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Treatment of Psychological Disorders

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What do you picture when you hear the term *psychotherapy?* Unless you've had some personal exposure to therapy, your image of it has likely been shaped by depictions you've seen on television or in the movies. A good example is the 1999 film *Analyze This,* a comedy starring Billy Crystal as psychiatrist Ben Sobol and Robert De Niro as Paul Vitti, a mob boss who is suffering from "panic attacks." Complications ensue when Vitti—a man no one says "no" to—demands that Dr. Sobol cure him of his problem before his rivals in crime turn his "weakness" against him.

With his glasses and beard, Billy Crystal's Dr. Sobol resembles many people's picture of a therapist. Like many movie therapists, Dr. Sobol practices "talk therapy." He listens attentively as his patients talk about what is troubling them. Occasionally he offers comments that reflect their thoughts and feelings back to them or that offer some illuminating insight into their problems. We can get a feeling for his approach from a funny scene in which the uneducated Vitti turns Dr. Sobol's techniques on him:

Vitti: Hey, let's see how you like it. Let's talk about your father.
Dr. Sobol: Let's not.
Vitti: What kind of work does your father do?
Dr. Sobol: It's not important.
Vitti: You paused.

Warner Bros./Shooting Star

The popular film Analyze This *derived much of its humor from common misconceptions about the process of psychotherapy.*

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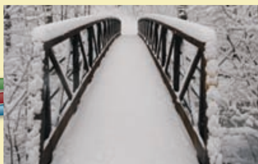
Dr. Sobol: I did not.
Vitti: You just paused. That means you had a feeling, like a thought. . . .
Dr. Sobol: You know, we're running out of time. Let's not waste it talking about my problems.
Vitti: Your father's a problem?
Dr. Sobol: No!
Vitti: That's what you just said.
Dr. Sobol: I did not!
Vitti: Now you're upset.
Dr. Sobol (getting upset): I am not upset!
Vitti: Yes you are.
Dr. Sobol: Will you stop it!
Vitti: You know what, I'm getting good at this.

As in this scene, the film derives much of its humor from popular conceptions—and misconceptions—about therapy. The technique that Vitti makes fun of does resemble one type of therapeutic process. Like Vitti, many people do associate needing therapy with a shameful weakness. Further, therapy is often of considerable benefit in assisting people to make significant changes in their lives—even if those changes are not as dramatic as Vitti's giving up his life of crime at the end of the movie. On the other hand, the film's comic exaggerations also highlight some misconceptions about therapy, including the following:

- Vitti is driven to see a "shrink" because he feels like he's "falling apart." In fact, therapists help people with all kinds of problems. People need not have severe symptoms of mental illness to benefit from therapy.
- Dr. Sobol is a psychiatrist, but most therapists are not. And although Dr. Sobol quotes Freud and the film's plot turns on interpreting a dream (in this case, it's the psychiatrist's dream!), many therapists make little or no use of Freudian techniques.
- Dr. Sobol relies on "talk therapy" to produce insights that will help his patients overcome their troubles. In reality, this approach is only one of the many techniques used by therapists.
- Dr. Sobol "cures" Vitti by getting him to acknowledge a traumatic event in his childhood (the death of his father) that is at the root of his problems. But only rarely does therapy produce a single dramatic insight that results in wholesale change for the client.

In this chapter, we'll take a down-to-earth look at *psychotherapy,* using the term in its broadest sense, to refer to all the diverse approaches used in the treatment of mental disorders and psychological problems. We'll start by discussing some general questions about the provision of treatment. After considering these issues, we'll examine the goals, techniques, and effectiveness of some of the more widely used approaches to therapy and discuss recent trends and issues in treatment. In the Personal Application, we'll look at practical questions related to finding and choosing a therapist and getting the most out of therapy. And in the Critical Thinking Application we'll address problems involved in determining whether therapy actually helps.



Key Learning Goals

15.1 Identify the three major categories of therapy, and discuss patterns of treatment seeking.

15.2 Distinguish the various types of mental health professionals involved in the provision of therapy.

The Elements of the Treatment Process

Sigmund Freud is widely credited with launching modern psychotherapy. Ironically, the landmark case that inspired Freud was actually treated by one of his colleagues, Josef Breuer. Around 1880, Breuer began to treat a young woman referred to as Anna O (which was a pseudonym—her real name was Bertha Pappenheim). Anna exhibited a variety of physical maladies, including headaches, coughing, and a loss of feeling and movement in her right arm. Much to his surprise, Breuer discovered that Anna's physical symptoms cleared up when he encouraged her to talk about emotionally charged experiences from her past.

When Breuer and Freud discussed the case, they speculated that talking things through had enabled Anna to drain off bottled-up emotions that had caused her symptoms. Breuer found the intense emotional exchange in this treatment not to his liking, so he didn't follow through on his discovery. However, Freud applied Breuer's insight to other patients, and his successes led him to develop a systematic treatment procedure, which he called *psychoanalysis.* Anna O called her treatment "the talking cure." However, as you'll see, psychotherapy isn't always curative, and many modern treatments place little emphasis on talking.

Freud's breakthrough ushered in a century of progress for psychotherapy. Psychoanalysis spawned many offspring as Freud's followers developed their own systems of treatment. Since then, approaches

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to treatment have steadily grown more numerous, more diverse, and more effective. Today, people can choose from a bewildering array of therapies.

Treatments: How Many Types Are There?

In their efforts to help people, psychotherapists use many treatment methods. These methods include discussion, advice, emotional support, persuasion, conditioning procedures, relaxation training, role playing, drug therapy, biofeedback, and group therapy. No one knows exactly how many distinct types of psychotherapy there are. One expert (Kazdin, 1994) estimates that there may be over 400 approaches to treatment. Fortunately, we can impose some order on this chaos. As varied as therapists' procedures are, approaches to treatment can be classified into three major categories:

1. *Insight therapies*. Insight therapy is "talk therapy" in the tradition of Freud's psychoanalysis. In insight therapies, clients engage in complex verbal interactions with their therapists. The goal in these discussions is to pursue increased insight regarding the nature of the client's difficulties and to sort through possible solutions. Insight therapy can be conducted with an individual or with a group. Broadly speaking, family therapy and marital therapy fall into this category.

2. *Behavior therapies*. Behavior therapies are based on the principles of learning, which were introduced in Chapter 6. Instead of emphasizing personal insights, behavior therapists make direct efforts to alter problematic responses (phobias, for instance) and maladaptive habits (drug use, for instance). Behavior therapists work on changing clients' overt behaviors. They use different procedures for different kinds of problems.

3. *Biomedical therapies*. Biomedical approaches to therapy involve interventions into a person's biological functioning. The most widely used procedures are drug therapy and electroconvulsive (shock) therapy. As the term bio*medical* suggests, these treatments have traditionally been provided only by physicians with a medical degree (usually psychiatrists). This situation is changing, however, as psychologists have been campaigning for prescription privileges (Norfleet, 2002; Welsh, 2003). To date psychologists have obtained prescription authority in two states (New Mexico and Louisiana), and they have made legislative progress toward this goal in many other states (Long, 2005). Although some psychologists have argued against pursuing the right to prescribe medication (Heiby, 2002; Robiner et al., 2003), the movement is gathering momentum and seems likely to prevail.

Clients: Who Seeks Therapy?

In the therapeutic triad (therapists, treatments, clients), the greatest diversity is seen among the clients. According to the 1999 Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999) about 15% of the U.S. population use mental health services in a given year. These people bring to therapy the full range of human problems: anxiety, depression, unsatisfactory interpersonal relations, troublesome habits, poor self-control, low self-esteem, marital conflicts, self-doubt, a sense of emptiness, and feelings of personal stagnation. The two most common presenting problems are excessive anxiety and depression (Narrow et al., 1993).

Interestingly, people often delay for many years before finally seeking treatment for their psychological problems (Kessler, Olfson, & Berglund, 1998). One recent large-scale study (Wang, Berglund et al., 2005) found that the median delay in seeking treatment was 6 years for bipolar disorder and for drug dependence, 8 years for depression, 9 years for generalized anxiety disorder, and 10 years for panic disorder! **Figure 15.1** summarizes data from the same study on the percentage of people with various disorders who seek treatment within the first year after the onset of the disorder. As you can see, the figures are surprisingly low for most disorders.

A client in treatment does *not* necessarily have an identifiable psychological disorder. Some people seek professional help for everyday problems (career decisions, for instance) or vague feelings of discontent

The case of Anna O, whose real name was Bertha Pappenheim, provided the inspiration for Sigmund Freud's invention of psychoanalysis.

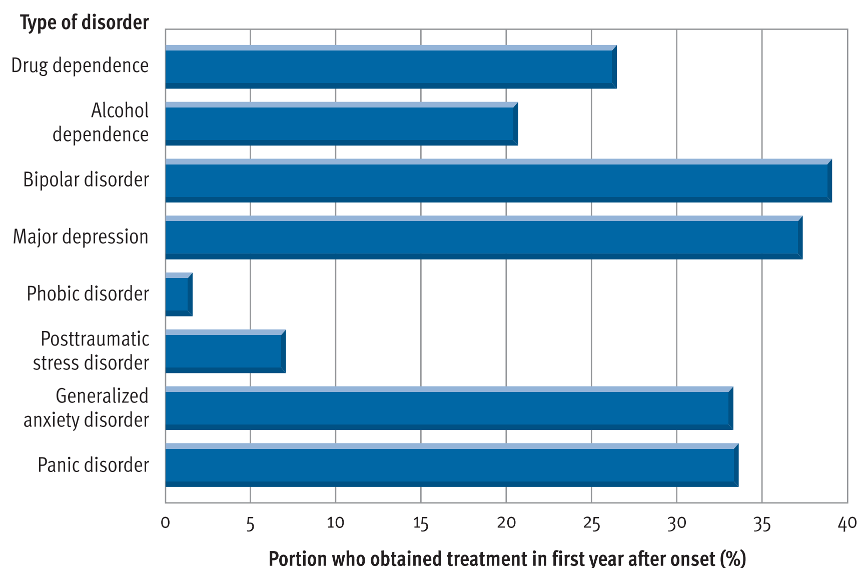

Figure 15.1
Treatment seeking for various disorders. In a study of the extent to which people seek treatment for psychological disorders, Wang et al. (2005) found that only a minority of people promptly pursue treatment for their disorder. The data summarized here show the percentage of people who obtain professional treatment within the first year after the onset of various disorders. The percentages vary depending on the disorder, but all the figures are surprisingly low.

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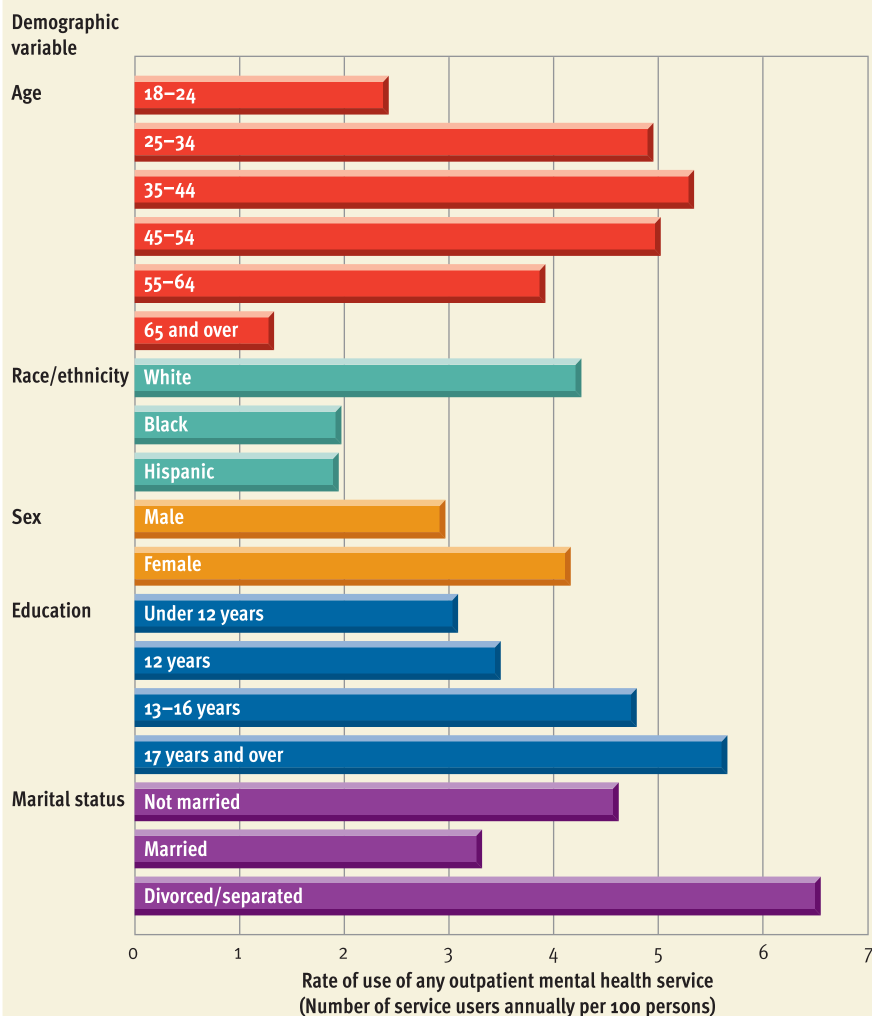
(Strupp, 1996). One surprising finding in recent research has been that only about half of the people who use mental health services in a given year meet the criteria for a full-fledged mental disorder (Kessler et al., 2005b).

People vary considerably in their willingness to seek psychotherapy. One study found that even among people who perceive a need for professional assistance, only 59% actually seek professional help (Mojtabai, Olfson, & Mechanic, 2002). As you can see in Figure 15.2, women are more likely than men to receive therapy. Treatment is also more likely when people have medical insurance and when they have more education (Olfson et al., 2002; Wang, Lane et al., 2005). *Unfortunately, it appears that many people who need therapy don't receive it* (Kessler et al., 2005b). As Figure 15.3 shows, only a portion of the people who need treatment get it. People who could benefit from therapy do not seek it for a variety of reasons. Lack of health insurance and cost concerns appear to be major barriers to obtaining needed care for many people. According to the Surgeon General's report, the biggest roadblock is the "stigma surrounding the receipt of mental health treatment." Unfortunately, many people equate seeking therapy with admitting personal weakness.

Figure 15.2

Therapy utilization rates. Olfson and colleagues (2002) gathered data on the use of nonhospital outpatient mental health services in the United States in relation to various demographic variables. In regard to marital status, utilization rates are particularly high among those who are divorced or separated. The use of therapy is greater among those who have more education; in terms of age, utilization peaks in the 35–44 age bracket. Females are more likely to pursue therapy than males are, but utilization rates are extremely low among ethnic minorities.



Therapists: Who Provides Professional Treatment?

People troubled by personal problems often solicit help from their friends, relatives, and clergy. These sources of assistance may provide excellent advice, but their counsel does not qualify as therapy. Therapy refers to *professional* treatment by someone with special training. However, a common source of confusion about psychotherapy is the variety of "helping professions" available to offer assistance (Murstein & Fontaine, 1993). Psychology and psychiatry are the principal professions involved in the provision of psychotherapy. However, therapy is increasingly provided by clinical social workers, psychiatric nurses, counselors, and marriage and family therapists. Let's look at the various mental health professions.

Psychologists

Two types of psychologists may provide therapy. ***Clinical psychologists* and *counseling psychologists* specialize in the diagnosis and treatment of psychological disorders and everyday behavioral problems.** Clinical psychologists' training emphasizes the treatment of full-fledged disorders. In contrast, counseling psychologists' training is slanted toward the treatment of everyday adjustment problems. In practice, however, quite a bit of overlap occurs between clinical and counseling psychologists in training, skills, and the clientele that they serve.

Both types of psychologists must earn a doctoral degree (Ph.D., Psy.D., or Ed.D.). A doctorate in psychology requires about five to seven years of training beyond a bachelor's degree. The process of gaining admission to a Ph.D. program in clinical psychology is highly competitive (about as difficult as getting into medical school). Psychologists receive most of their training in universities or independent professional schools. They then serve a one-year internship in a clinical setting, such as a hospital, usually followed by one or two years of postdoctoral fellowship training.

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In providing therapy, psychologists use either insight or behavioral approaches. In comparison to psychiatrists, they are more likely to use behavioral techniques and less likely to use psychoanalytic methods. Clinical and counseling psychologists do psychological testing as well as psychotherapy, and many also conduct research.

Psychiatrists

***Psychiatrists* are physicians who specialize in the diagnosis and treatment of psychological disorders.** Many psychiatrists also treat everyday behavioral problems. However, in comparison to psychologists, psychiatrists devote more time to relatively severe disorders (schizophrenia, mood disorders) and less time to everyday marital, family, job, and school problems.

Psychiatrists have an M.D. degree. Their graduate training requires four years of coursework in medical school and a four-year apprenticeship in a residency at a hospital. Their psychotherapy training occurs during their residency, since the required coursework in medical school is essentially the same for everyone, whether they are going into surgery, pediatrics, or psychiatry. In their provision of therapy, psychiatrists increasingly emphasize drug therapies (Olfson et al., 2002). In comparison to psychologists, psychiatrists are more likely to use psychoanalysis and less likely to use group therapies or behavior therapies. That said, contemporary psychiatrists primarily depend on medication as their principal mode of treatment.

Other Mental Health Professionals

Several other mental health professions also provide psychotherapy services, and some of these professions are growing rapidly. In hospitals and other institutions, *clinical social workers* and *psychiatric nurses* often work as part of a treatment team with a psychologist or psychiatrist. Psychiatric nurses, who may have a bachelor's or master's degree in their field, play a large role in hospital inpatient treatment. Clinical social workers generally have a master's degree and typically work with patients and their families to ease the patient's integration back into the community. Although social workers and psychiatric nurses have traditionally worked in institutional settings, they increasingly provide a wide range of therapeutic services as independent practitioners.

Many kinds of *counselors* also provide therapeutic services. Counselors are usually found working in schools, colleges, and assorted human service agencies (youth centers, geriatric centers, family planning centers, and so forth). Counselors typically have a master's degree. They often specialize in particular types of problems, such as vocational counseling, marital counseling, rehabilitation counseling, and drug counseling.

Although there are clear differences among the helping professions in education and training, their roles in the treatment process overlap considerably. In this chapter, we will refer to psychologists or psychiatrists as needed, but otherwise we'll use the terms *clinician, therapist,* and *provider* to refer to mental health professionals of all kinds, regardless of their professional degree.

Now that we have discussed the basic elements in psychotherapy, we can examine specific approaches to treatment in terms of their goals, procedures, and effectiveness. We'll begin with some representative insight therapies.

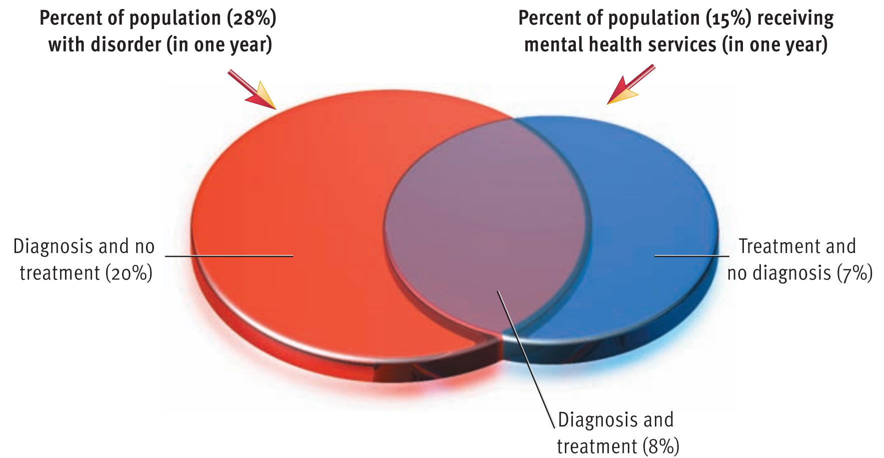

Figure 15.3
Psychological disorders and professional treatment. Not everyone who has a psychological disorder receives professional treatment, and not everyone who seeks treatment has a clear disorder. This graph, from the Surgeon General's report on mental health, shows that 15% of the U.S. adult population receive mental health treatment each year. Almost half of these people (7%) do not receive a psychiatric diagnosis, although some of them probably have milder disorders that are not assessed in epidemiological research. This graph also shows that over two-thirds of the people who *do* have disorders do *not* receive professional treatment. (Data from *Mental Health: A Report of the Surgeon General,* U.S. Public Health Service, 1999)

web link 15.1

Online Dictionary of Mental Health

This thematically arranged "dictionary" at the University of Sheffield (UK) Medical School comprises diverse links related to many forms of psychotherapy, the treatment of psychological disorders, and general issues of mental health.

REVIEW of Key Points

15.1 Approaches to treatment are diverse, but they can be grouped into three categories: insight therapies, behavior therapies, and biomedical therapies. Clients bring a wide variety of problems to therapy and do not necessarily have a disorder. People vary in their willingness to seek treatment. Many people delay seeking treatment, and many who need therapy do not receive it.

15.2 Therapists come from a variety of professional backgrounds. Clinical and counseling psychologists, psychiatrists, clinical social workers, psychiatric nurses, and counselors are the principal providers of therapeutic services. Each of these professions shows different preferences for approaches to treatment. Psychologists typically practice insight or behavior therapy. Psychiatrists rely more heavily on drug therapies.

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Key Learning Goals

15.3 Explain the logic of psychoanalysis and the techniques by which analysts probe the unconscious.

15.4 Clarify the nature of resistance and transference in psychoanalysis.

15.5 Understand the role of therapeutic climate and therapeutic process in client-centered therapy.

15.6 Discuss new approaches to insight therapy inspired by the positive psychology movement.

15.7 Articulate how group therapy is generally conducted, and identify some advantages of this approach.

15.8 Assess the efficacy of insight therapies and the role of common factors in therapy.

Insight Therapies

There are many schools of thought about how to do insight therapy. Therapists with various theoretical orientations use different methods to pursue different kinds of insights. However, what these varied approaches have in common is that ***insight therapies* involve verbal interactions intended to enhance clients' self-knowledge and thus promote healthful changes in personality and behavior.**

Although there may be hundreds of insight therapies, the leading eight or ten approaches appear to account for the lion's share of treatment. In this section, we'll delve into psychoanalysis, related psychodynamic approaches, client-centered therapy, and new approaches fostered by the positive psychology movement. We'll also discuss how insight therapy can be done with groups as well as individuals.

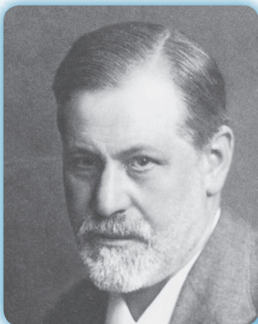
Psychoanalysis

11d

After the case of Anna O, Sigmund Freud worked as a psychotherapist for almost 50 years in Vienna. Through a painstaking process of trial and error, he developed innovative techniques for the treatment of psychological disorders and distress. His system of *psychoanalysis* came to dominate psychiatry for many decades. Although this dominance has eroded in recent years, a diverse collection of psychoanalytic approaches to therapy continue to evolve and to remain influential today (Gabbard, 2005; McWilliams & Weinberger, 2003; Ursano & Silberman, 2003).

***Psychoanalysis* is an insight therapy that emphasizes the recovery of unconscious conflicts, motives, and defenses through techniques such as free association and transference.** To appreciate the logic of psychoanalysis, we have to look at Freud's thinking about the roots of mental disorders. Freud mostly treated anxiety-dominated disturbances, such as phobic, panic, obsessive-compulsive, and conversion disorders, which were then called *neuroses*.

Freud believed that neurotic problems are caused by unconscious conflicts left over from early childhood. As explained in Chapter 12, he thought that these inner conflicts involve battles among the id, ego, and superego, usually over sexual and aggressive impulses. He theorized that people depend on defense mechanisms to avoid confronting these conflicts, which remain hidden in the depths of the unconscious (see Figure 15.4). However, he noted that defensive maneuvers often lead to self-defeating behavior. Furthermore, he asserted that defenses tend to be only partially successful in alleviating anxiety, guilt, and other distressing emotions. With this model in mind, let's take a look at the therapeutic procedures used in psychoanalysis.



National Library of Medicine

Sigmund Freud

"The news that reaches your consciousness is incomplete and often not to be relied on."

Probing the Unconscious

11d

Given Freud's assumptions, we can see that the logic of psychoanalysis is quite simple. The analyst attempts to probe the murky depths of the unconscious to discover the unresolved conflicts causing the client's neurotic behavior. In a sense, the analyst functions as a "psychological detective." In this effort to explore the unconscious, the therapist relies on two techniques: free association and dream analysis.

In *free association* clients spontaneously express their thoughts and feelings exactly as they occur, with as little censorship as possible. In free associating, clients expound on anything that comes to mind, regardless of how trivial, silly, or embarrassing it might be. Gradually, most clients begin to let everything pour out without conscious censorship. The analyst studies these free associations for clues about what is going on in the client's unconscious.

In *dream analysis* the therapist interprets the symbolic meaning of the client's dreams. Freud saw dreams as the "royal road to the unconscious," the most direct means of access to patients' innermost conflicts, wishes, and impulses. Clients are encouraged and trained to remember their dreams, which they describe in therapy. The therapist then analyzes the symbolism in these dreams to interpret their meaning.

To better illustrate these matters, let's look at an actual case treated through psychoanalysis (adapted from Greenson, 1967, pp. 40–41). Mr. N was troubled by an unsatisfactory marriage. He claimed to love his wife, but he preferred sexual relations with prostitutes. Mr. N reported that his parents also endured lifelong marital difficulties. His childhood conflicts about their relationship appeared to be related to his problems. Both dream analysis and free association can be seen in the following description of a session in Mr. N's treatment:

Mr. N reported a fragment of a dream. All that he could remember is that he was waiting for a red traffic light to change when he felt that someone had bumped into

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him from behind. . . . The associations led to Mr. N's love of cars, especially sports cars. He loved the sensation, in particular, of whizzing by those fat, old expensive cars. . . .

His father always hinted that he had been a great athlete, but he never substantiated it. . . . Mr. N doubted whether his father could really perform. His father would flirt with a waitress in a cafe or make sexual remarks about women passing by, but he seemed to be showing off. If he were really sexual, he wouldn't resort to that.

As is characteristic of free association, Mr. N's train of thought meandered about with little direction. Nonetheless, clues about his unconscious conflicts are apparent. What did Mr. N's therapist extract from this session? The therapist saw sexual overtones in the dream fragment, where Mr. N was bumped from behind. The therapist also inferred that Mr. N had a competitive orientation toward his father, based on the free association about whizzing by fat, old expensive cars. As you can see, analysts must *interpret* their clients' dreams and free associations. This is a critical process throughout psychoanalysis.

Interpretation 11d

***Interpretation* refers to the therapist's attempts to explain the inner significance of the client's thoughts, feelings, memories, and behaviors.** Contrary to popular belief, analysts do not interpret everything, and they generally don't try to dazzle clients with startling revelations. Instead, analysts move forward inch by inch, offering interpretations that should be just out of the client's own reach (Samberg & Marcus, 2005). Mr. N's therapist eventually offered the following interpretations to his client:

I said to Mr. N near the end of the hour that I felt he was struggling with his feelings about his father's sexual life. He seemed to be saying that his father was sexually not a very potent man. . . . He also recalls that he once found a packet of condoms under his father's pillow when he was an adolescent and he thought, "My father must be going to prostitutes." I then intervened and pointed out that the condoms under his father's pillow seemed to indicate more obviously that his father used the condoms with his mother, who slept in the same bed. However, Mr. N wanted to believe his wish-fulfilling fantasy: mother doesn't want sex with father and father is not very potent. The patient was silent and the hour ended.

As you may have already guessed, the therapist concluded that Mr. N's difficulties were rooted in an Oedipal complex (see Chapter 12). The man had unresolved sexual feelings toward his mother and hostile feelings about his father. These unconscious conflicts, rooted in Mr. N's childhood, were distorting his intimate relations as an adult.

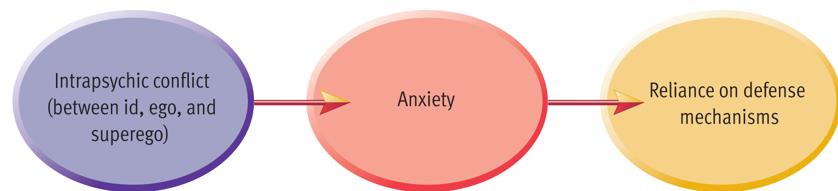

Figure 15.4
Freud's view of the roots of disorders. According to Freud, unconscious conflicts among the id, ego, and superego sometimes lead to anxiety. This discomfort may lead to pathological reliance on defensive behavior.

Resistance 11d

How would you expect Mr. N to respond to the therapist's suggestion that he was in competition with his father for the sexual attention of his mother? Obviously, most clients would have great difficulty accepting such an interpretation. Freud fully expected clients to display some resistance to therapeutic efforts. ***Resistance* refers to largely unconscious defensive maneuvers intended to hinder the progress of therapy.** Resistance is assumed to be an inevitable part of the psychoanalytic process (Samberg & Marcus, 2005). Why would clients try to resist the helping process? Because they don't want to face up to the painful, disturbing conflicts that they have buried in their unconscious. Although they have sought help, they are reluctant to confront their real problems.

Resistance can take many forms. Clients may show up late for their sessions, may merely pretend to engage in free association, or may express hostility toward their therapist. For instance, Mr. N's therapist noted that after the session just described, "The next day he [Mr. N] began by telling me that he was furious with me . . ." Analysts use a variety of strategies to deal with their clients' resistance. Often, a key consideration is the handling of transference, which we consider next.

web link 15.2

The American Psychoanalytic Association

The website for this professional organization provides a great deal of useful information about psychoanalytic approaches to treatment. The resources include news releases, background information on psychoanalysis, an engine for literature searches, and a bookstore.

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In psychoanalysis, the therapist encourages the client to reveal thoughts, feelings, dreams, and memories, which can then be interpreted in relation to the client's current problems.

Transference

Transference **occurs when clients unconsciously start relating to their therapist in ways that mimic critical relationships in their lives.** Thus, a client might start relating to a therapist as if the therapist were an overprotective mother, a rejecting brother, or a passive spouse. In a sense, the client *transfers* conflicting feelings about important people onto the therapist. For instance, in his treatment, Mr. N transferred some of the competitive hostility he felt toward his father onto his analyst.

Psychoanalysts often encourage transference so that clients can reenact relations with crucial people in the context of therapy. These reenactments can help bring repressed feelings and conflicts to the surface, allowing the client to work through them. The therapist's handling of transference is complicated and difficult, because transference may arouse confusing, highly charged emotions in the client.

Undergoing psychoanalysis is not easy. It can be a slow, painful process of self-examination that routinely requires three to five years of hard work. It tends to be a lengthy process because patients need time to gradually work through their problems and genuinely accept unnerving revelations (Williams, 2005). Ultimately, if resistance and transference can be handled effectively, the therapist's interpretations should lead the client to profound insights. For instance, Mr. N eventually admitted, "The old boy is probably right, it does tickle me to imagine that my mother preferred me and I could beat out my father. Later, I wondered whether this had something to do with my own screwed-up sex life with my wife." According to Freud, once clients recognize the unconscious sources of conflicts, they can resolve these conflicts and discard their neurotic defenses.

Modern Psychodynamic Therapies

Though still available, classical psychoanalysis as done by Freud is not widely practiced anymore (Kay & Kay, 2003). Freud's psychoanalytic method was geared to a particular kind of clientele that he was seeing in Vienna many years ago. As his followers fanned out across Europe and America, many found it necessary to adapt psychoanalysis to different cultures, changing times, and new kinds of patients (Karasu, 2005). Thus, many variations on Freud's original approach to psychoanalysis have developed over the years. These descendants of psychoanalysis, which continue to emphasize exploration of the unconscious, are collectively known as *psychodynamic approaches* to therapy.

Some of these adaptations, such as those made by Carl Jung (1917) and Alfred Adler (1927), were sweeping revisions based on fundamental differences in theory. Other variations, such as those devised by Melanie Klein (1948) and Heinz Kohut (1971), made substantial changes in theory while retaining certain central ideas. Still other revisions (Alexander, 1954; Stekel, 1950) simply involved efforts to modernize and streamline psychoanalytic techniques.

As a result, today we have a rich diversity of psychodynamic approaches to therapy (Magnavita, 2008). Recent reviews of these treatments suggest that interpretation, resistance, and transference continue to play key roles in therapeutic effects (Luborsky & Barrett, 2006). For example, evidence suggests that the amount of resistance manifested in psychodynamic therapy predicts the outcome of therapy. People who exhibit more resistance are less likely to experience a positive outcome and more likely to drop out of therapy (Luborsky & Barrett, 2006). Recent research also suggests that psychodynamic approaches can be helpful in the treatment of a diverse array of disorders, including panic disorder, borderline personality disorder, and substance abuse (Gibbons, Crits-Christoph, & Hearon, 2008).

web link 15.3

Psychoanalytic Electronic Publishing

This site houses a remarkable archive of psychoanalytic literature, including full-text versions of 26 academic journals concerned with psychoanalysis, 56 classic books on psychoanalysis, and *The Complete Psychological Works of Sigmund Freud*. A search engine allows users to track down information on specific topics.

Client-Centered Therapy

You may have heard of people going into therapy to "find themselves" or to "get in touch with their real feelings." These now-popular phrases emerged out of the human potential movement, which was stimulated in part by the work of Carl Rogers (1951, 1986). Using a humanistic perspective, Rogers devised *client-centered therapy* (also known as *person-centered therapy*) in the 1940s and 1950s.

Client-centered therapy **is an insight therapy that emphasizes providing a supportive emotional climate for clients, who play a major role in determining the pace and direction of their therapy.** You may wonder why the troubled, untrained client is put in charge of the pace and direction of the therapy. Rogers (1961) provides a compelling justification:

> *It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely upon the client for the direction of movement in the process. (pp. 11–12)*

Rogers's theory about the principal causes of neurotic anxieties is quite different from the Freudian explanation. As discussed in Chapter 12, Rogers maintains that most personal distress is due to inconsistency, or "incongruence," between a person's self-concept and reality (see **Figure 15.5**). According-

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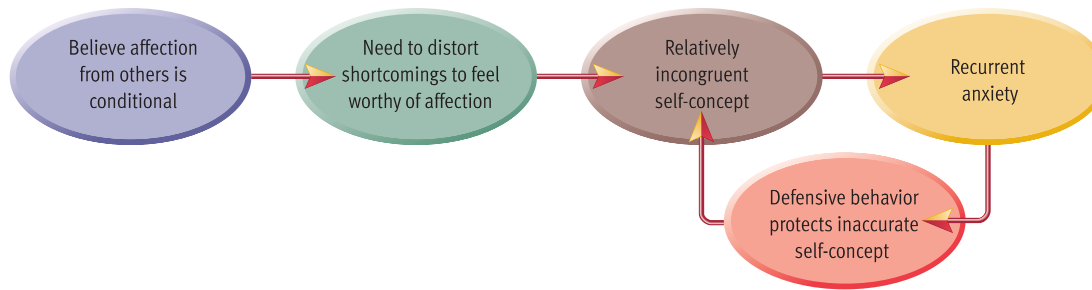


Figure 15.5
Rogers's view of the roots of disorders. Rogers's theory posits that anxiety and self-defeating behavior are rooted in an incongruent self-concept that makes one prone to recurrent anxiety, which triggers defensive behavior, which fuels more incongruence.

ing to his theory, incongruence makes people feel threatened by realistic feedback about themselves from others. For example, if you inaccurately viewed yourself as a hard-working, dependable person, you would feel threatened by contradictory feedback from friends or co-workers. According to Rogers, anxiety about such feedback often leads to reliance on defense mechanisms, to distortions of reality, and to stifled personal growth. Excessive incongruence is thought to be rooted in clients' overdependence on others for approval and acceptance.

Given Rogers's theory, client-centered therapists stalk insights that are quite different from the repressed conflicts that psychoanalysts go after. Client-centered therapists help clients to realize that they do not have to worry constantly about pleasing others and winning acceptance. They encourage clients to respect their own feelings and values. They help people restructure their self-concept to correspond better to reality. Ultimately, they try to foster self-acceptance and personal growth.

Therapeutic Climate 11d

According to Rogers, the *process* of therapy is not as important as the emotional *climate* in which the therapy takes place. He believes that it is critical for the therapist to provide a warm, supportive, accepting climate, which creates a safe environment in which clients can confront their shortcomings without feeling threatened. The lack of threat should reduce clients' defensive tendencies and thus help them open up. To create this atmosphere of emotional support, client-centered therapists must provide three conditions:

1. *Genuineness.* The therapist must be genuine with the client, communicating honestly and spontaneously. The therapist should not be phony or defensive.

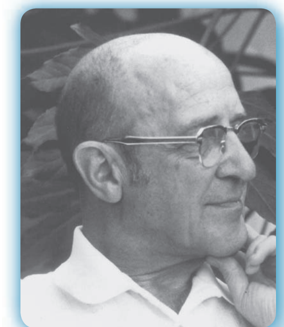
2. *Unconditional positive regard.* The therapist must also show complete, nonjudgmental acceptance of the client as a person. The therapist should provide warmth and caring for the client, with no strings attached. This does not mean that the therapist must approve of everything that the client says or does. A therapist can disapprove of a particular behavior while continuing to value the client as a human being.

3. *Empathy.* Finally, the therapist must provide accurate empathy for the client. This means that the therapist must understand the client's world from the client's point of view. Furthermore, the therapist must be articulate enough to communicate this understanding to the client.

Rogers firmly believed that a supportive emotional climate is the critical force promoting healthy changes in therapy. More recently, however, some client-centered therapists have begun to place more emphasis on the therapeutic process (Rice & Greenberg, 1992).

Therapeutic Process 11d

In client-centered therapy, the client and therapist work together as equals. The therapist provides relatively little guidance and keeps interpretation and advice to a minimum. So, just what does the client-centered therapist do, besides creating a supportive climate? Primarily, the therapist provides feedback to help clients sort out their feelings. The therapist's key task is *clarification.* Client-centered therapists try



Courtesy of Carl Rogers Memorial Library

Carl Rogers
"To my mind, empathy is in itself a healing agent."

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Client-centered therapists emphasize the importance of a supportive emotional climate in therapy. They also work to clarify, rather than interpret, the feelings expressed by their patients.

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to function like a human mirror, reflecting statements back to their clients, but with enhanced clarity. They help clients become more aware of their true feelings by highlighting themes that may be obscure in the clients' rambling discourse.

By working with clients to clarify their feelings, client-centered therapists hope to gradually build toward more far-reaching insights. In particular, they try to help clients better understand their interpersonal relationships and become more comfortable with their genuine selves. Obviously, these are ambitious goals. Client-centered therapy resembles psychoanalysis in that both seek to achieve a major reconstruction of a client's personality.

Therapies Inspired by Positive Psychology

The growth of the positive psychology movement has begun to inspire new approaches to insight therapy (Duckworth, Steen, & Seligman, 2005). As noted in Chapters 1 and 10, ***positive psychology* uses theory and research to better understand the positive, adaptive, creative, and fulfilling aspects of human existence.** The advocates of positive psychology maintain that the field has historically focused far too heavily on pathology, weakness, and suffering (and how to heal these conditions) rather than health and resilience (Seligman, 2003; Seligman & Csikszentmihalyi, 2000). They argue for increased research on contentment, well-being, human strengths, and positive emotions.

This philosophical approach has led to new therapeutic interventions. For example, *well-being therapy,* developed by Giovanni Fava and his colleagues (Fava, 1999; Ruini & Fava, 2004), seeks to enhance clients' self-acceptance, purpose in life, autonomy, and personal growth. It has been used successfully in the treatment of mood disorders and anxiety disorders (Fava et al., 2005).

Another new approach is *positive psychotherapy,* developed by Martin Seligman and colleagues (Seligman, Rashid, & Parks, 2006). Thus far, positive psychotherapy has been used mainly in the treatment of depression. This approach attempts to get clients to recognize their strengths, appreciate their blessings, savor positive experiences, forgive those who have wronged them, and find meaning in their lives. Preliminary research suggests that positive psychotherapy can be an effective treatment for depression. For example, in one study it was compared to treatment as usual (whatever the therapist would normally do) and treatment as usual with medication. The data shown in Figure 15.6 compare mean depression scores at the end of the study for participants in these three conditions (Seligman et al., 2006). As you can see, the lowest depression scores were observed in the group that received positive psychotherapy. These innovative interventions spurred by the positive psychology movement are in their infancy, but the early findings seem promising, and it will be interesting to see what the future holds.

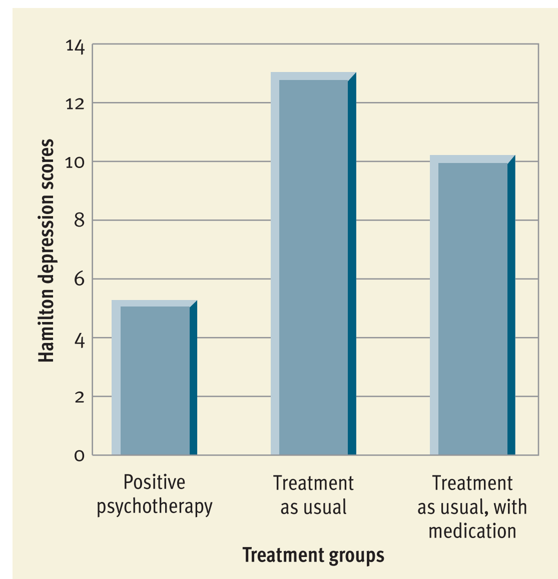

Figure 15.6
Positive psychotherapy for depression. In a study of the efficacy of positive psychotherapy, it was compared to treatment as usual (clinicians delivered whatever treatment they deemed appropriate) and to treatment as usual combined with antidepressant medication. At the end of 12 weeks of treatment, symptoms of depression were measured with the widely-used Hamilton Rating Scale for Depression. The mean depression scores for each group are graphed here. As you can see, the positive psychotherapy group showed less depression than the other two treatment groups, suggesting that positive psychotherapy can be an effective intervention for depression.

SOURCE: Adapted from Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61,* 774–788. (Figure 2, p. 784).

Group Therapy

Although it dates back to the early part of the 20th century, group therapy came of age during World War II and its aftermath in the 1950s (Rosenbaum, Lakin, & Roback, 1992). During this period, the expanding demand for therapeutic services forced clinicians to use group techniques (Scheidlinger, 1993). ***Group therapy* is the simultaneous psychological treatment of several clients in a group.** Most major insight therapies have been adapted for use with groups. Because of economic pressures in mental health care, the use of group therapy appears likely to grow in future years (Burlingame & McClendon,

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2008). Although group therapy can be conducted in a variety of ways, we will provide a general overview of the process as it usually unfolds with outpatient populations (see Alonso, Alonso, & Piper, 2003; Vinogradov, Cox, & Yalom, 2003; Wong, 2005).

Participants' Roles

A therapy group typically consists of 4–12 people, with 6–8 participants regarded as an ideal number (Vinogradov et al., 2003). The therapist usually screens the participants, excluding persons who seem likely to be disruptive. Some theorists maintain that judicious selection of participants is crucial to effective group treatment (Salvendy, 1993). There is some debate about whether it is better for the group to be homogeneous—made up of people who are similar in age, sex, and psychological problem. Practical necessities usually dictate that groups are at least somewhat diversified.

In group therapy, participants essentially function as therapists for one another (Stone, 2003). Group members describe their problems, trade viewpoints, share experiences, and discuss coping strategies. Most important, they provide acceptance and emotional support for each other. In this supportive atmosphere, group members work at peeling away the social masks that cover their insecurities. Once their problems are exposed, members work at correcting them. As members come to value one another's opinions, they work hard to display healthy changes to win the group's approval.

In group treatment, the therapist's responsibilities include selecting participants, setting goals for the group, initiating and maintaining the therapeutic process, and protecting clients from harm (Vinogradov et al., 2003). The therapist often plays a relatively subtle role in group therapy, staying in the background and focusing mainly on promoting group cohesiveness (although this strategy will vary depending on the nature of the group). The therapist models supportive behaviors for the participants and tries to promote a healthy climate. He or she always retains a special status, but the therapist and clients are usually on much more equal footing in group therapy than in individual therapy. The leader in group therapy expresses emotions, shares feelings, and copes with challenges from group members (Burlingame & McClendon, 2008).

Advantages of the Group Experience

Group therapies obviously save time and money, which can be critical in understaffed mental hospitals and other institutional settings (Vinogradov et al., 2003). Therapists in private practice usually charge less for group than individual therapy, making therapy affordable for more people. However, group therapy is *not* just a less costly substitute for individual therapy. For many types of patients and problems, group therapy can be just as effective as individual treatment (Knauss, 2005; Stone, 2003). Moreover, group therapy has unique strengths of its own. For example, in group therapy participants often come to realize that their misery is not unique. They are reassured to learn that many other people have similar or even worse problems. Another advantage is that group therapy provides an opportunity for participants to work on their social skills in a safe environment. Yet another plus is that certain types of problems and clients respond especially well to the social support that group therapy can provide.

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Group treatments have proven particularly helpful when members share similar problems, such as alcoholism, overeating, or having been sexually abused as a child. Many approaches to insight therapy that were originally designed for individuals—such as client-centered therapy—have been adapted for treatment of groups.

concept check 15.1

Understanding Therapists' Conceptions of Disorders

Check your understanding of the three approaches to insight therapy covered in the text by matching each approach with the appropriate explanation of the typical origins of clients' psychological disorders. The answers are in Appendix A.

Theorized causes of disorders

_______ **1.** Problems rooted in inadequate attention paid to one's strengths, blessings, and positive experiences

_______ **2.** Problems rooted in unconscious conflicts left over from childhood

_______ **3.** Problems rooted in inaccurate self-concept and excessive concern about pleasing others

Therapy

a. Psychoanalysis

b. Client-centered therapy

c. Positive psychotherapy

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Whether insight therapies are conducted on a group or an individual basis, clients usually invest considerable time, effort, and money. Are these therapies worth the investment? Let's examine the evidence on their effectiveness.

How Effective Are Insight Therapies?

Evaluating the effectiveness of any approach to treatment is a complex challenge (Hill & Lambert, 2004; Kendall, Holmbeck, & Verduin, 2004). For one thing, psychological disorders (like many physical illnesses) sometimes run their course and clear up on their own. **A *spontaneous remission* is a recovery from a disorder that occurs without formal treatment.** Thus, if a client experiences a recovery after treatment, one cannot automatically assume that the recovery was due to the treatment (see the Critical Thinking Application).

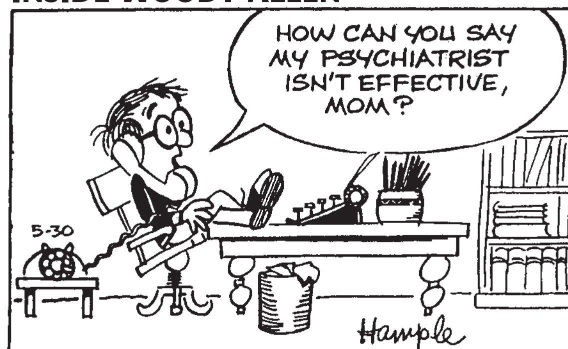
Evaluating the effectiveness of treatment is especially complicated for insight therapies (Aveline, Strauss, & Stiles, 2005). If you were to undergo insight therapy, how would you judge its efficacy? By how you felt? By looking at your behavior? By asking your therapist? By consulting your friends and family? What would you be looking for? Various schools of thought pursue entirely different goals. And clients' ratings of their progress are likely to be slanted toward a favorable evaluation because they want to justify their effort, their heartache, their expense, and their time. Even evaluations by professional therapists can be highly subjective (Luborsky et al., 1999). Moreover, people enter therapy with diverse problems of varied severity, creating huge confounds in efforts to assess the effectiveness of therapeutic interventions.

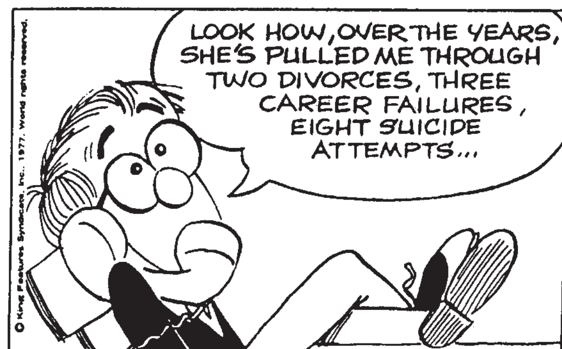
Despite these difficulties, thousands of outcome studies have been conducted to evaluate the effectiveness of insight therapy. These studies have examined a broad range of clinical problems and used diverse methods to assess therapeutic outcomes, including scores on psychological tests and ratings by family members, as well as therapists' and clients' ratings. These studies consistently indicate that insight therapy *is* superior to no treatment or to placebo treatment and that the effects of therapy are reasonably durable (Kopta et al., 1999; Lambert & Archer, 2006). And when insight therapies are compared head-to-head against drug therapies, they usually show roughly equal efficacy (Arkowitz & Lilienfeld, 2007; Pinquart, Duberstein, & Lyness, 2006). Studies generally find the greatest improvement early in treatment (the first 13–18 weekly sessions), with further gains gradually diminishing over time (Lambert, Bergin, & Garfield, 2004). Overall, about 50% of patients show a clinically meaningful recovery within about 20 sessions, and another 25% of patients achieve this goal after about 45 sessions (Lambert & Ogles, 2004; see Figure 15.7). Of course, these broad generalizations mask considerable variability in outcome, but the general trends are encouraging.

How Do Insight Therapies Work?

Although there is considerable evidence that insight therapy tends to produce positive effects for a sizable majority of clients, vigorous debate continues about the *mechanisms of action* underlying these positive effects (Kazdin, 2007). The advocates of various therapies tend to attribute the benefits of therapy to the particular methods and procedures used by each specific approach (Chambless & Hollon, 1998). In essence, they argue that different therapies achieve similar benefits through different processes. An alternative view espoused by many theorists is that the diverse approaches to therapy share certain *common factors* and that these common factors account for much of the improvement experienced by clients (Frank & Frank, 1991). Evidence supporting the common factors view has mounted in recent years (Ahn & Wampold, 2001; Sparks, Duncan, & Miller, 2008).

What are the common denominators that lie at the core of diverse approaches to therapy? The models proposed to answer to this question vary consid-





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erably, but the most widely cited common factors include (1) the development of a therapeutic alliance with a professional helper, (2) the provision of emotional support and empathic understanding by the therapist, (3) the cultivation of hope and positive expectations in the client, (4) the provision of a rationale for the client's problems and a plausible method for reducing them, and (5) the opportunity to express feelings, confront problems, gain new insights, and learn new patterns of behavior (Grencavage & Norcross, 1990; Weinberger, 1995). How important are these factors in therapy? Some theorists argue that common factors account for virtually *all* of the progress that clients make in therapy (Wampold, 2001). It seems more likely that the benefits of therapy represent the combined effects of common factors and specific procedures (Beutler & Harwood, 2002). Either way, it is clear that common factors play a significant role in insight therapy.

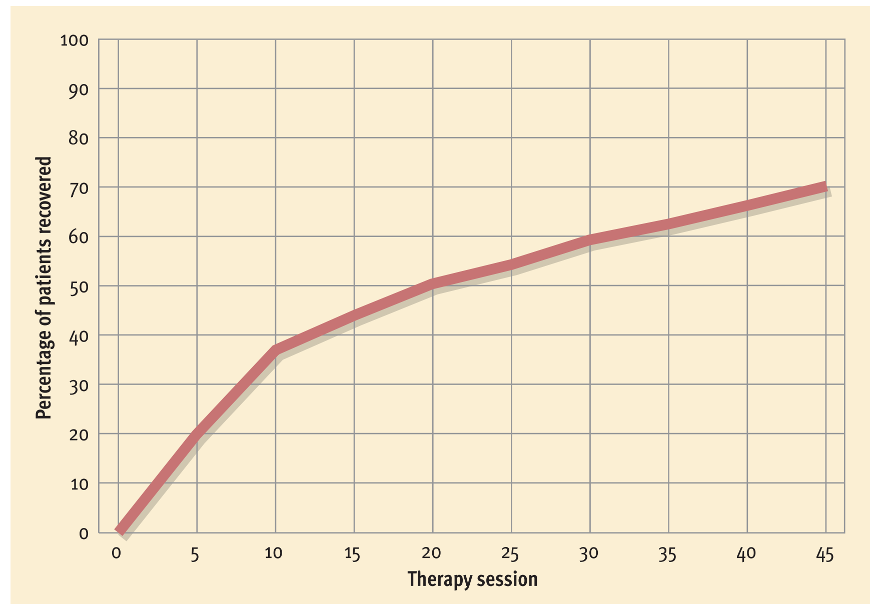


Figure 15.7
Recovery as a function of number of therapy sessions. Based on a national sample of over 6000 patients, Lambert, Hansen, and Finch (2001) mapped out the relationship between recovery and the duration of treatment. These data show that about half of the patients had experienced a clinically significant recovery after 20 weekly sessions of therapy. After 45 sessions of therapy, about 70% had recovered.

SOURCE: Adapted from Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69,* 159–172. Copyright © 2001 by the American Psychological Association. Used by permission of the authors.

REVIEW of Key Points

15.3 Freudian approaches to therapy assume that neuroses originate from unresolved conflicts lurking in the unconscious. Therefore, in psychoanalysis free association (discussing whatever comes to mind with no censorship) and dream analysis are used to explore the unconscious.

15.4 When an analyst's probing hits sensitive areas, resistance, which involves unconscious defensive maneuvers to hinder progress, can be expected. The transference relationship may be used to overcome this resistance so that the client can handle interpretations that lead to insight.

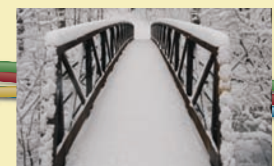
15.5 Rogers's client-centered therapy assumes that neurotic anxieties are derived from incongruence between a person's self-concept and reality. Accordingly, the client-centered therapist emphasizes trying to provide a supportive climate marked by genuineness, unconditional positive regard, and empathy. The process of client-centered therapy depends on clarification of the client's feelings to promote self-acceptance.

15.6 The growth of the positive psychology movement has begun to inspire new approaches to insight therapy, such as well-being therapy. Positive psychotherapy attempts to get clients to recognize their strengths, appreciate their blessings, savor positive experiences, and find meaning in their lives.

15.7 Participants in group therapy essentially act as therapists for one another, exchanging insights and emotional support. The therapist sets goals for the group and works to maintain a supportive climate. Group therapy is less expensive and has some advantages in comparison to individual therapy. People see that their problems are not unique, and they can work on social skills in a safe environment.

15.8 Evaluating the effectiveness of any approach to therapy is complex and difficult. Nonetheless, the weight of modern evidence suggests that insight therapies are superior to no treatment or to placebo treatment. Studies generally find the greatest improvement early in treatment. Much of the improvement seen in clients in therapy may be attributable to the operation of common factors, such as the development of a therapeutic alliance, the provision of emotional support, and the cultivation of hope.

Behavior Therapies



Key Learning Goals

15.9 Describe the goals and procedures of systematic desensitization.

15.10 Outline the goals and techniques of aversion therapy and social skills training.

15.11 Articulate the logic, goals, and techniques of cognitive therapy.

15.12 Evaluate the efficacy of behavior therapies.

Behavior therapy is different from insight therapy in that behavior therapists make no attempt to help clients achieve grand insights about themselves. Why not? Because behavior therapists believe that such insights aren't necessary to produce constructive change. For example, consider a client troubled by compulsive gambling. The behavior therapist doesn't care whether this behavior is rooted in unconscious conflicts or parental rejection. What the client needs is to get rid of the maladaptive behavior. Consequently, the therapist simply designs a program to eliminate the compulsive gambling.

The crux of the difference between insight therapy and behavior therapy is this: Insight therapists treat pathological symptoms as signs of an underlying problem, whereas behavior therapists think that the symptoms *are* the problem. Thus, ***behavior therapies* involve the application of learning**

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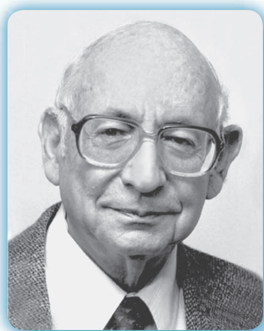
principles to direct efforts to change clients' maladaptive behaviors.

Behaviorism has been an influential school of thought in psychology since the 1920s. Nevertheless, behaviorists devoted little attention to clinical issues until the 1950s, when behavior therapy emerged out of three independent lines of research fostered by B. F. Skinner and his colleagues (Skinner, Solomon, & Lindsley, 1953) in the United States; by Hans Eysenck (1959) and his colleagues in Britain; and by Joseph Wolpe (1958) and his colleagues in South Africa (Glass & Arnkoff, 1992). Since then, there has been an explosion of interest in behavioral approaches to psychotherapy.

Behavior therapies are based on certain assumptions (Berkowitz, 2003). *First, it is assumed that behavior is a product of learning.* No matter how self-defeating or pathological a client's behavior might be, the behaviorist believes that it is the result of past learning and conditioning. *Second, it is assumed that what has been learned can be unlearned.* The same learning principles that explain how the maladaptive behavior was acquired can be used to get rid of it. Thus, behavior therapists attempt to change clients' behavior by applying the principles of classical conditioning, operant conditioning, and observational learning.

Systematic Desensitization

11e



Joseph Wolpe

"Neurotic anxiety is nothing but a conditioned response."

Devised by Joseph Wolpe (1958), systematic desensitization revolutionized psychotherapy by giving therapists their first useful alternative to traditional "talk therapy" (Fishman & Franks, 1992). ***Systematic desensitization* is a behavior therapy used to reduce phobic clients' anxiety responses through counterconditioning.** The treatment assumes that most anxiety responses are acquired through classical conditioning (as we discussed in Chapter 14). According to this model, a harmless stimulus (for instance, a bridge) may be paired with a fear-arousing event (lightning striking it) so that it becomes a conditioned stimulus eliciting anxiety. The goal of systematic desensitization is to weaken the association between the conditioned stimulus (the bridge) and the conditioned response of anxiety (see Figure 15.8). Systematic desensitization involves three steps.

In the first step, the therapist helps the client build an anxiety hierarchy. The hierarchy is a list of anxiety-arousing stimuli related to the specific source of anxiety, such as flying, academic tests, or snakes. The client ranks the stimuli from the least anxiety arousing to the most anxiety arousing. This ordered

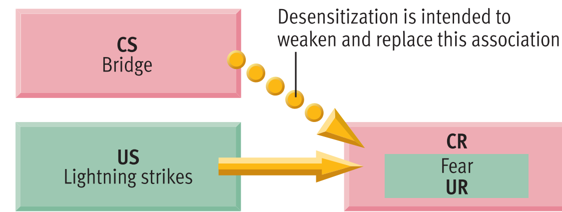


Figure 15.8
The logic underlying systematic desensitization.
Behaviorists argue that many phobic responses are acquired through classical conditioning, as in the example diagrammed here. Systematic desensitization targets the conditioned associations between phobic stimuli and fear responses.

list of stimuli is the *anxiety hierarchy.* An example of an anxiety hierarchy for one woman's fear of heights is shown in Figure 15.9.

The second step involves training the client in deep muscle relaxation. This second phase may begin during early sessions while the therapist and client are still constructing the anxiety hierarchy. Various therapists use different relaxation training procedures. Whatever procedures are used, the client must learn to engage in deep, thorough relaxation on command from the therapist.

In the third step, the client tries to work through the hierarchy, learning to remain relaxed while imagining each stimulus. Starting with the least anxiety-arousing stimulus, the client imagines the situation as vividly as possible while relaxing. If the client experiences strong anxiety, he or she drops the imaginary scene and concentrates on relaxation. The client keeps repeating this process until he or she can imagine a scene with little or no anxiety. Once a particular scene is conquered, the client moves on to the next stimulus situation in the anxiety hierarchy. Gradually, over a number of therapy sessions, the client progresses through the hierarchy, unlearning troublesome anxiety responses.

As clients conquer *imagined* phobic stimuli, they may be encouraged to confront the *real* stimuli. Although desensitization to imagined stimuli *can* be effective by itself, contemporary behavior therapists usually follow it up with direct exposures to the real anxiety-arousing stimuli (Emmelkamp, 2004). Indeed, behavioral interventions emphasizing direct exposures to anxiety-arousing situations have become behavior therapists' treatment of choice for phobic and other anxiety disorders. Usually, these real-life confrontations prove harmless, and individuals' anxiety responses decline.

According to Wolpe (1958, 1990), the principle at work in systematic desensitization is simple. Anxi-

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Systematic desensitization is a behavioral treatment for phobias. Early studies of the procedure's efficacy often used people who had snake phobias as research subjects because people with snake phobias were relatively easy to find. This research showed that systematic desensitization is generally an effective treatment.

ety and relaxation are incompatible responses. The trick is to recondition people so that the conditioned stimulus elicits relaxation instead of anxiety. This is *counterconditioning*—an attempt to reverse the process of classical conditioning by associating the crucial stimulus with a new conditioned response. Although Wolpe's explanation of how systematic desensitization works has been questioned, the technique's effectiveness in eliminating specific anxieties has been well documented (Spiegler & Guevremont, 2003).

An Anxiety Hierarchy for Systematic Desensitization	
Degree of fear	
5	I'm standing on the balcony of the top floor of an apartment tower.
10	I'm standing on a stepladder in the kitchen to change a light bulb.
15	I'm walking on a ridge. The edge is hidden by shrubs and treetops.
20	I'm sitting on the slope of a mountain, looking out over the horizon.
25	I'm crossing a bridge 6 feet above a creek. The bridge consists of an 18-inch-wide board with a handrail on one side.
30	I'm riding a ski lift 8 feet above the ground.
35	I'm crossing a shallow, wide creek on an 18-inch-wide board, 3 feet above water level.
40	I'm climbing a ladder outside the house to reach a second-story window.
45	I'm pulling myself up a 30-degree wet, slippery slope on a steel cable.
50	I'm scrambling up a rock, 8 feet high.
55	I'm walking 10 feet on a resilient, 18-inch-wide board, which spans an 8-foot-deep gulch.
60	I'm walking on a wide plateau, 2 feet from the edge of a cliff.
65	I'm skiing an intermediate hill. The snow is packed.
70	I'm walking over a railway trestle.
75	I'm walking on the side of an embankment. The path slopes to the outside.
80	I'm riding a chair lift 15 feet above the ground.
85	I'm walking up a long, steep slope.
90	I'm walking up (or down) a 15-degree slope on a 3-foot-wide trail. On one side of the trail the terrain drops down sharply; on the other side is a steep upward slope.
95	I'm walking on a 3-foot-wide ridge. The slopes on both sides are long and more than 25 degrees steep.
100	I'm walking on a 3-foot-wide ridge. The trail slopes on one side. The drop on either side of the trail is more than 25 degrees.

Figure 15.9
Example of an anxiety hierarchy. Systematic desensitization requires the construction of an anxiety hierarchy like the one shown here, which was developed for a woman who had a fear of heights but wanted to go hiking in the mountains.

SOURCE: Rudestam, K. E. (1980). *Methods of self-change: An ABC primer.* Belmont, CA: Wadsworth. Copyright © 1980 by Wadsworth Publishing. Reprinted by permission of the author.

Aversion Therapy

Aversion therapy is far and away the most controversial of the behavior therapies. It's not something that you would sign up for unless you were pretty desperate. Psychologists usually suggest it only as a treatment of last resort, after other interventions have failed. What's so terrible about aversion therapy? The client has to endure decidedly unpleasant stimuli, such as shocks or drug-induced nausea.

***Aversion therapy* is a behavior therapy in which an aversive stimulus is paired with a stimulus that elicits an undesirable response.** For example, alcoholics have had an *emetic drug* (one that causes nausea and vomiting) paired with their favorite drinks during therapy sessions (Landabaso et al., 1999). By pairing the drug with alcohol, the therapist hopes to create a conditioned aversion to alcohol (see Figure 15.10).

Aversion therapy takes advantage of the automatic nature of responses produced through classical conditioning. Admittedly, alcoholics treated with aversion therapy know that they won't be given an emetic outside of their therapy sessions. However, their reflex response to the stimulus of alcohol may

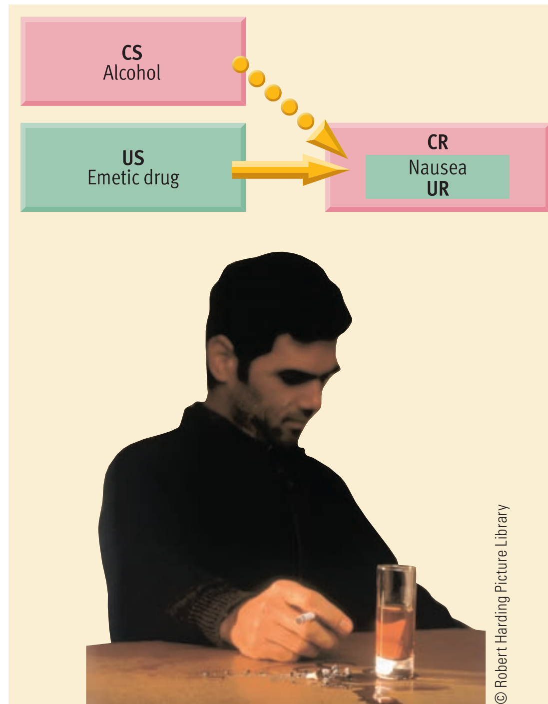

Figure 15.10
Aversion therapy. Aversion therapy uses classical conditioning to create an aversion to a stimulus that has elicited problematic behavior. For example, in the treatment of drinking problems, alcohol may be paired with a nausea-inducing drug to create an aversion to drinking.

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be changed so they respond to it with nausea and distaste (remember the power of conditioned taste aversions described in Chapter 6?). Obviously, this response should make it much easier to resist the urge to drink.

Aversion therapy is not a widely used technique, and when it is used it is usually only one element in a larger treatment program. Troublesome behaviors treated successfully with aversion therapy have included drug and alcohol abuse, sexual deviance, gambling, shoplifting, stuttering, cigarette smoking, and overeating (Bordnick et al., 2004; Emmelkamp, 1994; Grossman & Ruiz, 2004; Maletzky, 2002).

Courtesy of Aaron T. Beck

Aaron Beck

"Most people are barely aware of the automatic thoughts which precede unpleasant feelings or automatic inhibitions."

Social Skills Training

Many psychological problems grow out of interpersonal difficulties. Behavior therapists point out that people are not born with social finesse—they acquire social skills through learning. Unfortunately, some people have not learned how to be friendly, how to make conversation, how to express anger appropriately, and so forth. Social ineptitude can contribute to anxiety, feelings of inferiority, and various kinds of disorders. In light of these findings, therapists are increasingly using social skills training in efforts to improve clients' social abilities. This approach to therapy has yielded promising results in the treatment of social anxiety (Herbert et al., 2005), autism (Scattone, 2007), attention deficit disorder (Monastra, 2008) and schizophrenia (Granholm et al., 2008).

Social skills training **is a behavior therapy designed to improve interpersonal skills that emphasizes modeling, behavioral rehearsal, and shaping.** This type of behavior therapy can be conducted with individual clients or in groups. Social skills training depends on the principles of operant conditioning and observational learning. With *modeling,* the client is encouraged to watch socially skilled friends and colleagues in order to acquire appropriate responses (eye contact, active listening, and so on) through observation. In *behavioral rehearsal,* the client tries to practice social techniques in structured role-playing exercises. The therapist provides corrective feedback and uses approval to reinforce progress. Eventually, of course, clients try their newly acquired skills in real-world interactions. Usually, they are given specific homework assignments. *Shaping* is used in that clients are gradually asked to handle more complicated and delicate social situations. For example, a nonassertive client may begin by working on making requests of friends. Only much later will he be asked to tackle standing up to his boss at work.

web link 15.4

Association for Behavioral and Cognitive Therapies

The website for this professional organization has a variety of resources that are relevant to the general public. The most valuable of these resources are the fact sheets on cognitive-behavioral treatments for over 40 common problems and disorders. These fact sheets explain how cognitive-behavioral interventions can be used in the treatment of alcohol abuse, autism, chronic fatigue, eating disorders, insomnia, phobias, schizophrenia, shyness, and a host of other conditions.

Cognitive-Behavioral Treatments

In Chapter 14, we learned that cognitive factors play a key role in the development of many anxiety and mood disorders. Citing the importance of such findings, in the 1970s behavior therapists started to focus more attention on their clients' cognitions (Arnkoff & Glass, 1992; Hollon & Beck, 2004). ***Cognitive-behavioral treatments*** **use varied combinations of verbal interventions and behavior modification techniques to help clients change maladaptive patterns of thinking.** Some of these treatments, such as Albert Ellis's (1973) *rational-emotive behavior therapy* and Aaron Beck's (1976) *cognitive therapy,* emerged out of an insight therapy tradition, whereas other treatments, such as the systems developed by Donald Meichenbaum (1977) and Michael Mahoney (1974), emerged from the behavioral tradition. Here we will focus on Beck's cognitive therapy as an example of a cognitive-behavioral treatment (see Chapter 13 for a discussion of some of Ellis's ideas).

Cognitive therapy **uses specific strategies to correct habitual thinking errors that underlie various types of disorders.** In recent years cognitive therapy has been applied fruitfully to a wide range of disorders (Grant, Young, & DeRubeis, 2005; Hollon, Stewart, & Strunk, 2006), but it was originally devised as a treatment for depression. According to cognitive therapists, depression is caused by "errors" in thinking (see Figure 15.11). They assert that depression-prone people tend to (1) blame their setbacks on personal inadequacies without considering

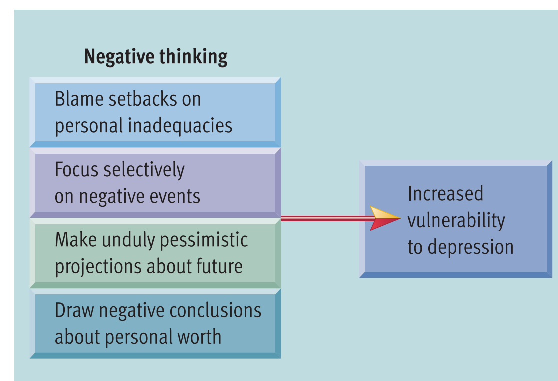

Figure 15.11
Beck's view of the roots of disorders. Beck's theory initially focused on the causes of depression, although it was gradually broadened to explain other disorders. According to Beck, depression is caused by the types of negative thinking shown here.

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circumstantial explanations, (2) focus selectively on negative events while ignoring positive events, (3) make unduly pessimistic projections about the future, and (4) draw negative conclusions about their worth as a person based on insignificant events. For instance, imagine that you got a low grade on a minor quiz in a class. If you made the kinds of errors in thinking just described, you might blame the grade on your woeful stupidity, dismiss comments from a classmate that it was an unfair test, gloomily predict that you will surely flunk the course, and conclude that you are not genuine college material.

The goal of cognitive therapy is to change clients' negative thoughts and maladaptive beliefs (Kellogg & Young, 2008). To begin, clients are taught to detect their automatic negative thoughts. These are self-defeating statements that people are prone to make when analyzing problems. Examples might include "I'm just not smart enough," "No one really likes me," or "It's all my fault." Clients are then trained to subject these automatic thoughts to reality testing. The therapist helps them to see how unrealistically negative the thoughts are.

Cognitive therapy uses a variety of behavioral techniques, such as modeling, systematic monitoring of one's behavior, and behavioral rehearsal (Wright, Beck, & Thase, 2003). Cognitive therapists often give their clients "homework assignments" that focus on changing clients' overt behaviors. Clients may be instructed to engage in overt responses on their own, outside of the clinician's office. For example, one shy, insecure young man in cognitive therapy was told to go to a singles bar and engage three different women in conversations for up to five minutes each (Rush, 1984). He was instructed to record his thoughts before and after each of the conversations. This assignment elicited various maladaptive patterns of thought that gave the young man and his therapist plenty to work on in subsequent sessions.

concept check 15.2

Understanding Therapists' Goals

Check your understanding of therapists' goals by matching various therapies with the appropriate description. The answers are in Appendix A.

Principal therapeutic goals	Therapy
_______ 1. Elimination of maladaptive behaviors or symptoms	a. Psychoanalysis
_______ 2. Acceptance of genuine self, personal growth	b. Client-centered therapy
_______ 3. Recovery of unconscious conflicts, character reconstruction	c. Cognitive therapy
_______ 4. Detection and reduction of negative thinking	d. Behavior therapy

How Effective Are Behavior Therapies?

Behavior therapists have historically placed more emphasis on the importance of measuring therapeutic outcomes than insight therapists have. Thus, there is ample evidence attesting to the effectiveness of behavior therapy (Jacob & Pelham, 2005). Of course, behavior therapies are not well suited to the treatment of some types of problems (vague feelings of discontent, for instance). Furthermore, it's misleading to make global statements about the effectiveness of behavior therapies, because they include many types of procedures designed for very different purposes. For example, the value of systematic desensitization for phobias has no bearing on the value of aversion therapy for sexual deviance. For our purposes, it is sufficient to note that there is favorable evidence on the efficacy of most of the widely used behavioral interventions (Zinbarg & Griffith, 2008). Behavior therapies can make important contributions to the treatment of phobias, obsessive-compulsive disorders, sexual dysfunction, schizophrenia, drug-related problems, eating disorders, psychosomatic disorders, hyperactivity, autism, and mental retardation (Berkowitz, 2003; Emmelkamp, 2004).

web link 15.5

The Beck Institute of Cognitive Therapy and Research

This site offers a diverse array of materials relating to Aaron Beck's cognitive therapy. Resources include newsletters, a referral system, a bookstore, recommended readings for clients, and questions and answers abut cognitive therapy.

REVIEW of Key Points

15.9 Behavior therapies use the principles of learning in direct efforts to change specific aspects of behavior. Wolpe's systematic desensitization is a treatment designed to relieve phobias. It involves the construction of an anxiety hierarchy, relaxation training, and step-by-step movement through the hierarchy, pairing relaxation with each phobic stimulus.

15.10 In aversion therapy, a stimulus associated with an unwanted response is paired with an unpleasant stimulus in an effort to eliminate the maladaptive response. Social skills training can improve clients' interpersonal skills through shaping, modeling, and behavioral rehearsal.

15.11 Cognitive-behavioral treatments concentrate on changing the way clients think about events in their lives. Cognitive therapists reeducate clients to detect and challenge automatic negative thoughts that cause depression and anxiety. Cognitive therapy also depends on modeling, behavioral rehearsal, and homework assignments.

15.12 Behavior therapists have historically placed more emphasis on the importance of measuring therapeutic outcomes than insight therapists have. There is ample evidence that behavior therapies are effective in the treatment of a wide variety of disorders.

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Key Learning Goals

15.13 Summarize the therapeutic actions and side effects of antianxiety and antipsychotic drugs.

15.14 Summarize the therapeutic actions and side effects of antidepressant and mood stabilizing drugs.

15.15 Evaluate the overall efficacy of drug treatments and controversies surrounding pharmaceutical research.

15.16 Describe electroconvulsive therapy and assess its therapeutic effects and risks.

15.17 Describe the therapeutic use of transcranial magnetic stimulation and direct brain stimulation.

Biomedical Therapies

In the 1950s, a French surgeon looking for a drug that would reduce patients' autonomic response to surgical stress noticed that chlorpromazine produced a mild sedation. Based on this observation, Delay and Deniker (1952) decided to give chlorpromazine to hospitalized schizophrenic patients. They wanted to see whether the drug would have calming effects. Their experiment was a dramatic success. Chlorpromazine became the first effective antipsychotic drug, and a revolution in psychiatry was begun. Hundreds of thousands of severely disturbed patients who had appeared doomed to spend the remainder of their lives in mental hospitals were gradually sent home, thanks to the therapeutic effects of antipsychotic drugs. Today, biomedical therapies such as drug treatment lie at the core of psychiatric practice.

Biomedical therapies **are physiological interventions intended to reduce symptoms associated with psychological disorders.** These therapies assume that psychological disorders are caused, at least in part, by biological malfunctions. As we discussed in the previous chapter, this assumption clearly has merit for many disorders, especially the more severe ones. We will discuss the two standard biomedical approaches to psychotherapy, drug therapy and electroconvulsive (shock) therapy, and then delve into some experimental, new treatments involving brain stimulation.

Treatment with Drugs 11e

Psychopharmacotherapy **is the treatment of mental disorders with medication.** We will refer to this kind of treatment more simply as *drug therapy*. The four main categories of therapeutic drugs for psychological problems are (1) antianxiety drugs, (2) antipsychotic drugs, (3) antidepressant drugs, and (4) mood-stabilizing drugs.

Antianxiety Drugs 11e

Many people routinely pop pills to relieve anxiety. The drugs involved in this common coping strategy are ***antianxiety drugs,*** **which relieve tension, apprehension, and nervousness.** The most popular of these drugs are Valium and Xanax. These are the trade names (the proprietary names that pharmaceutical companies use in marketing drugs) for diazepam and alprazolam, respectively.

Valium, Xanax, and other drugs in the *benzodiazepine* family are often called *tranquilizers*. These drugs exert their effects almost immediately, and they can be fairly effective in alleviating feelings of anxiety (Dubovsky, 2005). However, their effects are measured in hours, so their impact is relatively short-lived. Antianxiety drugs are routinely prescribed for people with anxiety disorders, but they are also given to millions of people who simply suffer from chronic nervous tension.

All the drugs used to treat psychological problems have potentially troublesome side effects that show up in some patients but not others. The antianxiety drugs are no exception. The most common side effects of Valium and Xanax are listed in Table 15.1. Some of these side effects—such as drowsiness, depression, nausea, and confusion—present serious problems for some patients. These drugs also have potential for abuse, drug dependence, and overdose, although these risks have probably been exaggerated in the press (Ballenger, 2000; Silberman, 1998). Another drawback is that patients who have been on antianxiety drugs for a while often experience withdrawal symptoms when their drug treatment is stopped (Raj & Sheehan, 2004).

Antipsychotic Drugs 11e

Antipsychotic drugs are used primarily in the treatment of schizophrenia. They are also given to people with severe mood disorders who become delusional.

Table 15.1 Side Effects of Xanax and Valium

	Patients Experiencing Side Effects (%)	
Side Effects	**Xanax**	**Valium**
Drowsiness	36.0	49.4
Lightheadedness	18.6	24.0
Dry mouth	14.9	13.0
Depression	11.9	17.0
Nausea, vomiting	9.3	10.0
Constipation	9.3	11.3
Insomnia	9.0	6.7
Confusion	9.3	14.1
Diarrhea	8.5	10.5
Tachycardia, palpitations	8.1	7.2
Nasal congestion	8.1	7.2
Blurred vision	7.0	9.1

Source: Evans, R. L. (1981). New drug evaluations: Alprazolam. *Drug Intelligence and Clinical Pharmacy, 15*, 633–637. Copyright © 1981 by Harvey Whitney Books Company. Reprinted by permission.

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The trade (and generic) names of some classic drugs in this category are Thorazine (chlorpromazine), Mellaril (thioridazine), and Haldol (haloperidol). ***Antipsychotic drugs* are used to gradually reduce psychotic symptoms, including hyperactivity, mental confusion, hallucinations, and delusions.** The traditional antipsychotics appear to decrease activity at certain subtypes of dopamine synapses, although the exact relationship between their neurochemical effects and their clinical effects remains obscure (Egan & Hyde, 2000; Miyamoto et al., 2003).

Studies suggest that antipsychotics reduce psychotic symptoms in about 70% of patients, albeit in varied degrees (Kane & Marder, 2005). When antipsychotic drugs are effective, they work their magic gradually, as shown in **Figure 15.12**. Patients usually begin to respond within one to three weeks, but considerable variability in responsiveness is seen (Emsley, Rabinowitz, & Medori, 2006). Further improvement may occur for several months. Many schizophrenic patients are placed on antipsychotics indefinitely, because these drugs can reduce the likelihood of a relapse into an active schizophrenic episode (Marder & van Kammen, 2005).

Antipsychotic drugs undeniably make a huge contribution to the treatment of severe mental disorders, but they are not without problems. They have many unpleasant side effects (Cohen, 1997; Wilkaitis, Mulvihill, & Nasrallah, 2004). Drowsiness, constipation, and cotton mouth are common. The drugs may also produce effects that resemble the symptoms of Parkinson's disease, including muscle tremors, muscular rigidity, and impaired motor coordination. After being released from a hospital, many schizophrenic patients discontinue their drug regimen because of the disagreeable side effects. Unfortunately, a relapse eventually occurs in most patients after they stop taking antipsychotic medication (Gitlin et al., 2001). In addition to minor side effects, antipsychotics may cause a severe and lasting problem called *tardive dyskinesia,* which is seen in about 20% of patients who receive long-term treatment with traditional antipsychotics (Miyamoto et al., 2003). ***Tardive dyskinesia* is a neurological disorder marked by involuntary writhing and ticlike movements of the mouth, tongue, face, hands, or feet.** Once this debilitating syndrome emerges, there is no cure, although spontaneous remission sometimes occurs after the discontinuation of antipsychotic medication (Pi & Simpson, 2000).

Psychiatrists are currently enthusiastic about a new class of antipsychotic agents called *atypical antipsychotic drugs* (such as clozapine, olanzapine, and quetiapine). These drugs are roughly as effective as traditional antipsychotics (Fleischhacker, 2002), and they can help some patients who do not respond to conventional antipsychotic medications (Volavka et al., 2002). Moreover, the atypical antipsychotics produce fewer unpleasant side effects and carry less risk for tardive dyskinesia (Correll, Leucht, & Kane, 2004; Lieberman et al., 2003). Of course, like all powerful drugs, they carry some risks, as they appear to increase patients' vulnerability to diabetes and cardiovascular problems (Meltzer et al., 2002).

Although they are much more expensive than traditional antipsychotics, the atypical antipsychotics have become the first line of defense in the treatment of schizophrenia (van Kammen & Marder, 2005). However, recent research has generated some controversy regarding this trend. These studies have found that the newer antipsychotics aren't any more effective than the older medications in reducing symptoms and that the side effects of the newer drugs are only marginally less troublesome than the side effects of the older drugs (Lieberman et al., 2005; Stroup, Kraus, & Marder, 2006). These findings raise vexing, complicated questions about the cost effectiveness of psychiatrists' reliance on the newer medications (Lieberman, 2006; Rosenheck, 2006).

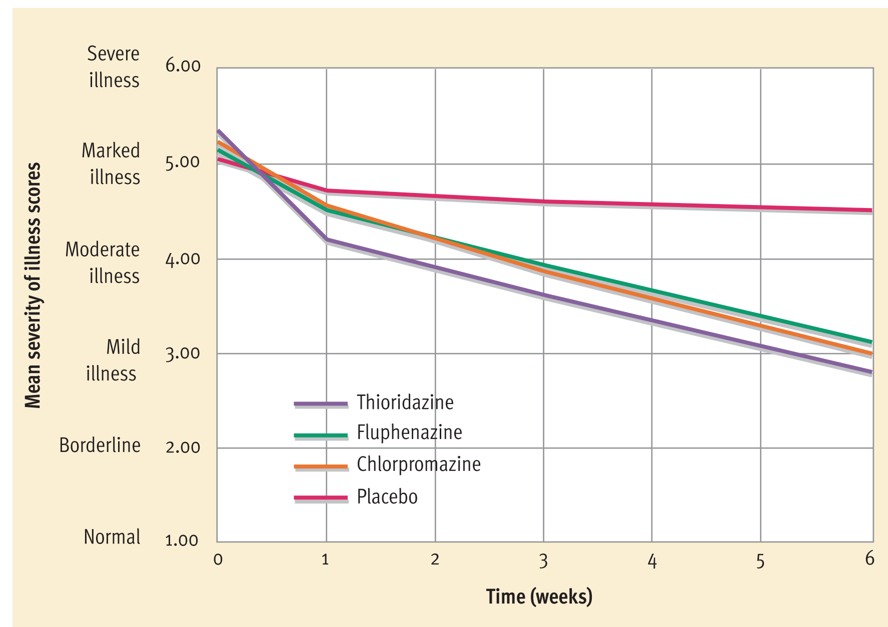

Figure 15.12
The time course of antipsychotic drug effects. Antipsychotic drugs reduce psychotic symptoms gradually, over a span of weeks, as graphed here. In contrast, patients given placebo medication show little improvement.

SOURCE: Cole, J. O., Goldberg, S. C., & Davis, J. M. (1966). Drugs in the treatment of psychosis. In P. Solomon (Ed.), *Psychiatric drugs.* New York: Grune & Stratton. From data in the NIMH-PSC Collaborative Study I. Reprinted by permission of J. M. Davis.

Antidepressant Drugs

11e

As their name suggests, ***antidepressant drugs* gradually elevate mood and help bring people out of a depression.** Prior to 1987, there were two principal classes of antidepressants: *tricyclics* (such as Elavil) and *MAO inhibitors* (such as Nardil). These two sets of drugs affect neurochemical activity in different ways

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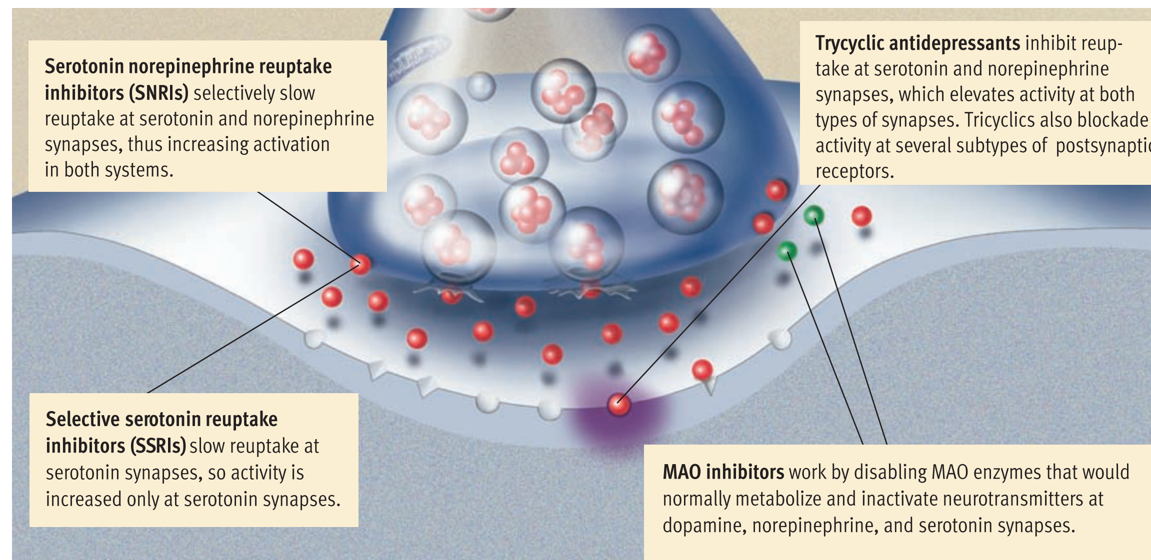
Figure 15.13

Antidepressant drugs' mechanisms of action. The four types of antidepressant drugs have somewhat different, albeit overlapping, effects on neurotransmitter activity. Tricyclics and MAO inhibitors have effects at a much greater variety of synapses, which presumably explains why they have more side effects. The more recently developed SSRIs and SNRIs zero in on more specific synaptic targets.



(see **Figure 15.13**) and tend to work with different patients. Overall, they are beneficial for about two-thirds of depressed patients (Gitlin, 2002), although only about one-third of treated patients experience a *complete resolution* of their symptoms (Shulman, 2001). The tricylics have fewer problems with side effects and complications than the MAO inhibitors (Potter et al., 2006). Like antipsychotic drugs, antidepressants exert their effects gradually over a period of weeks.

Today, psychiatrists are more likely to prescribe a newer class of antidepressants, called *selective serotonin reuptake inhibitors (SSRIs),* which slow the reuptake process at serotonin synapses, thus increasing serotonin activation. The drugs in this class, which include Prozac (fluoxetine), Paxil (paroxetine), and Zoloft (sertraline), seem to yield therapeutic gains similar to the tricyclics in the treatment of depression (Shelton & Lester, 2006) while producing fewer unpleasant or dangerous side effects (Kelsey, 2005). SSRIs have also proven valuable in the treatment of obsessive-compulsive disorders, panic disorders, and other anxiety disorders (Rivas-Vazquez, 2001). However, there is some doubt about how effective the SSRIs (and other antidepressants) are in relieving episodes of depression among patients suffering from bipolar disorder (Thase, 2005). Bipolar patients do not seem to respond as well as those who suffer from depression only. And in some cases antidepressants appear to foster a switch back into a manic episode (Altshuler et al., 2006).

A major concern in recent years has been evidence from a number of studies that SSRIs may increase the risk for suicide, primarily among adolescents and young adults (Healy & Whitaker, 2003; Holden, 2004). The challenge of collecting definitive data on this issue is much more daunting than one might guess, in part because suicide rates are already elevated among people who exhibit the disorders for which SSRIs are prescribed (Rihmer, 2003; Wessely & Kerwin, 2004). Some researchers have collected data that suggest that suicide rates have *declined* slightly because of widespread prescription of SSRIs (Baldessarini et al., 2007; Gibbons et al., 2006), while others have found no association between SSRIs and suicide (Lapiere, 2003; Simon et al., 2006).

Overall, however, when antidepressants are compared to placebo treatment, the data suggest that antidepressants lead to a slight elevation in the risk of suicidal behavior, from roughly 2% to 4% (Bridge et al., 2007; Dubicka, Hadley, & Roberts, 2006; Hammad, Laughren, & Racoosin, 2006). The increased suicide risk appears to mainly be a problem among a small minority of children and adolescents in the first month after starting antidepressants, especially during the first nine days (Jick, Kaye, & Jick, 2004). Thus, patients starting on SSRIs should be carefully monitored by their physicians and families (Culpepper et al., 2004). Regulatory warnings from the U.S. Food and Drug Administration (FDA) have led to a decline in the prescription of SSRIs among adolescents (Nemeroff et al., 2007). This trend has prompted concern that increases in suicide may occur among untreated individuals. This concern seems legitimate in that suicide risk clearly peaks in the month prior to people beginning treatment for depression, whether that treatment involves SSRIs or psychotherapy (see **Figure 15.14**; Simon & Savarino, 2007). This pattern presumably occurs because the escalating agony of depression finally prompts people to seek treatment, but it also suggests that getting treatment with drugs or therapy reduces suicidal risk. In the final analysis, this is a complex issue, but the one thing experts

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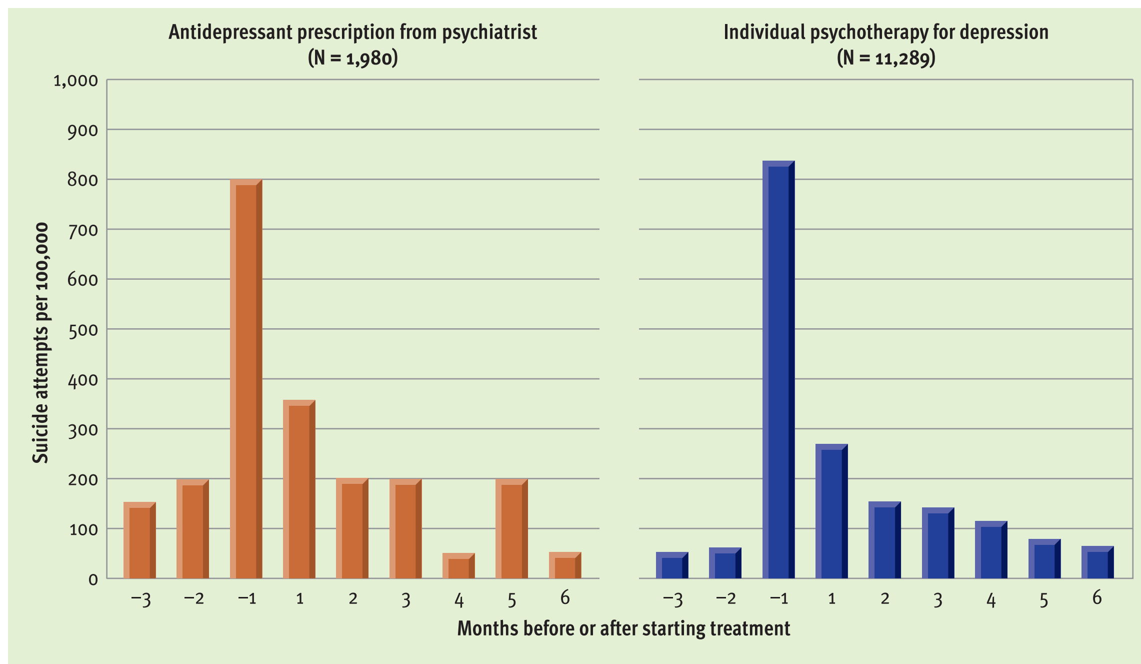

Figure 15.14
Probability of a suicide attempt in relation to the initiation of treatment. Examining medical records for thousands of patients, Simon and Savarino (2007) were able to gather information on the likelihood of a suicide attempt in the months before and after commencing treatment for depression. They compared patients who were put on an antidepressant medication against those who started in some form of insight or behavioral therapy. The data shown here, for young patients under the age of 25, indicate that suicide risk is highest in the month prior to treatment and next highest in the month after treatment is begun for both groups. These findings suggest that elevated suicide rates are not unique to starting on antidepressants and that getting treatment (whether it is medication or psychotherapy) reduces the risk of suicide.

SOURCE: Adapted from Simon, G. E., & Savarino, J. (2007). Suicide attempts among patients starting depression treatments with medications or psychotherapy. *American Journal of Psychiatry, 164,* 1029–1034 (Figure 2, p. 1032). Copyright © 2007 by the American Psychiatric Association. Adapted by permission of the American Psychiatric Association.

seem to agree on is that adolescents starting on SSRIs should be monitored closely.

The newest class of antidepressants consists of medications that inhibit reuptake at both serotonin and norepinephrine synapses, referred to as SNRIs. The first two drugs in this category are venlafaxine (Effexor) and duloxetine (Celexa). These drugs appear to produce slightly stronger antidepressant effects than the SSRIs (Thase & Denko, 2008). However, targeting two neurotransmitter systems also leads to a broader range of side effects, including troublesome elevations in blood pressure (Thase & Sloan, 2006).

Mood Stabilizers

Mood stabilizers **are drugs used to control mood swings in patients with bipolar mood disorders.** For many years, lithium was the only effective drug in this category. Lithium has proven valuable in preventing *future* episodes of both mania and depression in patients with bipolar illness (Geddes et al., 2004). Lithium can also be used in efforts to bring patients with bipolar illness out of *current* manic or depressive episodes (Keck & McElroy, 2006). However, antipsychotics and antidepressants are more commonly used for these purposes. On the negative side of the ledger, lithium does have some dangerous side effects if its use isn't managed skillfully (Jefferson & Greist, 2005). Lithium levels in the patient's blood must be monitored carefully, because high concentrations can be toxic and even fatal. Kidney and thyroid gland complications are the other major problems associated with lithium therapy.

In recent years a number of alternatives to lithium have been developed. The most popular of these newer mood stabilizers is an anticonvulsant agent called *valproate,* which has become more widely used than lithium in the treatment of bipolar disorders (Thase & Denko, 2008). Valproate appears to be roughly as effective as lithium in efforts to treat current manic episodes and to prevent future affective disturbances (Moseman et al., 2003). The advantage provided by valproate is that it has fewer side effects than lithium and is better tolerated by patients (Bowden, 2004).

How Effective Are Drug Therapies?

Drug therapies can produce clear therapeutic gains for many kinds of patients. What's especially impressive is that they can be effective with disorders that otherwise defy therapeutic endeavors. Nonetheless, drug therapies are controversial. Critics of drug therapy have raised a number of issues (Breggin & Cohen, 2007; Healy, 2004; Lickey & Gordon, 1991; Whitaker, 2002). First, some critics argue that drug therapies are not as effective as advertised and that they often produce superficial, short-lived curative effects. For example, Valium does not really solve problems with anxiety; it merely provides temporary relief from an unpleasant symptom. Moreover, relapse rates are substantial when drug regimens are discontinued. Second, critics charge that many drugs are overprescribed and many patients overmedicated. According to these critics, a number of physicians routinely hand out prescriptions without giving adequate consideration to more complicated and

web link 15.6

Dr. Bob's Psychopharmacology Tips
Psychopharmacology is the use of medication to treat psychological disorders. Physician and pharmacology specialist Robert Hsiang (University of Chicago) provides both broad and specific references about the interface of drugs and the human mind, including a searchable archive of professional information.

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"I medicate first and ask questions later."

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difficult interventions. Third, some critics charge that the damaging side effects of therapeutic drugs are underestimated by psychiatrists and that these side effects are often worse than the illnesses that the drugs are supposed to cure. Citing problems such as tardive dyskinesia, lithium toxicity, and addiction to antianxiety agents, these critics argue that the risks of therapeutic drugs aren't worth the benefits.

Critics maintain that the negative effects of psychiatric drugs are not fully appreciated because the pharmaceutical industry has managed to gain undue influence over the research enterprise as it relates to drug testing (Angell, 2000, 2004; Healy, 2004; Weber, 2006). Today, most researchers who investigate the benefits and risks of medications and write treatment guidelines have lucrative financial arrangements with the pharmaceutical industry (Bodenheimer, 2000; Choudhry, Stelfox, & Detsky, 2002; Lurie et al., 2006). Their studies are funded by drug companies, and they often receive substantial consulting fees. These financial arrangements have become so common, the prestigious *New England Journal of Medicine* had to relax its conflict-of-interest rules because it had difficulty finding expert reviewers who did not have financial ties to the drug industry (Drazen & Curfman, 2002). Unfortunately, these financial ties appear to undermine the objectivity required in scientific research, as studies funded by drug companies are far less likely to report unfavorable results than nonprofit-funded studies (Bekelman, Li, & Gross, 2003; Perlis et al., 2005; Rennie & Luft, 2000). Consistent with this finding, when specific antipsychotic drugs are pitted against each other in clinical trials, the sponsoring company's drug is reported to be superior to the other drugs in 90% of studies (Heres et al., 2006). Industry-financed drug trials also tend to be much too brief to detect the long-term risks associated with new drugs, and when unfavorable results emerge, the data are often withheld from publication (Antonuccio, Danton, & McClanahan, 2003). Also, research designs are often slanted in a multitude of ways so as to exaggerate the positive effects and minimize the negative effects of the drugs under scrutiny (Carpenter, 2002; Chopra, 2003; Moncrieff, 2001). The conflicts of interest that appear to be pervasive in contemporary drug research raise grave concerns that require attention from researchers, universities, and federal agencies.

Obviously, drug therapies have stirred up some debate. However, this controversy pales in comparison to the furious debates inspired by electroconvulsive (shock) therapy (ECT). ECT is so controversial that the residents of Berkeley, California, voted in 1982 to outlaw ECT in their city. However, in subsequent lawsuits, the courts ruled that scientific questions cannot be settled through a vote, and they overturned the law. What makes ECT so controversial? You'll see in the next section.

Electroconvulsive Therapy (ECT)

In the 1930s, a Hungarian psychiatrist named Ladislas von Meduna speculated that epilepsy and schizophrenia could not coexist in the same body. On the basis of this observation, which turned out to be inaccurate, von Meduna theorized that it might be useful to induce epileptic-like seizures in schizophrenic patients. Initially, a drug was used to trigger these seizures. However, by 1938 a pair of Italian psychiatrists (Cerletti & Bini, 1938) demonstrated that it was safer to elicit the seizures with electric shock. Thus, modern electroconvulsive therapy was born.

***Electroconvulsive therapy* (ECT) is a biomedical treatment in which electric shock is used to produce a cortical seizure accompanied by convulsions.** In ECT, electrodes are attached to the skull over the temporal lobes of the brain (see the photo on the facing page). A light anesthesia is induced, and the patient is given a variety of drugs to minimize the likelihood of complications. An electric current is then applied either to the right side or to both sides of the brain for about a second. Unilateral shock delivered to the right hemisphere is the preferred method of treatment today (Abrams, 2000). The current triggers a brief (about 30 seconds) convulsive seizure. The patient normally awakens in an hour or two and manifests some confusion, disorientation, and nausea, which usually clear up in a matter of hours. People typically receive between 6 and 12 treatments over a period of a month or so (Glass, 2001).

The clinical use of ECT peaked in the 1940s and 1950s, before effective drug therapies were widely

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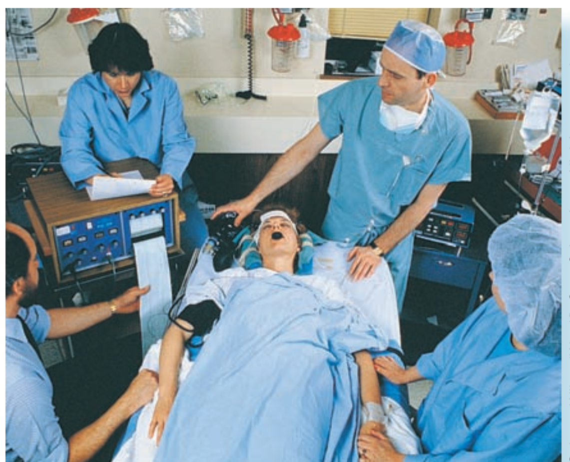

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This patient is being prepared for electroconvulsive therapy. The mouthpiece keeps the patient from biting her tongue during the electrically induced seizures.

available. ECT has long been controversial, and its use did decline in the 1960s and 1970s. Nonetheless, the use of ECT has seen a resurgence in recent decades. Although only about 8% of psychiatrists administer ECT, it is not a rare form of treatment (Hermann et al., 1998). Some critics argue that ECT is overused because it is a lucrative procedure that boosts psychiatrists' income while consuming relatively little of their time in comparison to insight therapy (Frank, 1990). Conversely, some ECT advocates argue that ECT is underutilized because the public harbors many misconceptions about its effects and risks (McDonald et al., 2004). Although ECT is used in the treatment of a variety of disorders, in recent decades it has primarily been recommended for the treatment of depression.

Effectiveness of ECT

The evidence on the therapeutic efficacy of ECT is open to varied interpretations. Proponents maintain that it is a remarkably effective treatment for major depression (Prudic, 2005; Rudorfer, Henry, & Sackeim, 2003). Moreover, they note that many patients who do not benefit from antidepressant medication improve in response to ECT (Nobler & Sackeim, 2006). However, opponents argue that the available studies are flawed and inconclusive and that ECT is probably no more effective than a placebo (Rose et al., 2003). Overall, there does seem to be enough favorable evidence to justify *conservative* use of ECT in treating severe mood disorders in patients who have not responded to medication (Carney & Geddes, 2003; Metzger, 1999). Unfortunately, relapse rates after ECT are distressingly high. Over 50% of patients relapse within 6 to 12 months, although relapse rates can be reduced by giving ECT patients antidepressant drugs (Sackeim et al., 2001).

Curiously, to the extent that ECT may be effective, no one is sure why. The discarded theories about how ECT works could fill several books. Many ECT advocates theorize that the treatment must affect neurotransmitter activity in the brain. However, the evidence supporting this view is fragmentary, inconsistent, and inconclusive (Abrams, 1992; Kapur & Mann, 1993). ECT opponents have a radically different, albeit equally unproven, explanation for why ECT might *appear* to be effective: They maintain that some patients find ECT so aversive that they muster all their willpower to climb out of their depression to avoid further ECT treatments.

Risks Associated with ECT

Even ECT proponents acknowledge that memory losses, impaired attention, and other cognitive deficits are common short-term side effects of electroconvulsive therapy (Lisanby et al., 2000; Sackeim et al., 2007). However, ECT proponents assert that these deficits are mild and usually disappear within a month or two (Glass, 2001). An American Psychiatric Association (2001) task force concluded that there is no objective evidence that ECT causes structural damage in the brain or that it has any lasting negative effects on the ability to learn and remember information. In contrast, ECT critics maintain that ECT-induced cognitive deficits are often significant and sometimes permanent (Breggin, 1991; Rose et al., 2003), although their evidence seems to be largely anecdotal. Given the concerns about the risks of ECT and the doubts about its efficacy, it appears that the use of ECT will remain controversial for some time to come.

concept check 15.3

Understanding Biomedical Therapies

Check your understanding of biomedical therapies by matching each treatment with its chief use. The answers are in Appendix A.

Treatment	Chief purpose
_______ **1.** Antianxiety drugs	**a.** To reduce psychotic symptoms
_______ **2.** Antipsychotic drugs	**b.** To bring a major depression to an end
_______ **3.** Antidepressant drugs	**c.** To suppress tension, nervousness, and apprehension
_______ **4.** Mood stabilizers	**d.** To prevent future episodes of mania or depression in bipolar disorders
_______ **5.** Electroconvulsive therapy (ECT)	

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New Brain Stimulation Techniques

Scientists are always on the lookout for new methods of treating psychological disorders that might exhibit greater efficacy or fewer complications than ECT and drug treatments. Some new approaches to treatment involving stimulation of the brain are being explored with promising results, although they remain highly experimental at this time.

One new approach is *transcranial magnetic stimulation,* which was discussed in Chapter 3 as a method for studying brain function. ***Transcranial magnetic stimulation (TMS)* is a technique that permits scientists to temporarily enhance or depress activity in a specific area of the brain.** In TMS, a magnetic coil mounted on a small paddle is held over specific areas of the head to increase or decrease activity in discrete regions of the cortex (Nahas et al., 2007). Neuroscientists are mostly experimenting with TMS as a treatment for depression. Thus far, treatments delivered to the right and left prefrontal cortex show promise in reducing depressive symptoms (Nobler & Sackeim, 2006; O'Reardon et al., 2007). TMS generally is well tolerated, with minimal side effects. But a great deal of additional research will be necessary before the therapeutic value of TMS can be determined.

The other new approach to treatment is *deep brain stimulation*. **In *deep brain stimulation (DBS)* a thin electrode is surgically implanted in the brain and connected to an implanted pulse generator so that various electrical currents can be delivered to brain tissue adjacent to the electrode** (George, 2003; see Figure 15.15). DBS has proven valuable in the treatment of the motor disturbances associated with Parkinson's disease, tardive dyskinesia, and some seizure disorders (Halpern et al., 2007; Wider et al., 2008). Researchers are currently exploring whether DBS may have value in the treatment of depression or obsessive-compulsive disorder (George et al., 2006; Hardesty & Sackeim, 2007). Obviously, this highly invasive procedure requiring brain surgery will never be a frontline therapy for mental disorders, but scientists hope that it may prove valuable for highly treatment-resistant patients who do not benefit from conventional therapies (Kuehn, 2007).

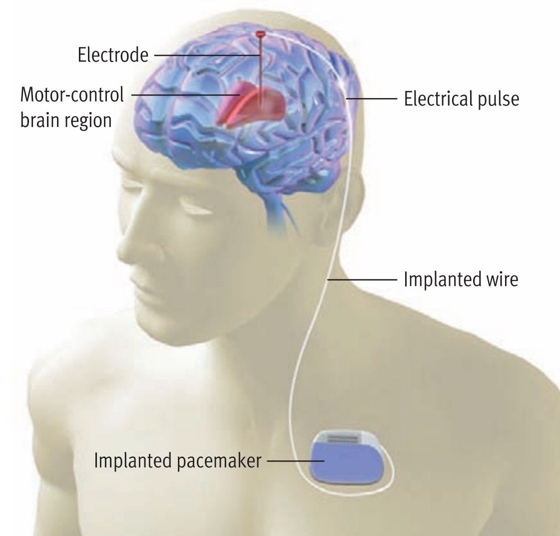

Figure 15.15
Deep brain stimulation. Deep brain stimulation requires a surgical procedure in which a thin electrode (about the width of a human hair) is inserted into deep areas of the brain. The electrode is connected to a pulse generator implanted under the skin of the chest. The placement of the electrode and the type of current generated depend on what condition is being treated. The electrode shown here was implanted in a motor area of the brain to treat the tremors associated with Parkinson's disease. Researchers are experimenting with other electrode placements in efforts to treat depression and obsessive-compulsive disorder.

SOURCE: Adapted from George, M. S. (2003). Stimulating the brain. *Scientific American, 289*(3), 67–73 (p. 70). © Bryan Christie Design.

REVIEW of Key Points

15.13 Antianxiety drugs exert their effects quickly and are fairly effective in reducing feelings of anxiety, but their impact is short-lived. They produce some nuisance side effects, and there can be complications involving abuse, dependence, and overdose. Antipsychotic drugs are used primarily in the treatment of schizophrenia. They reduce psychotic symptoms in about 70% of patients. Traditional antipsychotics can have a variety of serious side effects, which have been reduced in the newer, atypical antipsychotics.

15.14 Antidepressants are used to bring people out of episodes of depression. SSRIs are the dominant type used today, with SNRIs representing a new option. Side effects tend to be manageable, although there are concerns that antidepressants may increase suicide risk slightly. Mood stabilizers, such as lithium and valproate, are used to prevent the recurrence of episodes of disturbance in people with bipolar mood disorders.

15.15 Drug therapies can be quite effective, but they have their drawbacks. All of the drugs produce side effects, some of which can be very troublesome. Some critics maintain that drugs' curative effects are superficial and that some drugs are overprescribed. Disturbing questions have been raised about the scientific impartiality of contemporary research on therapeutic drugs.

15.16 Electroconvulsive therapy (ECT) is used to trigger a cortical seizure that is believed to have therapeutic value for mood disorders, especially depression. Evidence about the effectiveness of ECT is contradictory but seems sufficient to justify conservative use of the procedure. Cognitive deficits are the principal risk, with much debate about how severe and enduring these deficits tend to be.

15.17 Transcranial magnetic stimulation is a new technique that permits scientists to temporarily enhance or depress activity in a specific area of the cortex. It may have value in the treatment of depression. In deep brain stimulation a thin electrode is surgically implanted so that electrical currents can be delivered to selected areas of the brain. It may have value in the treatment of depression or obsessive-compulsive disorder.

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Current Trends and Issues in Treatment

Key Learning Goals

15.18 Articulate the concerns that have been expressed about the impact of managed care on the treatment of psychological disorders.

15.19 Discuss the merits of blending approaches to therapy, including the Featured Study on combining insight therapy and medication.

15.20 Analyze the barriers that lead to underutilization of mental health services by ethnic minorities and possible solutions to the problem.

The controversy about ECT is only one of many contentious issues and shifting trends in the world of mental health care. In this section, we will discuss the impact of managed care on psychotherapy, the continuing trend toward blending various approaches to therapy, and efforts to respond more effectively to increasing cultural diversity in Western societies.

Grappling with the Constraints of Managed Care

The 1990s brought a dramatic shift in how people in the United States pay for their health care. Alarmed by skyrocketing health care costs, huge numbers of employers and individuals moved from traditional fee-for-service arrangements to managed care health plans (Hogan & Morrison, 2003; Kiesler, 2000). In the *fee-for-service* system, hospitals, physicians, psychologists, and other providers charged fees for whatever health care services were needed, and most of these fees were reimbursed by private insurance or the government (through Medicaid, Medicare, and other programs). In *managed care systems* people enroll in prepaid plans with small co-payments for services, typically run by health maintenance organizations (HMOs), which agree to provide ongoing health care for a specific sum of money. Managed care usually involves a tradeoff: Consumers pay lower prices for their care, but they give up much of their freedom to choose their providers and to obtain whatever treatments they believe necessary. If an HMO's treatment expenses become excessive, it won't turn a profit, so HMOs have strong incentives to hold treatment costs down. The HMOs originally promised individuals and employers that they would be able to hold costs down without having a negative impact on the quality of care, by negotiating lower fees from providers, reducing inefficiency, and cracking down on medically unnecessary services. However, critics charge that managed care systems have squeezed all the savings they can out of the "fat" that existed in the old system and that they have responded to continued inflation in their costs by rationing care and limiting access to medically *necessary* services (Duckworth & Borus, 1999; Giles & Marafiote, 1998; Sanchez & Turner, 2003).

The possibility that managed care is having a negative effect on the quality of treatment is a source of concern throughout the health care professions, but the issue is especially sensitive in the domain of mental health care (Bursztajn & Brodsky, 2002; Campbell, 2000; Rosenberg & DeMaso, 2008). Critics maintain that mental health care has suffered particularly severe cuts in services because the question of what is "medically necessary" can be more subjective than in other treatment specialties (such as cardiology) and because patients who are denied psychotherapy services are relatively unlikely to complain (Duckworth & Borus, 1999). For example, a business executive who is trying to hide his depression or cocaine addiction from his employer will be reluctant to complain to his employer if therapeutic services are denied.

According to critics, the restriction of mental health services sometimes involves outright denial of treatment, but it often takes more subtle forms, such as underdiagnosing conditions, failing to make needed referrals to mental health specialists, and arbitrarily limiting the length of treatment (Miller, 1996). Long-term therapy is becoming a thing of the past unless patients can pay for it out of pocket, and the goal of treatment has been reduced to reestablishing a reasonable level of functioning (Zatzick, 1999). Many managed care systems hold down costs by rerouting patients from highly trained providers, such as psychiatrists and psychologists, to less-well-trained providers, such as masters-level counselors, who may not be adequately prepared to handle serious psychological disorders (Seligman & Levant, 1998). Cost containment is also achieved by requiring physicians to prescribe older antidepressant and antipsychotic drugs instead of the newer and much more expensive SSRIs and atypical antipsychotics (Docherty, 1999).

Unfortunately, there are no simple solutions to these problems on the horizon. Restraining the rapid growth of health care costs without compromising the quality of care, consumers' freedom of choice, and providers' autonomy is an enormously complex and daunting challenge. At this juncture, it is difficult to predict what the future holds. However, it is clear that economic realities have ushered in an era of transition for the treatment of psychological disorders and problems (Huey et al., 2005).

Blending Approaches to Treatment

In this chapter we have reviewed many approaches to treatment. However, there is no rule that a client

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ILLUSTRATED OVERVIEW OF FIVE MAJOR APPROACHES TO TREATMENT

THERAPY/FOUNDER	ROOTS OF DISORDERS

PSYCHOANALYSIS

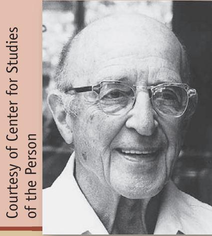
National Library of Medicine

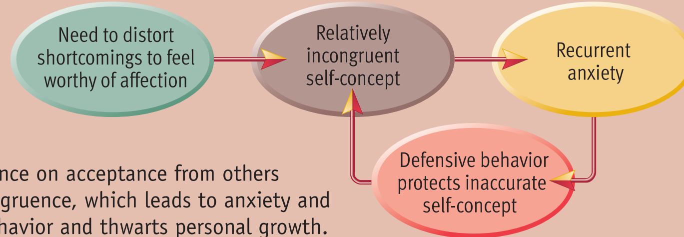
Developed by Sigmund Freud in Vienna, from the 1890s through the 1930s

Unconscious conflict resulting from fixations in earlier development cause anxiety, which leads to defensive behavior. The repressed conflicts typically center on sex and aggression.

CLIENT-CENTERED THERAPY

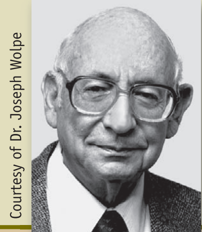
Created by Carl Rogers at the University of Chicago during the 1940s and 1950s


Courtesy of Center for Studies of the Person



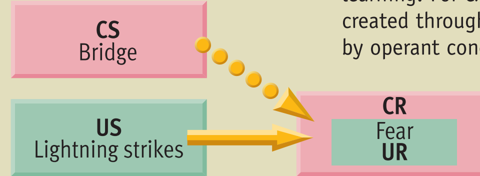
Overdependence on acceptance from others fosters incongruence, which leads to anxiety and defensive behavior and thwarts personal growth.

BEHAVIOR THERAPY


Courtesy of Dr. Joseph Wolpe

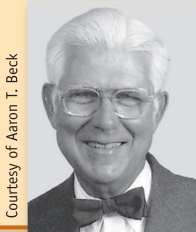
Launched primarily by South African Joseph Wolpe's description of systematic desensitization in 1958

Maladaptive patterns of behavior are acquired through learning. For example, many phobias are thought to be created through classical conditioning and maintained by operant conditioning.

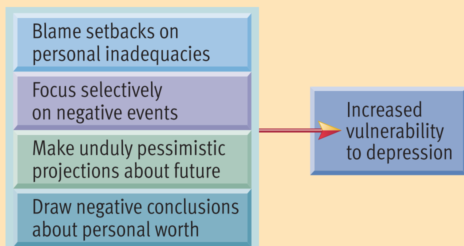


COGNITIVE–BEHAVIORAL TREATMENTS

One approach devised by Aaron Beck at the University of Pennsylvania in the 1960s and 1970s


Courtesy of Aaron T. Beck

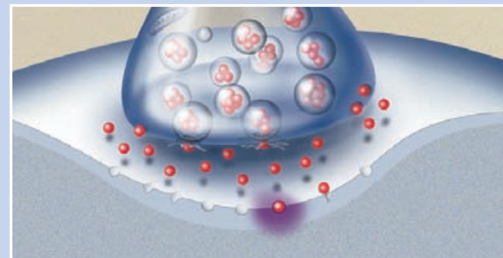
Pervasive negative thinking about events related to self fosters anxiety and depression, and other forms of pathology.



BIOMEDICAL THERAPY

Many researchers contributed; key breakthroughs in drug treatment made around 1950 by John Cade in Australia, Henri Laborit in France, and Jean Delay and Pierre Deniker, also in France

Most disorders are attributed to genetic predisposition and physiological malfunctions, such as abnormal neurotransmitter activity.
For example, schizophrenia appears to be associated with overactivity at dopamine synapses.



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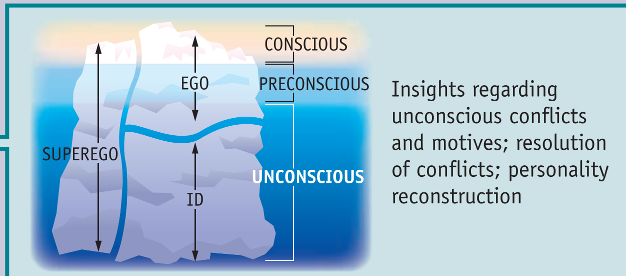
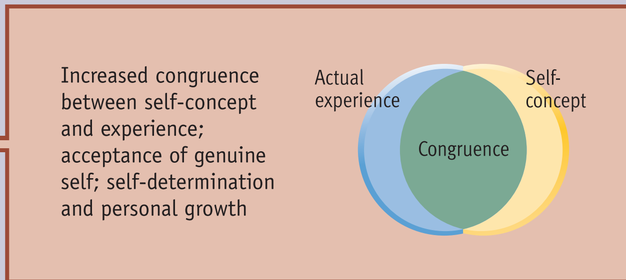
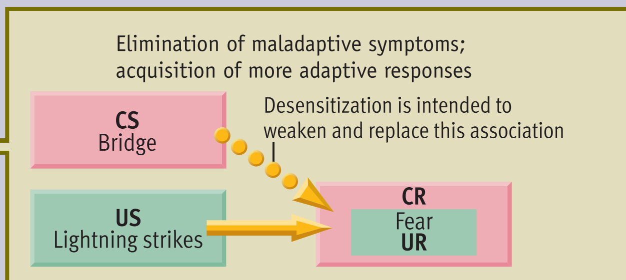
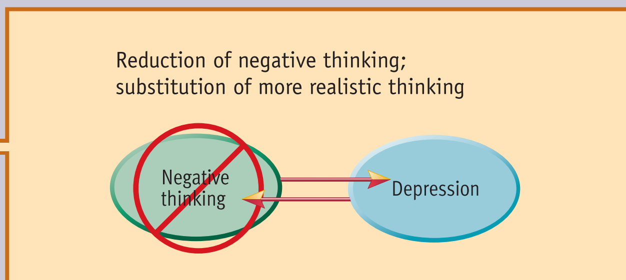
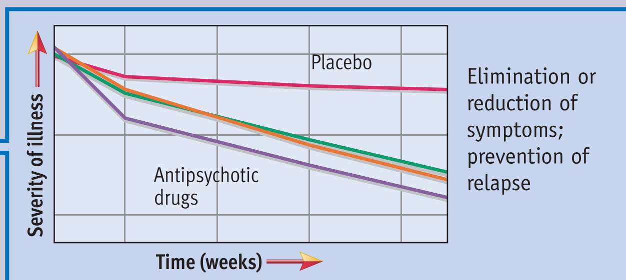
THERAPEUTIC GOALS











THERAPEUTIC TECHNIQUES

Free association, dream analysis, interpretation, transference

© Bruce Ayres/Stone/Getty Images

Genuineness, empathy, unconditional positive regard, clarification, reflecting back to client

© Zigy Kaluzny/Stone/Getty Images

Classical and operant conditioning, systematic desensitization, aversive conditioning, social skills training, reinforcement, shaping, punishment, extinction, biofeedback

© Kent News & Picture/Corbis Sygma

Thought stopping, recording of automatic thoughts, refuting of negative thinking, homework assignments

© John Greim/Photo Researchers, Inc.

Antianxiety, antidepressant, antipsychotic, and mood-stabilizing drugs, electro-convulsive therapy

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must be treated with just one approach. Often, a clinician will use several techniques in working with a client. For example, a depressed person might receive cognitive therapy, social skills training, and antidepressant medication. Multiple approaches are particularly likely when a treatment team provides therapy. Studies suggest that combining approaches to treatment has merit (Glass, 2004; Riba & Miller, 2003), as you will see in our Featured Study for this chapter.

FEATURED STUDY

SOURCE: Reynolds, C. F., III, Frank, E., Perel, J. M., Imber, S. D., Cornes, C., Miller, M. D., Mazumdar, S., Houck, P. R., Dew, M. A., Stack, J. A., Pollock, B. G., & Kupfer, D. J. (1999). Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: A randomized controlled trial in patients older than 50 years. *Journal of the American Medical Association, 28,* 39–45.

Combining Insight Therapy and Medication

Depression is common in older people and contributes to physical health problems, chronic disability, and increased mortality among the elderly. Geriatric depression is also a highly recurrent problem. After successful treatment of depression, elderly patients tend to relapse more quickly and more frequently than younger clients. The purpose of this study was to determine whether a combination of insight therapy and antidepressant medication could reduce the recurrence of depression in an elderly population.

Method

Participants. The participants were 107 elderly patients diagnosed with recurrent, unipolar, major depression. The mean age of the patients at the beginning of the study was 67.6. The subjects had all been successfully treated for a recent episode of depression and had remained stable for four months.

Treatments. The medication employed in the study was *nortriptyline,* a tricyclic antidepressant that appears to be relatively effective and well tolerated in elderly populations. The insight therapy was *interpersonal psychotherapy (IPT),* an approach to therapy that emphasizes the social roots of depression and focuses on how improved social relations can protect against depression (Klerman & Weissman, 1993). Clients learn how social isolation and unsatisfying interpersonal relationships can provoke depression and how confidants and supportive interactions can decrease vulnerability to depression.

Design. The subjects were randomly assigned to one of four maintenance treatment conditions: (1) monthly interpersonal therapy and medication, (2) medication alone, (3) monthly interpersonal therapy and placebo medication, and (4) placebo medication alone. A *double-blind* procedure was employed, so the clinicians who provided the treatments did not know which subjects were getting genuine medication as opposed to placebo pills. Patients remained in maintenance treatment for three years or until a recurrence of a major depressive episode.

Results

The relapse rates for the four treatment conditions are shown in **Figure 15.16**. The relapse rate for the combination of interpersonal therapy and medication was significantly less than that for either medication alone or interpersonal therapy alone (with placebo medication). The prophylactic value of the combined therapy proved most valuable to patients over 70 years of age and in the first year of the study, during which most relapses occurred.

Discussion

The authors conclude that "the continuation of combined medication and psychotherapy may represent the best long-term treatment strategy for preserving recovery in elderly patients with recurrent major depression" (p. 44). They speculate that the combined treatment may be "best-suited for dealing with both the biological and psychosocial substrates of old-age depression" (p. 45). How-

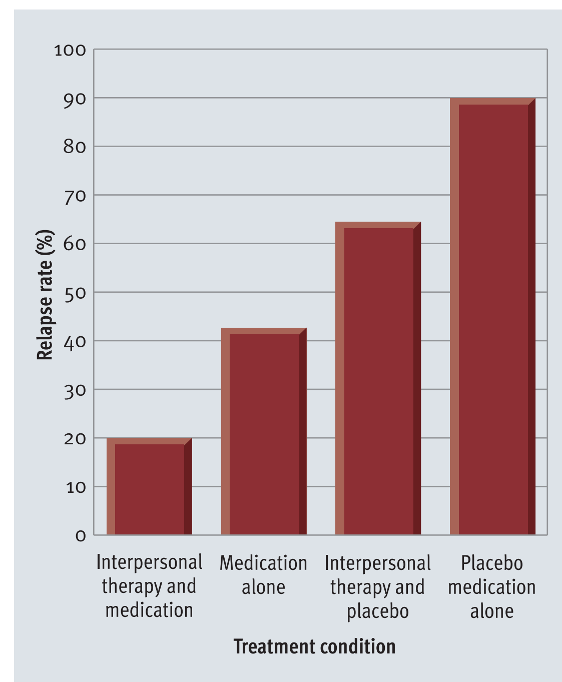

Figure 15.16
Relapse rates in the Reynolds et al. (1999) study. Following up over a period of three years, Reynolds et al. (1999) compared the preventive value of (1) monthly interpersonal therapy and medication, (2) medication alone, (3) monthly interpersonal therapy and placebo medication, and (4) placebo medication alone in a sample of elderly patients prone to recurrent depression. The combined treatment of insight therapy and medication yielded the lowest relapse rates and thus proved superior to either insight therapy or drug therapy alone.

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ever, they acknowledge the need for further research and recommend additional studies with newer antidepressant drugs (the SSRIs) that are increasingly popular.

Comment

This study was featured because it illustrated how to conduct a well-controlled experimental evaluation of the efficacy of therapeutic interventions. It also highlighted the value of combining approaches to treatment, which is a laudable trend in the treatment of psychological disorders. The fact that the study was published in the highly prestigious *Journal of the American Medical Association* also demonstrates how prominent and important research on therapeutic efficacy has become in the era of managed care.

The value of multiple approaches to treatment may explain why a significant trend seems to have crept into the field of psychotherapy: a movement away from strong loyalty to individual schools of thought and a corresponding move toward integrating various approaches to therapy (Castonguay et al., 2003; D. A. Smith, 1999). Most clinicians used to depend exclusively on one system of therapy while rejecting the utility of all others. This era of fragmentation may be drawing to a close. One survey of psychologists' theoretical orientations, which is summarized in **Figure 15.17**, found that 36% of the respondents described themselves as *eclectic* in approach (Norcross, Hedges, & Castle, 2002).

***Eclecticism* in the practice of therapy involves drawing ideas from two or more systems of therapy instead of committing to just one system.** Therapists can be eclectic in a number of ways (Arkowitz, 1992; Feixas & Botella, 2004; Goin, 2005). Two common approaches are theoretical integration and technical eclecticism. In *theoretical integration,* two or more systems of therapy are combined or blended to take advantage of the strengths of each. Paul Wachtel's (1977, 1991) efforts to blend psychodynamic and behavioral therapies is a prominent example. *Technical eclecticism* involves borrowing ideas, insights, and techniques from a variety of sources while tailoring one's intervention strategy to the unique needs of each client. Advocates of technical eclecticism, such as Arnold Lazarus (1992, 1995, 2008), maintain that therapists should ask themselves, "What is the best approach for this specific client, problem, and situation?" and then adjust their strategy accordingly.

Increasing Multicultural Sensitivity in Treatment

Modern psychotherapy emerged during the second half of the 19th century in Europe and America, spawned in part by a cultural milieu that viewed the self as an independent, reflective, rational being, capable of self-improvement (Cushman, 1992). Psychological disorders were assumed to have natural causes like physical diseases and to be amenable to medical treatments derived from scientific research. But the individualized, medicalized institution of modern psychotherapy reflects Western cultural values that are far from universal (Sue & Sue, 1999). In many nonindustrialized societies, psychological disorders are attributed to supernatural forces (possession, witchcraft, angry gods, and so forth), and victims seek help from priests, shamans, and folk healers, rather than doctors (Wittkower & Warnes, 1984). Thus, efforts to export Western psychotherapies to non-Western cultures have met with mixed success. Indeed, the highly culture-bound origins of modern therapies have raised questions about their applicability to ethnic minorities *within* Western culture (Miranda et al., 2005).

Research on how cultural factors influence the process and outcome of psychotherapy has burgeoned in recent years, motivated in part by the need to improve mental health services for ethnic minority groups in American society (Lee & Ramirez, 2000; Worthington, Soth-McNett, & Moreno, 2007). The data are ambiguous for a couple of ethnic groups, but studies suggest that American minority groups generally underutilize therapeutic services (Bender

web link 15.7

Psych Central

The work of John Grohol, Psych Central is a superb source for learning about all aspects of mental health, including psychological disorders and treatment, professional issues, and information for mental health care consumers. Almost 2000 annotated listings to information sources are offered here.

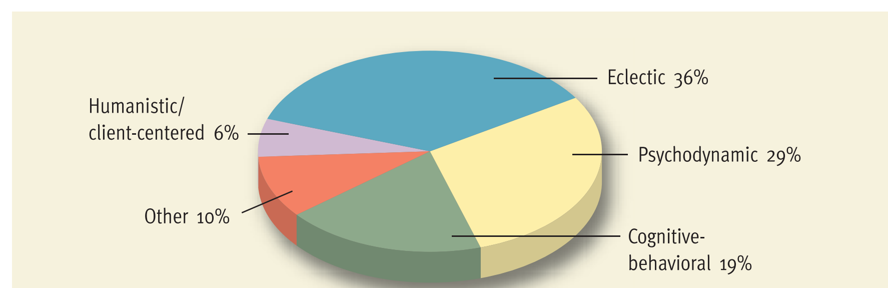


Figure 15.17

The leading approaches to therapy among psychologists. These data, from a survey of 531 psychologists who belong to the American Psychological Association's Division of Psychotherapy, provide some indication of how common an eclectic approach to therapy has become. The findings suggest that the most widely used approaches to therapy are eclectic, psychodynamic, and cognitive-behavioral treatments. (Based on data from Norcross, Hedges, & Castle, 2002)

et al., 2007; Olfson et al., 2002; Richardson, et al., 2003). Why? A variety of barriers appear to contribute to this problem (Snowden & Yamada, 2005; Zane et al., 2004; U.S. Department of Health and Human Services, 1999). One major consideration is that many members of minority groups have a history of frustrating interactions with American bureaucracies and are distrustful of large, intimidating institutions, such as hospitals and community mental health centers. Another issue is that most hospitals and mental health agencies are not adequately staffed with therapists who speak the languages used by minority groups in their service areas. Yet another problem is that the vast majority of therapists have been trained almost exclusively in the treatment of white middle-class Americans and are not familiar with the cultural backgrounds and unique characteristics of various ethnic groups. This culture gap often leads to misunderstandings and ill-advised treatment strategies.

Ethnicity aside, those who are poor are less likely than others to gain access to psychotherapy (Smith, 2005). This problem affects ethnic minorities disproportionately because many minority groups suffer from elevated rates of joblessness and poverty. And some critics argue that many middle-class therapists don't feel comfortable with impoverished clients and tend to distance themselves from the poor (Lott, 2002; Smith, 2005). Although this social class bias surely is not limited to therapists, it creates another huge barrier to equal access for those who already have to grapple with countless problems associated with poverty.

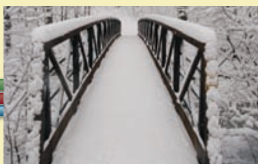
What can be done to improve mental health services for American minority groups? Researchers in this area have offered a variety of suggestions (Hong, Garcia, & Soriano, 2000; Miranda et al., 2005; Pedersen, 1994; Yamamoto et al., 1993). Discussions of possible solutions usually begin with the need to recruit and train more ethnic minority therapists. Studies show that ethnic minorities are more likely to go to mental health facilities that are staffed by a higher proportion of people who share their ethnic background (Snowden & Hu, 1996; Sue, Zane, & Young, 1994). Individual therapists have been urged to work harder at building a vigorous *therapeutic alliance* (a strong supportive bond) with their ethnic clients. A strong therapeutic alliance is associated with better therapeutic outcomes regardless of ethnicity, but some studies suggest that it is especially crucial for minority clients (Bender et al., 2007; Comas-Diaz, 2006). Finally, most authorities urge further investigation of how traditional approaches to therapy can be modified and tailored to be more compatible with specific cultural groups' attitudes, values, norms, and traditions (Hwang, 2006). A recent review of 76 studies that examined the effects of culturally adapted interventions found clear evidence that this tailoring process tends to yield positive effects (Griner & Smith, 2006). The benefits are particularly prominent when a treatment is tailored to a single, specific cultural group rather than a mixture of several or more cultural groups.

REVIEW of Key Points

15.18 In managed care systems, consumers usually pay lower prices but give up some of their freedom to obtain whatever treatments they believe necessary. Many clinicians and their clients believe that managed care has restricted access to mental health care and undermined its quality, as long-term therapy has become a thing of the past.

15.19 Combinations of insight, behavioral, and biomedical therapies are often used fruitfully in the treatment of psychological disorders. For example, the Featured Study showed how the tandem of interpersonal therapy and antidepressant medication could be valuable in preventing additional depressive episodes in an elderly population. Many modern therapists are eclectic, using specific ideas, techniques, and strategies gleaned from a number of theoretical approaches.

15.20 Because of cultural, language, and access barriers, therapeutic services are underutilized by most ethnic minorities in America. More culturally responsive approaches to treatment will require more minority therapists, more effort to build strong therapeutic alliances, and additional investigation of how traditional therapies can be tailored to be more compatible with specific ethnic groups' cultural heritage.



Key Learning Goals

15.21 Explain why people grew disenchanted with mental hospitals.

15.22 Assess the effects of the deinstitutionalization movement.

Institutional Treatment in Transition

Traditionally, much of the treatment of mental illness has been carried out in institutional settings, primarily in mental hospitals. **A *mental hospital* is a medical institution specializing in providing inpatient care for psychological disorders.** In the United States, a national network of state-funded mental hospitals started to emerge in the 1840s through the efforts of Dorothea Dix and other reformers (see Figure 15.18). Prior to these reforms, the mentally ill who were poor were housed in jails

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Figure 15.18

Dorothea Dix and the advent of mental hospitals in America. **During the 19th century, Dorothea Dix (inset) campaigned tirelessly to obtain funds for building mental hospitals. Many of these hospitals, such as the New York State Lunatic Asylum, were extremely large facilities. Although public mental hospitals improved the care of the mentally ill, they had a variety of shortcomings, which eventually prompted the deinstitutionalization movement.**

SOURCE: National Library of Medicine; (inset) Detail of painting of Dorothea Dix in Harrisburg State Hospital, photo by Ken Smith/LLR Collection.

and poorhouses or were left to wander the countryside. Today, mental hospitals continue to play an important role in the delivery of mental health services. However, since World War II, institutional care for mental illness has undergone a series of major transitions—and the dust hasn't settled yet. Let's look at how institutional care has evolved in recent decades.

Disenchantment with Mental Hospitals

By the 1950s, it had become apparent that public mental hospitals were not fulfilling their goals very well (Mechanic, 1980; Menninger, 2005). Experts began to realize that hospitalization often *contributed* to the development of pathology instead of curing it. What were the causes of these unexpected negative effects? Part of the problem was that the facilities were usually underfunded (Bloom, 1984). The lack of adequate funding meant that the facilities were overcrowded and understaffed. Hospital personnel were undertrained and overworked, making them hard-pressed to deliver minimal custodial care. Despite gallant efforts at treatment, the demoralizing conditions made most public mental hospitals decidedly nontherapeutic (Scull, 1990). These problems were aggravated by the fact that state mental hospitals served large geographic regions but were rarely placed near major population centers. As a result, most patients were uprooted from their community and isolated from their social support networks.

Disenchantment with the public mental hospital system inspired the *community mental health movement* that emerged in the 1960s (Duckworth & Borus, 1999; Huey, Ford, & Cole, 2005). The community mental health movement emphasizes (1) local, community-based care, (2) reduced dependence on hospitalization, and (3) the prevention of psychological disorders. Community mental health centers were intended to supplement mental hospitals with decentralized and more accessible services, but they have had their own funding struggles (Dixon & Goldman, 2004).

Deinstitutionalization

Mental hospitals continue to care for many people troubled by chronic mental illness, but their role in patient care has diminished. Since the 1960s, a policy of deinstitutionalization has been followed in the United States, as well as most other Western countries (Fakhoury & Priebe, 2002). ***Deinstitutionalization*** **refers to transferring the treatment of mental illness from inpatient institutions to community-based facilities that emphasize outpatient**

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care. This shift in responsibility was made possible by two developments: (1) the emergence of effective drug therapies for severe disorders and (2) the deployment of community mental health centers to coordinate local care (Goff & Gudeman, 1999).

The exodus of patients from mental hospitals has been dramatic. The average inpatient population in state and county mental hospitals had dropped from a peak of nearly 550,000 in the mid-1950s to around 70,000 by 2000, as shown in **Figure 15.19**. This trend does not mean that hospitalization for mental illness has become a thing of the past. A great many people are still hospitalized, but the shift has been toward placing them in local general hospitals for brief periods instead of distant psychiatric hospitals for long periods (Kiesler, 1992). In keeping with the philosophy of deinstitutionalization, these local facilities try to get patients stabilized and back into the community as swiftly as possible.

How has deinstitutionalization worked out? It gets mixed reviews. On the positive side, many people have benefited by avoiding disruptive and unnecessary hospitalization. Ample evidence suggests that alternatives to hospitalization can be as effective as and less costly than inpatient care (McGrew et al., 1999; Reinharz, Lesage, & Contandriopoulos, 2000). Moreover, follow-up studies of discharged patients reveal that a substantial majority prefer the greater freedom provided by community-based treatment (Leff, 2006).

Nonetheless, some unanticipated problems have arisen (Elpers, 2000; Munk-Jorgensen, 1999; Talbott, 2004). Many patients suffering from chronic psychological disorders had nowhere to go when they were released. They had no families, friends, or homes to return to. Many had no work skills and were poorly prepared to live on their own. These people were supposed to be absorbed by "halfway houses," sheltered workshops, and other types of intermediate care facilities. Unfortunately, many communities were never able to fund and build the planned facilities (Hogan & Morrison, 2003; Lamb, 1998). Thus, deinstitutionalization left two major problems in its wake: a "revolving door" population of people who flow in and out of psychiatric facilities, and a sizable population of homeless mentally ill people.

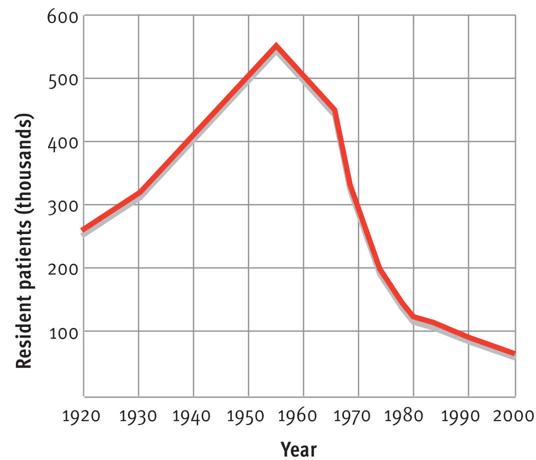

Figure 15.19
Declining inpatient population at state and county mental hospitals. The inpatient population in public mental hospitals has declined dramatically since the late 1950s, as a result of deinstitutionalization and the development of effective antipsychotic medication. (Data from the National Institute of Mental Health)

Mental Illness, the Revolving Door, and Homelessness

Although the proportion of hospital days attributable to mental illness has dwindled, admission rates for psychiatric hospitals have actually climbed. What has happened? Deinstitutionalization and drug therapy have created a revolving door through which many mentally ill people pass again and again (Castro et al., 2007; Geller, 1992; Langdon et al., 2001).

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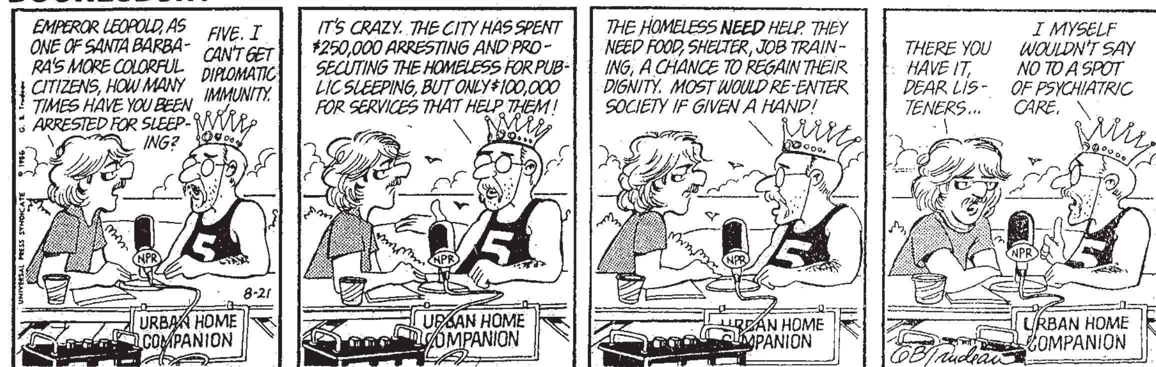

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Most of the people caught in the mental health system's revolving door suffer from chronic, severe disorders (usually schizophrenia) that often require hospitalization (Haywood et al., 1995). However, they respond to drug therapies in the hospital. Once they're stabilized through drug therapy, they no longer qualify for expensive hospital treatment according to the new standards created by deinstitutionalization and managed care. Thus, they're sent back out the door, into communities that often aren't prepared to provide adequate outpatient care. Because they lack appropriate care and support, their condition deteriorates and they soon require readmission to a hospital, where the cycle begins once again. Over two-thirds of all psychiatric inpatient admissions involve rehospitalizing a former patient. Moreover, 40% to 50% of patients are readmitted within a year of their release (Bridge & Barbe, 2004).

Deinstitutionalization has also been blamed for the growing population of homeless people. Studies have consistently found elevated rates of mental illness among the homeless. Taken as a whole, the evidence suggests that roughly one-third of homeless people suffer from severe mental illness (schizophrenic and mood disorders), that another one-third or more are struggling with alcohol and drug problems, that many qualify for multiple diagnoses, and that the prevalence of mental illness among the homeless may be increasing (Bassuk et al., 1998; Folsom et al., 2005; Haugland et al., 1997; North et al., 2004). In essence, homeless shelters have become a *de facto* element of America's mental health care system (Callicutt, 2006).

The popular media routinely equate homelessness with mental illness, and it is widely assumed that deinstitutionalization is largely responsible for the rapid growth of homelessness in America. Although deinstitutionalization has probably *contributed* to the growth of homelessness, many experts in this area maintain that it is an oversimplification to blame the problem of homelessness chiefly on deinstitutionalization (Main, 1998; Sullivan, Burnam, & Koegel, 2000).

In light of the revolving door problem and homelessness among the mentally ill, what can we conclude about deinstitutionalization? It appears to be a worthwhile idea that has been poorly executed (Lamb, 1998). Overall, the policy has probably been a benefit to countless people with milder disorders but a cruel trick on many others with severe, chronic disorders. Ultimately, it's clear that our society is not providing adequate care for a sizable segment of the mentally ill population (Appelbaum, 2002; Elpers, 2000; Gittelman, 2005; Torrey, 1996). That's not a new development. Inadequate care for mental illness has always been the norm. Societies always struggle with the problem of what to do with the mentally ill and how to pay for their care (Duckworth & Borus, 1999).

REVIEW of Key Points

15.21 Experts eventually realized that mental hospitals often contributed to the development of pathology instead of curing it, in part because they tended to be underfunded and understaffed, leading to demoralizing conditions. Disenchantment with the negative effects of mental hospitals led to the advent of more localized community mental health centers and a policy of deinstitutionalization.

15.22 As a result of deinstitutionalization, long-term hospitalization for mental disorders is largely a thing of the past. Deinstitutionalization has worked well for some patients, but it has spawned some unanticipated problems, including the revolving door problem and increased homelessness.

Reflecting on the Chapter's Themes

Key Learning Goals

15.23 Identify the two unifying themes highlighted in this chapter.

Cultural Heritage

Theoretical Diversity

In our discussion of psychotherapy, one of our unifying themes—the value of theoretical diversity—was particularly prominent, and one other theme—the importance of culture—surfaced briefly. Let's discuss the latter theme first. The approaches to treatment described in this chapter are products of modern, white, middle-class, Western culture. Some of these therapies have proven useful in some other cultures, but many have turned out to be irrelevant or counterproductive when used with different cultural groups, including ethnic minorities in Western society. Thus, we have seen once again that cultural factors influence psychological processes and that Western psychology cannot assume that its theories and practices have universal applicability.

As for theoretical diversity, its value can be illustrated with a rhetorical question: Can you imagine what the state of modern psychotherapy would be if everyone in psychology and psychiatry had simply accepted Freud's theories about the nature and

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treatment of psychological disorders? If not for theoretical diversity, psychotherapy might still be in the dark ages. Psychoanalysis can be a useful method of therapy, but it would be a tragic state of affairs if that were the *only* treatment available. Multitudes of people have benefited from alternative approaches to treatment that emerged out of tensions between psychoanalytic theory and other theoretical perspectives. People have diverse problems, rooted in varied origins, that call for the pursuit of different therapeutic goals. Thus, it's fortunate that people can choose from a diverse array of approaches to treatment. The illustrated overview on pages 646–647 summarizes and compares some of the approaches that we've discussed in this chapter. This summary chart shows that the major approaches to treatment each have their own vision of the nature of human discontent and the ideal remedy.

Of course, diversity can be confusing. The range and variety of available treatments in modern psychotherapy leaves many people puzzled about their options. Thus, in the Personal Application we'll sort through the practical issues involved in selecting a therapist.

REVIEW of Key Points

15.23 Our discussion of psychotherapy highlighted the value of theoretical diversity. Conflicting theoretical orientations have generated varied approaches to treatment. Our coverage of therapy also showed once again that cultural factors shape psychological processes.

PERSONAL APPLICATION

Key Learning Goals

15.24 Discuss where to seek therapy and the potential importance of a therapist's sex and professional background.

15.25 Evaluate the importance of a therapist's theoretical approach.

15.26 Summarize what one should look for in a prospective therapist and what one should expect out of therapy.

Looking for a Therapist

Answer the following "true" or "false."

____ **1** Psychotherapy is an art as well as a science.

____ **2** Psychotherapy can be harmful or damaging to a client.

____ **3** Psychotherapy does not have to be expensive.

____ **4** The type of professional degree that a therapist holds is relatively unimportant.

All of these statements are true. Do any of them surprise you? If so, you're in good company. Many people know relatively little about the practicalities of selecting a therapist.

The task of finding an appropriate therapist is complex. Should you see a psychologist or psychiatrist? Should you opt for individual therapy or group therapy? Should you see a client-centered therapist or a behavior therapist? The unfortunate part of this situation is that people seeking psychotherapy often feel overwhelmed by personal difficulties. The last thing they need is to be confronted by yet another complex problem.

Nonetheless, the importance of finding a good therapist cannot be overestimated. Treatment can sometimes have harmful rather than helpful effects. We have already discussed how drug therapies and ECT can sometimes be damaging, but problems are not limited to these interventions. Talking about your problems with a therapist may sound harmless, but studies indicate that insight therapies can also backfire (Lambert & Ogles, 2004; Lilienfeld, 2007). Although a great many talented therapists are available, psychotherapy, like any other profession, has incompetent practitioners as well. Therefore, you should shop for a skilled therapist, just as you would for a good attorney or a good mechanic.

In this application, we'll go over some information that should be helpful if you ever have to look for a therapist for yourself or for a friend or family member (based on Beutler, Bongar, & Shurkin, 2001; Ehrenberg & Ehrenberg, 1994; Pittman, 1994).

Where Do You Find Therapeutic Services?

Psychotherapy can be found in a variety of settings. Contrary to general belief, most therapists are not in private practice. Many work in institutional settings such as community mental health centers, hospitals, and human service agencies. The principal sources of therapeutic services are described in Table 15.2. The exact configuration of therapeutic services available will vary from one community to another. To find out what your community has to offer, it is a good idea to consult your friends, your local phone book, or your local community mental health center.

Is the Therapist's Profession or Sex Important?

Psychotherapists may be trained in psychology, psychiatry, social work, counseling, psychiatric nursing, or marriage and family therapy. Researchers have *not* found any re-

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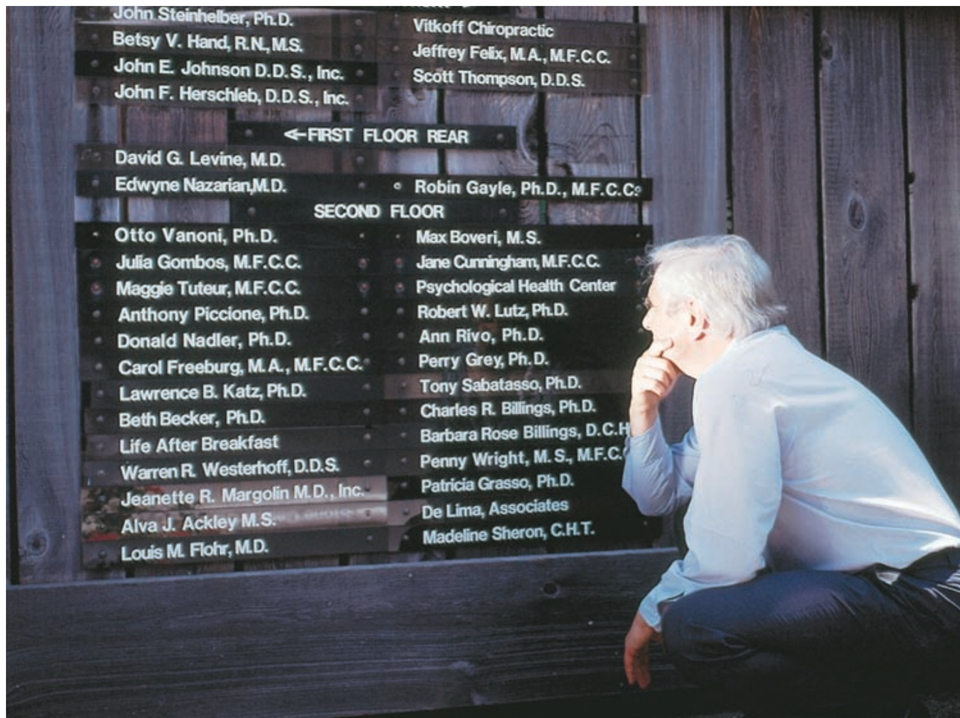

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Finding the right therapist is no easy task. You need to take into account the therapist's training and orientation, fees charged, and personality. An initial visit should give you a good idea of what a particular therapist is like.

liable associations between therapists' professional background and therapeutic efficacy (Beutler et al., 2004), probably because many talented therapists can be found in all of these professions. Thus, the kind of degree that a therapist holds doesn't need to be a crucial consideration in your selection process.

Whether a therapist's sex is important depends on your attitude (Nadelson, Notman, & McCarthy, 2005). If *you* feel that the therapist's sex is important, then for you it is. The therapeutic relationship must be characterized by trust and rapport. Feeling uncomfortable with a therapist of one sex or the other could inhibit the therapeutic process. Thus, you should feel free to look for a male or female therapist if you prefer to do so. This point is probably most relevant to female clients whose troubles may be related to sexism in our society (Kaplan, 1985). It is entirely reasonable for women to seek a therapist with a feminist perspective if that would make them feel more comfortable.

Speaking of sex, you should be aware that sexual exploitation is an occasional problem in the context of therapy. Studies indicate that a small minority of therapists take advantage of their clients sexually (Pope, Keith-Spiegel, & Tabachnick, 1986). These incidents almost always involve a male therapist making advances to a female client. The available evidence indicates that these sexual liaisons are usually harmful to clients (Gabbard, 1994; Williams, 1992). There are absolutely no situations in which therapist-client sexual relations are an ethical therapeutic practice. If a therapist makes sexual advances, a client should terminate treatment.

Table 15.2 Principal Sources of Therapeutic Services

Source	Comments
Private practitioners	Self-employed therapists are listed in the Yellow Pages under their professional category, such as psychologists or psychiatrists. Private practitioners tend to be relatively expensive, but they also tend to be highly experienced therapists.
Community mental health centers	Community mental health centers have salaried psychologists, psychiatrists, and social workers on staff. The centers provide a variety of services and often have staff available on weekends and at night to deal with emergencies.
Hospitals	Several kinds of hospitals provide therapeutic services. There are both public and private mental hospitals that specialize in the care of people with psychological disorders. Many general hospitals have a psychiatric ward, and those that do not usually have psychiatrists and psychologists on staff and on call. Although hospitals tend to concentrate on in-patient treatment, many provide outpatient therapy as well.
Human service agencies	Various social service agencies employ therapists to provide short-term counseling. Depending on your community, you may find agencies that deal with family problems, juvenile problems, drug problems, and so forth.
Schools and workplaces	Most high schools and colleges have counseling centers where students can get help with personal problems. Similarly, some large businesses offer in-house counseling to their employees.

Is Treatment Always Expensive?

Psychotherapy does not have to be prohibitively expensive. Private practitioners tend to be the most expensive, charging between $75 and $140 per (50-minute) hour. These fees may seem high, but they are in line with those of similar professionals, such as dentists and attorneys. Community mental health centers and social service agencies are usually supported by tax dollars. As a result they can charge lower fees than most therapists in private practice. Many of these organizations use a sliding scale, so that clients are charged according to how much they can afford to pay. Thus, most communities have inexpensive opportunities for psychotherapy. Moreover, most health insurance plans and HMOs provide coverage for at least some forms of mental health care.

Is the Therapist's Theoretical Approach Important?

Logically, you might expect that the diverse approaches to therapy ought to vary

in their effectiveness. For the most part, this is *not* what researchers find, however. After reviewing many studies of therapeutic efficacy, Jerome Frank (1961) and Lester Luborsky and his colleagues (1975) both quote the dodo bird who has just judged a race in *Alice in Wonderland: "Everybody* has won, and *all* must have prizes." Improvement rates for various theoretical orientations usually come out pretty close in most studies (Lambert & Bergin, 2004; Luborsky et al., 2002; Wampold, 2001; see **Figure 15.20**).

However, these findings are a little misleading, as the estimates of overall effectiveness have been averaged across many types of patients and many types of problems. Most experts seem to think that *for certain types of problems, some approaches to therapy are more effective than others* (Beutler, 2002; Crits-Christoph, 1997; Norcross, 1995). For example, Martin Seligman (1995) asserts that panic disorders respond best to cognitive therapy, that specific phobias are most amenable to treatment with systematic desensitization, and that obsessive-compulsive disorders are best treated with behavior therapy or medication. Thus, for a specific type of problem, a therapist's theoretical approach *may* make a difference.

It is also important to point out that the finding that different approaches to therapy are roughly equal in overall efficacy does not mean that all *therapists* are created equal. Some therapists unquestionably are more effective than others. However, these variations in effectiveness appear to depend on individual therapists' personal skills rather than on their theoretical orientation (Beutler et al., 2004). Good, bad, and mediocre therapists are found within each school of thought.

The key point is that effective therapy requires skill and creativity. Arnold Lazarus, who devised multimodal therapy, emphasizes that therapists "straddle the fence between science and art." Therapy is scientific in that interventions are based on extensive theory and empirical research (Forsyth & Strong, 1986). Ultimately, though, each client is a unique human being, and the therapist has to creatively fashion a treatment program that will help that individual.

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Therapy is both a science and an art. It is scientific in that practitioners are guided in their work by a huge body of empirical research. It is an art in that therapists often have to be creative in adapting their treatment procedures to individual patients and their idiosyncrasies.

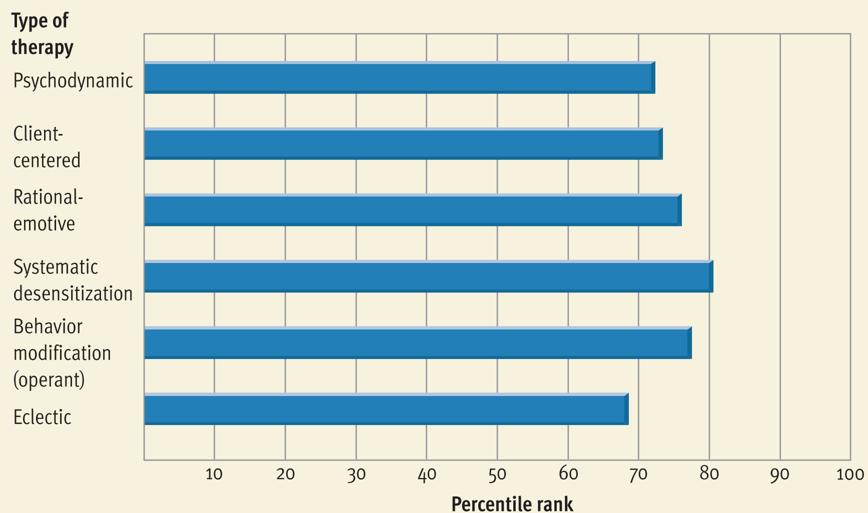

Figure 15.20
Estimates of the effectiveness of various approaches to psychotherapy. **Smith and Glass (1977) reviewed nearly 400 studies in which clients who were treated with a specific type of therapy were compared with a control group made up of individuals with similar problems who went untreated. The bars indicate the percentile rank (on outcome measures) attained by the average client treated with each type of therapy when compared to control subjects. The higher the percentile, the more effective the therapy was. As you can see, the various approaches were fairly similar in their overall effectiveness.**

SOURCE: Adapted from Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome series. *American Psychologist, 32,* 752–760. Copyright © 1977 by the American Psychological Association. Adapted by permission of the author.

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What Should You Look For in a Prospective Therapist?

Some clients are timid about asking prospective therapists questions about their training, approach, fees, and so forth. However, these are reasonable questions, and the vast majority of therapists will be most accommodating in providing answers. Usually, you can ask your preliminary questions over the phone. If things seem promising, you may decide to make an appointment for an interview (for which you will probably have to pay). In this interview, the therapist will gather more information to determine the likelihood of helping you, given his or her training and approach to treatment. At the same time, you should be making a similar judgment about whether *you* believe the therapist can help you with your problems.

What should you look for? First, you should look for personal warmth and sincere concern. Try to judge whether you will be able to talk to this person in a candid, nondefensive way. Second, look for empathy and understanding. Is the person capable of appreciating your point of view? Third, look for self-confidence. Self-assured therapists will communicate a sense of competence without trying to intimidate you with jargon or boasting needlessly about what they can do for you. When all is said and done, you should *like* your therapist. Otherwise, it will be difficult to establish the needed rapport.

What Is Therapy Like?

It is important to have realistic expectations about therapy, or you may be unnecessarily disappointed. Some people expect miracles. They expect to turn their life around quickly with little effort. Others expect their therapist to run their lives for them. These are unrealistic expectations.

Therapy is usually a slow process. Your problems are not likely to melt away quickly. Moreover, therapy is hard work, and your therapist is only a facilitator. Ultimately, *you* have to confront the challenge of changing your behavior, your feelings, or your personality. This process may not be pleasant. You may have to face up to some painful truths about yourself. As Ehrenberg and Ehrenberg (1986) point out, "Psychotherapy takes time, effort, and courage."

REVIEW of Key Points

15.24 Therapeutic services are available in many settings, and such services need not be expensive. Both excellent and mediocre therapists can be found in all of the mental health professions. Thus, therapists' personal skills are more important than their professional degree. Whether a therapist's sex is important depends on the client's attitude.

15.25 The various theoretical approaches to therapy appear to be fairly similar in overall effectiveness. However, for certain types of problems, some approaches are probably more effective than others, and all therapists are not created equal.

15.26 In selecting a therapist, warmth, empathy, confidence, and likability are desirable traits. It is important to have realistic expectations about therapy. Therapy tends to be a slow, challenging process requiring hard work.

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CRITICAL THINKING APPLICATION

From Crisis to Wellness—But Was It the Therapy?

Key Learning Goals

15.27 Understand how placebo effects and regression toward the mean can complicate the evaluation of therapy.

It often happens this way. Problems seem to go from bad to worse—the trigger could be severe pressures at work, an acrimonious fight with your spouse, or a child's unruly behavior spiraling out of control. At some point, you recognize that it might be prudent to seek professional assistance from a therapist, but where do you turn? If you are like most people, you will probably hesitate before actively seeking professional help. People hesitate because therapy carries a stigma, because the task of finding a therapist is daunting, and because they hope that their psychological problems will clear up on their own—which *does* happen with some regularity. When people finally decide to pursue mental health care, it is often because they feel like they have reached rock bottom in terms of their functioning and they have no choice. Motivated by their crisis, they enter into treatment, looking for a ray of hope. Will therapy help them feel better?

It may surprise you to learn that the answer *generally* would be "yes," even if professional treatment itself were utterly worthless and totally ineffectual. There are two major reasons that people entering therapy are likely to get better, regardless of whether their treatment is effective. You can probably guess one of these reasons, which has been mentioned repeatedly in the chapter: the power of the *placebo*. ***Placebo effects* occur when people's expectations lead them to experience some change even though they receive a fake treatment** (like getting a sugar pill instead of a real drug). Clients generally enter therapy with expectations that it will have positive effects, and as we have emphasized throughout this text, *people have a remarkable tendency to see what they expect to see*. Because of this factor, studies of the efficacy of medical drugs always include a placebo condition in which subjects are given fake medication (see Chapter 2). Researchers are often quite surprised by just how much the placebo subjects improve (Fisher & Greenberg, 1997; Walsh et al., 2002). Placebo effects can be powerful and should be taken into consideration whenever efforts are made to evaluate the efficacy of some approach to treatment.

The other factor at work is the main focus in this Application. It is an interesting statistical phenomenon that we have not discussed previously: *regression toward the mean*. ***Regression toward the mean* occurs when people who score extremely high or low on some trait are measured a second time and their new scores fall closer to the mean (average).** Regression effects work in both directions: On the second measurement high scorers tend to fall back toward the mean and low scorers tend to creep upward toward the mean. For example, let's say we wanted to evaluate the effectiveness of a one-day coaching program intended to improve performance on the SAT test. We reason that coaching is most likely to help students who have performed poorly on the test, so we recruit a sample of high school students who have previously scored in the bottom 20% on the SAT. Thanks to regression toward the mean, most of these students will score higher if they take the SAT a second time, so our coaching program may *look* effective even if it has no value. By the way, if we set out to see whether our coaching program could increase the performance of high scorers, regression effects would be working *against* us. If we recruited a sample of students who had scored in the upper 20% on the SAT, their scores would tend to move downward when tested a second time, which could cancel out most or all of the beneficial effects of the coaching program. The processes underlying regression toward the mean are complex matters of probability, but they can be approximated by a simple principle: If you are near the bottom, there's almost nowhere to go but up, and if you are near the top, there's almost nowhere to go but down.

What does all of this have to do with the effects of professional treatment for psychological problems and disorders? Well, chance variations in the ups and downs of life occur for all of us. But recall that most people enter psychotherapy during a time of severe crisis, when they are at a really low point in their lives. If you measure the

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Placebo effects and regression toward the mean are two prominent factors that make it difficult to evaluate the efficacy of various approaches to therapy.

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mental health of a group of people entering therapy, they will mostly get relatively low scores. If you measure their mental health again a few months later, chances are that most of them will score higher—with or without therapy—because of regression toward the mean. This is not a matter of idle speculation. Studies of untreated subjects demonstrate that poor scores on measures of mental health regress toward the mean when participants are assessed a second time (Flett, Vredenburg, & Krames, 1995; Hsu, 1995).

Does the fact that most people will get better even without therapy mean that there is no sound evidence that psychotherapy works? No, regression effects, along with placebo effects, do create major headaches for researchers evaluating the efficacy of various therapies, but these problems *can* be circumvented. Control groups, random assignment, placebo conditions, and statistical adjustments can be used to control for regression and placebo effects, as well as for other threats to validity. As discussed in the main body of the chapter, researchers have accumulated rigorous evidence that most approaches to therapy have demonstrated efficacy. However, our discussion of placebo and regression effects shows you some of the factors that make this type of research far more complicated and challenging than might be anticipated.

Recognizing how regression toward the mean can occur in a variety of contexts is an important critical thinking skill, so let's look at some additional examples. Think about an outstanding young pro baseball player who has a fabulous first season and is named "Rookie of the Year." What sort of performance would you predict for this athlete for the next year? Before you make

Placebo effects and regression toward the mean can help explain why phony, worthless treatments can have sincere supporters who really believe that the bogus interventions are effective.

your prediction, think about regression toward the mean. Statistically speaking, our Rookie of the Year is likely to perform well above average the next year, but not as well as he did in his first year. If you are a sports fan, you may recognize this pattern as the "sophomore slump." Many sports columnists have written about the sophomore slump, which they typically blame on the athlete's personality or motivation ("He got lazy,'" "He got cocky," "The money and fame went to his head," and so forth). A simple appeal to regression toward the mean could explain this sort of outcome, with no need to denigrate the personality or motivation of the athlete. Of course, sometimes the Rookie of the Year performs even better during his second year. Thus, our baseball example can be used to emphasize an important point. Regression toward the mean is not an inevitability. It is a statistical tendency that predicts what will happen far more often than not, but it is merely a matter of probability—which means it is a much more reliable principle when applied to groups (say, the top ten rookies in a specific year) rather than to individuals.

Let's return to the world of therapy for one last thought about the significance of both regression and placebo effects. Over the years, a host of quacks, charlatans, con artists, herbalists, and faith healers have marketed and sold an endless array of worthless treatments for both psychological problems and physical maladies. In many instances, people who have been treated with these phony therapies have expressed satisfaction or even praise and gratitude. For instance, you may have heard someone sincerely rave about some herbal remedy or psychic advice that you were pretty sure was really worthless. If so, you were probably puzzled by their glowing testimonials. Well, you now have two highly plausible explanations for why people can honestly believe that they have derived great benefit from harebrained, bogus treatments: placebo effects and regression effects. The people who provide testimonials for worthless treatments may have experienced *genuine* improvements in their conditions, but those improvements were probably the result of placebo effects and regression toward the mean. Placebo and regression effects add to the many reasons that you should always be skeptical about anecdotal evidence. And they help explain why charlatans can be so successful and why unsound, ineffective treatments can have sincere proponents.

Table 15.3 Critical Thinking Skills Discussed in This Application

Skill	Description
Recognizing situations in which placebo effects might occur	The critical thinker understands that if people have expectations that a treatment will produce a certain effect, they may experience that effect even if the treatment was fake or ineffectual.
Recognizing situations in which regression toward the mean may occur	The critical thinker understands that when people are selected for their extremely high or low scores on some trait, their subsequent scores will probably fall closer to the mean.
Recognizing the limitations of anecdotal evidence	The critical thinker is wary of anecdotal evidence, which consists of personal stories used to support one's assertions. Anecdotal evidence tends to be unrepresentative, inaccurate, and unreliable.

REVIEW of Key Points

15.27 People entering therapy are likely to get better even if their treatment is ineffective, because of placebo effects and regression toward the mean. Regression toward the mean occurs when people selected for their extremely high or low scores on some trait are measured a second time and their new scores fall closer to the mean. Regression and placebo effects may also help explain why people can often be deceived by phony, ineffectual treatments.

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CHAPTER 15 RECAP

Key Ideas

The Elements of the Treatment Process

- Approaches to treatment are diverse, but they can be grouped into three categories: insight therapies, behavior therapies, and biomedical therapies.
- Therapists come from a variety of professional backgrounds. Clinical and counseling psychologists, psychiatrists, clinical social workers, psychiatric nurses, counselors, and marriage and family therapists are key providers of therapeutic services.

Insight Therapies

- Insight therapies involve verbal interactions intended to enhance self-knowledge. In psychoanalysis, free association and dream analysis are used to explore the unconscious. When an analyst's probing hits sensitive areas, resistance can be expected.
- The transference relationship may be used to overcome this resistance so that the client can handle interpretations that lead to insight. Classical psychoanalysis is not widely practiced anymore, but Freud's legacy lives on in a rich diversity of modern psychodynamic therapies.
- The client-centered therapist tries to provide a supportive climate in which clients can restructure their self-concept. The process of therapy emphasizes clarification of the client's feelings and self-acceptance. Positive psychotherapy attempts to get clients to recognize their strengths, appreciate their blessings, savor positive experiences, and to find meaning in their lives.
- Most theoretical approaches to insight therapy have been adapted for use with groups. Evaluating the effectiveness of any approach to treatment is complex and difficult. Nonetheless, the weight of the evidence suggests that insight therapies are superior to no treatment or placebo treatment. Studies suggest that common factors make a significant contribution to the benefits of various therapies.

Behavior Therapies

- Behavior therapies use the principles of learning in direct efforts to change specific aspects of behavior. Wolpe's systematic desensitization is a counterconditioning treatment for phobias. In aversion therapy, a stimulus associated with an unwanted response is paired with an unpleasant stimulus in an effort to eliminate the maladaptive response.
- Social skills training can improve clients' interpersonal skills through shaping, modeling, and behavioral rehearsal. Beck's cognitive therapy concentrates on changing the way clients think about events in their lives. There is ample evidence that behavior therapies are effective in the treatment of a wide variety of disorders.

Biomedical Therapies

- Biomedical therapies are physiological interventions for psychological problems. Antianxiety drugs are used to relieve excessive apprehension. Antipsychotic drugs are used primarily in the treatment of schizophrenia. Antidepressants are used to bring people out of episodes of depression. Bipolar mood disorders are treated with lithium and other mood stabilizers.
- Drug therapies can be quite effective, but they have their drawbacks. All of the drugs produce problematic side effects. The adverse effects of psychiatric drugs may be underestimated because pharmaceutical research is not as impartial as it should be.
- Electroconvulsive therapy (ECT) is used to trigger a cortical seizure that is believed to have therapeutic value for mood disorders, especially depression. Evidence about the effectiveness and risks of ECT is contradictory. Transcranial magnetic stimulation may have value in the treatment of depression, and deep brain stimulation is being investigated as a treatment for depression and obsessive-compulsive disorder.

Current Trends and Issues in Treatment

- Many clinicians and their clients believe that managed care has restricted access to mental health care and undermined its quality. Combinations of insight, behavioral, and biomedical therapies are often used fruitfully in the treatment of psychological disorders. Many modern therapists are eclectic, using specific ideas, techniques, and strategies gleaned from a number of theoretical approaches.
- Because of cultural, language, and access barriers, therapeutic services are underutilized by ethnic minorities in America. However, the crux of the problem is the failure of institutions to provide culturally sensitive and responsive forms of treatment for ethnic minorities.

Institutional Treatment in Transition

- Disenchantment with the negative effects of mental hospitals led to the advent of more localized community mental health centers and a policy of deinstitutionalization. Long-term hospitalization for mental disorders is largely a thing of the past.
- Unfortunately, deinstitutionalization has left some unanticipated problems in its wake, such as the revolving door problem and increased homelessness. However, many theorists believe that homelessness is primarily an economic problem.

Reflecting on the Chapter's Themes

- Our discussion of psychotherapy highlighted the value of theoretical diversity. Conflicting theoretical orientations have generated varied approaches to treatment. Our coverage of therapy also showed once again that cultural factors shape psychological processes.

PERSONAL APPLICATION Looking for a Therapist

- Therapeutic services are available in many settings, and such services need not be expensive. Excellent therapists and mediocre therapists can be found in all of the mental health professions, using the full range of therapeutic approaches.
- In selecting a therapist, you should look for warmth, empathy, confidence, and likability, and it is reasonable to insist on a therapist of one sex or the other. Therapy is often a difficult, gradual process that usually requires hard work.

CRITICAL THINKING APPLICATION From Crisis to Wellness—But Was It the Therapy?

- People entering therapy are likely to get better even if their treatment is ineffective, because of placebo effects and regression toward the mean.
- Regression toward the mean occurs when people selected for their extremely high or low scores on some trait are measured a second time and their new scores fall closer to the mean. Regression and placebo effects may also help explain why people can often be deceived by phony, ineffectual treatments.

Key Terms

Antianxiety drugs (p. 638)
Antidepressant drugs (p. 639)
Antipsychotic drugs (p. 639)
Aversion therapy (p. 635)
Behavior therapies (pp. 633–634)
Biomedical therapies (p. 638)
Client-centered therapy (p. 628)
Clinical psychologists (p. 624)
Cognitive-behavioral treatments (p. 636)
Cognitive therapy (p. 636)
Counseling psychologists (p. 624)
Deep brain stimulation (DBS) (p. 644)
Deinstitutionalization (pp. 651–652)
Dream analysis (p. 626)
Eclecticism (p. 649)
Electroconvulsive therapy (ECT) (p. 642)
Free association (p. 626)
Group therapy (p. 630)
Insight therapies (p. 626)
Interpretation (p. 627)
Mental hospital (p. 650)
Mood stabilizers (p. 641)
Placebo effects (p. 658)
Positive psychology (p. 630)
Psychiatrists (p. 625)
Psychoanalysis (p. 626)
Psychopharmacotherapy (p. 638)
Regression toward the mean (p. 658)
Resistance (p. 627)
Social skills training (p. 636)
Spontaneous remission (p. 632)
Systematic desensitization (p. 634)
Tardive dyskinesia (p. 639)
Transcranial magnetic stimulation (TMS) (p. 644)
Transference (p. 628)

Key People

Aaron Beck (pp. 636–637)
Dorothea Dix (pp. 650–651)
Sigmund Freud (pp. 626–628)
Carl Rogers (pp. 628–630)
Joseph Wolpe (pp. 634–635)

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CHAPTER 15 PRACTICE TEST

1. After undergoing psychoanalysis for several months, Karen has suddenly started "forgetting" to attend her therapy sessions. Karen's behavior is most likely a form of:
A. resistance.
B. transference.
C. insight.
D. catharsis.

2. Because Suzanne has an unconscious sexual attraction to her father, she behaves seductively toward her therapist. Suzanne's behavior is most likely a form of:
A. resistance.
B. transference.
C. misinterpretation.
D. an unconscious defense mechanism.

3. The key task of the client-centered therapist is:
A. interpretation of the client's thoughts, feelings, memories, and behaviors.
B. clarification of the client's feelings.
C. confrontation of the client's irrational thoughts.
D. modification of the client's problematic behaviors.

4. The goal of behavior therapy is to:
A. identify the early childhood unconscious conflicts that are the source of the client's symptoms.
B. achieve major personality reconstruction.
C. alter the frequency of specific problematic responses by using conditioning techniques.
D. alter the client's brain chemistry by prescribing specific drugs.

5. A therapist openly challenges a client's statement that she is a failure as a woman because her boyfriend left her, insisting that she justify it with evidence. Which type of therapy is probably being used?
A. psychodynamic therapy
B. client-centered therapy
C. behavior therapy
D. cognitive therapy

6. Collectively, numerous studies of therapeutic outcome suggest that:
A. insight therapy is superior to no treatment or placebo treatment.
B. individual insight therapy is effective, but group therapy is not.
C. group therapy is effective, but individual insight therapy is not.
D. insight therapy is only effective if patients are in therapy for at least two years.

7. Systematic desensitization is particularly effective for the treatment of ______________ disorders.
A. generalized anxiety
B. panic
C. obsessive-compulsive
D. phobic

8. Linda's therapist has her practice active listening skills in structured role-playing exercises. Later, Linda is gradually asked to practice these skills with family members, friends, and finally, her boss. Linda is undergoing:
A. systematic desensitization.
B. biofeedback.
C. a token economy procedure.
D. social skills training.

9. After being released from a hospital, many schizophrenic patients stop taking their antipsychotic medication because:
A. their mental impairment causes them to forget.
B. of the unpleasant side effects.
C. most schizophrenics don't believe they are ill.
D. of all of the above.

10. Selective serotonin reuptake inhibitors (SSRIs) can be effective in the treatment of ______________ disorders.
A. depressive
B. schizophrenic
C. obsessive-compulsive
D. both a and c

11. Modern psychotherapy:
A. was spawned by a cultural milieu that viewed the self as an independent, rational being.
B. embraces universal cultural values.
C. has been successfully exported to many non-Western cultures.
D. involves both b and c.

12. The community mental health movement emphasizes:
A. segregation of the mentally ill from the general population.
B. increased dependence on long-term inpatient care.
C. local care and the prevention of psychological disorders.
D. all of the above.

13. Many people repeatedly go in and out of mental hospitals. Typically, such people are released because ____________________; they are eventually readmitted because ____________________.
A. they have been stabilized through drug therapy; their condition deteriorates once again because of inadequate outpatient care
B. they run out of funds to pay for hospitalization; they once again can afford it
C. they have been cured of their disorder; they develop another disorder
D. they no longer want to be hospitalized; they voluntarily recommit themselves

14. The type of professional training a therapist has:
A. is the most important indicator of his or her competence.
B. should be the major consideration in choosing a therapist.
C. is not all that important, since talented therapists can be found in all of the mental health professions.
D. involves both a and b.

15. Which of the following could be explained by regression toward the mean?
A. You get an average bowling score in one game and a superb score in the next game.
B. You get an average bowling score in one game and a very low score in the next game.
C. You get an average bowling score in one game and another average score in the next game.
D. You get a terrible bowling score in one game and an average score in the next game.

Answers

1 A p. 627
2 B p. 628
3 B pp. 629–630
4 C pp. 633–634
5 D pp. 636–637
6 A p. 632
7 D pp. 634–635
8 D p. 636
9 B p. 639
10 D p. 640
11 A p. 649
12 C p. 651
13 A pp. 652–653
14 C pp. 654–655
15 D pp. 658–659

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