessional Individual who has received on-the-job training (and, in some cases, undergraduate training) in mental health treatment in lieu of graduate education and full professional certification.

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effective, highly trained professionals may be freed for other roles, including prevention and community education programs, assessment of patients, training and supervision of paraprofessionals, and research. The reader should be cautioned about overinterpreting this finding, however. Professionals and paraprofessionals have been found to be equivalent only in the realm of the insight therapies, which we will discuss in a moment (Zilbergeld, 1986). Such differences have not yet been demonstrated in the areas of behavior therapies, which require extensive knowledge of operant and classical conditioning and of social learning theory.

Check Your Understanding

1. **RECALL:** People in individualistic cultures often view mental disorder as a problem originating in a person's mind. In contrast, people in collectivist cultures are more likely to see mental disorder as a symptom of a disconnect between the person and _________.
2. **RECALL:** How is a therapist different from a friend?
3. **APPLICATION:** Which type of therapist would be most likely to treat depression by searching for the cause in the unconscious mind?
4. **UNDERSTANDING THE CORE CONCEPT:** In what respect are all therapies alike?
   a. All may be legally administered only by licensed, trained professionals.
   b. All make use of insight into a patient's problems.
   c. All involve the aim of altering the mind, behavior, or social relationships.
   d. All focus on discovering the underlying cause of the patient's problem, which is often hidden in the unconscious mind.

Answers **1.** the family or community **2.** Unlike a friend, a therapist is a professional who (a) is trained in therapeutic techniques, (b) will not bring his or her own needs into the therapeutic relationship, and (c) will maintain confidentiality. **3.** a psychodynamic therapist **4.** c

13.2 KEY QUESTION HOW DO PSYCHOLOGISTS TREAT PSYCHOLOGICAL DISORDERS?

In the United States and most other Western nations, the sort of therapy Derek receives would depend on whether he had gone to a medical or psychological therapist. By choosing a psychologist like Dr. Sturm, he would almost certainly receive one of two main types of therapy described by our Core Concept:

core concept

Psychologists employ two main forms of treatment, the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).

The insight therapies, we shall see, were the first truly psychological treatments developed, and for a long time they were the only psychological therapies available. In recent years they have been joined by the behavior therapies, which are now among the most effective tools we have. But it is with the insight therapies that we begin.

Insight Therapies

The **insight therapies** attempt to change people on the *inside*—changing the way they think and feel. Sometimes called *talk therapies,* these methods share the assumption that distressed persons need to develop an understanding of the disordered thoughts, emotions, and motives that underlie their mental difficulties.

The insight therapies come in dozens of different "brands," but all aim at revealing and changing a patient's disturbed mental processes through discussion and interpretation. Some, like Freudian *psychoanalysis,* assume that problems lie hidden deep in the unconscious, so they employ elaborate and time-consuming techniques to draw them out. Others, like Carl Rogers's *nondirective therapy,*

Insight therapy Psychotherapy in which the therapist helps the patient/client understand (gain insight into) his or her problems.

minimize the importance of the unconscious and look for problems in the ways people consciously think and interact with each other. We have space here to sample only a few of the most influential ones, beginning with the legendary methods developed by Sigmund Freud himself.

Insight Therapies: Freudian psychoanalysis
- Neo-Freudian therapies
- Humanistic therapies
- Cognitive therapies
- Group therapies

Freudian Psychoanalysis In the classic Freudian view, psychological problems arise from tension created in the unconscious mind by forbidden impulses and threatening memories. Therefore, Freudian therapy, known as **psychoanalysis,** probes the unconscious in the attempt to bring these issues into the "light of day"—that is, into consciousness, where they can be rendered harmless. The major goal of psychoanalysis, then, is to reveal and interpret the unconscious mind's contents.

To get at unconscious material, Freud sought ways to get around the defenses the ego has erected to protect itself. One ingenious method called for *free association*, by which the patient would relax and talk about whatever came to mind, while the therapist would listen, ever alert for veiled references to unconscious needs and conflicts. Another method involved *dream interpretation,* which you may recall from Chapter 3.

CONNECTION • CHAPTER 12
The *ego defense mechanisms* include repression, regression, projection, denial, rationalization, reaction formation, displacement, and sublimation.

With these and other techniques, the psychoanalyst gradually develops a clinical picture of the problem and proceeds to help the patient understand the unconscious causes for symptoms. To give you the flavor of this process, we offer Freud's interpretation of a fascinating case involving a 19-year-old girl diagnosed with "obsessional neurosis" (now listed in the *DSM-IV* as *obsessive–compulsive disorder*). Please bear in mind that Freud's ideas no longer represent the mainstream of either psychology or psychiatry, but they remain important because many of Freud's techniques have carried over into newer forms of therapy. They are also important because many of Freud's concepts, such as *ego, repression, the unconscious, identification,* and *the Oedipus complex,* have become part of our everyday vocabulary. The following case, then—in which you may find Freud's interpretations shocking—will give you a sense of the way psychotherapy began about a century ago.

When Freud's patient entered psychoanalysis, she was causing her parents distress with a strange bedtime ritual that she performed each night. As part of this obsessional ritual, she first stopped the large clock in her room and removed other smaller clocks, including her wrist watch. Then, she placed all vases and flower pots together on her writing table, so—in her "neurotic" way of thinking—they could not fall and break during the night. Next, she assured that the door of her room would remain half open by placing various objects in the doorway. After these precautions, she turned her attention to the bed, where she was careful to assure that the bolster did not touch the headboard and a pillow must lie diagonally in the center of the bolster. Then, she shook the eiderdown in the quilt until all the feathers sank to the foot-end, after which she meticulously redistributed them evenly again. And, finally, she would crawl into bed and attempt to sleep with her head precisely in the center of the diagonal pillow.

Sigmund Freud's study, including the famous couch (right), is housed in London's Freud Museum. The 82-year-old Freud fled to London in 1938 upon the Nazi occupation of Austria and died there the following year.

The ritual did not proceed smoothly, however. She would do and then redo first one and then another aspect of the ritual, anxious that she had not performed everything properly—although she acknowledged to Freud that all aspects of her nightly precautions were irrational. The result was that it took the girl about two hours to get ready for bed each night.

Before you read Freud's interpretation, you might think about how you would make sense of such strange behaviors. Now then, in Freud's own words (1965/1920), here is the psychoanalytic interpretation of the case:

> The patient gradually learnt to understand that she banished clocks and watches from her room at night because they were symbols of the female genitals. Clocks, which we know may have other symbolic meanings besides this, acquire this significance of a genital organ by their relation to periodical processes and regular intervals. A woman may be heard to boast that

Psychoanalysis The form of psychodynamic therapy developed by Sigmund Freud. The goal of psychoanalysis is to release conflicts and memories from the unconscious.

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menstruation occurs in her as regularly as clockwork. Now this patient's special fear was that the ticking of the clocks would disturb her during sleep. The ticking of a clock is comparable to the throbbing of the clitoris in sexual excitation. This sensation, which was distressing to her, had actually on several occasions wakened her from sleep; now her fear of an erection of the clitoris expressed itself by the imposition of a rule to remove all going clocks and watches far away from her during the night. Flower-pots and vases are, like all receptacles, also symbols of the female genitals. Precautions to prevent them from falling and breaking during the night are therefore not lacking in meaning. . . . Her precautions against the vases breaking signified a rejection of the whole complex concerned with virginity. . . .

One day she divined the central idea of her ritual when she suddenly understood her rule not to let the bolster touch the back of the bed. The bolster had always seemed a woman to her, she said, and the upright back of the bedstead a man. She wished therefore, by a magic ceremony, as it were, to keep man and woman apart; that is to say, to separate the parents and prevent intercourse from occurring. . . .

If the bolster was a woman, then the shaking of the eiderdown till all the feathers were at the bottom, making a protuberance there, also had a meaning. It meant impregnating a woman; she did not neglect, though to obliterate the pregnancy again, for she had for years been terrified that intercourse between her parents might result in another child and present her with a rival. On the other hand, if the large bolster meant the mother then the small pillow could only represent the daughter. . . . The part of the man (the father) she thus played herself and replaced the male organ by her own head.

Horrible thoughts, you will say, to run in the mind of a virgin girl. I admit that; but do not forget that I have not invented these ideas, only exposed them. . . . (pp. 277–279)

This case shows how Freud used the patient's symptoms as symbolic signposts pointing to underlying and unconscious conflicts, desires, and memories. In the course of treatment, then, he would help the patient understand how her unconscious problems have been changed into her obsessive rituals by her ego defense mechanisms, such as *displacement* (by which the girl's fears about losing virginity were displaced into the ritual of protecting the vases in her bedroom). But whatever a patient's symptoms might be, the ego struggles to keep the "real" problem blocked from consciousness by means of the defense mechanism of *repression.* A psychoanalyst's main task, then, is to help a patient break through the barriers of repression and bring threatening thoughts to awareness. By doing so, the patient gains insight into the relationship between the current symptoms and the repressed conflicts. In the final stage of psychoanalysis, patients learn how the relationship they have established with the therapist reflects unresolved conflicts, especially problems they had with their parents. This projection of parental attributes onto the therapist is called *transference,* and so the final phase of therapy is known as the **analysis of transference.** According to psychoanalytic theory, the last step in recovery occurs when patients are finally released from the unconscious troubles established long ago in the relationship with their parents during early childhood (Munroe, 1955).

CONNECTION • CHAPTER 10
Repression is Freud's ego defense mechanism that causes forgetting by blocking off threatening memories in the unconscious.

Neo-Freudian Psychodynamic Therapies Please pardon us for doing a bit of analysis on Freud: He obviously had a flair for the dramatic, and he also possessed a powerful, charismatic personality—or, as he himself might have said, a strong ego. Accordingly, Freud encouraged his disciples to debate the principles of psychoanalysis, but he would tolerate no fundamental changes in his doctrines. This inevitably led to conflicts with some of his equally strong-willed followers, such as Alfred Adler, Carl Jung, and Karen Horney, who eventually broke with Freud to establish their own schools of therapy.

Analysis of transference The Freudian technique of analyzing and interpreting the patient's relationship with the therapist, based on the assumption that this relationship mirrors unresolved conflicts in the patient's past.

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In general the neo-Freudian renegades retained many of Freud's basic ideas and techniques, while adding some and modifying others. In the true psychodynamic tradition, the **neo-Freudian psychodynamic therapies** have retained Freud's emphasis on motivation. Most now have abandoned the psychoanalyst's couch and treat patients face-to-face. Most also see patients once a week for a few months, rather than several times a week for several years, as in classical psychoanalysis.

So how do the neo-Freudian therapists get the job done in a shorter time? Most have shifted their emphasis to *conscious* motivation—so they don't spend so much time probing for hidden conflicts and repressed memories. Most have also made a break with Freud on one or more of the following points:

- The significance of the self or ego (rather than the id)
- The influence of life experiences occurring after childhood (as opposed to Freud's emphasis on early-childhood experience)
- The role of social needs and interpersonal relationships (rather than sexual and aggressive desires)

And, as we saw in Chapter 10, each constructed a theory of disorder and therapy that had different emphases. We do not have space here to go into these approaches in greater detail, but let's briefly consider how a neo-Freudian therapist might have approached the case of the obsessive girl that Freud described. Most likely a modern psychodynamic therapist would focus on the current relationship between the girl and her parents, perhaps on whether she has feelings of inadequacy for which she is compensating by becoming the center of her parents' attention for two hours each night. And, instead of working so intensively with the girl, the therapist might well work with the parents on changing the way they deal with the problem. And what about Derek, whom we met at the beginning of the chapter? Again, a Freudian analyst would probe his early childhood memories for clues as to his depression. On the other hand, a modern psychodynamic therapist would be more likely to look for clues in his current relationships, assuming the cause to be social rather than sexual.

Humanistic Therapies In contrast with the psychodynamic emphasis on conflicting motives, the *humanistic* therapists believe that mental problems arise from low self-esteem, misguided goals, and unfulfilling relationships. Indeed, the primary symptoms for which college students seek therapy include feelings of alienation, failure to achieve all they feel they should, difficult relationships, and general dissatisfaction with their lives. Therapists often refer to these problems in everyday existence as *existential crises,* a term emphasizing how many human problems deal with questions about the meaning and purpose of one's existence. The humanistic psychologists have developed therapies aimed specifically at such problems.

Again, in contrast with the psychodynamic view, humanistic therapists believe that people are generally motivated by *healthy* needs for growth and psychological well-being. Thus, they dispute Freud's assumption of a personality divided into conflicting parts, dominated by a selfish id, and driven by hedonistic instincts and repressed conflicts. Instead, the humanists emphasize the concept of a whole person engaged in a continual process of growth and change. Thus, mental disorder occurs only when conditions interfere with normal development and produce low self-esteem. **Humanistic therapies,** therefore, attempt to help clients confront their problems by recognizing their own freedom, enhancing their self-esteem, and realizing their fullest potential (see Schneider & May, 1995). A humanistic therapist (if there had been one around a century ago) would probably have worked with Freud's patient to explore her self-concept and her feelings about her parents. As for Derek, a humanistic therapist might guess that his depression arose either from unsatisfying relationships or from a sense of personal inadequacy.

Neo-Freudian psychodynamic therapy Therapy for a mental disorder that was developed by psychodynamic theorists who embraced some of Freud's ideas but disagreed with others.

Humanistic therapy Treatment technique based on the assumption that people have a tendency for positive growth and self-actualization, which may be blocked by an unhealthy environment that can include negative self-evaluation and criticism from others.

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Humanistic therapist Carl Rogers (right center) facilitates a therapy group.

Client-centered therapy, developed by Carl Rogers (1951, 1977), assumes that healthy development can be derailed by a conflict between one's desire for a positive self-image and criticism by self and others. This conflict creates anxiety and unhappiness. The task of Rogerian therapy, then, is to create a nurturing environment in which clients can work through their concerns and finally achieve self-respect and self-actualization.

One of the main techniques used by Rogerian therapists involves **reflection of feeling** (also called *reflective listening*) to help clients understand their emotions. With this technique, therapists paraphrase their clients' words, attempting to capture the emotional tone expressed and acting as a sort of psychological "mirror" in which clients can see themselves. Notice how the Rogerian therapist uses this technique in the following excerpt from a therapy session with a young woman (Rogers, 1951, p. 152):

CLIENT: It probably goes all the way back into my childhood. . . . My mother told me that I was the pet of my father. Although I never realized it—I mean, they never treated me as a pet at all. And other people always seemed to think I was sort of a privileged one in the family. . . . And as far as I can see looking back on it now, it's just that the family let the other kids get away with more than they usually did me. And it seems for some reason to have held me to a more rigid standard than they did the other children.

THERAPIST: You're not so sure you were a pet in any sense, but more that the family situation seemed to hold you to pretty high standards.

CLIENT: M-hm. That's just what has occurred to me; and that the other people could sorta make mistakes, or do things as children that were naughty . . . but Alice wasn't supposed to do those things.

THERAPIST: M-hm. With somebody else it would be just—oh, be a little naughtiness; but as far as you were concerned, it shouldn't be done.

CLIENT: That's really the idea I've had. I think the whole business of my standards . . . is one that I need to think about rather carefully, since I've been doubting for a long time whether I even have any sincere ones.

THERAPIST: M-hm. Not sure whether you really have any deep values which you are sure of.

CLIENT: M-hm. M-hm.

Note how most of the therapist's statements in this example paraphrased, or "reflected," what the client has just said.

To summarize, the Rogerian therapist assumes that people have basically healthy motives. These motives, however, can be stifled or perverted by social pressures and low self-esteem. The therapist's task is mainly to help the client clarify feelings that stand in the way of personal growth. This is accomplished within a non-threatening atmosphere of *genuineness, empathy,* and *unconditional positive regard*—that is, nonjudgmental acceptance and respect for the client.

Is such an approach effective, or is it merely a naive hope? In fact, it has scientific support. An American Psychological Association task force, charged with finding research-based practices that contribute to the effectiveness of therapy, found that the common factor in therapies that work were precisely the Rogerian qualities of *empathy, positive regard, genuineness,* and *feedback* (Ackerman et al., 2001).

Client-centered therapy A humanistic approach to treatment developed by Carl Rogers, emphasizing an individual's tendency for healthy psychological growth through self-actualization.

Reflection of feeling Carl Rogers's technique of paraphrasing the clients' words, attempting to capture the emotional tone expressed.

Cognitive therapy Emphasizes rational thinking (as opposed to subjective emotion, motivation, or repressed conflicts) as the key to treating mental disorder.

Cognitive Therapies The insight therapies we have discussed so far focus primarily on people's emotions or motives. (See Figure 13.1.) **Cognitive therapy,** on the other hand, assumes that psychological problems arise from erroneous thinking and sees rational thinking as the key to positive therapeutic change (Butler et al., 2006). Cognitive therapy takes multiple forms, but we can give you some of its flavor with one example: Aaron Beck's cognitive therapy for depression.

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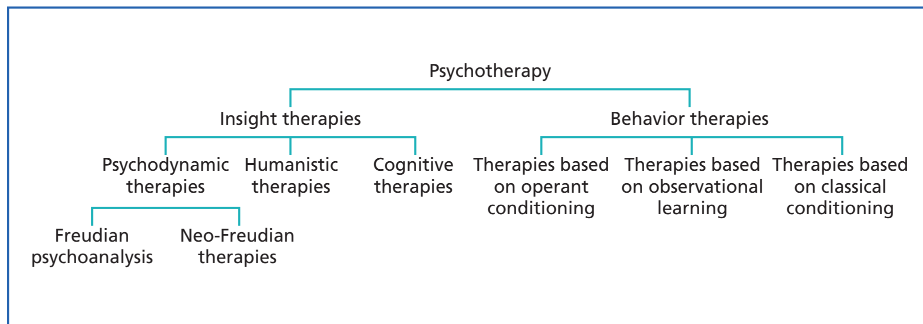


FIGURE 13.1
Types of Psychotherapy

Each of the two major branches of psychotherapy has many variations.

Beck, who was originally trained in classical psychoanalysis, broke with the Freudian tradition when he began noticing that the dreams and free associations of his depressed patients were filled with negative thoughts (Beck, 1976; Bowles, 2004). Commonly they would make such self-deprecating statements as, "Nobody would like me if they really knew me" and "I'm not smart enough to make it in this competitive school." Gradually Beck came to believe that depression occurs because of this negative self-talk. The therapist's job, then, is to help the client learn more positive ways of thinking.

Here's a sample of Beck's approach, taken from a therapy session with a college student of about Derek's age (Beck et al., 1979, pp. 145–146):

Client: I get depressed when things go wrong. Like when I fail a test.

Therapist: How can failing a test make you depressed?

Client: Well, if I fail, I'll never get into law school.

Therapist: Do you agree that the way you interpret the results of the test will affect you? You might feel depressed, you might have trouble sleeping, not feel like eating, and you might even wonder if you should drop out of the course.

Client: I have been thinking that I wasn't going to make it. Yes, I agree.

Therapist: Now what did failing mean?

Client: (tearful) That I couldn't get into law school.

Therapist: And what does that mean to you?

Client: That I'm just not smart enough.

Therapist: Anything else?

Client: That I can never be happy.

Therapist: And how do these thoughts make you feel?

Client: Very unhappy.

Therapist: So it is the meaning of failing a test that makes you very unhappy. In fact, believing that you can never be happy is a powerful factor in producing unhappiness. So, you get yourself into a trap—by definition, failure to get into law school equals "I can never be happy."

As you can see from this exchange, the cognitive therapist helps the individual confront the destructive thoughts that support depression. Studies have shown that Beck's approach can be at least as effective in the treatment of depression as is medication (Antonuccio, 1995; Beck, 2005).

In Derek's case, a cognitive therapist would probably probe for negative self-talk that might be feeding the depression. And how might a cognitive therapist have approached Freud's 19-year-old obsessive patient? The focus would have been on irrational beliefs, such as the idea that flowerpots and vases could, by themselves, fall down in the night and break. A cognitive therapist would also challenge the assumption that something catastrophic might happen (such as not

being able to sleep!) if she didn't perform her nightly ritual. In both cases, the assumption would be that the symptoms would disappear as positive thoughts replaced negative ones.

Group Therapies All the treatments we have discussed to this point involve one-to-one relationships between a patient or client and therapist. However, **group therapy** can have value in treating a variety of concerns, particularly problems with social behavior and relationships. This can be done in many ways—with couples, families, or groups of people who have similar problems, such as depression or drug addiction. Usually they meet together once a week, but some innovative therapy groups are even available on the Internet (Davison et al., 2000). Most typically, group approaches employ a humanistic perspective, although psychodynamic groups are also common. Among the benefits of group therapy, clients have opportunities to observe and imitate new social behaviors in a forgiving, supportive atmosphere. We will touch on only a small sample of group therapies below: self-help groups and marital and family therapy.

Self-Help Support Groups Perhaps the most noteworthy development in group therapy has been the surge of interest in **self-help support groups.** Thousands of such groups exist. Many are free, especially those that are not directed by a paid health care professional. Such groups give people a chance to meet under nonthreatening conditions to exchange ideas with others having similar problems and who are surviving and sometimes even thriving (Schiff & Bargal, 2000).

One of the oldest, Alcoholics Anonymous (AA), pioneered the self-help concept, beginning in the mid-1930s. Central to the original AA process is the concept of "12 steps" to recovery from alcohol addiction, based not on psychological theory but on the trial-and-error experience of early AA members. The first step begins with recognizing that one has become powerless over alcohol; the second affirms that faith in a "greater power" is necessary for recovery. In the remaining steps the individual seeks help from God and sets goals for making amends to those who have been hurt by his or her actions. Members are urged and helped by the group to accept as many of the steps as possible to maintain recovery.

The feminist consciousness-raising movement of the 1960s brought the self-help concept to a wider audience. As a result, self-help support groups now exist for an enormous range of problems, including:

- Managing life transition or other crises, such as divorce or death of a child
- Coping with physical and mental disorders, such as depression or heart attack
- Dealing with addictions and other uncontrolled behaviors, such as alcoholism, gambling, overeating, sexual excess, and drug dependency
- Handling the stress felt by relatives or friends of those who are dealing with addictions

Group therapy also makes valuable contributions to the treatment of terminally ill patients. The goals of such therapy are to help patients and their families live their lives as fully as possible, to cope realistically with impending death, and to adjust to the terminal illness (Adams, 1979; Yalom & Greaves, 1977). One general focus of such support groups for the terminally ill is to help them learn "how to live fully until you say goodbye" (Nungesser, 1990).

Couples and Family Therapy Perhaps the best setting in which to learn about relationships is in a group of people struggling with relationships. *Couples therapy* (or counseling), for example, may involve one or more couples who are learning to clarify their communication patterns and improve the quality of their interaction (Napier, 2000). By seeing couples together, a therapist can help the partners identify the verbal and nonverbal styles they use to dominate, control, or confuse each other. The therapist then helps them to reinforce more desirable responses in the other and with-

Group therapy Any form of psychotherapy done with more than one client/patient at a time. Group therapy is often done from a humanistic perspective.

Self-help support groups Groups, such as Alcoholics Anonymous, that provide social support and an opportunity for sharing ideas about dealing with common problems. Such groups are typically organized and run by laypersons, rather than professional therapists.

draw from conflicts. Couples are also taught nondirective listening skills that help clarify and express feelings and ideas (Jacobson et al., 2000; Wheeler et al., 2001).

Couples therapy typically focuses not on personalities but on the *processes* of the relationship, particularly on patterns of conflict and communication (Gottman, 1994; Christensen & Heavey, 1999). Difficult as this may be, changing a couple's interaction patterns can be more effective than individual therapy with one individual at a time (Gottman, 1994, 1999).

In *family therapy,* the "client" is an entire family group, with each family member being treated as part of a *system of relationships* (Fishman, 1993). A family therapist helps troubled family members perceive the issues or patterns that are creating problems for them. The aim is on altering the interpersonal dynamics (interactions) among people (Foley, 1979; Schwebel & Fine, 1994). Family therapy can not only reduce tensions within a family, but it can also improve the functioning of individual members by helping them recognize their roles in the group. It has proved to be especially effective in the treatment of anorexia nervosa, depression, and other mood disorders, and even as a boon to families struggling with schizophrenia (Miklowitz, 2007).

Virginia Satir, a pioneer of family therapy, noted that the therapist, too, has roles to play during therapy. Among them, the therapist acts as an interpreter and clarifier of the interactions that take place in the therapy session, as well as an advisor, mediator, and referee (Satir, 1983; Satir et al., 1991). As in couples therapy, family therapy focuses on the *situational* rather than the *dispositional* aspects of a problem. That is, the therapist helps family members look at how they interact. So, the therapist might point out how one family member's unhappiness affects everyone's feelings and relationships—rather than seeking to blame someone as "the problem." The goal of a family therapy meeting, then, is not to have a "gripe session," but to develop the family's ability to come together for constructive problem solving.

In couples therapy, the therapist can help people work together to improve the communication patterns that have developed in their relationship.

Behavior Therapies

If the problem is overeating, bed-wetting, shyness, antisocial behavior, or anything else that can be described in purely behavioral terms, the chances are good that it can be modified by one of the behavior therapies (also known as **behavior modification**). Based on the assumption that these undesirable behaviors have been learned and therefore can be *un*learned, **behavior therapy** relies on the principles of operant and classical conditioning. In addition to those difficulties listed above, behavior therapists report success in dealing with fears, compulsions, depression, addictions, aggression, and delinquent behaviors.

As the label suggests, behavior therapists focus on problem *behaviors,* rather than inner thoughts, motives, or emotions. They seek to understand how the problem behaviors might have been learned and, even more important, how they can be eliminated and replaced by more effective patterns. To see how this is done, we will look first at the therapy techniques borrowed from *classical conditioning.*

Behavior Therapies
- Systematic desensitization
- Aversion therapy
- Contingency management
- Token economies
- Participant modeling

CONNECTION • CHAPTER 3
In *classical conditioning,* a CS comes to produce essentially the same response as the UCS.

Classical Conditioning Therapies

The first example of behavior therapy, reported by psychologist Mary Cover Jones (1924), treated a fearful little boy named Peter, who was afraid of furry objects. Jones was able to desensitize the boy's fear, over a period of weeks, by gradually bringing a rabbit closer and closer to the boy while he was eating. Eventually, Peter was able to allow the rabbit to sit on his lap while he petted it. (You may notice the similarity to John Watson's experiments on Little Albert. Indeed, Jones was an associate of Watson and knew of the Little Albert study. Unlike Albert, however, Peter came to treatment already possessing an intense fear of rabbits and other furry objects.)

Surprisingly, it was another 14 years before behavior therapy reappeared, this time as a treatment for bed-wetting (Mowrer & Mowrer, 1938). The method

Behavior modification Another term for behavior therapy.

Behavior therapy Any form of psychotherapy based on the principles of behavioral learning, especially operant conditioning and classical conditioning.

involved a fluid-sensitive pad placed under the patient. When moisture set off an alarm, the patient would awaken. The treatment was effective in 75% of cases—an amazing success rate, in view of the dismal failure of psychodynamic therapy to prevent bed-wetting by talking about the "meaning" of the symptom. And it took yet another 20 years before behavior therapy entered the mainstream of psychological treatment. Why the delay? The old Freudian idea—that every symptom has an underlying, unconscious cause that must be discovered and eradicated—was extremely well rooted in clinical lore. Therapists dared not attack symptoms (behaviors) directly for fear of *symptom substitution:* the idea that by eliminating one symptom another, which could be much worse, could take its place.

Systematic Desensitization It took the psychiatrist Joseph Wolpe to challenge the entrenched notion of symptom substitution. Wolpe reasoned that the development of irrational fear responses and other undesirable emotionally based behaviors might follow the classical conditioning model, rather than the Freudian model. As you will recall, *classical conditioning* involves the association of a new stimulus with an unconditioned stimulus, so that the person responds the same way to both. Thus, a fear response might be associated with, say, crowds or spiders or lightning. Wolpe also realized another simple truth: The nervous system cannot be relaxed and agitated at the same time because these two incompatible processes cannot be activated simultaneously. Putting these two ideas together formed the foundation for Wolpe's method, called **systematic desensitization** (Wolpe, 1958, 1973).

Systematic desensitization begins with a training program, teaching patients to relax their muscles and their minds (Rachman, 2000). With the patient in this deeply relaxed state, the therapist begins the process of *extinction* by having the patient imagine progressively more fearful situations. This is done in gradual steps, called an *anxiety hierarchy,* that move from remote associations to imagining an intensely feared situation.

To develop the anxiety hierarchy, the therapist and client first identify all the situations that provoke the patient's anxiety and then arrange them in levels, ranked from weakest to strongest (Shapiro, 1995). For example, a patient suffering from severe fear of public speaking constructed the hierarchy of unconditioned stimuli seen in Table 13.2.

Later, during desensitization, the relaxed client vividly imagines the weakest anxiety stimulus on the list. If it can be visualized without discomfort, the client goes on to the next stronger one. After a number of sessions, the client can imagine the most distressing situations on the list without anxiety (Lang & Lazovik,

TABLE 13.2 A Sample Anxiety Hierarchy

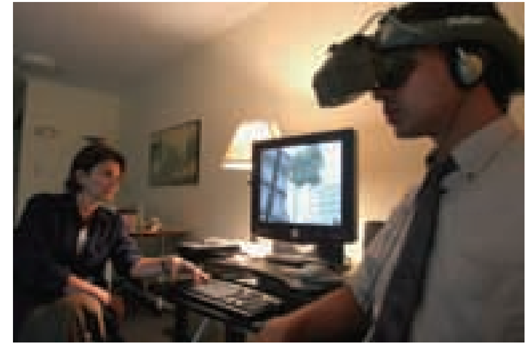
The following is typical of anxiety hierarchies that a therapist and a patient might develop to desensitize a fear of public speaking. The therapist guides the deeply relaxed patient in imagining the following situations:

1. Seeing a picture of another person giving a speech
2. Watching another person give a speech
3. Preparing a speech that I will give
4. Having to introduce myself to a large group
5. Waiting to be called on to speak in a meeting
6. Being introduced as a speaker to a group
7. Walking to the podium to make a speech
8. Making a speech to a large group

Systematic desensitization A behavioral therapy technique in which anxiety is extinguished by exposing the patient to an anxiety-provoking stimulus.

1963)—hence the term *systematic* desensitization. In some forms of systematic desensitization, called **exposure therapy,** the therapist may actually have the patient confront the feared object or situation, such as a spider or a snake, rather than just imagining it. You will recall that Sabra, whom you met at the beginning of Chapter 3, went through a form of desensitization to deal with her fear of flying. The technique has been used successfully with a multitude of patients with phobias, including many whose fears of blood, injections, and germs stand in the way of getting needed medical or dental treatment (Dittmann, 2005b).

A number of studies have shown that desensitization works especially well for the specific phobias (Smith & Glass, 1977). Desensitization has also been successfully applied to a variety of anxiety-related problems that include stage fright, social phobias, agoraphobia and anxiety about sexual performance (Dittman, 2005a). In the last few years, some cognitive–behavioral therapists have added a high-tech twist by using computer-generated images that expose phobic patients to fearful situations in a safe virtual-reality environment. To enter the virtual-reality environment, patients don a helmet containing a video screen, on which are projected images to which they will be desensitized: spiders, snakes, high places, closed-in spaces—all the common phobia-producing objects or images (Winerman, 2005e).



In "virtual reality," phobic patients can confront their fears safely and conveniently in the behavior therapist's office. On a screen inside the headset, the patient sees computer-generated images of feared situations, such as seeing a snake, flying in an airplane, or looking down from the top of a tall building.

Aversion Therapy So, desensitization therapy helps clients deal with stimuli that they want to avoid. But what about the reverse? What can be done to help those who are attracted to stimuli that are harmful or illegal? Examples include drug addiction, certain sexual attractions, and tendencies to violence—all problems in which undesirable behavior is elicited by some specific stimulus. **Aversion therapy** tackles these problems with a conditioning procedure designed to make tempting stimuli repulsive by pairing them with unpleasant (aversive) stimuli. For example, the therapist might use electric shocks or nausea-producing drugs, whose effects are highly unpleasant but not in themselves dangerous to the client. In time, the negative reactions (unconditioned responses) to the aversive stimuli come to be associated with the conditioned stimuli (such as an addictive drug), and so the client develops an aversion that replaces the desire.

Exposure therapy A form of desensitization therapy in which the patient directly confronts the anxiety-provoking stimulus (as opposed to imagining the stimulus).

Aversion therapy As a classical conditioning procedure, aversive counterconditioning involves presenting the individual with an attractive stimulus paired with unpleasant (aversive) stimulation to condition a repulsive reaction.

To give another example, if you were to elect aversion therapy to help you quit smoking, you might be required to chain-smoke cigarettes while having a foul odor blown in your face—until you develop a strong association between smoking and nausea. (See Figure 13.2.) A similar conditioning effect occurs in alcoholics who drink while taking Antabuse, a drug often prescribed to encourage sobriety.

In some ways, aversion therapy resembles nothing so much as torture. So why would anyone submit voluntarily to it? Sometimes the courts may assign a probationer to aversion therapy. Usually, however, people submit to this type of treatment because they have a troublesome addiction that has resisted other treatments.

Operant Conditioning Therapies Four-year-old Tyler has a screaming fit when he goes to the grocery store with his parents and they refuse to buy him candy. He acquired this annoying behavior through operant conditioning, by being rewarded when his parents have given in to his demands. In fact, most behavior problems found in both children and adults have been shaped by rewards and punishments. Consider, for example, the similarities between Tyler's case and the employee who chronically arrives late for work or the student who waits until the last minute to study for a test. Changing such behaviors requires operant conditioning techniques. Let's look at two therapeutic variations on this operant theme.

CONNECTION • CHAPTER 3
In *operant conditioning*, behavior changes because of consequences, such as rewards and punishments.

Contingency Management Tyler's parents may learn to extinguish his fits at the grocery store by simply withdrawing their attention—no easy task, by the way. In addition, the therapist may coach them to "catch Tyler being good" and give him the

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DO IT YOURSELF! Behavior Self-Modification

Is there a behavioral habit that you would like to acquire—studying, initiating conversations with others, exercising to keep fit? Write this activity in behavioral terms on the line below. (Don't use mentalistic words, such as "feeling" or "wanting." Behaviorists require that you keep things objective by specifying only an observable behavior.)

The desired new behavior: ______________________________

____

When or under what conditions would you like to engage in this new behavior? On the line below, write in the time or stimulus conditions when you want to initiate the behavior (for example: in class, when relaxing with friends, or at a certain time every morning).

The time or conditions for the new behavior: ____________

____

To increase your likelihood of producing the desired response, apply some positive reinforcement therapy to yourself. Choose an appropriate reward that you will give yourself when you have produced the desired behavior at the appropriate time. Write the reward that you will give yourself on the line below.

Your reward: ____

____

Give yourself feedback on your progress by keeping a daily record of the occurrence of your new behavior. This could be done, for example, on a calendar or a graph. In time, you will discover that the desired behavior has increased in frequency. You will also find that your new habit carries its own rewards, such as better grades or more satisfying social interactions (Kazdin, 1994).

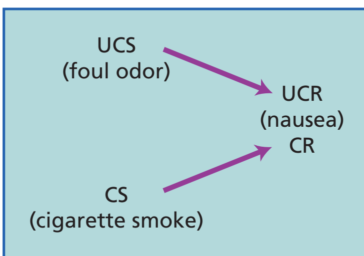

FIGURE 13.2
Conditioning an Aversion for Cigarette Smoke

Aversion therapy for smoking might simultaneously pair a foul odor with cigarette smoke blown in the smoker's face. The foul odor (such as rotten eggs) produces nausea. This response then becomes the conditioned response associated with cigarette smoke.

(*Source:* From J. Wolpe, *The Practice of Behavior Therapy,* 4th ed. Published by Allyn & Bacon, Boston, MA. Copyright © 1991 by Pearson Education. Reprinted by permission of the publisher.)

attention he needs then. Over time, the changing contingencies will work to extinguish the old, undesirable behaviors and help to keep the new ones in place. This approach is an example of **contingency management:** changing behavior by modifying its consequences. It has proved effective in managing behavior problems found in such diverse settings as families, schools, work, prisons, the military, and mental hospitals. The careful application of reward and punishment can also reduce the self-destructive behaviors in autistic children (Frith, 1997). And, if you would like to change some undesirable habit or acquire a new one, you can even apply contingency management techniques to yourself: See the accompanying box, "Do It Yourself! Behavior Self-Modification."

Token Economies The special form of therapy called a **token economy,** commonly used in group settings such as classrooms and institutions, is the behavioral version of group therapy (Ayllon & Azrin, 1968; Martin & Pear, 1999). The method takes its name from the plastic tokens sometimes awarded by therapists or teachers as immediate reinforcers for desirable behaviors. In a classroom, earning a token might mean sitting quietly for several minutes, participating in a class discussion, or turning in an assignment. Later, recipients may redeem the tokens for food, merchandise, or privileges. Often, "points" or play money are used in place of tokens. The important thing is that the individual receive something as a reinforcer immediately after giving desired responses. With the appropriate modifications, the token economy also works well with children having developmental disabilities, with mental patients, and with correctional populations (Higgins et al., 2001).

Participant Modeling: An Observational-Learning Therapy "Monkey see—monkey do," we say. And sure enough, monkeys learn fears by observation and imitation. One study showed that laboratory monkeys with no previous aversion to snakes could acquire a simian version of *ophidiophobia* by observing their parents reacting fearfully to real snakes and toy snakes. (You don't remember that phobia? Look back at Table 12.3 on page 546.) The more disturbed the monkey parents were at the sight of the snakes, the greater the resulting fear in their offspring (Mineka et al., 1984). A follow-up study showed that such fears were not just a family matter. When other monkeys that had previously shown no fear of snakes were given the opportunity to observe unrelated adults responding to snakes fearfully, they quickly acquired the same response, as you can see in Figure 13.3 (Cook et al., 1985).

Contingency management An operant conditioning approach to changing behavior by altering the consequences, especially rewards and punishments, of behavior.

Token economy An operant technique applied to groups, such as classrooms or mental hospital wards, involving the distribution of "tokens" or other indicators of reinforcement contingent on desired behaviors. The tokens can later be exchanged for privileges, food, or other reinforcers.

Like monkeys, people also learn fears by observing the behavior of others. But for therapeutic purposes, observational learning in the form of *participant modeling* can also be used to encourage *healthy* behaviors. In **participant modeling**, then, the client, or *participant*, observes and imitates someone *modeling* desirable behaviors. Athletic coaches, of course, have used participant modeling for years. Similarly, a behavior therapist treating a snake phobia might model the desired behavior by first approaching a caged snake, then touching the snake, and so on. The client then imitates the modeled behavior but at no time is forced to perform. If the therapist senses resistance, the client may return to a previously successful level. As you can see, the procedure is similar to systematic desensitization, with the important addition of observational learning. In fact, participant modeling draws on concepts from both operant and classical conditioning.

The power of participant modeling in eliminating snake phobias can be seen in a study that compared the participant modeling technique with several other approaches: (1) *symbolic modeling*, a technique in which subjects receive indirect exposure by watching a film or video in which models deal with a feared situation; (2) desensitization therapy, which, as you will remember, involves exposure to an imagined fearful stimulus; and (3) no therapeutic intervention (the control condition). As you can see in Figure 13.4, participant modeling was the most successful. The snake phobia was virtually eliminated in 11 of the 12 subjects in the participant modeling group (Bandura, 1970).

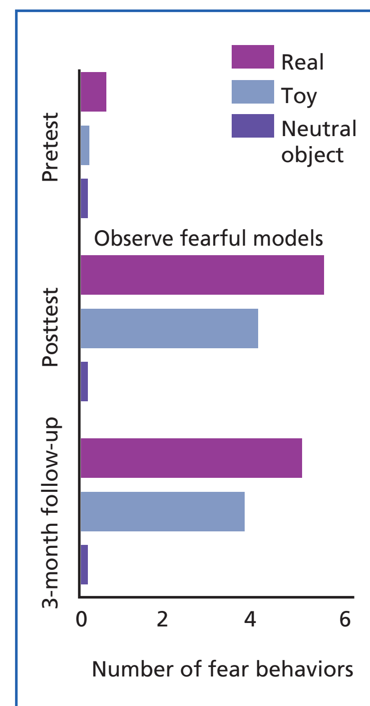

FIGURE 13.3
Fear Reactions in Monkeys

In a pretest, young monkeys raised in laboratories show little fear of snakes (top bars). But after observing other monkeys showing a strong fear of snakes, they are conditioned to fear both real snakes and toy snakes (middle bars). A follow-up test shows that the fear persists over a 3-month interval (bottom bars).

(*Source:* From "Observational Conditioning of Snake Fear in Unrelated Rhesus Monkeys," by M. Cook, S. Mineka, B. Wokenstein, and K. Laitsch, *Journal of Abnormal Psychology, 94*, pp. 591–610. Copyright © 1985 by American Psychological Association. Reprinted by per-

Cognitive–Behavioral Therapy: A Synthesis

Suppose you are having difficulty controlling feelings of jealousy every time the person you love is friendly with someone else. Chances are that the problem originates in your cognitions about yourself and the others involved ("Marty is stealing Terry away from me!") These thoughts may also affect your behavior, making you act in ways that could drive Terry away from you. A dose of therapy aimed at *both* your cognitions and your behaviors may be a better bet than either one alone.

In brief, **cognitive–behavioral therapy** combines a cognitive emphasis on thoughts and attitudes with the behavioral strategies that we have just discussed. This dual approach assumes that an irrational self-statement often underlies maladaptive behavior. For example, an addicted smoker might automatically tell himself, "One more cigarette won't hurt me" or "I'll go crazy if I don't have a smoke now." These irrational self-statements must be changed or replaced with rational, constructive coping statements before the unacceptable behavior pattern can be modified. Here is an example of healthier thinking: "I can get through this craving if I distract myself with something else I like to do, like going to a movie."

So, in cognitive–behavioral treatment, the therapist and client work together to modify irrational self-talk, set attainable behavioral goals, develop realistic strategies for attaining them, and evaluate the results. In this way, people change the way they approach problems and gradually develop new skills and a sense of self-efficacy (Bandura, 1986, 1992; Schwarzer, 1992).

Participant modeling A social learning technique in which a therapist demonstrates and encourages a client to imitate a desired behavior.

Cognitive–behavioral therapy A newer form of psychotherapy that combines the techniques of cognitive therapy with those of behavioral therapy.

Rational–emotive behavior therapy (REBT) Albert Ellis's brand of cognitive therapy, based on the idea that irrational thoughts and behaviors are the cause of mental disorders.

Rational–Emotive Behavior Therapy: Challenging the "Shoulds" and "Oughts"

One of the most famous forms of cognitive–behavioral therapy was developed by the colorful and notorious Albert Ellis (1987, 1990, 1996) to help people eliminate self-defeating thought patterns. Ellis has dubbed his treatment **rational–emotive behavior therapy (REBT)**, a name derived from its method of challenging certain "irrational" beliefs and behaviors.

What are the irrational beliefs challenged in REBT, and how do they lead to maladaptive feelings and actions? According to Ellis, maladjusted individuals base their lives on a set of unrealistic values and unachievable goals. These

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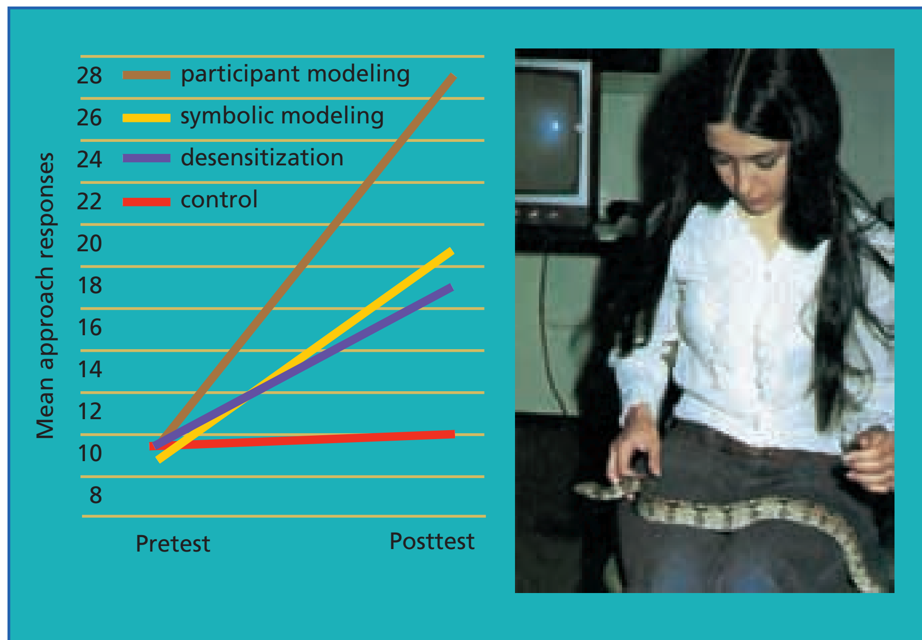
FIGURE 13.4
Participant Modeling Therapy

The client shown in the photo first watches a model make a graduated series of snake-approach responses and then repeats them herself. Eventually, she can pick up the snake and let it move about on her. The graph compares the number of approach responses clients made before and after receiving participant modeling therapy with the responses of those exposed to two other therapeutic techniques and a control group. The graph shows that participant modeling was far more effective in the posttest.

(*Source:* From "Modeling Therapy," by D. Albert Bandura. Reprinted by permission of the author.)



CONNECTION • CHAPTER 10

Compare Ellis's "neurotic" goals with Karen Horney's neurotic trends.

"neurotic" goals and values lead people to hold unrealistic expectations that they should always succeed, that they should always receive approval, that they should *always* be treated fairly, and that their experiences should always be pleasant. (You can see the most common irrational beliefs in the accompanying box, "Do It Yourself! Examining Your Own Beliefs.") For example, in your own daily life, you may frequently tell yourself that you "should" get an A in math or that you "ought to" spend an hour exercising every day. Further, he says, if you are unable to meet your goals and seldom question this neurotic self-talk, it may come to control your actions or even prevent you from choosing the life you want. If you were to enter REBT, your therapist would teach you to recognize such assumptions, question how rational they are, and replace faulty ideas with more valid ones. Don't "should" on yourself, warned Ellis.

DO IT YOURSELF! Examining Your Own Beliefs

It may be obvious that the following are not healthy beliefs, but Albert Ellis found that many people hold them. Do you? Be honest: Put a check mark beside each of the following statements that accurately describes how you feel about yourself.

1. _____ I must be loved and approved by everyone.
2. _____ I must be thoroughly competent, adequate, and achieving.
3. _____ It is catastrophic when things do not go the way I want them to go.
4. _____ Unhappiness results from forces over which I have no control.
5. _____ People must always treat each other fairly and justly; those who don't are nasty and terrible people.
6. _____ I must constantly be on my guard against dangers and things that could go wrong.
7. _____ Life is full of problems, and I must always find quick solutions to them.
8. _____ It is easier to evade my problems and responsibilities than to face them.
9. _____ Unpleasant experiences in my past have had a profound influence on me. Therefore, they must continue to influence my current feelings and actions.
10. _____ I can achieve happiness by just enjoying myself each day. The future will take care of itself.

In Ellis's view, all these statements were irrational beliefs that can cause mental problems. The more items you have checked, the more "irrational" your beliefs. His cognitive approach to therapy, known as rational–emotive behavior therapy, concentrates on helping people see that they can "drive themselves crazy" with such irrational beliefs. For example, a student who parties rather than studying for a test holds belief #8. A person who is depressed about not landing a certain job holds irrational belief #3. You can obtain more information on Ellis's system from his books.

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So, how might a cognitive–behavioral therapist have dealt with Freud's obsessive patient? First, taking a cognitive approach, the therapist would challenge the girl's irrational beliefs, as we suggested earlier. Then, switching to a behavioral mode, the therapist might teach the girl relaxation techniques to use when she began to get ready for bed each evening. These techniques then would substitute for the obsessive ritual. It is also likely that the therapist would work with the parents, focusing on helping them learn not to reward the girl with attention for her ritual behavior.

Positive Psychotherapy (PPT) Our depressed client Derek might be an especially good candidate for a new form of cognitive-behavioral treatment called **positive psychotherapy (PPT),** developed by Martin Seligman. Like the humanists, Seligman and his fellow *positive psychologists* see their mission as balancing psychology's negative emphasis on mental disorders with their own positive emphasis on growth, health, and happiness. So it was a "natural" for Seligman to tackle the problem of depression by accentuating the positive (Seligman et al., 2006). Unlike the humanists, however, the PPT approach is largely cognitive–behavioral, with an emphasis on research.

In PPT Derek might find himself treated more like a student than a patient. For example, the therapist might give him a "homework" assignment, such as the "three good things" exercise: "Before you go to sleep, write down three things that went well today and why they went well." Derek would also learn to focus on positive emotions, respond constructively to others, and otherwise to seek more pleasure in his work and home life. How well does this work? Seligman and his group have applied this approach to dozens of clients and report preliminary results showing that PPT relieved depression far more effectively than did conventional therapy or antidepressant medication (Seligman et al., 2006).

Changing the Brain by Changing the Mind Brain scans now show that cognitive–behavioral therapy not only helps people change their minds, but it can change the brain itself (Dobbs, 2006b). In one study, patients who suffered from obsessions, such as worrying that they had not turned off their stoves or locked their doors, were given cognitive behavior modification (Schwartz et al., 1996). When they felt an urge to run home and check on themselves, they were trained to relabel their experience as an obsession or compulsion—not a rational concern. They then focused on waiting out this "urge" rather than giving in to it, by distracting themselves with other activities for about 15 minutes. Positron emission tomography (PET) scans of the brains of subjects who were trained in this technique indicated that, over time, the part of the brain responsible for that nagging fear or urge gradually became less active.

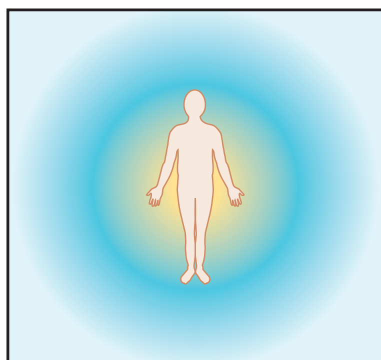
As that study shows, psychology has come a long way since the days when we wondered whether thoughts and behavior were the product of nature *or* nurture. With cognitive–behavioral therapy we now know that experience can change the biology behind behavior.

Evaluating the Psychological Therapies

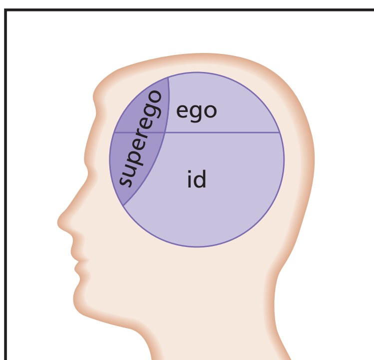
Now that we have looked at a variety of psychological therapies (see Figure 13.5), let us step back and ask how effective therapy is. Think about it: How could you tell objectively whether therapy really works? The answer to this question hasn't always been clear (Kopta et al., 1999; Shadish et al., 2000).

Lots of evidence says that most people who have undergone therapy *like* it. This was shown, for example, by surveying thousands of subscribers to *Consumer Reports* (1995). Respondents indicated how much their treatment helped, how satisfied they were with the therapist's treatment of their problems, how much their "overall emotional state" changed following therapy, as well as what kind of therapy they had undergone. For about 3000 of the 7000 who

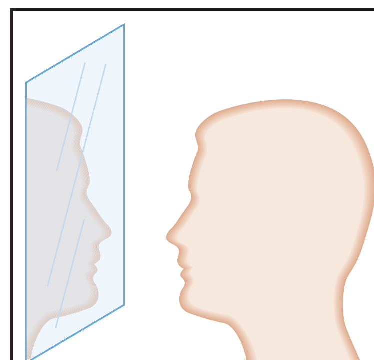
Positive psychotherapy (PPT) A relatively new form of cognitive-behavioral treatment that seeks to emphasize growth, health, and happiness.



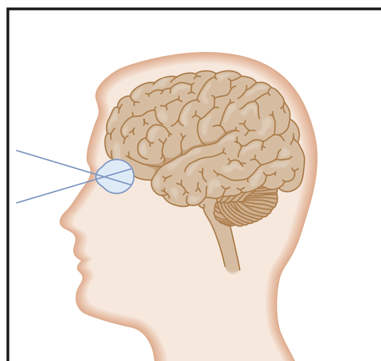
Behavior therapies
aim to change things *outside the individual*: rewards, punishments, and cues in the environment in order to change the person's external behaviors.



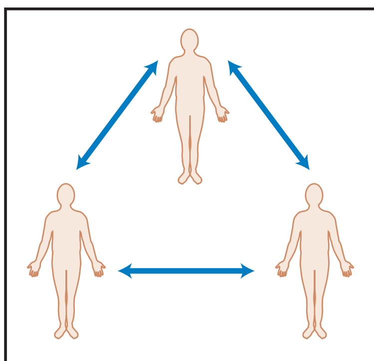
Psychodynamic therapies
aim to make changes *inside the person's mind*, especially the unconscious.



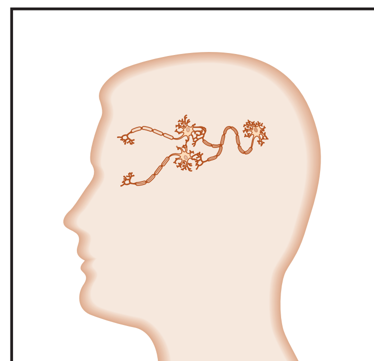
Humanistic therapies
aim to change the way people *see themselves*.



Cognitive therapies
aim to change the way people *think and perceive*.



Group therapies
aim to change the way people *interact*.



Biomedical therapies
aim to change the structure or function of the brain.

FIGURE 13.5
A Comparison of Different Types of Therapy

answered the questionnaire, "therapy" merely meant talking to a friend, a relative, or to clergy (as might be expected from our discussion earlier in this chapter). Another 2900 saw a mental health professional; the rest saw family doctors or attended support groups. Among the results: (a) Therapy works—that is, it was perceived to have helped clients diminish or eliminate their psychological problems; (b) long-term therapy is better than short-term therapy; and (c) all forms of therapy are about equally effective for improving clients' problems (see Jacobson & Christensen, 1996).

We can't give a thumbs-up to therapy, however, merely because people say they like it or that it helped them (Hollon, 1996). Testimonials don't make for good science—which is why psychologists now demand that therapy be judged by studies having a *comparison group* or *control group*. Let's turn, therefore, to the controlled studies of therapy's effectiveness, beginning with a report that nearly upset the therapeutic applecart.

CONNECTION • CHAPTER 1
A *control group* is treated exactly as the experimental group, except for the crucial independent variable.

Eysenck's Controversial Proclamation The issue of therapy's effectiveness came to a head in 1952, when British psychologist Hans Eysenck proclaimed that roughly two-thirds of all people who develop nonpsychotic mental disorders would recover within two years, *whether they get therapy or not*. Eysenck's evidence came from a review of several outcome studies of various kinds of insight therapy, all of which

compared patients who received therapy to those who were on waiting lists, awaiting their turn in treatment. What he noted was that just as many people on the waiting lists recovered as those in therapy. If taken at face value, this meant that psychotherapy was essentially worthless—no better than having no treatment at all! To say the least, this wasn't received happily by therapists. But Eysenck's challenge had an immensely productive result: It stimulated therapists to do a great deal of research on the effectiveness of their craft.

In Response to Eysenck Major reviews of the accumulating evidence on therapy began to be reported in 1970 (by Meltzoff & Kornreich), in 1975 (by Luborsky et al.), and in 1977 (by Smith and Glass). Overall, this literature—numbering some 375 studies—supported two major conclusions. First, therapy is, after all, more effective than no therapy—much to everyone's relief! And second, Eysenck had overestimated the improvement rate in no-therapy control groups.

Gradually, then, a scientific consensus supporting the value of psychotherapy emerged (Meredith, 1986; VandenBos, 1986). In fact, for a broad range of disorders, psychotherapy has been demonstrated to have an effect comparable or superior to many established medical practices (Wampold, 2007). Moreover, the research began to show that therapy was effective not only in Western industrialized countries (in the United States, Canada, and Europe) but also in a variety of cultural settings throughout the world (Beutler & Machado, 1992; Lipsey & Wilson, 1993). A number of writers have cautioned, however, that therapists must be sensitive to cultural differences and adapt their techniques appropriately (Matsumoto, 1996; Shiraev & Levy, 2001).

New Questions But the new studies have raised new questions. Are some therapies better than others? Can we identify therapies that are best suited for treating specific disorders? The Smith and Glass survey (1977) hinted that the answers to those questions were "Yes" and "Yes." Smith and Glass found that the behavior therapies seemed to have an advantage over insight therapies for the treatment of many anxiety disorders. More recent evaluations have found insight therapies can also be used effectively to treat certain problems, such as marital discord and depression. Indeed, there is now a clear trend toward matching specific therapies to specific conditions. It is important to realize, however, that these therapeutic techniques do not necessarily "cure" psychological disorders. In the treatment of schizophrenia, mental retardation, or autism, for example, psychological therapies may be deemed effective when people suffering from these afflictions learn more adaptive behaviors (Hogarty et al., 1997).

PSYCHOLOGYMATTERS

Where Do Most People Get Help?

The effectiveness of psychotherapy for a variety of problems seems to be established beyond doubt. Having said that, we should again acknowledge that *most people experiencing mental distress do not turn to professional therapists for help*. Rather they turn to "just people" in the community (Wills & DePaulo, 1991). Those suffering from mental problems often look to friends, clergy, hairdressers, bartenders, and others with whom they have a trusting relationship. In fact, for some types of problems—perhaps the most common problems of everyday living—a sympathetic friend may be just as effective as a trained professional therapist (Berman & Norton, 1985; Christensen & Jacobson, 1994).

To put the matter in a different way: Most mental problems are not the crippling disorders that took center stage in the previous chapter. Rather, the psychological difficulties most of us face result from lost jobs, difficult marriages, misbehaving children, friendships gone sour, loved ones dying. . . . In brief, the most familiar problems involve chaos, confusion, choice, frustration, stress, and loss. People who find themselves in the throes of these adjustment difficulties

may not need extensive psychotherapy, medication, or some other special treatment. They need someone to help them sort through the pieces of their problems. Usually this means that they turn to someone like you.

So, what can you do when someone asks you for help? First, you should realize that some problems do indeed require immediate professional attention. These include a suicide threat or an indication of intent to harm others. You should not delay finding competent help for someone with such tendencies. Second, you should remember that most therapy methods require special training, especially those calling for cognitive–behavioral therapy techniques or psychodynamic interpretations. We urge you to learn as much as you can about these methods—but we strongly recommend that you leave them to the professionals. Some other techniques, however, are simply extensions of good human relationships, and they fall well within the layperson's abilities for mental "first aid." Briefly, we will consider three of these:

- *Listening.* You will rarely go wrong if you just listen. Sometimes listening is all the therapy a person in distress needs. It works by encouraging the speaker to organize a problem well enough to communicate it. Consequently, those who talk out their problems frequently arrive at their own solutions. As an **active listener,** you take the role a step farther by giving the speaker feedback: nodding, maintaining an expression that shows interest, paraphrasing, and asking for clarification when you don't understand. As we saw in the client-centered therapy excerpts on pages 580 and 581, active listening lets the speaker know that the listener is interested and *empathetic* (in tune with the other person's feelings). At the same time, you will do well to avoid the temptation of giving advice. Advice robs the recipient of the opportunity to work out his or her own solutions.
- *Acceptance.* Nondirective therapists call this a *nonjudgmental attitude.* It means accepting the person and the problem as they are. It also means suppressing shock, disgust, or condemnation that would create a hostile climate for problem solving.
- *Exploration of alternatives.* People under stress may see only one course of action, so you can help by identifying other potential choices and exploring the consequences of each. (You can point out that *doing nothing* is also a choice.) Remember that, in the end, the choice of action is not up to you but to the individual who owns the problem.

Active listener A person who gives the speaker feedback in such forms as nodding, paraphrasing, maintaining an expression that shows interest, and asking questions for clarification.

Beyond these basic helping techniques lies the territory of the trained therapist. Again, we strongly advise you against trying out the therapy techniques discussed in this chapter for any of the serious psychological disorders discussed in the previous chapter or listed in the *DSM-IV.*

Check Your Understanding

1. **RECALL:** On what form of behavioral learning is the behavioral technique of counterconditioning based?
2. **APPLICATION:** You could use contingency management to change the behavior of a child who comes home late for dinner by
   a. pairing food with punishment.
   b. having the child observe someone else coming home on time and being rewarded.
   c. refusing to let the child have dinner when he comes home late.
   d. having the child relax and imagine being home on time for dinner.
3. **RECALL:** What is the primary goal of psychoanalytic therapy? That is, what makes psychoanalytic therapy different from behavioral therapy or the cognitive therapies?
4. **RECALL:** Carl Rogers invented a technique to help people see their own thinking more clearly. Using this technique, the therapist paraphrases the client's statements. Rogers called this _____.
5. **RECALL:** Which form of therapy directly confronts a client's self-defeating and irrational thought patterns?
6. **RECALL:** Eysenck caused a furor with his claim that people who receive psychotherapy _____.

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7. **UNDERSTANDING THE CORE CONCEPT:** A phobia would be best treated by _____, while a problem of choosing a major would be better suited for _____.
   a. behavioral therapy/insight therapy
   b. cognitive therapy/psychoanalysis
   c. insight therapy/behavioral therapy
   d. humanistic therapy/behavioral therapy

Answers **1.** classical conditioning **2.** c **3.** Psychoanalysis seeks to reveal and resolve problems in the patient's unconscious, particularly repressed traumatic memories, unfulfilled desires, and unconscious conflicts. **4.** reflection of feeling **5.** rational-emotive behavior therapy **6.** improve no more often than people who receive no therapy at all **7.** a

13.3 KEY QUESTION HOW IS THE BIOMEDICAL APPROACH USED TO TREAT PSYCHOLOGICAL DISORDERS?

The mind exists in a delicate biological balance. It can be upset by irregularities in our genes, hormones, enzymes, and metabolism, as well as by damage from accidents and disease. When something goes wrong with the brain, we can see the consequences in abnormal patterns of behavior or peculiar cognitive and emotional reactions. The biomedical therapies, therefore, attempt to treat these mental disorders by intervening directly in the brain. Our Core Concept specifies the targets of these therapies:

> **Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.**

core concept

Each of the biomedical therapies emerges from the medical model of abnormal mental functioning, which assumes an organic basis for mental illnesses and treats them as diseases—as we saw in Chapter 12. We begin our examination of these biomedical therapies with medicine's arsenal of prescription psychoactive drugs.

Drug Therapy

In the history of the treatment of mental disorder, nothing has ever rivaled the revolution created by the discovery of drugs that could calm anxious patients, elevate the mood of depressed patients, and suppress hallucinations in psychotic patients. This brave new therapeutic era began in 1953 with the introduction of the first antipsychotic drugs (often called "tranquilizers"). As these drugs found wide application, many unruly, assaultive patients almost miraculously became cooperative, calm, and sociable. In addition, many thought-disordered patients, who had previously been absorbed in their delusions and hallucinations, began to respond to the physical and social environment around them.

The effectiveness of drug therapy had a pronounced effect on the census of the nation's mental hospitals. In 1955, over half a million Americans were living in mental institutions, each staying an average of several years. Then, with the introduction of tranquilizers, the numbers began a steady decline. In just over 10 years, fewer than half that number actually resided in mental hospitals, and those who did were usually kept for only a few months.

Drug therapy has long since steamrolled out of the mental hospital and into our everyday lives. Currently, millions of people take drugs for anxiety, stress, depression, hyperactivity, insomnia, fears and phobias, obsessions and compulsions, addictions, and numerous other problems. Clearly, a drug-induced revolution has occurred. But what are these miraculous drugs?

You have probably heard of Prozac and Valium, but those are just two of scores of psychoactive drugs that can alter your mood, your perceptions, your desires, and perhaps your basic personality. Here we will consider four major

Drug Therapies
- Antipsychotic drugs
- Antidepressants and mood stabilizers
- Antianxiety drugs
- Stimulants

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categories of drugs used today: *antipsychotics, antidepressants and mood stabilizers, antianxiety drugs,* and *stimulants.*

Antipsychotic Drugs As their name says, the **antipsychotics** treat the symptoms of psychosis: delusions, hallucinations, social withdrawal, and agitation (Dawkins et al., 1999). Most work by reducing the activity of the neurotransmitter dopamine in the brain—although the precise reason why this may has an antipsychotic effect is not known. For example, *chlorpromazine* (sold under the brand name Thorazine) and *haloperidol* (brand name: Haldol) are known to block dopamine receptors in the synapse between nerve cells. A newer antipsychotic drug, *clozapine* (Clozaril), both decreases dopamine activity and increases the activity of another neurotransmitter, serotonin, which also inhibits the dopamine system (Javitt & Coyle, 2004; Sawa & Snyder, 2002). While these drugs reduce overall brain activity, they do not merely "tranquilize" the patient. Rather, they reduce schizophrenia's "positive" symptoms (hallucinations, delusions, emotional disturbances, and agitated behavior), although they do little for the "negative" symptoms of social distance, jumbled thoughts, and poor attention spans seen in many patients (Wickelgren, 1998a). A recent study suggests that, for reducing psychotic symptoms, the newer "second generation" antipsychotic drugs being promoted by the drug companies may be no more effective than the older ones (Lieberman et al., 2005; Rosenheck et al., 2006).

CONNECTION • CHAPTER 12
Positive symptoms of schizophrenia include active hallucinations, delusions, and extreme emotions; negative symptoms include withdrawal and "flat" emotions.

Unfortunately, long-term administration of any antipsychotic drug can have unwanted side effects. Physical changes in the brain have been noted (Gur & Maany, 1998). But most worrisome is **tardive dyskinesia,** which produces an incurable disturbance of motor control, especially of the facial muscles. Although some of the newer drugs, like clozapine, have reduced motor side effects because of their more selective dopamine blocking, they also can cause serious problems, too. Are antipsychotic drugs worth the risk? There is no easy answer. The risks must be weighed against the severity of the patient's current suffering.

Antipsychotics Medicines that diminish psychotic symptoms, usually by effects on the dopamine pathways in the brain.

Tardive dyskinesia An incurable disorder of motor control, especially involving muscles of the face and head, resulting from long-term use of antipsychotic drugs.

Antidepressants Medicines that treat depression, usually by their effects on the serotonin and/or norepinephrine pathways in the brain.

Antidepressants and Mood Stabilizers The drug therapy arsenal also includes several compounds that have revolutionized the treatment of depression and bipolar disorder. As with other psychoactive drugs, neither the *antidepressants* nor *mood stabilizers* can provide a "cure." Their use, however, has made a big difference in the lives of many people suffering from mood disorders.

Antidepressant Drugs All three major classes of **antidepressants** work by "turning up the volume" on messages transmitted over certain brain pathways, especially those using norepinephrine and serotonin (Holmes, 2001). *Tricyclic* compounds such as Tofranil and Elavil reduce the neuron's reabsorption of neurotransmitters after they have been released in the synapse between brain cells—a process called *reuptake.* A second group includes the famous antidepressant Prozac (fluoxetine). These drugs, known as SSRIs (selective serotonin reuptake inhibitors), interfere with the reuptake of serotonin in the synapse. As a result, the SSRIs keep serotonin available in the synapse longer. For many people, this prolonged serotonin effect lifts depressed moods (Hirschfeld, 1999; Kramer, 1993). The third group of antidepressant drugs, the *monoamine oxidase (MAO) inhibitors,* limits the activity of the enzyme MAO, a chemical that breaks down norepinephrine in the synapse. When MAO is inhibited, more norepinephrine is available to carry neural messages across the synapse.

CONNECTION • CHAPTER 2
Reuptake is a process by which neurotransmitters are taken intact from the synapse and cycled back into the terminal buttons of the axon. Reuptake, therefore, "tones down" the message being sent from one neuron to another.

Strangely, most patients report that it takes at least a couple of weeks before antidepressants begin to lift the veil of depression. And recent research seems to suggest why. In animal studies, antidepressants stimulate the growth of neurons in this brain's hippocampus. No one is sure why the hippocampus seems to be involved in depression, but the animal studies offer another tantalizing clue: Stress slows the growth of new neurons in this part of the brain—and depression is believed to be a stress response (Santarelli et al., 2003).

The possibility of suicide poses a special concern in the treatment of depression. And now it seems that the very drugs used for treating depression may provoke or amplify suicidal thoughts, particularly during the first few weeks of therapy and especially in children (Bower, 2004b). One recent study revived hopes by showing that the increased short-term risk is small—less than 1% (Bridge et al., 2007). And another study shows that patients taking antidepressants have a somewhat *lower* risk of suicide over the long haul (Bower, 2007). Obviously, the picture is confusing at the moment and the Food and Drug Administration is advising prescribers to use caution. (Bower, 2006b; Jick et al., 2004).

Controversy over SSRIs In his book *Listening to Prozac,* psychiatrist and Prozac advocate Peter Kramer (1993) encourages the use of the drug to deal not only with depression but with general feelings of social unease and fear of rejection. Such claims have brought heated replies from therapists who fear that drugs may merely mask the psychological problems that people need to face and resolve. Some worry that the wide use of antidepressants may produce changes in the personality structure of a huge segment of our population—changes that could bring unanticipated social consequences (Breggin & Breggin, 1994; Sleek, 1994). In fact, more prescriptions are being written for antidepressants than there are people who have been diagnosed as clinically depressed (Coyne, 2001). The problem seems to be especially acute on college and university campuses, where increasing numbers of students are taking antidepressants (Young, 2003). At present, no one knows what the potential dangers might be of altering the brain chemistry of large numbers of people over long periods.

Just as worrisome for the medical model, another report suggests that antidepressants may owe nearly as much to their hype as to their effects on the brain. According to data mined from the Food and Drug Administration files, studies showing positive results find their way into print far more often than do studies showing no effects for these medicines. While these drugs do better overall than placebos, reports of their effects seem to be exaggerated by selective publication of positive results (Turner et al., 2008).

Mood Stabilizers A simple chemical, *lithium* (in the form of *lithium carbonate*), has proved highly effective as a mood stabilizer in the treatment of bipolar disorder (Paulus, 2007; Schou, 1997). Not just an antidepressant, lithium affects both ends of the emotional spectrum, dampening swings of mood that would otherwise range from uncontrollable periods of hyperexcitement to the lethargy and despair of depression. Unfortunately, lithium also has a serious drawback: In high concentrations, it is toxic. Physicians have learned that safe therapy requires that small doses be given to build up therapeutic concentrations in the blood over a period of a week or two. Then, as a precaution, patients must have periodic blood analyses to ensure that lithium concentrations have not risen to dangerous levels. In a welcome development, scientists have found a promising alternative to lithium for the treatment of bipolar disorder (Azar, 1994; Walden et al., 1998). *Divalproex sodium* (brand name: Depakote), originally developed to treat epilepsy, seems to be even more effective than lithium for most patients but with fewer dangerous side effects (Bowden et al., 2000).

Antianxiety Drugs To reduce stress and suppress anxiety associated with everyday hassles, untold millions of Americans take **antianxiety drugs,** either *barbiturates* or *benzodiazepines*. Barbiturates act as central nervous system depressants, so they have a relaxing effect. But barbiturates can be dangerous if taken in excess or in combination with alcohol. By contrast, the benzodiazepines, such as Valium and Xanax, work by increasing the activity of the neurotransmitter GABA, thereby decreasing activity in brain regions more specifically involved in feelings of anxiety. The benzodiazepines are sometimes called "minor tranquilizers."

Many psychologists believe that these antianxiety drugs—like the antidepressants—are too often prescribed for problems that people should face rather than

Antianxiety drugs A category of medicines that includes the barbiturates and benzodiazepines, drugs that diminish feelings of anxiety.

CONNECTION • CHAPTER 2

GABA is the major inhibitory neurotransmitter in the brain.

mask with chemicals. Nevertheless, antianxiety compounds can be useful in helping people deal with specific situations, such as anxiety prior to surgery. Here are some cautions to bear in mind about these compounds (Hecht, 1986):

- If used over long periods, barbiturates and benzodiazepines can be physically and psychologically addicting (Holmes, 2001; Schatzberg, 1991).
- Because of their powerful effects on the brain, these medicines should not be taken to relieve anxieties that are part of the ordinary stresses of everyday life.
- When used for extreme anxiety, antianxiety drugs should not normally be taken for more than a few days at a time. If used longer than this, their dosage should be gradually reduced by a physician. Abrupt cessation after prolonged use can lead to withdrawal symptoms, such as convulsions, tremors, and abdominal and muscle cramps.
- Because antianxiety drugs depress parts of the central nervous system, they can impair one's ability to drive, operate machinery, or perform other tasks that require alertness (such as studying or taking exams).
- In combination with alcohol (also a central nervous system depressant) or with sleeping pills, antianxiety drugs can lead to unconsciousness and even death.

Finally, we should mention that some antidepressant drugs have also been found useful for reducing the symptoms of certain anxiety disorders such as panic disorders, agoraphobia, and obsessive–compulsive disorder. (A modern psychiatrist might well have prescribed antidepressants for Freud's obsessive patient.) But because these problems may arise from low levels of serotonin, they may respond even better to drugs like Prozac that specifically affect serotonin function.

Stimulants Ranging from caffeine to nicotine to amphetamines to cocaine—any drug that produces excitement or hyperactivity falls into the category of **stimulants.** We have seen that stimulants find some use in the treatment of narcolepsy. They also have an accepted niche in treating *attention-deficit/hyperactivity disorder (ADHD).* While it may seem strange to prescribe stimulants (a common one is Ritalin) for hyperactive children, studies comparing stimulant therapy with behavior therapy and with placebos have shown a clear role for stimulants (American Academy of Pediatrics, 2001). Although the exact mechanism is unknown, stimulants may work in hyperactive children by increasing the availability of dopamine, glutamate, and/or serotonin in their brains (Gainetdinov et al., 1999).

As you can imagine, the use of stimulants to treat ADHD has generated controversy (O'Connor, 2001). Some objections, of course, stem from ignorance of the well-established calming effect these drugs have in children with this condition. Other worries have more substance. For some patients, the drug will interfere with normal sleep patterns. Additionally, there is evidence that stimulant therapy can slow a child's growth (National Institute of Mental Health, 2004). Legitimate concerns also center on the potential for abuse that lurks in the temptation to see every child's behavior problem as a symptom of ADHD (Smith, 2002a). And finally, critics suggest that the prescription of stimulants to children might encourage later drug abuse (Daw, 2001). Happily, recent studies have found cognitive-behavioral therapy (CBT) to be comparable to stimulants as a treatment for ADHD (Sinha, 2005). Even better, say many experts, is a *combination therapy* regimen that employs both CBT and stimulants.

Stimulants Drugs that normally increases activity level by encouraging communication among neurons in the brain. Stimulants, however, have been found to suppress activity level in persons with attention-deficit/hyperactivity disorder.

Evaluating the Drug Therapies The drug therapies have caused a revolution in the treatment of severe mental disorders, starting in the 1950s, when virtually the only treatments available were talk therapies, hospitalization, restraints, "shock treatment," and lobotomies. Of course, none of the drugs discovered so far can "cure" any mental disorder. Yet, in many cases they can alter the brain's chemistry to suppress symptoms.

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But is all the enthusiasm warranted? According to neuroscientist Elliot Valenstein, a close look behind the scenes of drug therapy raises important questions (Rolnick, 1998; Valenstein, 1998). Valenstein believes that much of the faith in drug therapy for mental disorders rests on hype. He credits the wide acceptance of drug therapy to the huge investment drug companies have made in marketing their products. Particularly distressing are concerns raised recently about the willingness of physicians to prescribe drugs for children—even though the safety and effectiveness of many drugs has not been established in young people (K. Brown, 2003a).

Few question that drugs are the proper first line of treatment for certain conditions, such as bipolar disorder and schizophrenia. In many other cases, however, the apparent advantages of drug therapy are quick results and low cost. Yet some research raises doubts about simplistic time-and-money assumptions. Studies show, for example, that treating depression, anxiety disorders, and eating disorders with cognitive–behavioral therapy—alone or in combination with drugs—may be both more effective and economical in the long run than reliance on drugs alone (Clay, 2000).

Psychosurgery The general term for surgical intervention in the brain to treat psychological disorders.

Other Medical Therapies for Psychological Disorders

Describing a modern-day counterpart to Phineas Gage, the headline in the *Los Angeles Times* read, ".22-Caliber Surgery Suicide Bid Cures Psychological Disorder" (February 23, 1988). The article revealed that a 19-year-old man suffering from severe obsessive–compulsive disorder had shot a .22 caliber bullet through the front of his brain in a suicide attempt. Remarkably, he survived, his pathological symptoms were gone, and his intellectual capacity was not affected.

CONNECTION • CHAPTER 2
Phineas Gage survived—with a changed personality—after a steel rod was blasted through his frontal lobe.

We don't recommend this form of therapy, but the case does illustrate the potential effects of physical intervention in the brain. In this vein, we will look briefly at two medical alternatives to drug therapy that were conceived to alter the brain's structure and function, psychosurgery and direct stimulation of the brain.

Psychosurgery With scalpels in place of bullets, surgeons have long aspired to treat mental disorders by severing connections between parts of the brain or by removing small sections of brain. In modern times, **psychosurgery** is usually considered a method of last resort. Nevertheless, psychosurgery has a history dating back at least to medieval times, when surgeons might open the skull to remove "the stone of folly" from an unfortunate madman. (There is, of course, no such "stone"—and there was no anesthetic except alcohol for these procedures.)

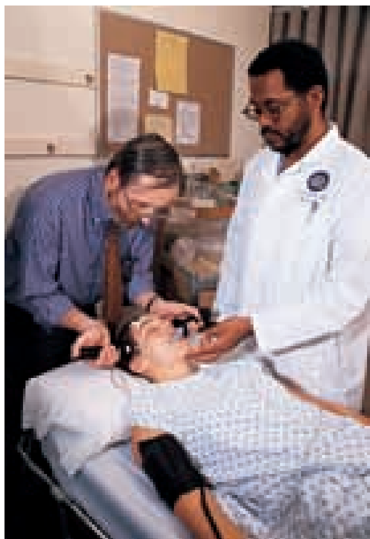
In modern times, the best-known form of psychosurgery involved the now-discredited *prefrontal lobotomy.* This operation, developed by Portuguese psychiatrist Egas Moñiz,[2] severed certain nerve fibers connecting the frontal lobes with deep brain structures, especially those of the thalamus and hypothalamus—much as happened accidentally to Phineas Gage. The original candidates for Moñiz's scalpel were agitated schizophrenic patients and patients who were compulsive and anxiety ridden. Surprisingly, this rather crude operation often produced a dramatic reduction in agitation and anxiety. On the down side, the operation permanently destroyed basic aspects of the

In medieval times, those suffering from madness might be treated by **trephenation**, *or making a hole in the skull. This painting portrays the operation as the removal of the "stone of folly."*

[2]In an ironic footnote to the history of psychosurgery, Moñiz was shot by one of his disgruntled patients, who apparently had not become as pacified as Moñiz had expected. This fact, however, did not prevent Moñiz from receiving the Nobel Prize for Medicine in 1949.

patients' personalities. Frequently, they emerged from the procedure crippled by a loss of interest in their personal well-being and their surroundings. As experience with lobotomy accumulated, doctors saw that it destroyed patients' ability to plan ahead, made them indifferent to the opinions of others, rendered their behavior childlike, and gave them the intellectual and emotional flatness of a person without a coherent sense of self. Not surprisingly, when the antipsychotic drug therapies came on the scene in the 1950s, with a promise to control psychotic symptoms with no obvious risk of permanent brain damage, the era of lobotomy came to a close (Valenstein, 1980).

Psychosurgery is still occasionally done, but it is now much more limited to precise and proven procedures for very specific brain disorders. In the "split-brain" operation, for example, severing the fibers of the corpus callosum can reduce life-threatening seizures in certain cases of epilepsy, with relatively few side effects. Psychosurgery is also done on portions of the brain involved in pain perception in cases of otherwise intractable pain. Today, however, no *DSM-IV* diagnoses are routinely treated with psychosurgery.



A sedated patient about to receive ECT. Electroconvulsive therapy involves a weak electrical current to a patient's temples, causing a convulsion. Some psychiatrists have found ECT successful in alleviating symptoms of severe depression, but it remains a treatment of last resort for most therapists.

Electroconvulsive therapy (ECT) A treatment used primarily for depression and involving the application of an electric current to the head, producing a generalized seizure. Sometimes called "shock treatment."

Transcranial magnetic stimulation (TMS) A treatment that involves magnetic stimulation of specific regions of the brain. Unlike ECT, TMS does not produce a seizure.

CONNECTION • CHAPTER 2

In most people, speech is controlled in the brain's left hemisphere.

Brain-Stimulation Therapies Electrical stimulation of the brain, also known as **electroconvulsive therapy (ECT)**, is still widely used, especially in severely depressed patients who have not responded to drugs or psychotherapy for depression. (You will recall that the therapist said that Derek was not a good candidate for ECT.) The treatment induces a convulsion by applying an electric current (75 to 100 volts) to a patient's temples briefly—from one-tenth to a full second. The convulsion usually runs its course in less than a minute. Patients are prepared for this traumatic intervention by putting them to "sleep" with a short-acting barbiturate, plus a muscle relaxant. This not only renders them unconscious but minimizes any violent physical spasms during the seizure (Abrams, 1992; Malitz & Sackheim, 1984). Within half an hour the patient awakens but has no memory of the seizure or of the events preparatory to treatment.

Does it work? Crude as it may seem to send an electric current through a person's skull and brain, studies have shown ECT to be a useful tool in treating depression, especially those in whom suicidal tendencies demand an intervention that works far more quickly than medication or psychotherapy (Shorter & Healy, 2007). Typically the symptoms of depression often yield in a three- or four-day course of treatment, in contrast with the one- to two-week period required for drug therapy.

Although most clinicians regard ECT, properly done, as safe and effective, some critics fear that it also could be abused to silence dissent or punish patients who are uncooperative (Butcher et al., 2008; Holmes, 2001). Other worries about ECT stem from the fact that its effects are not well understood. To date no definitive theory explains why inducing a mild convulsion should alleviate disordered symptoms, although there are some hints that it may also stimulate neuron growth in parts of the brain, particularly the hippocampus.

Most worrisome, perhaps, are the memory deficits sometimes caused by electroconvulsive therapy (Breggin, 1979, 1991). Proponents claim, however, that patients generally recover full memory functions within months of the treatment (Calev et al., 1991). In the face of such concerns, the National Institute of Mental Health investigated the use of ECT and, in 1985, gave it a cautious endorsement for treating a narrow range of disorders, especially severe depression. Then, in 1990, the American Psychiatric Association also proclaimed ECT to be a valid treatment option. To minimize even short-term side effects, however, ECT is usually administered "unilaterally"—only to the right temple—to reduce the possibility of speech impairment.

Another promising new therapeutic tool for stimulating the brain with magnetic fields may offer all the benefits of ECT without the risk of memory loss. Still in the experimental stages, **transcranial magnetic stimulation (TMS)** involves directing high-powered magnetic stimulation to specific parts of the brain. Stud-

ies indicate that TMS may be useful for treating not only depression but schizophrenia and bipolar disorder (George, 2003). Because most applications of TMS therapy do not require the induction of a seizure, researchers hope also that it offers a safer alternative to ECT.

Most recently, neurologist Helen Mayberg has reported using *deep brain stimulation,* which requires the surgical implantation of a microelectrode through a small hole in the skull and directly into the brain, where it delivers a continual trickle of electric current. Dr. Mayberg likens the treatment to a "pacemaker" for an area of cortex that seems to range out of control in depression (Gutman, 2006). Although the treatment at present is still highly experimental and has been used on only a few patients, Mayberg reports many positive outcomes, with little risk to her patients (Mayberg et al., 2005). She views the treatment not as an alternative to other therapies but as a promising last-resort for severely depressed patients who have not responded to other approaches.

Hospitalization and the Alternatives

We have seen that mental hospitals were originally conceived as places of refuge—"asylums"—where disturbed people could escape the pressures of normal living. In fact, they often worked very well (Maher & Maher, 1985). But by the 20th century these hospitals had become overcrowded and, at best, little more than warehouses for the disturbed with nowhere else to go. Rarely were people of means committed to mental hospitals; instead, they were given private care, including individual psychotherapy (Doyle, 2002a). By contrast, in the large public mental hospitals, a feeble form of "group therapy" was often done with a whole ward—perhaps 50 patients—at a time. But too many patients and too few therapists meant that little, if any, real therapy occurred. The drugs that so profoundly altered treatment in mental hospitals did not appear until the 1950s, so prior to that time institutionalized patients often found themselves controlled by straitjackets, locked rooms, and, sometimes, lobotomies. It's too bad that Maxwell Jones didn't come to the rescue a half-century earlier, with his frontal attack on the mental hospital system.

The Therapeutic Community

In 1953—at about the time antipsychotic drugs were introduced—psychiatrist Maxwell Jones proposed replacing traditional hospital "treatment" for mental disorders with a **therapeutic community** designed to bring meaning to patients' lives. He envisioned the daily hospital routine itself structured as a therapy that would help patients learn to cope with the world outside. With these goals in mind, he abolished the dormitory accommodations that had been typical of mental hospitals and gave patients more private living quarters. He required that they make decisions about meals and daily activities. Then, as they were able to take more responsibilities, patients assumed the tasks of everyday living, including laundry, housekeeping, and maintenance. Further, Jones involved them in helping to plan their own treatment, which included not only group psychotherapy but occupational therapy and recreational therapy (Jones, 1953).

Eventually, variations on the therapeutic community concept were adopted across the United States, Canada, Britain, and Europe—sometimes more on paper than in reality, as we saw in Rosenhan's "pseudopatient" study in Chapter 12. But the changes did not come cheaply. The newer approach obviously required more staff and more costly facilities. The high costs led to a search for still another alternative, which came in the form of community-based treatment—which began to look more and more attractive with the increasing availability of drug therapies.

Therapeutic community Jones's term for a program of treating mental disorder by making the institutional environment supportive and humane for patients.

Deinstitutionalization and Community Mental Health

For mental health professionals of all stripes, the goal of **deinstitutionalization** was to remove patients from mental hospitals and return them to their communities for treatment in a

Deinstitutionalization The policy of removing patients, whenever possible, from mental hospitals.

Deinstitutionalization put mental patients back in the community—but often without adequate resources for continued treatment.

more familiar and supportive environment. The concept of deinstitutionalization also gained popularity with politicians, who saw large sums of money being poured into mental hospitals (filled, incidentally, with nonvoting patients). Thus, by the 1970s, a consensus formed among politicians and the mental health community that the major locus of treatment should shift from mental hospitals back to the community. There both psychological and drug therapies would be dispensed from outpatient clinics, and recovering patients could live with their families, in foster homes, or in group homes. This vision became known as the **community mental health movement.**

Unfortunately, the reality did not match the vision (Doyle, 2002a; Torrey, 1996, 1997). Community mental health clinics—the centerpieces of the community mental health movement—rarely received the full funding they needed. Chronic patients were released from mental hospitals, but they often returned to communities that could offer them few therapeutic resources and to families ill-equipped to cope with them (Smith et al., 1993). Then, as patients returned to the community and needed care, they entered psychiatric wards at local general hospitals—rather than mental hospitals. As a result, hospital care has continued to consume a large share of mental health expenditures in the United States (Kiesler, 1993; U.S. Department of Health and Human Services, 2002).

Some disturbed individuals, who would have been hospitalized in an earlier time, have now all but disappeared from view within their communities. Among them, an estimated 150,000 persons, especially those with chronic schizophrenia, have ended up homeless, with no network of support (Torrey, 1997). Although estimates vary widely, up to 52% of homeless men and 71% of homeless women in the United States probably suffer from psychological disorders, and many of them are former mental hospital patients (Lamb, 1998). Many also have problems with alcohol or other drugs. Under these conditions, they survive by shuttling from agency to agency. With no one to monitor their behavior, they usually stop taking their medication, and so their condition deteriorates until they require a period of rehospitalization.

Despite the dismal picture we have painted, community treatment has not proved altogether unsuccessful. After a review of ten studies in which mental patients were randomly assigned to hospital treatment or to various community-based programs, Kiesler (1982) reported that patients more often improved in the community treatment programs. Further, those given community-based treatment were less likely to be hospitalized at a later date. When community health programs have adequate resources, they can be highly effective (McGuire, 2000).

Unfortunately, some 60 million Americans live in rural areas where they have no easy access to mental health services. But, thanks to the Internet and the telephone, some of them can now get help through remote "telehealth" sessions (Winerman, 2006c). Using the telehealth approach, psychologists and other professionals can quickly establish a link with their rural clients, to answer questions, make referrals, and even provide therapy. Besides the convenience, the cost savings in commuting time for therapists is huge.

Most recently, a daring new community mental health approach is being tried in five communities across the nation. Leader of this effort is psychiatrist William McFarlane, who believes—and has evidence to support his belief—that psychosis can be prevented if the early symptoms are recognized and treated aggressively (Schmidt, 2007). To do so, McFarlane's group identifies at-risk youth through such symptoms as declining schoolwork, confused thoughts, difficulty in speaking clearly, and hearing nonexistent sounds: About one-third of such individuals actually become psychotic. After enrollment in their program (which is optional), the youths receive counseling aimed at helping them cope with stress, and those with the highest risk factors also get a low dose of antipsychotic medication. Critics object to the program because of its high false-positive identification rate (two-thirds of untreated individuals with these symptoms do *not* develop psychosis) and because antipsychotic medications can have

Community mental health movement An effort to deinstitutionalize mental patients and to provide therapy from outpatient clinics. Proponents of community mental health envisioned that recovering patients could live with their families, in foster homes, or in group homes.

serious side effects. Nevertheless, the program is in progress: Stay tuned for the results.

PSYCHOLOGYMATTERS

What Sort of Therapy Would You Recommend?

Now that we have looked at both the psychological and biomedical therapies, consider the following situation. A friend tells you about some personal problems he or she is having and requests your help in finding a therapist. Because you are studying psychology, your friend reasons, you might know what kind of treatment would be best. How do you respond?

First, you can lend a friendly ear, using the techniques of active listening, acceptance, and exploration of alternatives, which we discussed earlier in the chapter. In fact, this may be all that your troubled friend needs. But if your friend wants to see a therapist or if the situation looks in any way like one that requires professional assistance, you can use your knowledge of mental disorders and therapies to help your friend decide what sort of therapist might be most appropriate. To take some of the burden off your shoulders, both of you should understand that any competent therapist will always refer the client elsewhere if the required therapy lies outside the therapist's specialty.

The "telehealth" approach to therapy brings mental health services to clients in rural areas, where help might not otherwise be available.

A Therapy Checklist Here, then, are some questions you will want to consider before you recommend a particular type of therapist:

- *Is medical treatment needed?* While you should not try to make a diagnosis, you should encourage your friend to see a medical specialist, such as a psychiatrist or nurse practitioner if you suspect that the problem involves a major mental disorder, such as psychosis, mania, or bipolar disorder. Medical evaluation is also indicated if you suspect narcolepsy, sleep apnea, epilepsy, Alzheimer's disease, or other problems recognized to have a biological basis. If your suspicion is confirmed, the treatment may include a combination of drug therapy and psychotherapy.
- *Is there a specific behavior problem?* For example, does your friend want to eliminate a fear of spiders or a fear of flying? Is the problem a rebellious child? A sexual problem? Is she or he depressed—but not psychotic? If so, behavior therapy or cognitive–behavioral therapy with a counseling or clinical psychologist is probably the best bet. (Most psychiatrists and other medical practitioners are not usually trained in these procedures.) You can call the prospective therapist's office and ask for information on specific areas of training and specialization.
- *Would group therapy be helpful?* Many people find valuable help and support in a group setting, where they can learn not only from the therapist but also from other group members. Groups can be especially effective in dealing with shyness, lack of assertiveness, and addictions, and with complex problems of interpersonal relationships. (As a bonus, group therapy is often less expensive than individual therapy.) Professionals with training in several disciplines, including psychology, psychiatry, and social work, run therapy groups. Again, your best bet is a therapist who has had special training in this method and about whom you have heard good things from former clients.
- *Is the problem one of stress, confusion, or choice?* Most troubled people don't fall neatly into one of the categories that we have discussed in the previous points. More typically, they need help sorting through the chaos of their lives, finding a pattern, and developing a plan to cope. This is the territory of the insight therapies.

Some Cautions We now know enough about human biology, behavior, and mental processes to know some treatments to avoid. Here are some particularly important examples:

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- *Drug therapies to avoid.* The minor tranquilizers (antianxiety drugs) are too frequently prescribed for patients leading chronically stressful lives. As we have said, because of their addicting and sedating effects, these drugs should only be taken for short periods—if at all. Similarly, some physicians ignore the dangers of sleep-inducing medications for their patients who suffer from insomnia. While these drugs have legitimate uses, many such prescriptions carry the possibility of drug dependence and of interfering with the person's ability to alter the conditions that may have caused the original problem.
- *Advice and interpretations to avoid.* Although psychodynamic therapy can be helpful, patients should also be cautioned that some such therapists may give ill-advised counsel in problems of anger management. Traditionally, Freudians have believed that individuals who are prone to angry or violent outbursts harbor deep-seated aggression that needs to be vented. But, as we have seen, research shows that trying to empty one's aggressions through aggressive behavior, such as shouting or punching a pillow, may actually increase the likelihood of later aggressive behavior.

With these cautions in mind, then, your friend can contact several therapists to see which has the combination of skills and manner that offer the best fit for her problem and her personality.

Check Your Understanding

1. **APPLICATION:** Imagine that you are a psychiatrist. Which type of drug would you prescribe for a patient diagnosed with attention-deficit/hyperactivity disorder (ADHD)?
2. **RECALL:** Which class of drugs blocks dopamine receptors in the brain? Which type magnifies the effects of serotonin?
3. **RECALL:** Name three types of medical therapies for mental disorder, including one that has now been largely abandoned as ineffective and dangerous.
4. **RECALL:** The community mental health movement followed a deliberate plan of _____ for mental patients.
5. **UNDERSTANDING THE CORE CONCEPT:** _____, _____, and _____ all are medical techniques for treating mental disorders by directly altering the function of the brain.

Answers **1.** a stimulant **2.** Antipsychotic drugs block dopamine receptors in the brain. Antidepressants, particularly the selective serotonin reuptake inhibitors (SSRIs), amplify the effects of serotonin. **3.** Electroconvulsive therapy, drug therapy, and prefrontal lobotomy; the latter is no longer done as a treatment for mental disorders. **4.** deinstitutionalization **5.** Any three of the following would be correct: drug therapies, psychosurgery, ECT, and transcranial magnetic stimulation.

13.4 KEY QUESTION HOW DO THE PSYCHOLOGICAL THERAPIES AND BIOMEDICAL THERAPIES COMPARE?

Now that we have looked at both the psychological and medical therapies, can we say which approach is best? In this section, we will see that the answer to that question depends on the disorder. But before we look at the treatment choices for several major conditions, we should acknowledge some other influences that cloud the issue of medical versus psychological treatments.

We have seen that psychologists and psychiatrists have long been at odds over the best forms of treatment for mental disorders. In part, the dispute is over territory and money: Who gets to treat people with mental problems—and bill their insurance? The big pharmaceutical companies, with billions of dollars at stake, play a huge role in this dispute, too. You can glimpse the sort of hardball game Big Pharma plays by noting the advertising for prescription drugs that is directed at the general public. Because of these conflicting interests and pressures, research on medical and psychological therapies has been done largely in parallel, with

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Drug companies now do a hard sell on psychotropic drugs through advertisements like this one aimed at the general public. Here, the not-so-subtle message is that unhappy people can be treated with medication.

each side promoting its own approach and ignoring the other's. Unfortunately, this has meant that comparatively little research has C focused on the effectiveness of **combination therapies,** involving both medication and psychotherapy used in concert.

Combination therapy A therapeutic approach that involves both psychological and medical techniques—most often a drug therapy with a behavioral or cognitive-behavioral therapy.

That said, let's take a look at how we might weigh the options of medical and psychological treatment in some specific disorders with which you are now familiar. Here's the Core Concept:

While a combination of psychological and medical therapies is better than either one alone for treating some (but not all) mental disorders, most people who suffer from unspecified "problems in living" are best served by psychological treatment alone.

core concept

More specifically, what we will find is that a very large numbers of people with psychological problems do not have a *DSM-IV* disorder but need psychological counseling or therapy to help them work through difficult periods in their lives.

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On the other hand, many of the well-known *DSM-IV* disorders, including the mood disorders, most of the anxiety disorders, and schizophrenia, are best treated by a combination of medical and psychological therapies. Let's begin with the latter.

Depression: Psychological versus Medical Treatment

Fluoxetine (Prozac) is the planet's most widely prescribed drug. Together with other SSRI medications, it represents a $10 billion, worldwide industry (Bower, 2006b). But it may be worth every penny, if it is effective in treating depression, thought to be the world's most common disorder. But how effective is it? And how effective is it in comparison with psychological therapies?

CBT versus Drugs Studies show that antidepressant drugs and cognitive–behavioral therapy (CBT)—the psychological treatment for which we have the most evidence of efficacy—are equally effective ways of treating depression, at least in the short run (DeRubeis et al., 1999; Hollon 1996; Hollon et al., 2002). A recent study, however, found that CBT may have the edge over drug therapy over the long term. While 58 percent of patients improved under either treatment regimen, at the end of a two-year follow-up, only one-quarter of those in CBT had a recurrence of their depression, while half of the medication group had experienced a relapse (DeRubeis et al., 2005).

But what happens if depressed patients get antidepressants *and* CBT? The research shows that they generally do even better than with either treatment alone (Keller et al., 2000; Thase et al., 1997). Advances in understanding the brain substrates of depression now suggest why such a combination therapy approach seems to be best. Neuroscientist Helen Mayberg has shown that CBT and the antidepressants work their wonders by targeting different parts of the brain. Antidepressants seem to act through the limbic system—which contains the brain's main emotion pathways. In contrast, CBT affects a part the frontal cortex associated with reasoning. The common factor in both approaches is an "alarm switch" that gets turned off, either by the effect of drugs on the "fast" emotion pathway in the limbic system or by the effect of CBT on the brain's "slow" emotional circuitry in the cortex (Goldapple et al., 2004). Thus, as research from the clinic and the lab come together, many clinicians have come to favor a *combination therapy* approach for depression, using both drugs and CBT. A recent study supports a combined drug-and-medicine approach for bipolar patients, as well (Miklowitz et al., 2007).

ECT And what about electroconvulsive therapy (ECT)? Although clinicians commonly assert that ECT is the most effective treatment for psychotic depression (Hollon et al., 2002), only one study, done in Sweden, has compared ECT head-to-head with antidepressants. The principal finding: Suicide attempts were less common among those patients receiving ECT than among those taking antidepressants (Brådvik & Berglund, 2006). As for transcranial magnetic stimulation, it is too early to tell. As of this writing, no studies have reported a one-on-one comparison of TMS with other therapies for depression.

Anxiety Disorders: Psychological versus Medical Treatment

The evidence points to a similar conclusion in the anxiety disorders—with one important exception. Again, many studies show that, for most anxiety disorders, either cognitive–behavioral therapy or drug therapy can be effective. Among the relatively few studies that have included a comparison of medicine and psychotherapy in combination, two have found that the most effective way of treating panic disorder is a combination of cognitive-behavioral therapy and antidepressants (Barlow et al., 2000; Roy-Byrne et al., 2005). Similarly, psychologist Richard Heimberg, who studies *social phobia,* a condition that affects more than

5 million Americans, reports that CBT and antidepressants relieve the anxieties of about 80 percent of his patients (Dittman, 2005a; Heimberg et al., 1998).

We said that there is an important exception to the rule of combination therapy for anxiety disorders. It is this: Medication is *not* effective for treating the *specific phobias*. In fact, studies suggest that drugs may even interfere with *exposure therapy*, which is the treatment of choice (Antony & Barlow, 2002).

Schizophrenia: Psychological versus Medical Treatment

Ever since the discovery of antipsychotics more than 50 years ago, these drugs have represented the front line of treatment for schizophrenia. Supplemental treatment, in the form of family therapy, social skills training (often in community residental treatment centers), and occupational therapy (through sheltered workshops, such as Goodwill Industries) has brought schizophrenic patients back into contact with their communities. But until recently, conventional psychological therapies were little used. In the last few years, however, advocates of cognitive–behavioral therapy have been trying their hands at treating schizophrenia, with encouraging results, even with patients who have not responded to medication (McGurk et al., 2007; Rector & Beck, 2001).

"The Worried Well": Not Everyone Needs Drugs

While a combination of psychological therapy and drugs may be best for some disorders, we have seen that drugs are *not* useful for treating specific phobias. Likewise, medication has little value as a therapy for most learning disabilities, sexual dysfunctions, most personality disorders, and most developmental disorders (with the exception of ADHD). In addition, we should remember that many people who have psychological problems do not have a diagnosed mental disorder, such as depression, a phobia, or schizophrenia. These are the people that clinicians sometimes call "the worried well." That's not to say that their problems are not real and genuinely troubling. But they do not have one of the "brand name" disorders specifically listed in the *DSM-IV*. Technically, they are classified under the heading of "other conditions that may be a focus of clinical attention," but they suffer from what we might term generic "problems in living"—often problems involving difficult choices (e.g., "Should I stay in this marriage?" or "What career should I pursue?"). Again, these are problems that, by themselves, do not require drugs or other medical intervention. The difficulty is that people with such problems-in-living too often persuade a physician to prescribe antidepressants or antianxiety medications. What they really need is a referral to a mental health professional who could help them sort through their problems and choices.

PSYCHOLOGYMATTERS

Using Psychology to Learn Psychology

Consider the ways in which psychotherapy is like your educational experiences in college:

- Most therapists, like most professors, are professionals with special training in what they do.
- Most patients/clients are like students in that they are seeking professional help to change their lives in some way.
- Much of what happens in therapy and in the classroom involves learning: new ideas, new behaviors, new insights, and new connections.

Learning as Therapy It may help you learn psychology (and other subjects, as well) to think of your college education in therapeutic terms. As we have seen, therapy seems to work best when therapist and client have a good working rela-

tionship and when the client believes in the value of the experience—and the same is almost certainly true for the student–professor relationship. You can take the initiative in establishing a personal-but-professional relationship with your psychology professor by doing the following two things: (a) asking questions or otherwise participating in class (at appropriate times and without dominating, of course) and (b) seeking your instructor's help on points you don't understand or on course-related topics you would like to pursue in more detail (doing so during regular office hours). The result will be learning more about psychology because you will be taking a more active part in the learning process. Incidentally, an active approach to the course will also help you stand out from the crowd in the professor's mind, which could be helpful if you later need a faculty recommendation.

Now consider a parallel between group therapy and education. In group therapy, patients learn from each other, as well as from the therapist. Much the same can occur in your psychology course, if you consider other students as learning resources. As we noted earlier in this book, the most successful students often spend part of their study time sharing information in groups.

Change Behavior, Not Just Thinking One other tip for learning psychology we can borrow from the success of behavior therapies: the importance of changing behavior, as well as thinking. It is easy to "intellectualize" a fact or an idea passively when you read about it or hear about it in class. But you are likely to find that the idea makes little impact on you ("I know I *read* about it, but I can't *remember* it!") if you don't use it. The remedy is to do something with your new knowledge: Tell someone about it, come up with illustrations from your own experience, or try acting in a different way. For example, after reading about active listening in this chapter, try it the next time you talk to a friend. Educators sometimes speak of this as "active learning."

And, we suggest, it's one of those psychological therapies that works best without drugs!

Critical Thinking Applied: Evidence-Based Practice

The field of therapy for mental disorders is awash in controversy. Psychologists and psychiatrists dispute the value of drugs versus psychological therapies. Arguments rage over the advantages and disadvantages of electroconvulsive therapy for treating depression. And, as we saw in the pervious chapter, debates still echo the issues Rosenhan raised over three decades ago about the effectiveness of mental hospitals and the reliability of psychiatric diagnoses. But there is no dispute more acrimonious than the one over *evidence-based practice,* a dispute that is particularly bitter among clinical psychologists (Bower, 2005a).

What Is the Issue?

A decade ago, the American Psychological Association established a special task force charged with evaluating the effectiveness of various psychological therapies (Chambless et al., 1996). The thrust of their findings is that literally dozens of specific disorders can be treated successfully by therapies that have been validated in well-designed experiments (Barlow, 1996). Here are a few examples of therapies pronounced effective by the APA task force:

- Behavior therapy for specific phobias, enuresis (bedwetting), autism, and alcoholism
- Cognitive–behavioral therapy for chronic pain, anorexia, bulimia, agoraphobia, and depression
- Insight therapy for couples relationship problems

More recently, a report by the American Psychological Society focused specifically on evidence-based treatments for depression (Hollon et al., 2002). That document asserts that several varieties of psychotherapy can be effective. These include cognitive, behavioral, and family therapy. (The APS report also acknowledged that there is a legitimate role for both drug and elec-

troconvulsive therapies in the treatment of depression.) As we have seen, some studies now suggest that, for depression, a combination of cognitive–behavioral therapy and drug therapy can have a greater effect than either treatment alone (Keller et al., 2000).

So, what's all the fuss about? At issue is whether counselors and therapists should be *limited* to the use of therapy methods known as **empirically supported treatments (EST)**, that is, to treatments that have been validated by research evidence showing that they actually work (Westen et al., 2005). So how could anyone possibly object to that, you might ask? It may surprise you to learn that psychologists line up on both sides of this issue (Johnson, 2006). Those in opposition say that the devil is in the details: They say that they are not antiscience, but they believe "empirically supported treatments" is a fuzzy concept (Westen & Bradley, 2005). They also worry about an overly strict interpretation that might inhibit a practitioner's freedom to meet the needs of an individual client. Let's take a critical look at these details.

What Critical Thinking Questions Should We Ask?

No one doubts that the people on both sides of the evidence-based practice issue are decent and honorable and that among them are genuine experts on therapy. So we won't question their credibility. But it might be a good idea to ask: What biases does each side have that might make them weigh the options differently?

The Evidence-Based Practice Movement Those pushing the idea of evidence-based practice point to a long history of misguided, and even harmful therapies—from beatings to lobotomies—to which people with mental problems have been subjected. Even in modern times, some practitioners continue to advocate techniques that can potentially harm their clients (Lilienfeld, 2007). These include "scared straight" interventions for juvenile offenders, facilitated communication for autism, recovered-memory therapies, induction of "alter" personalities in cases diagnosed as dissociative identity disorder, DARE (antidrug education) programs in the schools, boot-camp programs for conduct disorder in prisoner populations, sexual reorientation for homosexuality, and catharsis ("get-it-out-of-your-system") treatment for anger disorders. An even longer list (based on a survey of clinical psychologists), ranging from the merely ineffective to the crackpot, would include: angel therapy, past lives therapy, treatments for PTSD caused by alien abduction, aromatherapy, therapeutic touch, Neuro-Linguistic Programming, primal scream therapy, and handwriting analysis (Norcross et al, 2006).

Empirically supported treatment (EST) Treatment regimen that has been demonstrated to be effective through research.

On a more positive note, those who favor evidence-based practice argue that, if psychology is a science, then its practitioners must follow the science wherever it leads, even if that means giving up favored treatments that don't work. But what would that leave in the therapeutic tool kit? As we have seen, abundant evidence supports the use of behavioral therapy for phobias, obsessive–compulsive disorder, certain sexual dysfunctions, autism, and enuresis (bed-wetting). In addition, cognitive–behavioral therapy has been demonstrated to be effective for depression, the anxiety disorders, and the treatment of chronic pain, while the insight therapies have a superlative record for dealing with relationship problems.

Those Favoring Caution While acknowledging that we have made great strides in developing highly effective treatments for a number of disorders, those urging caution point out that we are light-years from having the tools to treat all mental disorders—even with the use of drugs. Consequently, they fear that insurance companies and HMOs will be unwilling to pay for treatments not on the official list or for any deviations from "approved" treatments, no matter what the needs of the individual patient. They also worry that the managed care companies will force therapists into a one-size-fits-all approach that would ignore both the clinician's judgment and the client's individual needs (Shedler, 2006). Because therapy is such a time-consuming process, they also fear that nonmedical therapists will be squeezed out of the picture by drug prescribers who may take only a few minutes with each patient.

Those with reservations about evidence-based practice have several other, more subtle, concerns (Westen & Bradley, 2005). For example, they point out that therapy is more than the application of specific *techniques:* Researchers find that a common element in successful therapy is a caring, hopeful relationship and a new way of looking at oneself and the world (Wampold et al., 2007). This conclusion has been supported by studies that find the effectiveness of therapy to depend less on the *type of therapy* used and more on the *quality of the relationship* (also called the *therapeutic alliance*) between therapist and client (Wampold & Brown, 2005). Therapy also involves a host of *individual client factors,* such as motivation, intelligence, and the nature of the problem itself. We can represent these three aspects of therapy graphically, as in Figure 13.6. For some problems (such as a relationship issue or a vocational choice problem—the "problems in living" that we discussed earlier), no specific ESTs exist. Moreover, the specific type of therapy used in such cases may be less important than a supportive therapeutic relationship (DeAngelis, 2005; Martin et al., 2000).

Finally, the critics of evidence-based practice also point out that most patients/clients present themselves with multiple problems, such as an anxiety disorder *and* a per-

FIGURE 13.6
Three Aspects of Therapy

Therapy is more than a set of techniques. It also involves a number of individual variables (including the nature of the problem) and the relationship between the client and therapist—the *therapeutic alliance.* All must come together for therapy to be successful.

sonality disorder. Yet most ESTs have been validated on an unusually "pure" sample of individuals presenting single problems. Moreover, most research aimed at validating therapeutic techniques is severely restricted to just a few sessions—usually no more than a dozen—after which most patients still have some residual problems. But little evidence exists to validate what sort of therapy is required over the long term to finish the process.

To end this discussion on a more encouraging note: A recent study of 200 practitioners found that they all tended to modify their approach to treatment to fit the needs of their clients, as the situation unfolds during counseling or psychotherapy (Holloway, 2003b). That is, despite our emphasis in this chapter on conflicting opinions about treatment of psychological disorders, most practitioners are quite willing to adapt their methods to the individual client, rather than holding rigidly to a particular theoretical orientation. And that is good news, indeed, coming from a field that has traditionally had strongly divided allegiances. It appears that the emphasis on science-based practice is finally breaking down the old therapeutic boundaries.

What Conclusions Can We Draw?

Both sides make good points. (See Table 13.3.) On the one hand, practitioners should favor empirically validated treatments, when they are clearly appropriate and effective. And they certainly should eschew treatments that are ineffective or harmful. But who is going to make that determination: the individual practitioners, the insurance companies, legislators, or professional organizations? Your authors think that the professional psychology associations, such as the APA, must take stands against putting the therapist into a straightjacket by limiting him or her to a cast-in-stone list of treatments and disorders for which those treatments may be applied.

In fact, the American Psychological Association has a proposed policy under consideration (APA Presidential Task Force, 2006). The policy would define *evidence-based practice in psychology* as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." Who wouldn't agree with that? Many people, it turns out. In particular, the evidence-based practice advocates are concerned that "clinical expertise" could trump "research," with the result that clinicians could ignore the science and do as they please (Stuart & Lilienfeld, 2007). It is a knotty issue that doesn't lend itself to easy answers.

Is there a solution in sight? A partial solution may lie in a proposal made by David Barlow (2004), who suggested that psychologists make a distinction between *psychological treatments* and what he calls "generic psychotherapy." The empirically validated therapies for specific disorders listed in the *DSM-IV* would fall under the heading of *psychological treatments,* while reserving the term *psychotherapy* for work with the nonspecific "problems-in-living" that make up a large proportion of the caseloads of many counselors and clinicians. Barlow's proposal would, at least, shrink the disputed territory.

TABLE 13.3 Summary of the Evidence-Based Practice (EBP) Debate

Arguments Favoring EBP	Arguments opposing EBP
• Some treatments are clearly harmful, and practitioners should not be allowed to use them. • Specific empirically supported therapies (ESTs) have been demonstrated to be effective in dealing with certain disorders. • Psychology is a science, and psychological practitioners should follow what the research shows to be best. • Giving clinical judgment equal weight with science would lead to anarchy, in which clinicians could ignore the evidence and do what they please.	• Empirically supported therapies (ESTs) is a poorly defined, even meaningless, concept. • EBP is a "one-size-fits-all" approach that would limit the flexibility of clinicians to deal with individual client's problems, particularly those who have multiple problems or do not fit a *DSM-IV* category. • Insurance companies would not pay for therapy that was not on an approved list of empirically validated treatments. • EBP would prevent practitioners from trying new ideas and developing even more effective therapies. • Scientists have not yet validated treatments for many disorders, so under an EBP approach many people might have to go without treatment. • Evidence suggests that certain common factors (e.g., the therapeutic alliance) are just as important as the specific type of treatment.

Chapter Summary

13.1 What Is Therapy?

Core Concept 13.1: Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.

People seek **therapy** for a variety of problems, including *DSM-IV* disorders and problems of everyday living. Treatment comes in many forms, both psychological and biomedical, but most involve diagnosing the problem, finding the source of the problem, making a prognosis, and carrying out treatment. In earlier times, treatments for those with mental problems were usually harsh and dehumanizing, often based on the assumption of demonic possession. Only recently have people with emotional problems been treated as individuals with "illnesses," which has led to more humane treatment.

Currently in the United States, there are two main approaches to therapy: the **psychological** and the **biomedical therapies.** Other cultures often have different ways of understanding and treating mental disorders, often making use of the family and community. In the United States there is a trend toward increasing use of **paraprofessionals** as mental health care providers, and the literature generally supports their effectiveness.

Biomedical therapy (p. 575)
Paraprofessional (p. 575)
Psychological therapy (p. 574)
Therapeutic alliance (p. 572)
Therapy (p. 570)

MyPsychLab Resources 13.1:

Watch: Asylum: History of Mental Institutions in America

Explore: Psychotherapy Practitioners and Their Activities

13.2 How Do Psychologists Treat Psychological Disorders?

Core Concept 13.2: Psychologists employ two main forms of treatment, the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).

Psychoanalysis, the first of the *insight therapies,* grew out of Sigmund Freud's theory of personality. Using such techniques as *free association* and dream interpretation, its goal is to bring repressed material out of the unconscious into consciousness, where it can be interpreted and neutralized, particularly in the **analysis of transference. Neo-Freudian psychodynamic therapies** typically emphasize the patient's current social situation, interpersonal relationships, and self-concept.

Among other insight therapies, **humanistic therapy** focuses on individuals becoming more fully self-actualized. In one form, **client-centered therapy,** practitioners strive to be *nondirective* in helping their clients establish a positive self-image.

Another form of insight therapy, **cognitive therapy** concentrates on changing negative or irrational thought patterns about oneself and one's social relationships. The client must learn more constructive thought patterns and learn to apply the new technique to other situations. This has been particularly effective for depression.

Group therapy can take many approaches. **Self-help support groups,** such as AA, serve millions, even though they are not usually run by professional therapists. *Family therapy* and *couples therapy* usually concentrate on situational difficulties and interpersonal dynamics as a total system in need of improvement, rather than on internal motives.

The **behavior therapies** apply the principles of learning—especially operant and classical conditioning—to problem behaviors. Among the classical conditioning techniques, **systematic desensitization** is commonly employed to treat fears. **Aversion therapy** may also be used for eliminating unwanted responses. Operant techniques include **contingency management,** which especially involves positive reinforcement and extinction strategies. And, on a larger scale, behavior therapy may be used to treat or manage groups in the form of a **token economy. Participant modeling,** based on research in observational learning, may make use of both classical and operant principles, involving the use of models and social skills training to help individuals practice and gain confidence about their abilities.

In recent years a synthesis of cognitive and behavioral therapies has emerged, combining the techniques of insight therapy with methods based on behavioral learning theory. **Rational–emotive behavior therapy** helps clients recognize that their irrational beliefs about themselves interfere with life and helps them learn how to change those thought patterns. **Positive psychotherapy (PPT)** is a similar approach coming out of the positive psychology movement. Brain scans suggest that **cognitive–behavioral therapy** produces physical changes in brain functioning.

The effectiveness of therapy was challenged in the 1950s by Eysenck. Since that time, however, research has shown that psychotherapy can be effective for a variety of psychological problems. Often it is more effective than drug therapy. As the research on mental disorders becomes more refined, we are learning to match specific psychotherapies to specific disorders.

Most people do not get psychological help from professionals. Rather, they get help from teachers, friends, clergy, and others in their community who seem sympathetic. Friends can often help through **active listening,** acceptance, and exploration of alternatives, but serious problems require professional assistance.

Active listener (p. 592)
Analysis of transference (p. 578)
Aversion therapy (p. 585)
Behavior modification (p. 583)
Behavior therapy (p. 583)
Client-centered therapy (p. 580)
Cognitive therapy (p. 580)
Cognitive–behavioral therapy (p. 587)
Contingency management (p. 586)
Exposure therapy (p. 585)
Group therapy (p. 582)
Humanistic therapy (p. 579)
Insight therapy (p. 576)
Neo-Freudian psychodynamic therapy (p. 579)
Participant modeling (p. 587)
Positive psychotherapy (PPT) (p. 589)
Psychoanalysis (p. 577)
Rational–emotive behavior therapy (REBT) (p. 587)
Reflection of feeling (p. 580)
Self-help support groups (p. 582)
Systematic desensitization (p. 584)
Token economy (p. 586)

MyPsychLab Resources 13.2:

Watch: Cognitive Behavioral Therapy

Explore: Key Components of Psychoanalytic, Humanistic, Behavior, and Cognitive Therapies

13.3 How Is the Biomedical Approach Used to Treat Psychological Disorders?

Core Concept 13.3: Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.

Biomedical therapies concentrate on changing the physiological aspects of mental illness. Drug therapy includes **antipsychotic, antidepressant,** *mood stabilizing,* **antianxiety drugs,** and **stimulants.** Most affect the function of neurotransmitters, but the precise mode of action is not known for any of them. Nevertheless, such drugs have caused a revolution in the medical treatment of mental disorder, such as schizophrenia, depression, bipolar disorder, anxiety disorders, and ADHD. Critics, however, warn of their abuse, particularly in treating the ordinary stress of daily living.

Psychosurgery is rarely done anymore because of its radical, irreversible side effects. **Electroconvulsive therapy,** however, is still widely used—primarily with depressed patients—although it, too, remains controversial. A new and potential less harmful alternative involves **transcranial magnetic stimulation** of specific brain areas. Meanwhile, hospitalization has been a mainstay of medical treatment, although the trend is away from mental hospitals to community-based treatment. The policy of **deinstitutionalization** was based on the best intentions, but many mental patients have been turned back into their communities with few resources and little treatment. When the resources are available, however, community treatment is often successful.

If someone asks your advice on finding a therapist, you can refer him or her to any competent mental health professional. While you should avoid trying to make a diagnosis or attempting therapy for mental disorders, you may use your knowledge of psychology to steer the person toward a medical specialist, a behavior therapist, group therapy, or some other psychological treatment that you believe might be appropriate. There are, however, some specific therapies and therapeutic techniques to avoid.

Antianxiety drugs (p. 595)
Antidepressants (p. 594)
Antipsychotics (p. 594)
Community mental health movement (p. 600)
Deinstitutionalization (p. 599)
Electroconvulsive therapy (ECT) (p. 598)
Psychosurgery (p. 597)
Stimulants (p. 596)
Tardive dyskinesia (p. 594)
Therapeutic community (p. 599)
Transcranial magnetic stimulation (TMS) (p. 598)

MyPsychLab Resources 13.3:

Explore: Drugs Commonly Used to Treat Psychiatric Disorders

Watch: Alternative Approaches to Treating ADHD

13.4 How Do the Psychological Therapies And Biomedical Therapies Compare?

Core Concept 13.4: While a combination of psychological and medical therapies is better than either one alone for treating some (but not all) mental disorders, most people who suffer from unspecified "problems in living" are best served by psychological treatment alone.

Both medical and biological therapies can point to their successes, but until recently, few studies have compared medical and psychological therapies directly. New studies show that for depression, a **combination therapy,** consisting of CBT and medication, is often best. Comparative data for ECT and the new transcranial magnetic stimulation are sparse. As for the anxiety disorders, some studies have shown a combination of drugs and CBT to be effective. A clear exception involves the specific phobias, for which behavioral therapy is superior to drug therapy—which may actually aggravate the problem. For schizophrenia, medications are the front line of treatment, although they do not cure the disorder. Until recently, conventional psychotherapies were not often used with schizophrenia, but new research suggests that combination therapy may be effective.

Medication is not useful for treating many psychological problems, such as learning disabilities, many sexual dysfunctions, most personality disorders, and most developmental disorders. In addition, most people who have psychological problems do not have a *DSM-IV* disorder but rather suffer from "problems in living."

Education and psychotherapy have many points in common. In particular, both involve learning and the ultimate goal of changes in behavior. The authors suggest that both education and psychotherapy are more likely to be successful when the client takes an active role.

Combination therapy (p. 603)
Empirically supported treatment (EST) (p. 607)

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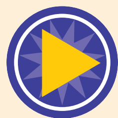
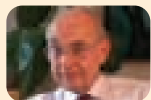
Discovering Psychology Viewing Guide



Watch the following video by logging into MyPsychLab (www.mypsychlab.com). After you have watched the video, complete the activities that follow.



PROGRAM 22: PSYCHOTHERAPY

PROGRAM REVIEW

1. What are the two main approaches to therapies for mental disorders?
   a. the Freudian and the behavioral
   b. the client-centered and the patient-centered
   c. the biomedical and the psychological
   d. the chemical and the psychosomatic
2. The prefrontal lobotomy is a form of psychosurgery. Although no longer widely used, it was at one time used in cases in which a patient
   a. was an agitated schizophrenic.
   b. had committed a violent crime.
   c. showed little emotional response.
   d. had a disease of the thalamus.
3. Leti had electroconvulsive shock therapy a number of years ago. She is now suffering a side effect of that therapy. What is she most likely to be suffering from?
   a. tardive dyskinesia
   b. the loss of her ability to plan ahead
   c. depression
   d. memory loss
4. Vinnie suffers from manic-depressive disorder, but his mood swings are kept under control because he takes the drug
   a. chlorpromazine.
   b. lithium.
   c. Valium.
   d. tetracycline.
5. The Silverman family is receiving genetic counseling because a particular kind of mental retardation runs in their family. What is the purpose of such counseling?
   a. to explain the probability of passing on defective genes
   b. to help eliminate the attitudes of biological biasing
   c. to repair specific chromosomes
   d. to prescribe drugs that will keep problems from developing
6. In psychodynamic theory, what is the source of mental disorders?
   a. biochemical imbalances in the brain
   b. unresolved conflicts in childhood experiences
   c. the learning and reinforcement of nonproductive behaviors
   d. unreasonable attitudes, false beliefs, and unrealistic expectations
7. Imagine you are observing a therapy session in which a patient is lying on a couch, talking. The therapist is listening and asking occasional questions. What is most likely to be the therapist's goal?
   a. to determine which drug the patient should be given
   b. to change the symptoms that cause distress
   c. to explain how to change false ideas
   d. to help the patient develop insight
8. Rinaldo is a patient in psychotherapy. The therapist asks him to free associate. What would Rinaldo do?
   a. describe a dream
   b. release his feelings
   c. talk about anything that comes to mind
   d. understand the origin of his present guilt feelings
9. According to Hans Strupp, in what major way have psychodynamic therapies changed?
   a. Less emphasis is now placed on the ego.
   b. Patients no longer need to develop a relationship with the therapist.
   c. Shorter courses of treatment can be used.
   d. The concept of aggression has become more important.
10. In the program, a therapist helped a girl learn to control her epileptic seizures. What use did the therapist make of the pen?
    a. to record data
    b. to signal the onset of an attack
    c. to reduce the girl's fear
    d. to reinforce the correct reaction
11. When Albert Ellis discusses with the young woman her fear of hurting others, what point is he making?
    a. It is the belief system that creates the "hurt."
    b. Every normal person strives to achieve fulfillment.
    c. Developing a fear-reduction strategy will reduce the problem.
    d. It is the use of self-fulfilling prophecies that cause others to be hurt.

12. What point does Enrico Jones make about investigating the effectiveness of different therapies in treating depression?
    a. All therapies are equally effective.
    b. It is impossible to assess how effective any one therapy is.
    c. The job is complicated by the different types of depression.
    d. The most important variable is individual versus group therapy.
13. What is the most powerful antidepressant available for patients who cannot tolerate drugs?
    a. genetic counseling
    b. electroconvulsive therapy
    c. psychoanalysis
    d. family therapy
14. All of the following appear to be true about the relation between depression and genetics, *except* that
    a. depression has been linked to a defect in chromosome #11.
    b. depression appears to cause genetic mutation.
    c. most people who show the genetic marker for depression do not exhibit depressive symptoms.
    d. genetic counseling allows families to plan and make choices based on their risk of mental illness.
15. For which class of mental illness would Chlorpromazine be prescribed?
    a. mood disorder
    b. psychosis
    c. personality disorder
    d. anxiety disorder
16. Which approach to psychotherapy emphasizes developing the ego?
    a. behavioral
    b. desensitization
    c. humanistic
    d. psychodynamic
17. In behavior modification therapies, the goal is to
    a. understand unconscious motivations.
    b. learn to love oneself unconditionally.
    c. change the symptoms of mental illness through reinforcement.
    d. modify the interpretations that one gives to life's events.
18. Which style of therapy has as its primary goal to make the client feel as fulfilled as possible?
    a. humanistic
    b. cognitive-behavioral
    c. Freudian
    d. social learning
19. Which psychologist introduced rational-emotive therapy?
    a. Carl Rogers
    b. Hans Strupp
    c. Albert Ellis
    d. Rollo May
20. Which type of client would be ideal for modern psychoanalytic therapy?
    a. someone who is smart, wealthy, and highly verbal
    b. someone who is reserved and violent
    c. someone who has a good sense of humor but takes herself seriously
    d. someone who grew up under stressful and economically deprived conditions

QUESTIONS TO CONSIDER

1. Why might it be that behavioral and medical approaches to the same psychological problem can result in similar effects on the brain? Does this imply that in the future, effective behavioral treatments can be developed for cases that had been successful only through medical intervention?
2. How does someone decide on an appropriate therapy?
3. Can everyone benefit from psychotherapy, or do you think it is only for people with serious problems?
4. Why is there a stigma sometimes associated with seeking professional help for psychological problems? What might be some effective ways to change that?
5. If you found that you had a specific phobia, would you be willing to undergo exposure therapy?

ACTIVITIES

1. Identify the services and resources available in your community in case you ever need emotional support in a crisis, want to seek therapy, or know someone who needs this information. How much do these services cost? Look for names of accredited professional therapists and counselors, support groups, hotlines, medical and educational services, and in church and community programs. Is it difficult to find information?
2. Do you have any self-defeating expectations? Do you feel that you might benefit from cognitive therapy? Write out statements of positive self-expectations. Then try to use them in situations in which you feel anxious or insecure. Do they have any effect?
3. Run an Internet search with the goal of finding social support groups for various psychological disorders. In what ways do they serve a therapeutic role? How are they helpful, and how might they potentially be counterproductive?