15

Therapy

Since the beginning of the movie age, mentally ill people and their treatment have been the subject of some of Hollywood's most popular and influential films. In addition to the false or exaggerated portrayals of mental health treatment facilities, consider how people with mental illness are depicted. They are either cruel, sociopathic criminals (Anthony Hopkins in *Silence of the Lambs*) or helpless, incompetent victims (Jack Nicholson in *One Flew Over the Cuckoo's Nest* and Winona Ryder in *Girl Interrupted*). Likewise, popular films about mental illness often feature mad doctors, heartless nurses, and brutal treatment methods. Although these portrayals may boost movie ticket sales, they also perpetuate harmful stereotypes (Kondo, 2008).

Like many people, your impressions of therapy may be unfairly guided by these Hollywood depictions of psychological disorders and their treatment. To offset this potential bias, we will present a balanced, factual overview of the latest research on psychotherapy and mental illness. As you'll see, modern psychotherapy can be very effective and prevent much needless suffering, not only for people with psychological disorders but also for those seeking help with everyday problems in living.

You'll also discover that professional therapists include not only psychologists, but also psychiatrists, psychiatric nurses, social workers, counselors, and clergy with training in pastoral counseling. There are numerous forms of psychotherapy. According to one expert (Kazdin, 1994), there may be over 400 approaches to treatment. To organize our discussion, we have grouped treatments into three categories: *insight therapies*, *behavior therapies*, and *biomedical therapies*. After exploring these approaches, we conclude with a discussion of issues that are common to all major forms of psychotherapy.

Paramount Pictures

An Overview of the Three Approaches to Therapy

Insight	Behavior	Biomedical
Psychoanalysis (Freud) Psychodynamic	Classical conditioning • Systematic desensitization • Aversion therapy	Psychopharmacology
Cognitive • Rational–emotive therapy (Ellis) • Cognitive–behavior therapy (Beck)	Operant conditioning • Shaping • Reinforcement • Punishment • Extinction	Electroconvulsive therapy
Humanistic • Client–centered therapy (Rogers)	Observational learning • Modeling	Psychosurgery
Group, family, and marital		

Achievement

Objective 15.1: *Discuss potential problems with media portrayals of therapy, four common myths about therapy, and its three general approaches.*

/Getty Images

Insight Therapies

Psychoanalysis/Psychodynamic Therapies
Cognitive Therapies
Humanistic Therapies
Group, Family, and Marital Therapies

CRITICAL THINKING/ACTIVE LEARNING
Hunting for Good Therapy Films

Behavior Therapies

Classical Conditioning Techniques
Operant Conditioning Techniques
Observational Learning Techniques
Evaluating Behavior Therapies

Biomedical Therapies

Psychopharmacology
Electroconvulsive Therapy and Psychosurgery
Evaluating Biomedical Therapies

Therapy and Critical Thinking

Therapy Essentials

PSYCHOLOGY AT WORK
Careers in Mental Health

RESEARCH HIGHLIGHT
Mental Health and the Family—PTSD

GENDER & CULTURAL DIVERSITY
Similarities and Differences

Institutionalization
Evaluating and Finding Therapy

PSYCHOLOGY AT WORK
Non Professional Therapy—Talking to the Depressed

Application

WHY STUDY PSYCHOLOGY?

Do you recognize these myths?

- *Myth: There is one best therapy.*

  Fact: Many problems can be treated equally well with many different forms of therapy.

- *Myth: Therapists can read your mind.*

  Fact: Good therapists often seem to have an uncanny ability to understand how their clients are feeling and to know when someone is trying to avoid certain topics. This is not due to any special mind-reading ability. It reflects their specialized training and daily experience working with troubled people.

Michael Goldman/Masterfile

- *Myth: People who go to therapists are crazy or weak.*

  Fact: Most people seek counseling because of stress in their lives or because they realize that therapy can improve their level of functioning. It is difficult to be objective about our own problems. Seeking therapy is a sign not only of wisdom but also of personal strength.

- *Myth: Only the rich can afford therapy.*

  Fact: Therapy can be expensive. But many clinics and therapists charge on a sliding scale based on the client's income. Some insurance plans also cover psychological services.

Achievement

Objective 15.2: *Discuss psychotherapy and insight therapy.*

Psychotherapy *Techniques employed to improve psychological functioning and promote adjustment to life*

Achievement

Objective 15.3: *Define psychoanalysis, and describe its five major methods.*

Psychoanalysis *Freudian therapy designed to bring unconscious conflicts, which usually date back to early childhood experiences, into consciousness; also Freud's theoretical school of thought emphasizing unconscious processes*

Figure 15.1 ***Modern insight therapy in action*** Although each of the insight therapies is unique, they all share a common goal of increasing client/patient understanding and self-knowledge. The belief is that once people have "insight" into what motivates or troubles them, they can overcome their psychological and interpersonal difficulties and improve their adjustment (Corey, 2009).

Insight Therapies

We begin our discussion of professional **psychotherapy** with traditional *psychoanalysis* and its modern counterpart, *psychodynamic* therapy. Then we explore *cognitive*, *humanistic*, *group*, and *family therapies*. Although these therapies differ significantly, they're often grouped together as *insight therapies* because they seek to increase *insight* into clients' difficulties (Castonguay & Hill, 2007; Corey, 2009). The general goal is to help people gain greater control over and improvement in their thoughts, feelings, and behaviors (Figure 15.1).

Psychoanalysis/Psychodynamic Therapies: Unlocking the Secrets of the Unconscious

Zigy Kaluzny/Stone/Getty Images

As the name implies, in **psychoanalysis**, a person's *psyche* (or mind) is *analyzed*. Traditional psychoanalysis is based on Sigmund Freud's central belief that abnormal behavior is caused by unconscious conflicts among the three parts of the psyche—the *id*, *ego*, and *superego* (Chapter 13).

During psychoanalysis, these unconscious conflicts are brought to consciousness (Figure 15.2a). The patient discovers the underlying reasons for his or her behavior and comes to realize that the childhood conditions under which the conflicts developed no longer exist. Once this realization (or insight) occurs, the conflicts can be resolved and the patient can develop more adaptive behavior patterns.

Unfortunately, according to Freud, the ego has strong *defense mechanisms* that block

unconscious thoughts from coming to light. Thus, to gain insight into the unconscious, the ego must be "tricked" into relaxing its guard. With that goal, psychoanalysts employ five major methods: *free association*, *dream analysis*, *analyzing resistance*, *analyzing transference*, *and interpretation* (Figure 15.2b).

1. *Free association* According to Freud, when you let your mind wander and remove conscious censorship over thoughts—a process called **free association**—interesting and even bizarre connections seem to spring into awareness. Freud believed that the first thing to come to a patient's mind is often an important clue to what the person's unconscious wants to conceal.

2. *Dream analysis* Recall from Chapter 5 that, according to Freud, defenses are lowered during sleep, and forbidden desires and unconscious conflicts can be freely expressed. Even while dreaming, however, these feelings and conflicts are recognized as being unacceptable and must be disguised as images that have deeper symbolic meaning. Thus, during Freudian **dream analysis**, a therapist might interpret a dream of riding a horse or driving a car (the *manifest content*) as a desire for, or concern about, sexual intercourse (the *latent content*).

3. *Analyzing resistance* During free association or dream analysis, Freud believed patients often show **resistance**—for example, suddenly "forgetting" what they were saying, changing the subject, not talking, and/or arriving late or missing appointments. It is the therapist's job to confront this resistance and to help patients face their problems.

4. *Analyzing transference* During psychoanalysis, patients supposedly disclose intimate feelings and memories, and patients often apply (or *transfer*) some of their unresolved emotions and attitudes from past relationships onto the therapist. The therapist uses this process of **transference** to help the patient "relive" painful past relationships in a safe, therapeutic setting so that he or she can move on to healthier relationships.

5. *Interpretation* The core of all psychoanalytic therapy is **interpretation**. During free association, dream analysis, resistance, and transference, the analyst listens closely and tries to find patterns and hidden conflicts. At the right time, the therapist explains (or *interprets*) the underlying meanings to the client.

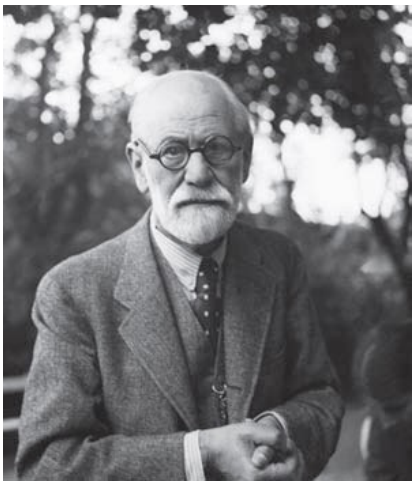
Free Association *In psychoanalysis, reporting whatever comes to mind without monitoring its contents*

Dream Analysis *In psychoanalysis, interpreting the underlying true meaning of dreams to reveal unconscious processes*

Resistance *In psychoanalysis, the person's inability or unwillingness to discuss or reveal certain memories, thoughts, motives, or experiences*

Transference *In psychoanalysis, the patient may displace (or transfer) unconscious feelings about a significant person in his or her life onto the therapist*

Interpretation *A psychoanalyst's explanation of a patient's free associations, dreams, resistance, and transference; more generally, any statement by a therapist that presents a patient's problem in a new way*



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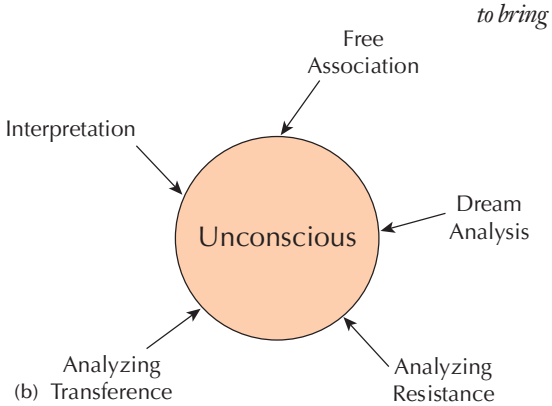
Sigmund Freud (1856-1939) *Freud believed that during psychoanalysis the therapist's (or psychoanalyst's) major goal was to bring unconscious conflicts into consciousness.*

CartoonStock

(a) "The way this works is that you say the first thing that comes to your mind..."



(b)

Figure 15.2 ***Freud's infamous couch*** (a) The therapist's couch is a well-known fixture of traditional psychoanalysis (and cartoons). Freud believed that this arrangement—with the therapist out of the patient's view and the patient relaxed—makes the unconscious more accessible and helps patients relax their defenses. (b) Once the patient is relaxed, the psychoanalyst attempts to access the unconscious through these five methods.

Achievement

Objective 15.4: *What are the two major criticisms of psychoanalysis?*

Evaluation

As you can see, most of psychoanalysis rests on the assumption that repressed memories and unconscious conflicts actually exist. But, as noted in Chapters 7 and 13, this assumption is the subject of a heated, ongoing debate. Critics also point to two other problems with psychoanalysis:

- *Limited applicability.* Freud's methods were developed in the early 1900s for a particular clientele—upper-class Viennese people (primarily women). Although psychoanalysis has been refined over the years, critics say it still seems to suit only a select group of individuals. Success appears to be best with less severe disorders, such as anxiety disorders, and with highly motivated, articulate patients. Critics jokingly proposed the acronym *YAVIS* to describe the perfect psychoanalysis patient: young, attractive, verbal, intelligent, and successful (Schofield, 1964).

  In addition, psychoanalysis is time consuming (often lasting several years with four to five sessions a week) and expensive. And it seldom works well with severe mental disorders, such as schizophrenia. This is logical because psychoanalysis is based on verbalization and rationality—the very abilities most significantly disrupted by serious disorders. Critics suggest that spending years on a couch chasing unconscious conflicts from the past allows patients to escape from the responsibilities and problems of adult life—in effect, the patient becomes "couchridden."

- *Lack of scientific credibility.* The goals of psychoanalysis are explicitly stated—to bring unconscious conflicts to conscious awareness. But how do you know when this goal has been achieved? If patients accept the analyst's interpretations of their conflicts, their "insights" may be nothing more than cooperation with the therapist's belief system.

On the other hand, if patients refuse to accept the analyst's interpretations, the analyst may say they're exhibiting resistance. Moreover, the therapist can always explain away a failure. If patients get better, it's because of their insights. If they don't, then the insight was not real—it was only intellectually accepted. Such reasoning does not meet scientific standards. The ability to prove or disprove a theory is the foundation of the scientific approach.

Psychoanalysts acknowledge that it is impossible to scientifically document certain aspects of their therapy. However, they insist that most patients benefit (Castonguay & Hill, 2007; Wachtel, 2008). Many analysands (patients) agree.

Achievement

Objective 15.5: *Differentiate between psychoanalysis and psychodynamic therapy.*

Psychodynamic Therapy *A briefer, more directive, and more modern form of psychoanalysis that focuses on conscious processes and current problems*

Modern Psychodynamic Therapy

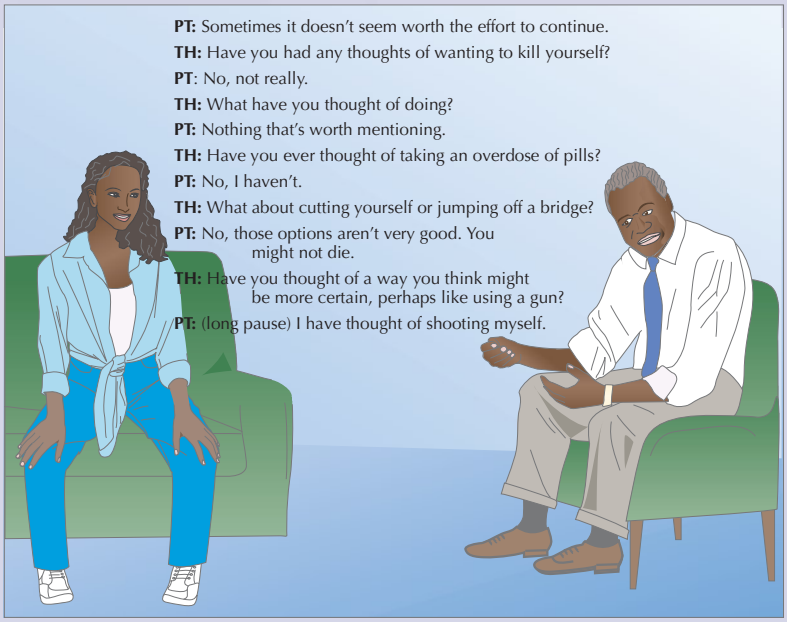
Partly in response to criticisms of traditional psychoanalysis, more streamlined forms of psychoanalysis have been developed. In modern **psychodynamic therapy**, treatment is briefer. Therapists and patients usually meet only one to two times a week, rather than several times a week, and for only a few weeks or months versus several years. The patient is also seen face to face (rather than reclining on a couch). In addition, the therapist takes a more directive approach (rather than waiting for unconscious memories and desires to slowly be uncovered).

Also, contemporary psychodynamic therapists focus less on unconscious, early childhood roots of problems, and more on conscious processes and current problems. Such refinements have helped make psychoanalysis shorter, more available, and more effective for an increasing number of people (Knekt et al., 2008; Lehto et al., 2008; Lerner, 2008).

Interpersonal therapy (IPT) is a psychodynamically based, and particularly influential, brief form of psychotherapy. As the name implies, *interpersonal* therapy focuses almost exclusively on the client's current relationships and issues that arise from those relationships. Its goal is to relieve immediate symptoms and help the client learn better ways to solve future interpersonal problems. Originally designed for acute depression, IPT is similarly effective for a variety of disorders, including marital conflict, eating disorders, parenting problems, and drug addiction (de Maat et al., 2007; Lerner, 2008; Weissman, 2007).

Assessment

VISUAL QUIZ



No small segment of therapy can truly convey an actual full-length therapy session. However, this brief excerpt of an exchange between a patient (PT) and therapist (TH) using a *psychodynamic* approach does demonstrate several psychoanalytic/psychodynamic techniques. Try to identify examples of free association, dream analysis, resistance, or transference in this discussion.

Answer: The clearest example is *resistance*. When the therapist asks her about thoughts of suicide, she initially resists and then admits she has thought of shooting herself. Keep in mind that all therapists in this situation would probe beyond this point in the discussion to follow up on the patient's suicide risk.

Assessment

STOP

CHECK & REVIEW

Psychoanalysis/Psychodynamic Therapies

Objective 15.1: *Discuss potential problems with media portrayals of therapy, four common myths about therapy, and its three general approaches.*

Films about mental illness and its treatment generally present unrealistic and negative stereotypes that bias the public. There are four common myths about therapy: There is one best therapy, therapists can read your mind, people who go to therapists are crazy or weak, and only the rich can afford therapy. There also are three general approaches to therapy—*insight*, *behavior*, and *biomedical*.

Objective 15.2: *Discuss psychotherapy and insight therapy.*

Professional **psychotherapy** refers to techniques employed to improve psychological functioning and promote adjustment to life. The general goal of *insight therapy* is to increase client/patient understanding and self-knowledge. Once people gain this "insight," they can control and improve their functioning.

Objective 15.3: *Define psychoanalysis, and describe its five major methods.*

Freudian **psychoanalysis** works to bring unconscious conflicts into consciousness. The five major techniques of psychoanalysis are **free association, dream analysis, analyzing resistance, analyzing transference,** and **interpretation.**

Objective 15.4: *What are the two major criticisms of psychoanalysis?*

It is time-consuming, expensive, and suits only a small group of people. It also has *limited availability,* and it *lacks scientific credibility.*

Objective 15.5: *Differentiate between psychoanalysis and psychodynamic therapy.*

Compared to traditional psychoanalysis, modern **psychodynamic therapy** is briefer, the patient is treated face to face (rather than reclining on a couch), the therapist takes a more directive approach (rather than waiting for unconscious memories and desires to slowly be uncovered), and the focus is on conscious processes and current problems (rather than unconscious problems of the past).

Questions

1. The system of psychotherapy developed by Freud that seeks to bring unconscious conflicts into conscious awareness is known as _____. (a) transference; (b) cognitive restructuring; (c) psychoanalysis; (d) the "hot seat" technique
2. Which psychoanalytic concept best explains the following situations?
   a. Mary is extremely angry with her therapist, who seems unresponsive and uncaring about her personal needs.
   b. Although John is normally very punctual in his daily activities, he is frequently late for his therapy session.
3. What are the two major criticisms of psychoanalysis?
4. How does modern psychodynamic therapy differ from psychoanalysis?

Check your answers in Appendix B.

Click & Review
for additional assessment options:
wiley.com/college/huffman

Achievement

Objective 15.6: *Discuss cognitive therapy, self-talk, cognitive restructuring, and cognitive-behavior therapy.*

Cognitive therapy *Therapy that treats problem behaviors and mental processes by focusing on faulty thought processes and beliefs*

Self-Talk *Internal dialogue; the things people say to themselves when they interpret events*

Cognitive Restructuring *Process in cognitive therapy to change destructive thoughts or inappropriate interpretations*

Cognitive-Behavior Therapy *Combines cognitive therapy (changing faulty thinking) with behavior therapy (changing faulty behaviors)*

Achievement

Objective 15.7: *What is the general goal of Ellis's rational-emotive behavior therapy (REBT)?*

Rational-Emotive Behavior Therapy (REBT) *Ellis's cognitive therapy to eliminate emotional problems through rational examination of irrational beliefs*

Cognitive Therapies: A Focus on Faulty Thoughts and Beliefs

The mind is its own place, and in itself can make a Heavn' of Hell, a Hell of Heav'n
JOHN MILTON, *PARADISE LOST*, LINE 247

Cognitive therapy assumes that faulty thought processes—beliefs that are irrational, overly demanding, or that fail to match reality—create problem behaviors and emotions (Barlow, 2008; Corey 2009; Davies, 2008; Ellis, 1996, 2003b, 2004; Kellogg & Young, 2008).

Like psychoanalysts, cognitive therapists believe that exploring unexamined beliefs can produce insight into the reasons for disturbed behaviors. However, instead of believing that therapeutic change occurs because of insight into unconscious processes, cognitive therapists believe that insight into negative **self-talk** (the unrealistic things a person tells him- or herself) is most important. Through a process called **cognitive restructuring**, this insight allows clients to challenge their thoughts, change how they interpret events, and modify maladaptive behaviors (Figure 15.3).

This last point of changing maladaptive behavior is the central goal of a closely aligned type of cogitive therapy, called **cognitive-behavior therapy**. As you'll see in the upcoming section, the aptly named behavior therapists focus on changing behavior, and cognitive-behavior therapists work to reduce both self-destructive thoughts *and* self-destructive behaviors.

Albert Ellis and Rational-Emotive Behavior Therapy (REBT)

One of the best-known cognitive therapists, and the so-called "grandfather" of cognitive-behavior therapy, Albert Ellis (1913–2007) suggested irrational beliefs are the primary culprit in problem emotions and behaviors (David, 2007). According to Ellis, outside events do not cause us to have feelings. We feel as we do because of our irrational beliefs. Therefore, his **rational-emotive behavior therapy (REBT)** is

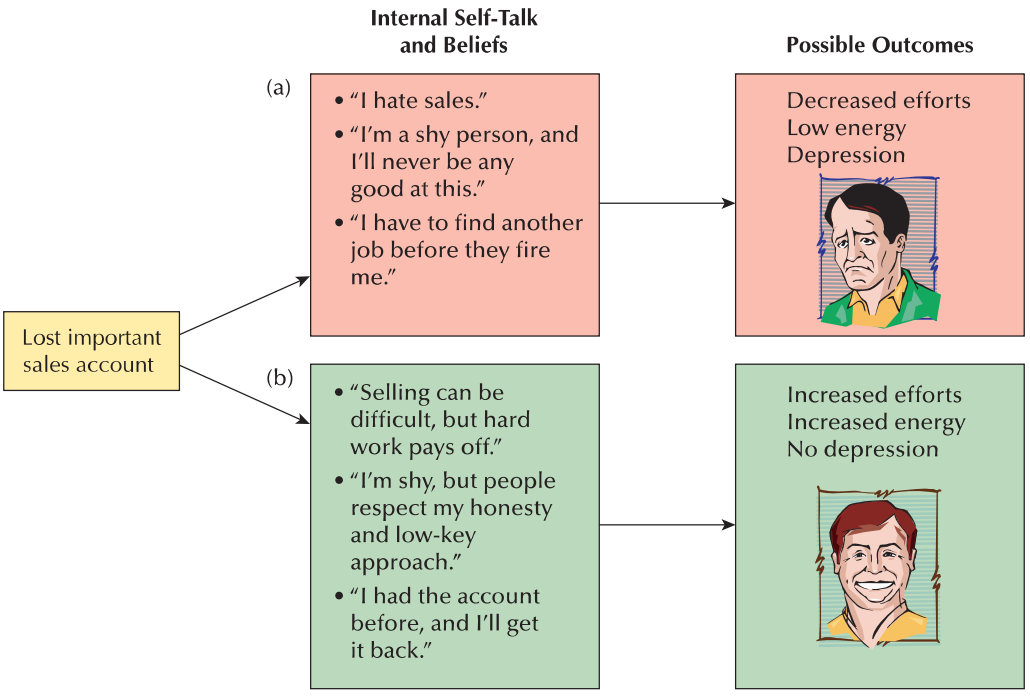
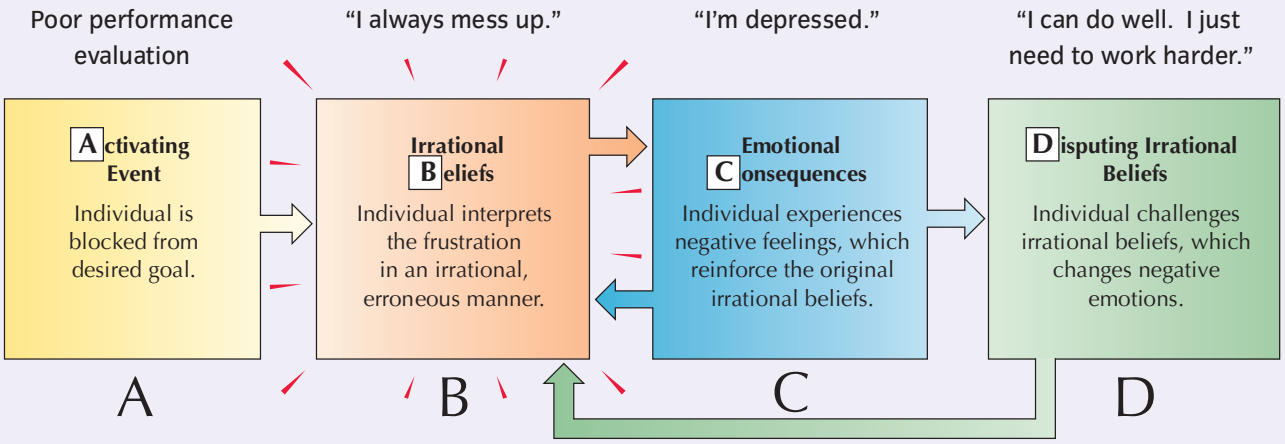


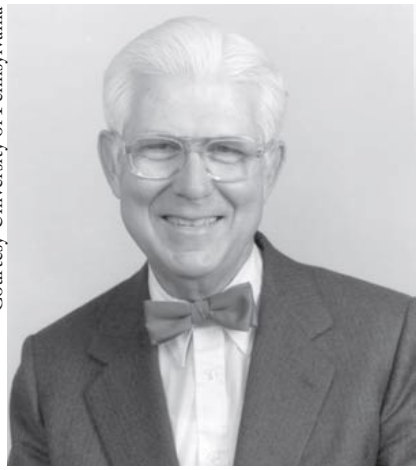
Figure 15.3 ***Psychology at work—using cognitive therapy to improve sales*** (a) Note how the negative interpretation and destructive self-talk leads to destructive and self-defeating outcomes. (b) Cognitive therapy teaches clients to challenge and change their negative beliefs and negative self-talk into positive ones, which, in turn, leads to more positive outcomes.

Process Diagram 15.1

Ellis's A-B-C-D Approach



According to Albert Ellis, our emotional reactions are produced by our interpretation of an (A) *activating* event, not by the event itself. For example, if you receive a poor performance evaluation at work, you might directly attribute your bad mood to the negative feedback. Ellis would argue that your irrational (B) belief ("I always mess up") between the event and the *emotional* (C) *consequences* is what upset you. Furthermore, ruminating on all the other bad things in your life maintains your negative emotional state. Ellis's therapy emphasizes (D) *disputing*, or challenging, these irrational beliefs, which, in turn, causes changes in maladaptive emotions—it breaks the vicious cycle.



Courtesy University of Pennsylvania

Aaron Beck

Achievement

Objective 15.8: *Describe Beck's cognitive therapy.*

directed toward challenging and changing these irrational beliefs (Ellis, 1961, 2003a, 2003b, 2004). Ellis calls REBT an A-B-C-D approach: **A** stands for *activating event*, **B** the person's *belief system*, **C** the emotional and behavioral *consequences*, and **D** *disputing* erroneous beliefs. (See Process Diagram 15.1.)

What role does a therapist play in REBT? Ellis believes that most irrational beliefs develop when people demand certain "musts" ("I must get into graduate school") and "shoulds" ("He should love me") from themselves and others. Unfortunately, this general concept of "demandingness," as well as the person's unrealistic, irrational beliefs, generally goes unexamined unless the client is confronted directly. In therapy, Ellis actively argues with clients, cajoling and teasing them, sometimes in very blunt language. Once clients recognize their self-defeating thoughts, Ellis begins working with them on how to *behave* differently—to test out new beliefs and to learn better coping skills.

With or without professional therapy, many of us would benefit from examining and overcoming our irrational beliefs. If you'd like to apply Ellis's approach to your own life, complete the following *Try This Yourself* activity (p. 516).

Aaron Beck's Cognitive Therapy

Another well-known cognitive therapist is Aaron Beck (1976, 2000; Beck & Grant, 2008). Like Ellis, Beck believes that psychological problems result from illogical thinking and from destructive self-talk. But Beck developed a somewhat different form of *cognitive-behavior therapy* to treat psychological problems, especially depression. Beck

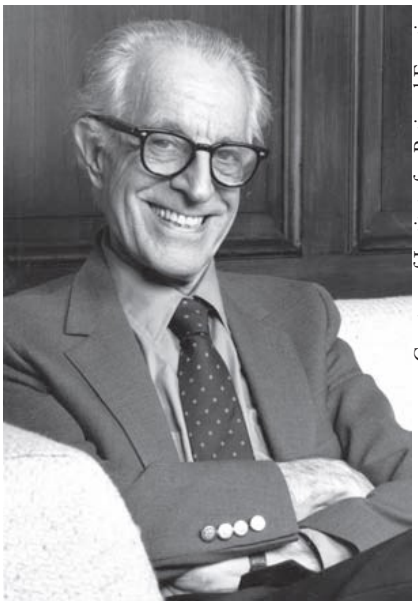
Try This Yourself

Application

Overcoming Irrational Misconceptions

Albert Ellis believes that most people require the help of a therapist to allow them to see through their defenses and force them to challenge their self-defeating thoughts. However, you may be able to improve some of your own irrational beliefs and responses with the following suggestions:

1. **Identify your belief system.** Identify your irrational beliefs by asking yourself why you feel the particular emotions you do. Ellis believes that, by confronting your thoughts and feelings, you can discover the irrational assumptions that are creating the problem consequences.
2. **Evaluate the consequences.** Emotions such as anger, anxiety, and depression often seem "natural." But they don't have to happen. Rather than perpetuating negative emotions by assuming they must be experienced, focus on whether your reactions make you more effective and enable you to solve your problems.
3. **Dispute the self-defeating beliefs.** Once you have identified an overly demanding or irrational belief, argue against it. For example, it is gratifying when people you cherish love you in return, but if they do not, continuing to pursue them or insisting that they must love you will only be self-defeating.
4. **Practice effective ways of thinking.** Continue to examine your emotional reactions to events and situations in order to create opportunities to dispute irrational beliefs and substitute realistic perceptions. Practice behaviors that are more effective by rehearsing them at home and imagining outcomes that are more successful.



Courtesy of Institute for Rational Emotive

Albert Ellis (1913–2007)

has identified several distorted thinking patterns that he believes are associated with depression-prone people:

1. *Selective perception.* Focusing selectively on negative events while ignoring positive events.
2. *Overgeneralization.* Over generalizing and drawing negative conclusions about one's self-worth (e.g., believing you are worthless because you lost a promotion or failed an exam).
3. *Magnification.* Magnifying or exaggerating the importance of undesirable events or personal shortcomings, and seeing them as catastrophic and unchangeable.
4. *All-or-nothing thinking.* Seeing things in black-or-white categories—everything is either totally good or bad, right or wrong, a success or a failure.

Cartoon Stock

"I wish you'd stop being so negative."

In the initial phases of Beck's cognitive-behavior therapy, clients are taught to recognize and keep track of their thoughts (Concept Diagram 15.1). Examples might be: "How come I'm the only one alone at this party" (selective perception) and "If I don't get straight A's, I'll never get a good job" (all-or-nothing thinking). Next, the therapist trains the client to develop ways to test these automatic thoughts against reality. If the client believes that straight A's are necessary for a certain job, the therapist needs to find only one instance of this not being the case to refute the belief. Obviously, the therapist chooses the tests carefully so that they do not confirm the client's negative beliefs but lead instead to positive outcomes.

This approach—identifying dysfunctional thoughts followed by active testing—helps depressed people discover that negative attitudes are largely a product of unrealistic or faulty thought processes.

At this point, Beck introduces the *behavior* phase of therapy, persuading the client to actively pursue pleasurable activities. Depressed individuals often lose motivation, even for experiences they used to find enjoyable. Simultaneously taking an active rather than a passive role and reconnecting with enjoyable experiences help in recovering from depression.

Concept Diagram 15.1

Tracking Faulty Thoughts

In cognitive-behavior therapy, clients often record their thoughts in "thought journals" so that, together with the therapist, they can compare their thoughts with reality, detecting and correcting faulty thinking.

Name: Jordan Holley Date: November 11

DYSFUNCTIONAL THOUGHT RECORD

Directions: When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** and as soon as possible jot down the thought or mental image in the Automatic Thought Column.

DATE/ TIME	SITUATION	AUTOMATIC THOUGHT(S)	EMOTION(S)	ALTERNATIVE RESPONSE	OUTCOME
	1. What actual event or stream of thoughts, or daydreams, or re-collection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	1. (optional) What cognitive distortion did you make? (e.g., all-or-nothing thinking, mind-reading, catastrophizing.) 2. Use questions at the bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0-100%) is the emotion? 3. What will you do? (or did you do?)
Nov. 10, 9p.m.	My mom called last night. When I saw her number on the caller I.D., I felt my jaw clench and my heart rate go up.	She's going to nag me again to spend the whole Thanks-giving weekend there to make me feel guilty I was 90% this was it, so I didn't pick up.	I felt angry and frustrated Intensity = about 80%	Cognitive distortion was mind-reading or maybe all-or-nothing thinking. The evidence that the automatic thoughts were true is from my past talks with my mom. Maybe she was calling for another reason, not to make me feel guilty about Thanksgiving. The worst that could happen is that she'd make me feel guilty again... If so, I could refuse to feel that way. I could also say I didn't like the repeated pressure - it makes me guilty and sad. Maybe she'd understand and we'd break this pattern, or she'd stop nagging me so much. Now, I feel angry whenever she calls and often don't pick up the phone. If I changed my thinking, maybe I'll feel better about her calls, at least sometimes. So, I should work on not expecting the worst when she calls.	1. 50% 2. Now I feel more optimistic, anger is decreased to about 20%. 3. Next time I will remind myself of the alternative response before picking up the phone.

© John Wiley & Sons

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? If it did happen, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of changing my thinking? (5) What should I do about it? (6) If _____ (friend's name) was in this situation and had this thought, what would I tell him/her?

Achievement

Objective 15.9: *What are the chief successes and criticisms of cognitive therapy?*

Evaluating Cognitive Therapies

Cognitive therapies are highly effective treatments for depression, anxiety disorders, bulimia nervosa, anger management, addiction, procrastination, and even some symptoms of schizophrenia and insomnia (Beck & Grant, 2008; Dobson, 2008; Ellis, 2003a, 2003b, 2004; Kellogg & Young, 2008; Neenan, 2008; Palmer & Gyllensten, 2008).

However, both Beck and Ellis have been criticized for ignoring or denying the client's unconscious dynamics, overemphasizing rationality, and minimizing the importance of the client's past (Hammack, 2003). Other critics suggest that cognitive therapies are successful because they employ *behavior techniques*, not because they change the underlying cognitive structure (Bandura, 1969, 1997, 2006, 2008; Laidlaw & Thompson, 2008; Wright & Beck, 1999). Imagine that you sought treatment for depression and learned to construe events more positively and to curb your *all-or-nothing* thinking. Further imagine that your therapist also helped you identify activities and behaviors that would promote greater fulfillment. If you found your depression lessening, would you attribute the improvement to your changing thought patterns or to changes in your overt behavior?

Achievement

Objective 15.10: *Define humanistic therapy and describe Rogers's client-centered therapy.*

Humanistic Therapy *Therapy that focuses on removing obstacles that block personal growth and potential*

Client-Centered Therapy *Rogers's therapy emphasizing the client's natural tendency to become healthy and productive; techniques include empathy, unconditional positive regard, genuineness, and active listening*

Empathy *In Rogerian terms, an insightful awareness and ability to share another's inner experience*

Unconditional Positive Regard *Rogers's term for love and acceptance with no contingencies attached*

Humanistic Therapies: Blocked Personal Growth

Humanistic therapy assumes that people with problems are suffering from a disruption of their normal growth potential, and, hence, their self-concept. When obstacles are removed, the individual is free to become the self-accepting, genuine person everyone is capable of being.

Carl Rogers and Client-Centered Therapy

One of the best-known humanistic therapists, Carl Rogers, developed an approach that encourages people to actualize their potential and relate to others in genuine ways. His approach is referred to as **client-centered therapy**. Using the term *client* instead of *patient* was very significant to Rogers. He believed the label "patient" implied being sick or mentally ill rather than responsible and competent. Treating people as clients demonstrates *they* are the ones in charge of the therapy (Rogers, 1961, 1980). It also emphasizes the equality of the therapist–client relationship.

Client-centered therapy, like other insight therapies, explores thoughts and feelings to obtain insight into the causes for behaviors. For Rogerian therapists, however, the focus is on providing an accepting atmosphere and encouraging healthy emotional experiences. Clients are responsible for discovering their own maladaptive patterns.

Rogerian therapists create a therapeutic relationship by focusing on four important qualities of communication: *empathy*, *unconditional positive regard*, *genuineness*, and *active listening*.

1. **Empathy** is a sensitive understanding and sharing of another person's inner experience. When we put ourselves in other people's shoes, we enter their inner world. Therapists pay attention to body language and listen for subtle cues to help them understand the emotional experiences of clients. To help clients explore their feelings, the therapist uses open-ended statements such as "You found that upsetting" or "You haven't been able to decide what to do about this" rather than asking questions or offering explanations.
2. **Unconditional positive regard** is genuine caring for people based on their innate value as individuals. Because humanists believe human nature is positive and each person is unique, clients can be respected and cherished without their having to prove themselves worthy of the therapist's esteem. Unconditional positive regard allows the therapist to trust that clients have the best answers for their own lives.

Pat Byrnes/The Cartoon Bank, Inc.

"Just remember, son, it doesn't matter whether you win or lose—unless you want Daddy's love."

To maintain a climate of unconditional positive regard, the therapist avoids making evaluative statements such as "That's good" and "You did the right thing." Such comments give the idea that the therapist is judging them and that clients need to receive approval. Humanists believe that when people receive unconditional caring from others, they become better able to value themselves in a similar way.

3. **Genuineness**, or *authenticity*, is being aware of one's true inner thoughts and feelings and being able to share them honestly with others. When people are genuine, they are not artificial, defensive, or playing a role. If a Rogerian therapist were pleased or displeased with a client's progress, he or she would feel free to share those feelings. When therapists are genuine with their clients, they believe their clients will, in turn, develop self-trust and honest self-expression.

Genuineness *In Rogerian terms, authenticity or congruence; the awareness of one's true inner thoughts and feelings and being able to share them honestly with others*

4. **Active listening** involves reflecting, paraphrasing, and clarifying what the client says and means. To *reflect* is to hold a mirror in front of the person, enabling that person to see him- or herself. To *paraphrase* is to summarize in different words what the client is saying. To *clarify* is to check that both the speaker and listener are on the same wavelength. By being an *active listener*, the clinician communicates that he or she is genuinely interested in what the client is saying (Figure 15.4).

Active Listening *Listening with total attention to what another is saying; involves reflecting, paraphrasing, and clarifying what the person says and means*

Evaluating Humanistic Therapies

Supporters say there is empirical evidence for the efficacy of client-centered therapy (Hardcastle et al., 2008; Kirschenbaum & Jourdan, 2005; Lein & Wills, 2007; Stiles et al., 2008). But critics argue that the basic tenets of humanistic therapy, such as self-actualization and self-awareness, are difficult to test scientifically. Most of the research on the outcomes of humanistic therapy relies on client self-reports. However, people undergoing any type of therapy are motivated to justify their time and expense. In addition, research on specific therapeutic techniques, such as Rogerian "empathy" and "active listening," has had mixed results (Clark, 2007; Hodges & Biswas-Diener, 2007; Rosenthal, 2007).

Achievement

Objective 15.11: *What are the key criticisms of humanistic therapy?*

David Young Wolff/PhotoEdit

Figure 15.4 ***Active listening*** Noticing a client's brow furrowing and hands clenching while he is discussing his marital problems, a clinician might respond, "It sounds like you're angry with your wife and feeling pretty miserable right now." Can you see how this statement *reflects* the client's anger, *paraphrases* his complaint, and gives *feedback* to clarify the communication?

Try This Yourself

Application

Roger Ressmeyer/©Corbis

Carl Rogers (1902-1987)

Client-Centered Therapy in Action

Would you like to check your understanding of *empathy*, *unconditional positive regard*, *genuineness*, and *active listening*? Identify the techniques being used in the following excerpt (Shea, 1988, pp. 32–33). Check your responses with those in Appendix B.

THERAPIST (TH): What has it been like coming down to the emergency room today?

CLIENT (CL): Unsettling, to say the least. I feel very awkward here, sort of like I'm vulnerable. To be honest, I've had some horrible experiences with doctors. I don't like them.

TH: I see. Well, they scare the hell out of me, too (smiles, indicating the humor in his comment).

CL: (Chuckles) I thought you were a doctor.

TH: I am (pauses, smiles)—that's what's so scary.

CL: (Smiles and laughs)

TH: Tell me a little more about some of your unpleasant experiences with doctors, because I want to make sure I'm not doing anything that is upsetting to you. I don't want that to happen.

CL: Well, that's very nice to hear. My last doctor didn't give a hoot about what I said, and he only spoke in huge words.

In case you're wondering, this is an excerpt from an actual session—humor and informality can be an important part of the therapeutic process.

Assessment

STOP

CHECK & REVIEW

Cognitive and Humanistic Therapies

Objective 15.6: *Discuss cognitive therapy, self-talk, cognitive restructuring, and cognitive-behavior therapy.*

Cognitive therapy focuses on faulty thought processes and beliefs to treat problem behaviors. Through insight into negative **self-talk** (the unrealistic things people say to themselves), the therapist can use **cognitive restructuring** to challenge and change destructive thoughts or inappropriate behaviors. **Cognitive-behavior therapy** focuses on changing both self-destructive thoughts and self-defeating behaviors.

Objective 15.7: *What is the general goal of Ellis's rational-emotive behavior therapy (REBT)?*

The general goal of **rational-emotive behavior therapy (REBT)** is to eliminate emotional problems through rational examination of irrational and self-defeating beliefs.

Objective 15.8: *Describe Beck's cognitive therapy.*

Beck developed a form of cognitive therapy that is particularly effective for depression. He helps clients identify their distorted thinking patterns, followed by active testing of these thoughts and encouragement toward pleasurable activities.

Objective 15.9: *What are the chief successes and criticisms of cognitive therapy?*

Cognitive therapies have been successful in treating a wide variety of psychological problems (e.g., Beck's success with depression). They have been criticized for ignoring the importance of unconscious processes, overemphasizing rationality, and minimizing the client's past. Some critics also attribute any success with cognitive therapies to the use of behavioral techniques.

Objective 15.10: *Define humanistic therapy, and describe Rogers's client-centered therapy.*

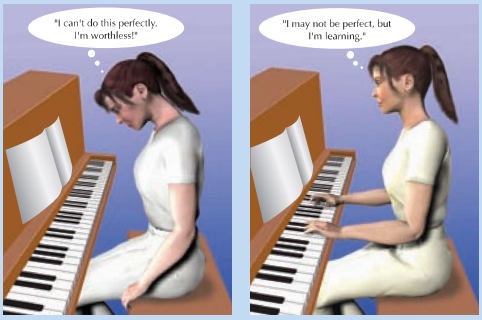
Humanistic therapy assumes problems develop from blocked personal growth, and therapists work alongside clients to remove these obstacles. Rogers **client-centered therapy** emphasizes **empathy**, **unconditional positive regard**, **genuineness**, and **active listening**.

Objective 15.11: *What are the key criticisms of humanistic therapy?*

The basic tenets are difficult to evaluate scientifically, most outcome studies rely on self-reports, and research on their specific techniques has had mixed results.

Questions

1. Cognitive therapists assume that problem behaviors and emotions are caused by _____. (a) faulty thought processes and beliefs; (b) a negative self-image; (c) incongruent belief systems; (d) lack of self-discipline
2. The figure on the next page illustrates the process by which the therapist and client work to change destructive ways of thinking called _____.
3. What are the four steps (the A–B–C–D) of Ellis's REBT?



4. Beck identified four destructive thought patterns associated with depression (selective perception, overgeneralization, magnification, and all-or-nothing thinking). Using these terms, label the following thoughts:
   _____ a. Mary left me, and I'll never fall in love again. I'll always be alone.
   _____ b. My ex-spouse is an evil monster, and our entire marriage was a sham.
5. Label each of the following Rogerian therapy techniques:
   _____ a. A sensitive understanding and sharing of another's inner experience
   _____ b. The honest sharing of inner thoughts and feelings
   _____ c. A nonjudgmental and caring attitude toward another that does not have to be earned

Check your answers in Appendix B.

Click & Review
for additional assessment options:
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Group, Family, and Marital Therapies: Healing Interpersonal Relationships

Achievement

Objective 15.12: *Discuss, group, self-help, family, and marital therapies.*

The therapies described thus far all consider the individual as the unit of analysis and treatment. In contrast, group, family, and marital therapies treat multiple individuals simultaneously.

Group Therapy

Group therapy began as a response to the need for more therapists than were available and for a more economical form of therapy. What began as a practical and economic necessity, however, has become a preferred approach in its own right. In **group therapy**, multiple people meet together to work toward therapeutic goals. Typically, 8 to 10 people meet with a therapist on a regular basis, usually once a week for two hours. The therapist can work from any of the psychotherapeutic orientations discussed in this chapter. And, as in individual therapy, members of the group talk about problems in their own lives.

Group Therapy *A number of people meet together to work toward therapeutic goals*

A variation on group therapy is the **self-help group**. Unlike other group therapy approaches, a professional does not guide these groups. They are simply groups of people who share a common problem (such as alcoholism, single parenthood, or breast cancer) and who meet to give and receive support. Faith-based 12-step programs such as *Alcoholics Anonymous*, *Narcotics Anonymous*, and *Spenders Anonymous* are examples of self-help groups.

Self-Help Group *Leaderless or nonprofessionally guided groups in which members assist each other with a specific problem, as in Alcoholics Anonymous*

Although group members don't get the same level of individual attention found in one-on-one therapies, group and self-help therapies provide their own unique advantages (Corey 2009; Minuchin, Lee, & Simon, 2007; Qualls, 2008):

1. *Less expense.* In a typical group of eight or more, the cost of traditional one-on-one therapy can be divided among all members of the group. Self-help groups, which typically operate without a professional therapist, are even more cost-saving.
2. *Group support.* During times of stress and emotional trouble, it is easy to imagine that we are alone and that our problems are unique. Knowing that others have similar problems can be very reassuring. In addition, seeing others improve can be a source of hope and motivation.
3. *Insight and information.* Because group members typically have comparable problems, they can learn from each other's mistakes and share insights. Furthermore, when a group member receives similar comments about his or her behavior from

several members of the group, the message may be more convincing than if it comes from a single therapist.

4. *Behavior rehearsal.* Group members can role-play one another's employer, spouse, parents, children, or prospective dates. By role-playing and observing different roles in relationships, people gain practice with new social skills. They also gain valuable feedback and insight into their problem behaviors.

Therapists often refer their patients to group therapy and self-help groups to supplement individual therapy. Someone who has a problem with alcohol, for example, can find comfort and help with others who have "been there." They exchange useful information, share their coping strategies, and gain hope by seeing others overcome or successfully manage their shared problems. Research on self-help groups for alcoholism, obesity, and other disorders suggests they can be very effective—either alone or in addition to individual psychotherapy (McEvoy, 2007; Oei & Dingle, 2008; Silverman et al., 2008).

Family and Marital Therapies

> Mental health problems do not affect three or four out of five persons but one out of one.
>
> Dr. William Menninger

Mental disorders have wide ranging effects on the individual sufferer, as well as on his or her friends, family, co-workers, and society in general. Because a family or marriage is a particularly close and intimate system of interdependent parts, the problem of any one individual unavoidably affects all the others (Minuchin, Lee, & Simon, 2007; Qualls, 2008). A teen's delinquency or a spouse's drug problem affects both members of the couple and each individual within the family.

Sometimes the problems parents have with a child arise from conflicts in the marriage. Other times a child's behavior creates distress in an otherwise well-functioning couple. The line between *marital* (or *couples*) therapy and *family therapy* is often blurred. Given that most married couples have children, our discussion will focus on family therapy, in which the primary aim is to change maladaptive family interaction patterns (Figure 15.5). All members of the family attend therapy sessions. At times the therapist may also see family members individually or in twos or threes. (The therapist, incidentally, may take any orientation—cognitive, behavioral, etc.)

Many families initially come into therapy believing that one member is *the* cause of all their problems ("Johnny's delinquency" or "Mom's drinking"). However, family therapists generally find that this "identified patient" is the scapegoat (a person blamed for someone else's problems) for deeper disturbances. For example, instead of confronting their own problems with intimacy, the parents may focus all their attention and frustration on the delinquent child. It is usually necessary to change ways of interacting within the family system to promote the health of individual family members and the family as a whole.

Family therapy is also useful in treating a number of disorders and clinical problems, such as marital infidelity, anger management, etc. (Bagarozzi, 2008; Birchler et al., 2008; Greenberg et al., 2008). As we discussed in Chapter 14, patients with schizophrenia are also more likely to relapse if their family members express emotions, attitudes, and behaviors that involve criticism, hostility, or emotional overinvolvement. Family therapy can help family members modify their behavior toward the patient. It also seems to be the most favorable setting for the treatment of adolescent drug abuse (Minuchin, Lee, & Simon, 2007; Ng et al., 2008; O'Farrell et al., 2008; Sim & Wong, 2008).

Figure 15.5 ***What happens in family and marital therapy?*** Rather than one-on-one counseling, family therapists generally work with the entire family to improve communication and resolve conflicts.

Tony Freeman/Photoedit

Application

CRITICAL THINKING

ACTIVE LEARNING

Miramax/The Kobal Collection/ The Picture Desk

Will Hunting, a janitor at MIT, is an intellectual genius. But he is low in emotional intelligence (EI) (Chapter 12). Will's need for revenge gets him into a fight, and he is court-ordered to go into therapy. A number of therapists attempt to work with Will and fail. Sean proves to be up to the task because he "speaks his language"—the language of the streets.

Hunting for Good Therapy Films

(Contributed by Thomas Frangicetto)

This chapter opened with Hollywood's generally negative and unrealistic portrayals of therapy. There are notable exceptions, like *Good Will Hunting*. But even this film has a few overly dramatic and unprofessional scenes. For example, during the first therapy session between Will Hunting (played by Matt Damon) and his therapist Sean (played by Robin Williams), Sean grabs Will by the throat and threatens him for insulting his deceased wife.

Despite its limits, *Good Will Hunting* provides a reasonably accurate portrayal of several therapy techniques. It also provides an opportunity to review important terms related to insight therapy and improve your critical thinking skills. If you haven't seen the film, here's a brief summary:

Key Term Review

Identify which insight therapy term is being illustrated in the following:

1. From the moment Will first walks into Sean's office, he engages in a highly creative and relentless avoidance of the therapist's attempts to get him to talk about himself. This is an example of _____.
2. Despite Will's insults and verbal attacks, Sean continues working with him while expressing a nonjudgmental attitude and genuine caring for Will. Sean is displaying _____.
3. During the therapy sessions, Sean often shares his true inner thoughts and feelings with Will. This type of honest communication is called _____.
4. Will's troublesome relationships and antisocial behaviors appear to result from his hidden belief that he is unlovable, and because he blames himself for the abuse he received as a child. How would Ellis's rational-emotive-behavior therapy explain this in terms of the A–B–C–D approach? The *activating event* (A) is _____. The *irrational belief* (B) is _____. And the *emotional consequence* (C) is _____. Can you create a *disputing irrational belief* (D) statement that Will could use to challenge this irrational belief?
5. After listening to Will focusing solely on the negative aspects of his life and ignoring all the positives, Sean says, "All you see is every negative thing 10 miles down the road." With this statement, Sean wants Will to recognize that he is using _____, one of Beck's thinking patterns associated with depression.

Check your answers in Appendix B.

Critical Thinking Application

Sean is a therapist in need of therapy himself—he is still grieving the death of his wife. A competent therapist would never behave the way Sean does in certain scenes. However, he does effectively portray several characteristics of good professional therapy. In addition, he displays several critical thinking components (CTCs) found in the Prologue (pp. 000). *Empathy* and *active listening* are two of the most obvious components that Sean—and all therapists—employ. Can you identify other CTCs that you think a good therapist might use?

Assessment

STOP

CHECK & REVIEW

Group, Family, and Marital Therapies

Objective 15.12: *Discuss group, self-help, family, and marital therapies.*

In **group therapy**, a number of people (usually 8 to 10) come together to work toward therapeutic goals. A variation on group therapy is the **self-help group** (like Alcoholics Anonymous), which is not guided by a professional. Although group members do not get the same level of attention as in individual therapy, group therapy has important advantages. First, it is less expensive. It also provides group support, insight and information, and opportunities for behavior rehearsal.

The primary aim of family and marital therapy is to change maladaptive interaction patterns. Because a family is a system of interdependent parts, the problem of any one member unavoidably affects all the others.

Questions

1. In _____, multiple people meet together to work toward therapeutic goals. (a) encounter groups; (b) behavior therapy; (c) group therapy; (d) conjoint therapy
2. What are the four major advantages of group therapy?
3. Why do individual therapists often refer their patients to self-help groups?
4. _____ treats the family as a unit, and members work together to solve problems. (a) Aversion therapy; (b) An encounter group; (c) A self-help group; (d) Family therapy

Check your answers in Appendix B.

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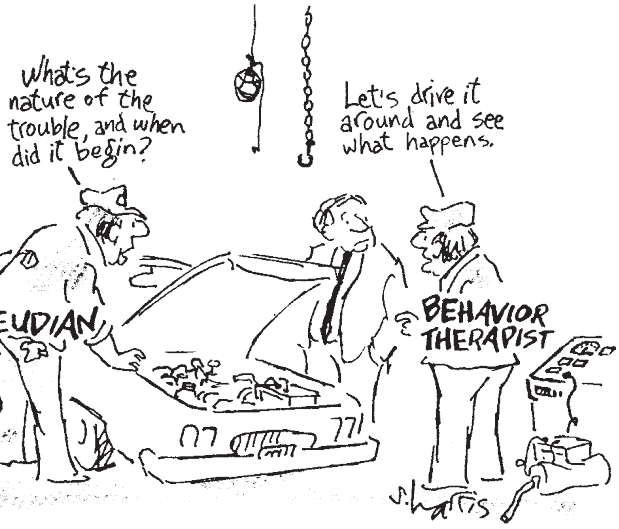
Achievement

Objective 15.13: *What is behavior therapy?*

Behavior Therapies

Have you ever understood why you were doing something that you would rather not do, but continued to do it anyway? Sometimes having insight into a problem does not automatically solve it. **Behavior therapy** focuses on the problem behavior itself, rather than on any underlying causes (Cooper, Heron, & Heward, 2007; Miltenberger, 2008). That is not to say that the person's feelings and interpretations are disregarded; they are just not emphasized. The therapist diagnoses the problem by listing the maladaptive behaviors that occur and the adaptive behaviors that are absent. The therapist then attempts to shift the balance of the two, drawing on principles of classical conditioning, operant conditioning, and observational learning (Chapter 6).

Behavior Therapy *Group of techniques based on learning principles used to change maladaptive behaviors*



Sidney Harris

Classical Conditioning Techniques: The Power of Association

Behavior therapists use the principles of classical conditioning. These principles are derived from Pavlov's model for associating two stimulus events. They work to decrease maladaptive behavior by creating new stimulus associations and behavioral responses to replace faulty ones. Two techniques based on these principles are *systematic desensitization* and *aversion therapy* (Process Diagram 15.2).

1. **Systematic desensitization** begins with relaxation training, followed by imagining or directly experiencing various versions of a feared object or situation while remaining deeply relaxed (Wolpe & Plaud, 1977).

The goal is to replace an anxiety response with a relaxation response when confronting the feared stimulus. Recall from Chapter 2 that the parasympathetic nerves control autonomic functions when we are relaxed. Because the opposing sympathetic nerves are dominant when we are anxious, it is physiologically impossible to be both relaxed and anxious at the same time.

Desensitization is a three-step process. First, a client is taught how to maintain a state of deep relaxation that is physiologically incompatible with an anxiety response. Next, the therapist and client construct a *hierarchy*, or ranked listing of 10 or so anxiety-arousing images (Process Diagram 15.2a). In the final step, the relaxed client mentally visualizes or physically experiences items at the bottom of the hierarchy. The client then works his or her way upward to the most anxiety-producing images at the top of the hierarchy. If at any time an image or situation begins to create anxiety, the client stops momentarily and returns to a state of complete relaxation. Eventually, the fear response is extinguished.

2. **Aversion therapy** uses principles of classical conditioning to create anxiety rather than extinguish it (Figure 15.6). People who engage in excessive drinking, for example, build up a number of pleasurable associations. These pleasurable associations cannot always be prevented. However, aversion therapy provides *negative associations* to compete with the pleasurable ones. Someone who wants to stop drinking, for example, could take a drug called Antabuse that causes vomiting whenever alcohol enters the system. When the new connection between alcohol and nausea has been classically conditioned, engaging in the once desirable habit will cause an immediate negative response (Process Diagram 15.2b).

Achievement

Objective 15.14: *Describe how classical conditioning, operant conditioning, and observational learning are used in behavior therapy.*

Systematic Desensitization *A gradual process of extinguishing a learned fear (or phobia) by working through a hierarchy of fear-evoking stimuli while staying deeply relaxed*

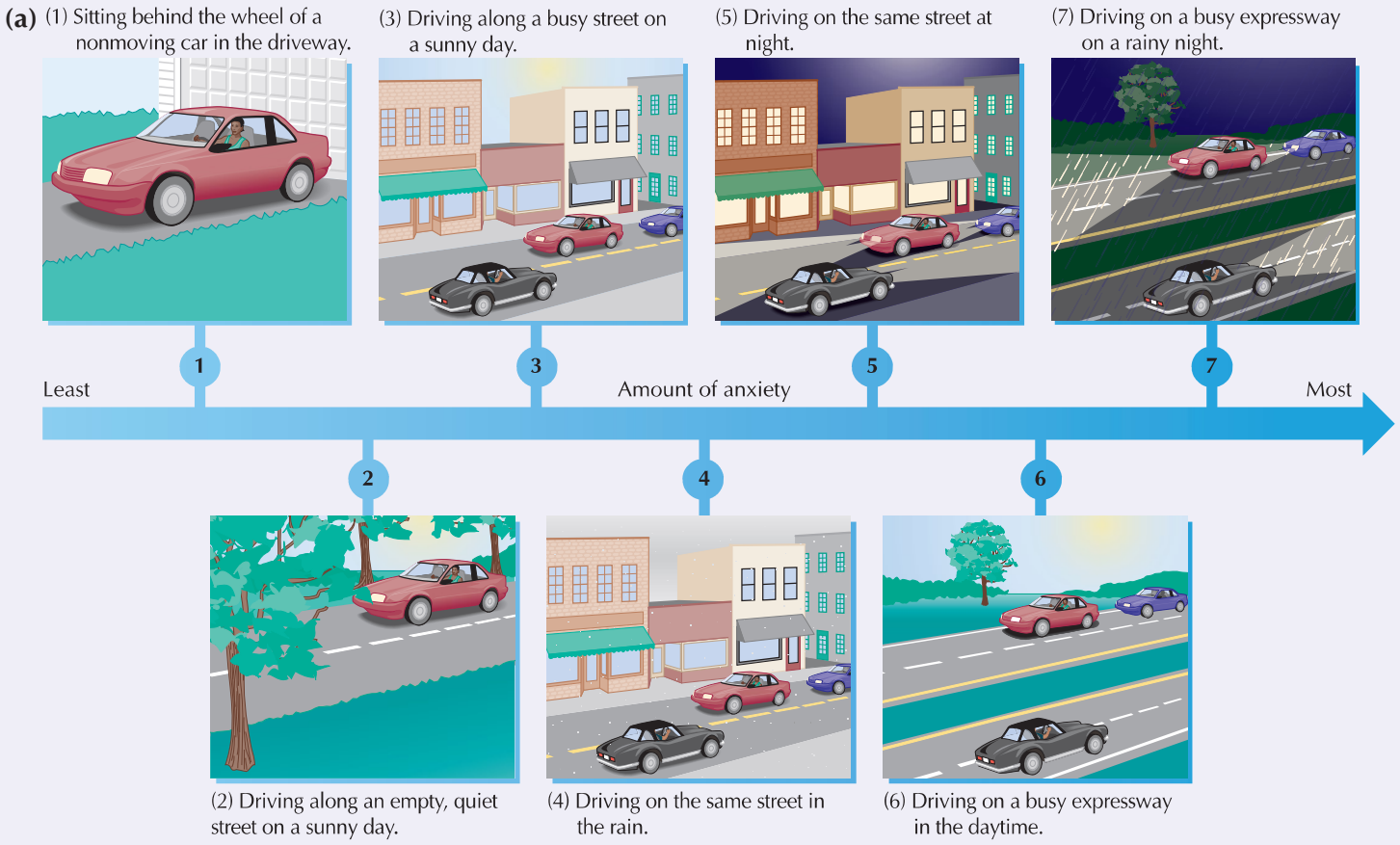
Aversion Therapy *Pairing an aversive (unpleasant) stimulus with a maladaptive behavior*

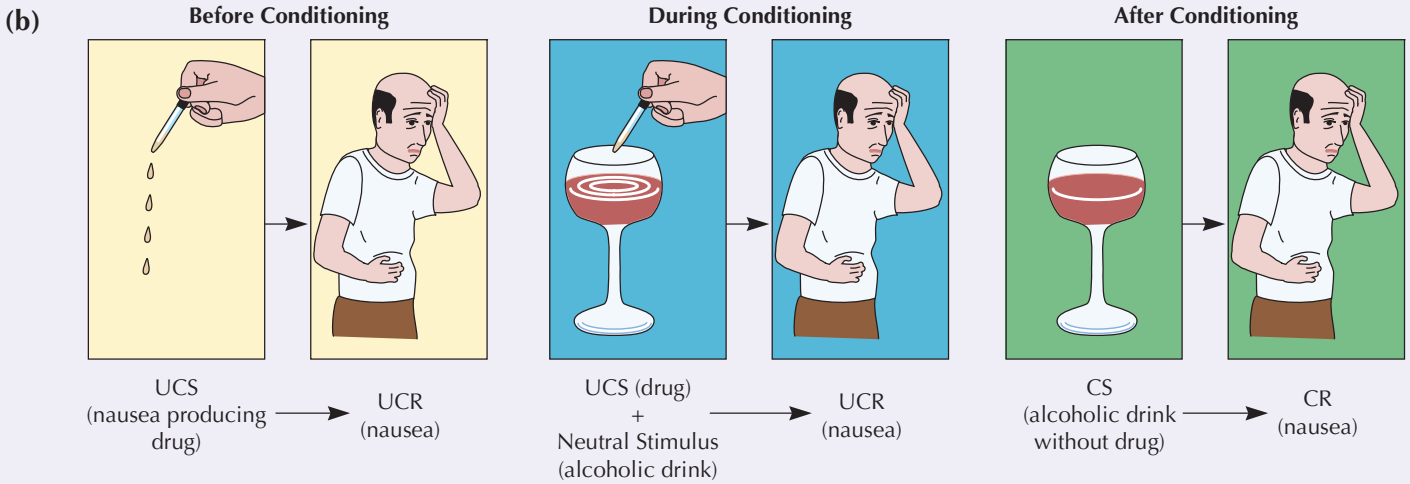
James King-Holmes/Photo Researchers

Figure 15.6 ***Virtual reality therapy*** Rather than mental imaging or actual physical experiences of a fearful situation, modern therapy can use the latest in computer technology—virtual reality headsets and data gloves. A client with a fear of heights, for example, can have experiences ranging from climbing a stepladder all the way to standing on the edge of a tall building, while never leaving the therapist's office.

Process Diagram 15.2

Overcoming Maladaptive Behaviors – Phobias and Alcoholism





(a) *During systematic desensitization*, the client begins by constructing a hierarchy, or ranked listing, of anxiety-arousing images or situations starting with one that produces very little anxiety and escalating to those that arouse extreme anxiety. To extinguish a driving phobia, the patient begins with images of actually sitting behind the wheel of a nonmoving car and ends with driving on a busy expressway.

(b) *Aversion therapy for alcoholism* is based on classical conditioning. A nausea-producing drug (Antabuse) is paired with alcohol to create an aversion (dislike) for drinking.

Try This Yourself

Application

Stockbyte/Getty Images

Do You Have Test Anxiety?

Nearly everyone is somewhat anxious before an important exam. If you find this anxiety helpful and invigorating, skip ahead to the next section. However, if the days and evenings before a major exam are ruined by your anxiety and you sometimes "freeze up" while taking the test, you can benefit from an informal type of systematic desensitization.

Step 1: Review and practice the relaxation technique taught in Chapter 3.
Step 2: Create a 10-step "test-taking" hierarchy—starting with the least anxiety-arousing image (perhaps the day your instructor first mentions an upcoming exam) and ending with actually taking the exam.
Step 3: Beginning with the least arousing image—hearing about the exam—picture yourself at each stage. While maintaining a calm, relaxed state, work your way through all 10 steps. If you become anxious at any stage, stay there, repeating your relaxation technique until the anxiety diminishes.
Step 4: If you start to feel anxious the night before the exam, or even during the exam itself, remind yourself to relax. Take a few moments to shut your eyes and review how you worked through your hierarchy.

Aversion therapy has had some limited success, but it has always been controversial. Is it ethical to hurt someone (even when the person has given permission)? It also has been criticized because it does not provide lasting relief. Do you recall the taste aversion studies in Chapter 6? It was discovered that when sheep meat was tainted with a nausea-producing drug, coyotes quickly learned to avoid sheep. Why doesn't it work with people? Interestingly, humans understand that the nausea is produced by the Antabuse and do not generalize their learning to the alcohol itself. Once they leave treatment, most alcoholics go back to drinking (and do not continue taking the Antabuse).

Operant Conditioning Techniques: Increasing the "Good" and Decreasing the "Bad"

Operant conditioning techniques use shaping and reinforcement to increase adaptive behaviors, and punishment and extinction to decrease maladaptive behaviors (Figure 15.7). In behavior therapy, a behavior to be acquired is called the *target behavior*. *Shaping*—being rewarded for successive approximations of the target behavior—is one operant technique for eventually performing the target behavior. One of the most successful applications of shaping and reinforcement has been with autistic children. Children with *autism* do not communicate or interact normally with other people. Shaping has been used to develop their language skills. The child is first rewarded for any sounds; later, only for words and sentences.

Shaping can also help people acquire social skills. If you are painfully shy, for example, a behavior therapist might first ask you to role-play simply saying hello to someone you find attractive. Then, you might practice behaviors that gradually lead you to suggest a get-together or date. During such *role-playing*, or *behavior rehearsal*, the clinician would give you feedback and reinforcement.

Adaptive behaviors can also be taught or increased with techniques that provide immediate reinforcement in the form of tokens (Kazdin, 2008; Tarbox, Ghezzi, & Wilson, 2006). For example, patients in an inpatient treatment facility might at first be given tokens (to be exchanged for primary rewards, such as food, treats, TV time, a private room, or outings) for merely attending group therapy sessions. Later they will be rewarded only for actually participating in the sessions. Eventually, the tokens can be discontinued when the patient receives the reinforcement of being helped by participation in the therapy sessions.

ABC Television

Figure 15.7 ***"The Nanny"—psychology at work*** Like the techniques used in the popular TV program The Nanny, behavior therapists may train parents to reward children for appropriate behavior. They also train parents to withdraw attention (extinction) or to use time-out procedures (punishment) to weaken or eliminate inappropriate behavior.

Observational Learning Techniques: The Power of Modeling

We all learn many things by observing others. Therapists use this principle in **modeling therapy**, in which clients are asked to observe and imitate appropriate *models* as they perform desired behaviors. For example, Albert Bandura and his colleagues (1969) asked clients with snake phobias to watch other (nonphobic) people handle snakes. After only two hours of exposure, over 92 percent of the phobic observers allowed a snake to crawl over their hands, arms, and necks. When the therapy combines live modeling with direct and gradual practice, it is called *participant modeling* (Figure 15.8).

Evaluating Behavior Therapies: How Well Do They Work?

Behavior therapy has been effective with various problems, including phobias, obsessive-compulsive disorder, eating disorders, autism, mental retardation, and delinquency (Ekers, Richards, & Gilbody, 2008; Freeman et al., 2008; Miltenberger, 2008). Some patients have even returned to their homes and communities after years of institutionalization. However, critics of behavior therapy raise important questions that fall into two major categories:

1. *Generalizability.* Critics argue that patients are not consistently reinforced in the "real world," and their newly acquired behaviors may disappear. To deal with this possibility, behavior therapists work to gradually shape clients toward rewards that are typical of life outside the clinical setting.
2. *Ethics.* Is it ethical for one person to control another's behavior? Are there some situations in which behavior therapy should not be used? In the classic movie *A Clockwork Orange*, dangerously powerful people used behavior modification principles to control the general population. Behaviorists reply that rewards and punishments already control our behaviors. Behavior therapy actually increases a person's freedom by making these controls *overt* and by teaching people to change their own behavior.

Modeling Therapy *Watching and imitating models that demonstrate desirable behaviors*

Achievement

Objective 15.15: *What are the key successes and criticisms of behavior therapies?*

Digital Vision/Getty Images

Figure 15.8 ***Psychology at work*** Modeling is also part of social skills training and assertiveness training. Clients learn how to interview for a job by first watching the therapist role-play the part of the interviewee. The therapist models the appropriate language (assertively asking for a job), body posture, and so forth. The client then imitates the therapist's behavior and plays the same role. Over the course of several sessions, the client becomes gradually desensitized to the anxiety of interviews and learns valuable interview skills.

Assessment

STOP

CHECK & REVIEW

Behavior Therapies

Objective 15.13: *What is behavior therapy?*

Behavior therapies use learning principles to change maladaptive behaviors.

Objective 15.14: *Describe how classical conditioning, operant conditioning, and observational learning are used in behavior therapy.*

Classical conditioning principles are used to change faulty associations. In **systematic desensitization**, the client replaces anxiety with relaxation, and in **aversion therapy**, an aversive stimulus is paired with a maladaptive behavior. Shaping, reinforcement, punishment, and extinction are behavior therapy techniques based on operant conditioning principles. Observational learning techniques often include **modeling therapy**, which is based on acquisition of skills or behaviors through observation.

Objective 15.15: *What are the key successes and criticisms of behavior therapies?*

Behavior therapies have been successful with a number of psychological disorders. But they are criticized for possible lack of generalizability and the questionable ethics of attempting to control behavior.

Questions

1. A group of techniques used to change maladaptive behaviors is known as _____.
2. In behavior therapy, _____ techniques use shaping and reinforcement to increase adaptive behaviors. (a) classical conditioning; (b) modeling; (c) operant conditioning; (d) social learning
3. Describe how shaping can be used to develop desired behaviors.
4. What are the two criticisms of behavior therapy?

Check your answers in Appendix B.

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Achievement

Objective 15.16: *Define biomedical therapy.*

Biomedical Therapy *Using biological interventions (drugs, electroconvulsive therapy, and psychosurgery) to treat psychological disorders*

Achievement

Objective 15.17: *Discuss psychopharmacology, electroconvulsive therapy (ECT), and psychosurgery.*

Psychopharmacology *The study of drug effects on mind and behavior*

Antianxiety Drugs *Medications used to produce relaxation, reduce anxiety, and decrease overarousal in the brain*

Antipsychotic Drugs *Medications used to diminish or eliminate hallucinations, delusions, withdrawal, and other symptoms of psychosis; also known as neuroleptics or major tranquilizers*

Mood Stabilizer Drugs *Medications used to treat the combination of manic episodes and depression characteristic of bipolar disorders*

Antidepressant Drugs *Medications used to treat depression, some anxiety disorders, and certain eating disorders (such as bulimia)*

Cordella Molloy/Photo Researchers

Biomedical Therapies

Biomedical therapies are based on the premise that mental health problems are caused, at least in part, by chemical imbalances or disturbed nervous system functioning. In most cases, a psychiatrist, rather than a psychologist, must prescribe biomedical therapies. But psychologists commonly work with patients receiving biomedical therapies. They also conduct research programs to evaluate the therapy's effectiveness. In this section, we will discuss three forms of biomedical therapies: *psychopharmacology*, *electroconvulsive therapy* (*ECT*), and *psychosurgery*.

Psychopharmacology: Treating Psychological Disorders with Drugs

Since the 1950s, drug companies have developed an amazing variety of chemicals to treat abnormal behaviors. In some cases discoveries from **psychopharmacology** (the study of drug effects on mind and behavior) have helped correct a chemical imbalance. In these instances, using a drug is similar to administering insulin to people with diabetes, whose own bodies fail to manufacture enough. In other cases, drugs are used to relieve or suppress the symptoms of psychological disturbances even when the underlying cause is not known to be biological. Psychiatric drugs are classified into four major categories: antianxiety, antipsychotic, mood stabilizer, and antidepressant (Concept Diagram 15.2).

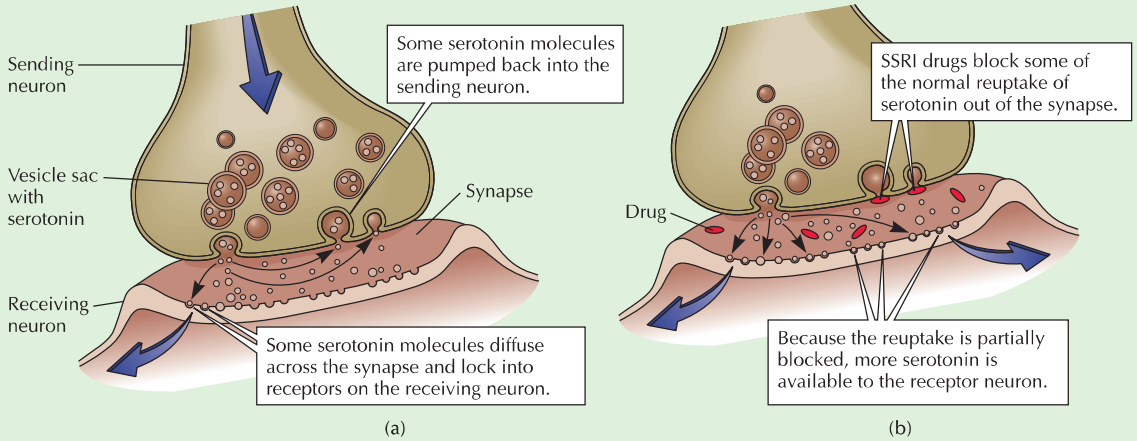
- **Antianxiety drugs** (also known as *anxiolytics* and "minor tranquilizers") lower the sympathetic activity of the brain—the crisis mode of operation—so that anxious responses are diminished or prevented and are replaced by feelings of tranquility and calmness (Barlow, 2008; Swartz & Margolis, 2008).
- **Antipsychotic drugs**, or *neuroleptics*, are used to treat schizophrenia and other acute psychotic states. Unfortunately, these drugs are often referred to as "major tranquilizers," creating the mistaken impression that they invariably have a strong sedating effect. The main effect of antipsychotic drugs is to diminish or eliminate psychotic symptoms, including hallucinations, delusions, withdrawal, and apathy. Traditional antipsychotics work by decreasing activity at the dopamine synapses in the brain. A large majority of patients show marked improvement when treated with these drugs.
- **Mood stabilizer drugs**, such as *lithium*, can help relieve manic episodes and depression for people suffering from bipolar disorder. Because lithium acts relatively slowly—it can take three or four weeks before it takes effect—its primary use is in preventing future episodes and helping to break the manic-depressive cycle.
- **Antidepressant drugs** are used primarily to treat people with depression. There are four types of antidepressant drugs: *tricyclics*, *monoamine oxidase inhibitors (MAOIs)*, *selective serotonin reuptake inhibitors (SSRIs)*, and *atypical antidepressants*. Each class of drugs affects neurochemical pathways in the brain in slightly different ways, increasing or decreasing the availability of certain chemicals. SSRIs (such as *Paxil* and *Prozac*) are by far the most commonly prescribed antidepressants. The atypical antidepressants are a miscellaneous group of drugs used for patients who fail to respond to the other drugs or for people who experience side effects common to other antidepressants.

What about herbal remedies? *Some recent research suggests that the herbal supplement St. John's Wort may be an effective treatment for mild to moderate depression, with fewer side effects than traditional medications (Butterweck, 2003; Lecrubier et al., 2002; Mayers et al., 2003). However, other studies have found the drug to be ineffective for people with major depression (Hypericum Depression Trial Study, 2002). Herbal supplements, like kava, valerian, and gingko biloba, also have been used in the treatment of anxiety, insomnia, and memory problems (e.g., Connor & Davidson, 2002; Parrott et al., 2004). Although many people assume that these products are safe because they are "natural," they can produce a number of potentially serious side effects. For this reason and also because the U.S. Food and Drug Administration does not regulate herbal supplements, researchers advise caution and a wait-and-see approach (Crone & Gabriel, 2002; Swartz & Margolis, 2008).*

Drug Treatments for Psychological Disorders

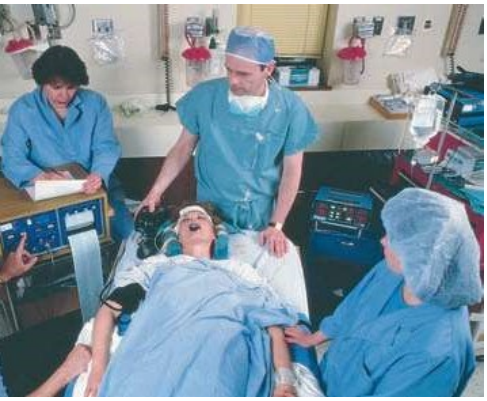
"Before Prozac, she loathed company."

Type of Drug (Chemical Group)	Psychological Disorder	Generic Name	Brand Name
Antianxiety drugs (Benzodiazepines)	Anxiety disorders	Alprazolam Diazepam Lorazepam	Xanax Valium Ativan
Antipsychotic drugs (Phenothiazines Butyrophenones Atypical antipsychotics)	Schizophrenia and bipolar disorders	Chlorpromazine Fluphenazine Thioridazine Haloperidol Clozapine Resperidone Quetiapine	Thorazine Prolixin Mellaril Haldol Clozaril Risperdal Seroquel
Mood stabilizer drugs (Antimanic)	Bipolar disorder	Lithium carbonate Carbamazepine	Eskalith CR Lithobid Tegretol
Antidepressant drugs (Tricyclic antidepressants Monoamine oxidase inhibitors (MAOIs) Selective serotonin re-uptake inhibitors (SSRIs) Serotonin and norepinephrine reup-take inhibitors (SNRIs) Atypical antidepressants)	Depressive disorders	Imipramine Amitriptyline Phenelzine Paroxetine Fluoxetine Venlafaxine Duloxetine Bupropion	Tofranil Elavil Nardil Paxil Prozac Effexor Cymbalta Wellbutrin



How Prozac and other SSRI antidepressants work (a) Under normal conditions, a nerve impulse (or action potential) travels down the axon to the terminal buttons of a sending neuron. If the vesicle sac of this particular neuron contains the neurotransmitter serotonin, the action potential will trigger its release. Some of the serotonin will travel across the synapse and lock into the receptors on the receiving neuron. Excess serotonin within the synapse will be pumped back up into the sending neuron for storage (the "serotonin reuptake"). (b) When selective serotonin reuptake inhibitors (SSRIs), like Prozac, are taken to treat depression and other disorders, they block the normal reuptake of excess serontonin that lingers in the synaptic gap after being released from the sending neuron. This leaves more serotonin molecules free to stimulate receptors on the receiving neuron, which enhances its mood lifting effects.

Electroconvulsive Therapy (ECT) *Biomedical therapy based on passing electrical current through the brain; used almost exclusively to treat serious depression when drug therapy fails*



James D. Wilson/Woodfin Camp & Associates

Figure 15.9 ***Electroconvulsive therapy (ECT)*** Electroconvulsive therapy may seem barbaric, but for some severely depressed people it is their only hope for lifting the depression. Unlike portrayals of ECT in movies like *One Flew Over the Cuckoo's Nest* and *The Snake Pit*, patients show few, if any, visible reactions to the treatment owing to modern muscle-relaxant drugs that dramatically reduce muscle contractions during the seizure. Most ECT patients are also given an anesthetic to block their memories of the treatment, but some patients still find the treatment extremely uncomfortable. However, many others find it lifesaving (Jain et al., 2008; Khalid et al., 2008).

Achievement

Objective 15.18: *What are the major contributions and criticisms of biomedical therapies?*

Psychosurgery *Operative procedures on the brain designed to relieve severe mental symptoms that have not responded to other forms of treatment*

Lobotomy *Outmoded medical procedure for mental disorders, which involved cutting nerve pathways between the frontal lobes and the thalamus and hypothalamus*

Tardive Dyskinesia *Movement disorder involving facial muscles, tongue, and limbs; a possible side effect of long-term use of antipsychotic medications*

Electroconvulsive Therapy and Psychosurgery: Promising or Perilous?

In **electroconvulsive therapy (ECT)**, also known as *electroshock therapy* (EST), a moderate electrical current is passed through the brain between two electrodes placed on the outside of the head (Figure 15.9). The current triggers a widespread firing of neurons, or convulsions. The convulsions produce many changes in the central and peripheral nervous systems, including activation of the autonomic nervous system, increased secretion of various hormones and neurotransmitters, and changes in the blood–brain barrier.

During the early years of ECT, some patients received hundreds of treatments. Today most receive 12 or fewer treatments. Sometimes the electrical current is applied only to the right hemisphere, which causes less interference with verbal memories and left-hemispheric functioning. Modern ECT is used primarily in cases of severe depression that do not respond to antidepressant drugs or psychotherapy. It also is used with suicidal patients because it works faster than antidepressant drugs (Goforth & Holsinger, 2007; Birkenhäger, Renes, & Pluijms, 2004).

Although clinical studies of ECT conclude that it is effective for very severe depression (Jain et al., 2008; Khalid et al., 2008), its use remains controversial because it creates massive functional (and perhaps structural) changes in the brain. ECT is also controversial because we simply don't know why it works. Most likely it helps reestablish levels of neurotransmitters that control moods.

The most extreme, and least used, biomedical therapy is **psychosurgery**—brain surgery to reduce serious, debilitating psychological problems. (It is important to note that psychosurgery is *not* the same as brain surgery used to remove physical problems, such as a tumor or blood clot.) Attempts to change disturbed thinking and behavior by altering the brain have a long history. In Roman times, for example, it was believed that a sword wound to the head could relieve insanity. In 1936, a Portuguese neurologist, Egaz Moniz, treated uncontrollable psychoses by cutting the nerve fibers between the frontal lobes (where association areas for monitoring and planning behavior are found) and lower brain centers (Hergenhahn 2009; Pressman, 1998; Valenstein, 1998). Thousands of patients underwent this procedure, called a **lobotomy**, before it was eliminated because of serious complications. Today lobotomies are almost never used. Psychiatric drugs offer a less risky and more effective treatment.

Evaluating Biomedical Therapies: Are They Effective?

Like all forms of therapy, the biomedical therapies have both proponents and critics. Let's explore the research in this area.

Pitfalls of Psychopharmacology

Drug therapy provides enormous benefits, but it also poses several potential problems. First, although drugs may provide relief of symptoms, they seldom provide "cures." In addition, many patients stop taking their medications once they feel better, which generally results in the return of symptoms. Also, some patients become physically dependent on the drugs, and researchers are still learning about the long-term effects and potential interactions of drug treatments. Furthermore, psychiatric medications can cause a variety of side effects, ranging from mild fatigue to severe impairments in memory and movement.

One of the most serious side effects of long-term use of antipsychotic drugs is a movement disorder called **tardive dyskinesia**, which develops in 15 to 20 percent of patients. The symptoms generally appear after the drugs have been taken for long periods of time (hence the term *tardive*, from the Latin root for "slow"). They include involuntary movements of the tongue, facial muscles, and limbs (*dyskinesia*, meaning "disorder of movement") that can be severely disabling. When my students see films depicting schizophrenia, they often confuse the patient's sucking and smacking of the lips or lateral jaw movements as signs of the disorder rather than signs of the motor disturbances of *tardive dyskinesia*.

A final potential problem with drug treatment is that its relative inexpensiveness, and its generally faster results than traditional talk therapy, have led to its overuse in some cases. One report found that antidepressants are prescribed roughly 50 percent of the time a patient walks into a psychiatrist's office (Olfson et al., 1998).

Despite the problems associated with psychotherapeutic drugs, they have led to revolutionary changes in mental health. Before the use of drugs, some patients were destined to spend a lifetime in psychiatric institutions. Today, most patients improve enough to return to their homes and live successful lives if they continue to take their medications to prevent relapse.

Challenges to ECT and Psychosurgery

As mentioned earlier, ECT remains controversial, but it may soon become obsolete thanks to advances in treatment, such as **repetitive transcranial magnetic stimulation (rTMS)**, in which a pulsed magnetic coil is held close to a person's head. When used to treat depression, the coil is usually placed over the prefrontal cortex, a region linked to deeper parts of the brain that regulate mood. Studies have shown marked improvement in depression, and, unlike ECT, patients experience no seizures or memory loss. Currently, the cost effectiveness and long-term benefits of rTMS over ECT remain uncertain (Bloch et al., 2008; Knapp et al., 2008; Wasserman, Epstein, & Ziemann, 2008).

Like ECT, psychosurgery is highly controversial, and because of its potentially serious or fatal side effects and complications, some critics suggest it should be banned altogether.

John Neuberger/PhotoEdit

The pros and cons of drug therapy *Psychotherapeutic drugs like Prozac often help relieve suffering and symptoms associated with psychological disorders. However, they also have major and minor side effects. Physicians and patients must carefully weigh both the costs and the benefits.*

Repetitive Transcranial Magnetic Stimulation (rTMS)
Biomedical treatment involving repeated pulses of magnetic energy being passed through the brain

Assessment

STOP

CHECK & REVIEW

Biomedical Therapies

Objective 15.16: *Define biomedical therapy.*

Biomedical therapies use biological techniques to relieve psychological disorders.

Objective 15.17: *Discuss psychopharmacology, electroconvulsive therapy (ECT) and psychosurgery.*

Psychopharmacology, or treatment with drugs, is the most common biomedical therapy. **Antianxiety drugs** (Valium, Ativan) generally are used to treat anxiety disorders, **anti-psychotic drugs** (Thorazine, Haldol) treat the symptoms of schizophrenia, **antidepressant drugs** (Prozac, Effexor) treat depression, and **mood stabilizers** (lithium) can help patients with bipolar disorder. Drug therapy has been responsible for major improvements in many disorders. However, there are also problems with dosage levels, side effects, and patient cooperation.

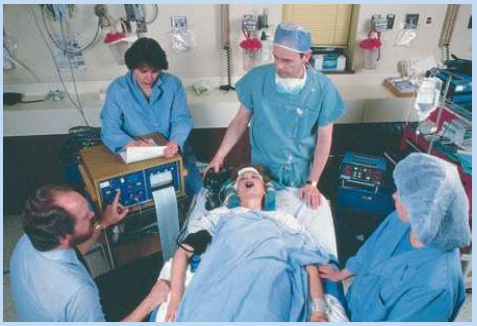
Electroconvulsive therapy (ECT) is used primarily to relieve serious depression when medication has not worked. But it is risky and considered a treatment of last resort. **Psychosurgeries**, such as a **lobotomy**, have been used in the past but are rarely used today.

Objective 15.18: *What are the major cont ributions and criticisms of biomedical therapies?*

Drug therapy is enormously beneficial, but it also has several problems. For example, it offers symptom relief, but few "cures," patients often stop medications once symptoms are relieved, patients may become dependent, and little is known about the long term effects and drug interactions. In addition, there are potentially dangerous side effects, and possible over use. ECT and psychosurgery are both controversial and are generally used as a last resort.

Questions

1. The dramatic reduction in numbers of hospitalized patients today compared to past decades is primarily attributable to _____. (a) biomedical therapy; (b) psychoanalysis; (c) psychosurgery; (d) drug therapy.
2. What are the four major categories of psychiatric drugs?
3. The effectiveness of antipsychotic drugs is thought to result primarily from blockage of _____ receptors. (a) serotonin; (b) dopamine; (c) epinephrine (d) all of these options
4. In electroconvulsive therapy (ECT), _____.
   a. current is never applied to the left hemisphere
   b. convulsions activate the ANS, stimulate hormone and neurotransmitter release, and change the blood-brain barrier
   c. convulsions are extremely painful and long lasting
   d. most patients today receive hundreds of treatments because it is safer than in the past



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5. ECT is used primarily to treat _____. (a) phobias; (b) conduct disorders; (c) depression; (d) schizophrenia

Check your answers in Appendix B.

Click & Review
for additional assessment options:
wiley.com/college/huffman

Therapy and Critical Thinking

As you discovered in the Prologue to this text and throughout the individual chapters, critical thinking is one of the most important skills you'll develop while studying psychology. Nowhere is this more important than in this chapter. For example, we mentioned at the start of this chapter that there are over 400 forms of therapy. How are you going to choose one of these for yourself or someone you know?

In the first part of this section, we discuss the five goals that are common to all psychotherapies. Then we explore the key cultural similarities and differences in therapies around the world. We conclude with specific tips for finding a therapist. Can you see how these discussions help you see the overall "big picture"? Noncritical thinkers often fail to *synthesize* large bodies of information. When it comes to therapy, they may get lost "in the trees" and give up their search for therapists because they can't step outside and see "the forest."

Achievement

Objective 15.19: *Identify the five most common goals of therapy, and discuss the eclectic approach.*

Therapy Essentials: Five Common Goals

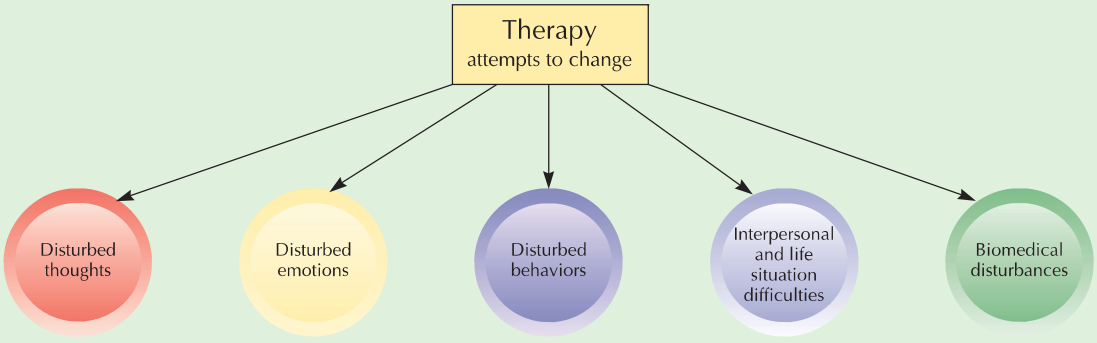
All major forms of therapy are designed to help the client in five specific areas (Concept Diagram 15.3). Depending on the individual therapist's training and the client's needs, one or more of these five areas may be emphasized more than the others.

Although most therapists work with clients in several of these areas, the emphasis varies according to the therapist's training. As you learned earlier in this chapter, psychoanalysts and psychodynamic therapists generally emphasize unconscious thoughts and emotions. Cognitive therapists focus on their client's faulty thinking and belief patterns. And humanistic therapists attempt to alter the client's negative emotional

Concept Diagram 15.3

The Five Most Common Goals of Therapy

Most therapies focus on one or more of these five goals. Can you identify which would be of most interest to a psychoanalyst, a cognitive therapist, a behavior therapist, and a psychiatrist?



Disturbed thoughts. Therapists work to change faulty or destructive thoughts, provide new ideas or information, and guide individuals toward finding solutions to problems.

Disturbed emotions. Therapists help clients understand and control their emotions and relieve their emotional discomfort.

Disturbed behaviors. Therapists help clients eliminate troublesome behaviors and guide them toward more effective lives.

Interpersonal and life situation difficulties. Therapists help clients improve their relationships with others and avoid or minimize sources of stress in their lives.

Biomedical disturbances. Therapists work to relieve biological disruptions that directly cause or contribute to psychological difficulties (for example, chemical imbalances that lead to depression).

responses. Behavior therapists, as the name implies, focus on changing maladaptive behaviors, and therapists who use biomedical techniques attempt to change biological disorders.

Keep in mind that the terms *psychoanalyst* and *cognitive therapist* simply refer to the theoretical background and framework that guide a clinician's thinking. Just as Democrats and Republicans approach political matters in different ways, behavior and cognitive therapists approach therapy differently. And just as Democrats and Republicans borrow ideas from one another, clinicians from different perspectives also share ideas and techniques. Clinicians who regularly borrow freely from various theories are said to take an **eclectic approach**.

Eclectic Approach *Combining techniques from various theories to find the most appropriate treatment*

PSYCHOLOGY AT WORK *Careers in Mental Health*

Achievement

Objective 15.20: *Identify the six key types of mental health professionals.*

Do you enjoy helping people and think you would like a career as a therapist? Have you wondered how long you will have to go to college or the type of training that is required to be a therapist? Most colleges have counseling or career centers with numerous resources and trained staff who can help you answer these (and other) questions. To get you started, I have included a brief summary in Table 15.1 of the major types of mental health professionals, their degrees, years of required education beyond the bachelor's degree, and type of training.

TABLE 15.1 MAJOR TYPES OF MENTAL HEALTH PROFESSIONALS

Occupational Title	Degree	Nature of Training
Clinical Psychologists	Ph.D. (Doctor of Philosophy), Psy.D. (Doctor of Psychology)	Most often have a doctoral degree with training in research and clinical practice, and a supervised one-year internship in a psychiatric hospital or mental health facility. As clinicians, they work with patients suffering from mental disorders, but many also work in colleges and universities as teachers and researchers in addition to having their own private practice.
Counseling Psychologists	M.A. (Master of Arts), Ph.D. (Doctor of Philosophy), Psy.D. (Doctor of Psychology), Ed.D. (Doctor of Education)	Similar training to clinical psychologists, but counseling psychologists usually have a master's degree with more emphasis on patient care and less on research. They generally work in schools or other institutions and focus on problems of living rather than mental disorders.
Psychiatrists	M.D. (Doctor of Medicine)	After four years of medical school, an internship and residency in psychiatry are required, which involves supervised practice in psychotherapy techniques and biomedical therapies. With the exception of certain states in the U.S., M.D.s are generally the only mental health specialists who can regularly prescribe drugs.
Psychiatric Nurses	R.N. (Registered Nurse), M.A. (Master of Arts), Ph.D. (Doctor of Philosophy)	Usually have a bachelor's or master's degree in nursing, followed by advanced training in the care of mental patients in hospital settings and mental health facilities.
Psychiatric Social Workers	M.S.W. (Master in Social Work), D.S.W. (Doctorate in Social Work), Ph.D. (Doctor of Philosophy)	Normally have a master's degree in social work, followed by advanced training and experience in hospitals or outpatient settings working with people who have psychological problems.
School Psychologists	M.A. (Master of Arts), Ph.D. (Doctor of Philosophy), Psy.D. (Doctor of Psychology), Ed.D. (Doctor of Education)	Generally begin with a bachelor's degree in psychology, followed by graduate training in psychological assessment and counseling involving school-related issues and problems.

Application

RESEARCH HIGHLIGHT

Objective 15.21: *Briefly summarize the major effects of mental disorders, like PTSD, on the family.*

Mental Health and the Family—PTSD

Contributed by Nicholas Greco IV, M.S., BCETS, CATSM
College of Lake County, IL

Paul Avallone/Zuma Press

Chapter 14 discussed several categories of mental disorders, while this chapter has focused on their various treatments. Unfortunately, the effects and treatment for family members, who share the suffering, are not as equally well known nor as adequately studied.

In this section, we'll focus on the growing number of military men and women returning home from the wars in Iraq and Afghanistan with serious psychological disorders, most notably posttraumatic stress disorder (PTSD). We'll also emphasize how this particular anxiety disorder affects the lives and mental health of their family members.

PTSD is a complicated, often comorbid disorder that goes beyond the symptoms of reexperiencing of the event, the avoidance of talking or thinking about the event, and the hyperarousal symptoms such as irritability, exaggerated startle response, and hypervigilance. Family members want to help but may feel alienated from their loved ones, confused about the disorder, and helpless. Many individuals with PTSD also have secondary depression or even other anxiety disorders such as panic disorder, thus straining an already taxed family life even further.

The pathology of the "typical soldier" is as varied as the soldier. By definition, the greater the trauma, the higher the likelihood of suffering from PTSD. A U.S. soldier's risk of developing PTSD is more likely when the combat is intense or they are wounded or have witnessed someone wounded or killed (Hoge, Castro, Messer, et al., 2004). Psychologists estimate that one in six soldiers deployed to Iraq or Afghanistan experience PTSD symptoms, and this number rises to one in three for those wounded, and even higher for Reserve and National Guard members (Munsey, 2008).

To put things into perspective, there have been 1.6 million soldiers deployed to Iraq or Afghanistan to date. Hypothetically, if 1 out of 6 of the 1.6 million soldiers suffer from combat-exposed PTSD, 256,000 service members may be affected (Lineberry, Bostwick, & Rundell, 2006). Each of these 256,000 soldiers has family and loved ones who may also experience the pain of PTSD. Keep in mind that while the veteran feels isolated and alone, his or her family may feel the same way. Both the veteran and their loved ones often feel no one understands what they are going through.

In many families, PTSD is not a dinnertime discussion. In fact, it is often rarely discussed at all. Family members may walk on eggshells to avoid the person's irritability and anger. Often times, the family sees the person as depressed, moody, and not someone who they want to be around—especially if the person is self-medicating with drugs or alcohol.

Ignoring the PTSD will not make it go away, but in fact, may escalate the moodiness to chronic mood instability; mood swings, verbal and physical abuse, and increased addiction to drugs and/or alcohol. Untreated PTSD may last a lifetime, and leads to various psychosocial stressors including divorce and unemployment as well as domestic violence and substance abuse. Veterans typically adopt a code of silence about the trauma, as they are fearful of being judged and criticized, and re-experiencing the event. The family shares this code of silence by failing to discuss the PTSD, ignoring or overlooking the behaviors of the person, and perpetuating the illness.

Family members also may commonly experience a number of reactions, including sympathy, depression, fear and worry, avoidance, guilt and shame, anger, and other mixed emotions (Carlson & Ruzek, 2008). Sympathy is a natural human characteristic, which is initially helpful. But it also can be detrimental, as expectations for the trauma survivor may be lowered. This, in turn, sends the wrong message to the individual—that they may not be strong enough to overcome the trauma.

Like the PTSD victim, family members may suffer from their own unique forms of anxiety and depression. Fear and worries abound when the family is unsure of what the survivor will be like on any given day. PTSD survivors often become hypervigilant and want to protect their surroundings with guard dogs, alarms, guns, and the like. They may also not want family members going too far from home or leaving home at all. Their feelings of being unsafe, coupled with this newfound reliance on safety and security, weigh heavily on the family.

Family members also may worry what the trauma survivor will do if they become angry in public, whether they can invite friends to the home, how that person's drinking will harm their health, or whether or not they will have a roof over their heads if the trauma survivor is unable to keep a job.

In addition, the family may avoid discussing the traumatic event not only with their loved one, but also with others. Here we see the code of silence wherein the family takes a protective stance against discussing something that makes them feel sad, vulnerable, and helpless. The family, also may change their lives to make the survivor feel less pain or to avoid his or her negative reactions.

Can you see how the family is assimilating many avoidance features of the family member with PTSD? They also are becoming co-dependent, and angry at the victim

or the trauma itself, or its effect on their lives. They may blame the loved one for "not getting better," for "not moving on," and for ultimately changing the family life and lifestyle.

Over time, family members may also begin to mimic the victim's anger and irritability as a response to what they experience from the trauma survivor as well as their own frustrations. The drug and alcohol abuse, the sleep disruptions, and the health problems of the PTSD survivor may become a problem for the families as well.

Finally, constant worry about the trauma survivor may lead family members to neglect their own health issues and engage in bad habits such as smoking, overeating, drinking, and less physical activities. These responses are examples of secondary or vicarious traumatization. The family member is essentially living their life through the trauma survivor's life. As such, they become co-dependent, an enabler, a rescuer, and may even blame themselves for their spouse or family member's symptoms.

How can we help? Experts agree that the key lies in support, education, and intervention for the traumatized individual as well as for family members. The Department of Defense is currently sponsoring a $25 million five-year study called the STRONG STAR Multidisciplinary Research Consortium which will include eight randomized clinical trials (Munsey, 2008). These studies will be designed to study active and recently discharged military personnel diagnosed with PTSD. There are a number of other studies underway; however, we must keep in mind that those with PTSD find it difficult to talk about the trauma, to deal with the emotions that come up in therapy, and may ultimately discontinue treatment. Family members play a key role in helping the individual with PTSD, and ultimately in helping themselves, by becoming not only an advocate for their loved one, but informing the clinician about how the family is affected.

Learning about PTSD also can be both informative and therapeutic for the family in terms of dealing with the many emotions and symptoms of PTSD. The more the family understands the condition and understands what the person is going through, the better able they will be to help the person through the difficult times.

Finally, family members must set firm boundaries for unacceptable behaviors such as verbal, physical, and substance abuse. Children of veterans with PTSD need to know that they are loved and that home is a safe place. The non-PTSD parent can play an integral role by discussing mommy or daddy's symptoms, reassuring them that it is not their fault, validating the child's emotions, calming their fears, and maintaining the family unit by having the family participate in family therapy.

PTSD may be a complicated disorder, but these steps may allow a better life for the PTSD veteran and the family who shares his or her suffering.

Achievement

GENDER & CULTURAL DIVERSITY *Similarities and Differences*

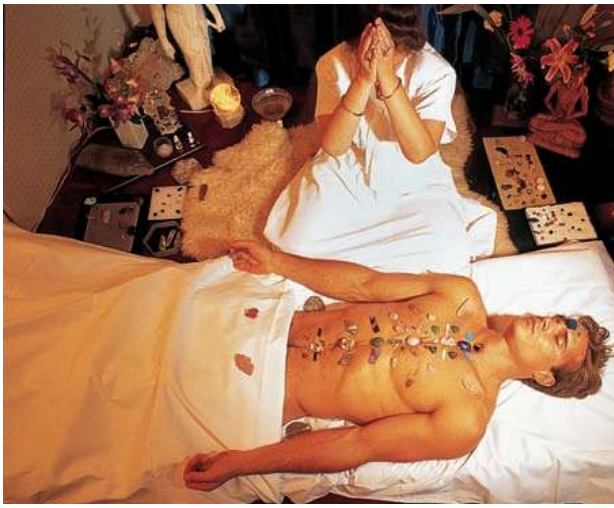
Achievement

Objective 15.22: *Describe the major similarities and differences in therapy across cultures.*

The therapies described in this chapter are based on Western European and North American culture. Does this mean they are unique? Or do our psychotherapists share some of the same techniques and approaches that, say, a native healer or shaman does? Or are there fundamental cultural differences between therapies? What about women? Do they have different issues in therapy? As mentioned earlier, looking at each of these questions requires critical thinking. Let's carefully consider these issues one at a time.

Cultural Similarities When we look at therapies in all cultures, we find that they have certain key features in common (Laungani, 2007; Lee 2002; Sue & Sue, 2008). Richard Brislin (1993, 2000) has summarized some of these features:

- *Naming the problem.* People often feel better just by knowing that others experience the same problem and that the therapist has had experience with their particular problem.
- *Qualities of the therapist.* Clients must feel that the therapist is caring, competent, approachable, and concerned with finding solutions to their problem.
- *Therapist credibility.* Among native healers, credibility may be established by having served as an apprentice to a revered healer. In Western cultures, word-of-mouth testimonials and status symbols (such as diplomas on the wall) establish the therapist's credibility.



Alan Levenson/Stone/Getty Images

Alternative therapies *In all cultures, therapy involves specific actions or treatments. In this photo, the therapist is using crystals, laying on of stones, and meditation.*

Sky Bonillo/PhotoEdit

Figure 15.10 ***Emphasizing interdependence*** In Japanese *Naikan therapy*, the patient sits quietly from 5:30 A.M. to 9:00 P.M. for seven days and is visited by an interviewer every 90 minutes. During this time, the patient is instructed to reflect on his or her relationships with others, with the goals of discovering personal guilt for having been ungrateful and troublesome to others and developing gratitude toward those who have helped the patient (Nakamura, 2006; Ryback, Ikerni, & Miki, 2001; Ozawa-de Silva, 2007). The reasoning is that when these goals are attained, the patient will have a better self-image and interpersonal attitude. In what ways do the goals and methods of Naikan therapy differ from the therapies we have described in this chapter? Would this approach work with Westerners? Why or why not?

Achievement

Objective 15.23: *What are the unique concerns of women in therapy?*

- *Familiar framework.* If the client believes that evil spirits cause psychological disorders, the therapist will direct treatment toward eliminating these spirits. Similarly, if the client believes in the importance of talking through their problems, insight therapy will be the likely treatment of choice.
- *Techniques that bring relief.* In all cultures, therapy involves action. Either the client or the therapist must do something. Moreover, what they do must fit the client's expectations—whether it is performing a ceremony to expel demons or talking with the client about his or her thoughts and feelings.
- *A special time and place.* The fact that therapy occurs outside the client's everyday experiences seems to be an important feature of all therapies.

Cultural Differences Although there are basic similarities in therapies across cultures, there are also important differences. In the traditional Western European and North American model, the emphasis is on the "self" and on independence and control over one's life—qualities that are highly valued in individualistic cultures. In collectivist cultures, however, the focus of therapy is on interdependence and accepting the realities of one's life (Sue & Sue, 2008) (Figure 15.10).

Not only does culture affect the types of therapy that are developed, but it also influences the perceptions of the therapist. What one culture considers abnormal behavior may be quite common—and even healthy—in others. For this reason, recognizing cultural differences is very important for both therapists and clients and for effecting behavioral change (Laungani, 2007; Sue & Sue, 2008; Tseng, 2004).

Women and Therapy Within our individualistic Western culture, men and women present different therapy needs and problems. For example, women are generally more comfortable and familiar with their emotions, have fewer negative attitudes toward therapy, and are more likely than men to seek psychological help. However, research has identified five unique concerns related to women and psychotherapy (Halbreich & Kahn, 2007; Hall, 2007; Hyde, 2007; Matlin, 2008; Russo & Tartaro, 2008).

1. *Rates of diagnosis and treatment of mental disorders.* Women are diagnosed and treated for mental illness at a much higher rate than men. Is this because women are "sicker" than men as a group? Or are they just more willing to admit their problems? Or perhaps the categories for illness may be biased against women. More research is needed to answer this question.
2. *Stresses of poverty.* Poverty is an important contributor to many psychological disorders. Therefore, women bring special challenges to the therapy situation because of their overrepresentation in the lowest economic groups.
3. *Stresses of aging.* Aging brings special concerns for women. They live longer than men, tend to be poorer, to be less educated, and to have more serious health problems. Elderly women, primarily those with age-related dementia, account for over 70 percent of the chronically mentally ill who live in nursing homes in the United States.
4. *Violence against women.* Rape, violent assault, incest, and sexual harassment all take a harsh toll on women's mental health. With the exception of violent assault, these

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Figure 15.11 ***Meeting women's unique needs*** Therapists must be sensitive to possible connections between clients' problems and their gender. Rather than prescribing drugs to relieve depression in women, for example, it may be more appropriate for therapists to explore ways to relieve the stresses of multiple roles or poverty. Can you see how helping a single mother identify parenting resources such as play groups, parent support groups, and high-quality child care might be just as effective at relieving depression as prescribing drugs?

forms of violence are much more likely to happen to women than to men. These violent acts may lead to depression, insomnia, posttraumatic stress disorder, eating disorders, and other problems.

5. *Stresses of multiple roles.* Women today are mothers, wives, homemakers, wage earners, students, and so on. The conflicting demands of their multiple roles often create special stresses (Figure 15.11).

Institutionalization: Treating Chronic and Serious Mental Disorders

Achievement

Objective 15.24: *Discuss issues with involuntary commitment and deinstitutionalization.*

We all believe in the right to freedom. But what about people who threaten suicide or are potentially violent? Should some people be involuntarily committed to protect them from their own mental disorders? Despite Hollywood film portrayals, forced institutionalization of the mentally ill poses serious ethical problems, and it is generally reserved for only the most serious and life-threatening situations.

Involuntary Commitment

The legal grounds for involuntary commitment vary from state to state. But, generally, people can be sent to psychiatric hospitals if they are believed to be:

- of danger to themselves (usually suicidal) or dangerous to others (potentially violent);
- in serious need of treatment (indicated by bizarre behavior and loss of contact with reality); and/or
- there is no reasonable, less restrictive alternative.

In emergencies, psychologists and other professionals can authorize temporary commitment for 24 to 72 hours. During this observation period, laboratory tests can be performed to rule out medical illnesses that could be causing the symptoms. The patient also can receive psychological testing, medication, and short-term therapy.

James Shaffer/PhotoEdit

Figure 15.12 ***Outpatient support*** Community mental health (CMH) centers are a prime example of alternative treatment to institutionalization. CMH centers provide outpatient services, such as individual and group therapy and prevention programs. They also coordinate short-term inpatient care and programs for discharged mental patients, such as halfway houses and aftercare services. The downside of CMH centers and their support programs is that they are expensive. Investing in primary prevention programs (such as more intervention programs for people at high risk for mental illness) could substantially reduce these costs.

Deinstitutionalization

Although the courts have established stringent requirements for involuntary commitment, abuses do occur. There are also problems with long-term chronic institutionalization. And properly housing and caring for the mentally ill is very expensive. In response to these problems, many states have a policy of *deinstitutionalization*, discharging patients from mental hospitals as soon as possible and discouraging admissions.

Deinstitutionalization has been a humane and positive step for many. But some patients are discharged without continuing provision for their protection. Many of these people end up living in rundown hotels or understaffed nursing homes, in jails, or on the street with no shelter or means of support. It is important to note that a sizable percentage of homeless people do have mental disorders. The rise in homelessness is also due to such economic factors as increased unemployment, underemployment, and a shortage of low-income housing.

What else can be done? Rather than returning patients to state hospitals, most clinicians suggest expanding and improving community care (Figure 15.12). They also recommend that general hospitals be equipped with special psychiatric units where acutely ill patients receive inpatient care. For less disturbed individuals and chronically ill patients, they recommend walk-in clinics, crisis intervention services, improved residential treatment facilities, and psychosocial and vocational rehabilitation. State hospitals can then be reserved for the most unmanageable patients.

Evaluating and Finding Therapy: Does It Work? How to Choose?

Have you ever thought about going to a therapist? If you've gone, was it helpful? In this section, we will discuss questions about the effectiveness of therapy and how to find a therapist.

Judging Effectiveness

Scientifically evaluating the effectiveness of therapy can be tricky. How can you trust the perception and self-report of clients or clinicians? Both have biases and a need to justify the time, effort, and expense of therapy.

To avoid these problems, psychologists use controlled research studies. Clients are randomly assigned to different forms of therapy or to control groups who receive no treatment. After therapy, clients are independently evaluated, and reports from friends and family members are collected. Until recently, these studies were simply compared. But with a new statistical technique called *meta-analysis*, which combines and analyzes data from many studies, years of such studies and similar research can be brought together to produce a comprehensive report.

The good news, for both consumers and therapists, is that after years of controlled research and meta-analysis we have fairly clear evidence that therapy does work! Forty to 80 percent of people who receive treatment are better off than people who do not. Furthermore, short-term treatments can be as effective as long-term treatments (Castonguay & Hill, 2007; Cleaves & Latner, 2008; Knekt et al., 2008; Loewental & Winter, 2006; Stiles et al., 2008; Wachtel, 2008). In addition, some therapies are more effective than others for specific problems. For example, phobias seem to respond best to systematic desensitization, and obsessive-compulsive disorders can be significantly relieved with cognitive-behavior therapy accompanied by medication.

Achievement

Objective 15.25: *Is therapy effective, and how can we find a good therapist?*

Finding a Therapist

How do we find a good therapist for our specific needs? If you have the time (and the money) to explore options, take the time to "shop around" for a therapist best suited to your specific goals. Consulting your psychology instructor or college counseling system for referrals can be an important first step. However, if you are in a crisis—you have suicidal thoughts, you have failing grades, or you are the victim of abuse—get help fast. Most communities have medical hospital emergency services and telephone hotlines that provide counseling services on a 24-hour basis. And most colleges and universities have counseling centers that provide immediate, short-term therapy to students free of charge.

If you are encouraging someone else to get therapy, you might offer to help locate a therapist and go with him for his first visit. If he refuses help and the problem affects you, it is often a good idea to seek therapy yourself. You will gain insights and skills that will help you deal with the situation more effectively.

Assessment

PSYCHOLOGY AT WORK

Non Professional Therapy—Talking to the Depressed

I know that everyone here knows that feeling when people say to you, "Hey, shape up! Stop thinking only about your troubles. What's to be depressed about? Go swimming or play tennis and you'll feel a lot better. Pull up your socks!" And how you, hearing this, would like nothing more than to remove one of those socks and choke them to death with it. (Laughter mixed with some minor cheering.)

(Cavett, 2008)

These are the words of famous columnist and commentator, Dick Cavett, speaking about his personal bouts with deep depression to a large audience currently in the throes of the same disease. If you have a friend or loved one with serious depression, it may feel like you're walking through a minefield when you're attempting to comfort and help them. What do the experts suggest that you say (or NOT say)? Here are a few general tips:

1. ***Don't trivialize the disease.*** Depression, like cancer or heart disease, is a critical, life-threatening illness. Asking someone "What do you have to be depressed about?" or encouraging them to "pull up their socks" is akin to asking the cancer patient why they have cancer, why they don't just smile and exercise more, or why they can't just think positive thoughts?
2. ***Don't be a cheerleader or a Mr. or Ms. fix-it.*** You can't pep-talk someone out of deep depression, and offering cheap advice or solutions is the best way to insure that you'll be the last person they'll turn to for help. According to Dick Cavett, "When you're downed by this affliction, if there were a curative magic wand on the table eight feet away, it would be too much trouble to go over and pick it up."
3. ***Don't equate normal, everyday "down times" with clinical depression.*** Virtually everyone has experienced down moods and times of loss and deep sadness. Unless you have shared true, clinical depression, comments like, "I know just how you feel," only makes it clear that you don't understand what clinical depression is all about. As they say, "If you don't got it, you don't get it!"

What can you do?

Educate yourself. Your psychology instructor, college library, book stores, and the Internet all provide a wealth of information. You also can check out the resources available on our text website at www.wiley.com/college/huffman.

Be Rogerian! Carl Roger's four important qualities of communication (*empathy*, *unconditional positive regard*, *genuineness*, and *active listening*) (pp. 518–519) are probably the best, and safest, approach for any situation—including talking with a depressed person.

Achievement

Objective 15.26: *Briefly summarize how to deal with someone who's seriously depressed.*

Get help! The most dangerous problem associated with depression is the high risk of suicide (see Chapter 14, pp. 491–492). If a friend or loved one mentions suicide, or if you believe they are considering it, get professional help fast! Consider calling the police for emergency intervention, and/or the person's therapist, or the toll-free 7/24 hotline: 1-800-SUICIDE.

Assessment

STOP

CHECK & REVIEW

Therapy and Critical Thinking

Objective 15.19: *Identify the five most common goals of therapy, and discuss the eclectic approach.*

There are numerous forms of therapy. But they all focus treatment on five basic areas of disturbance—thoughts, emotions, behaviors, interpersonal and life situations, and biomedical problems. Many therapists take an **eclectic approach** and combine techniques from various theories.

Objective 15.20: *Identify the six key types of mental health professionals.*

Clinical psychologists, counseling psychologists, psychiatrists, psychiatric nurses, psychiatric social workers, and school psychologists are the six most common types of mental health professionals.

Objective 15.21: *Briefly summarize the major effects of mental disorders, like PTSD, on the family.*

Mental disorders, like PTSD, and their treatment have been studied extensively, but we often overlook the effects on the family who develop their own forms of pathology. The entire family also suffers from increased rates of divorce, substance abuse, unemployment, and other life problems. Support, education, and intervention should be provided for all family members.

Objective 15.22: *Describe the major similarities and differences in therapy across cultures.*

Therapies in all cultures share six culturally universal features: naming a problem, qualities of the therapist, therapist credibility, familiar framework, techniques that bring relief, and a special time and place. Important cultural differences in therapies also exist. For example, therapies in individualistic cultures emphasize the self and control over one's life, whereas therapies in collectivist cultures emphasize interdependence. Japan's Naikan therapy is a good example of a collectivist culture's therapy.

Objective 15.23: *What are the unique concerns of women in therapy?*

Therapists must take five considerations into account when treating women clients: higher rate of diagnosis and treatment of mental disorders, stresses of poverty, stresses of multiple roles, stresses of aging, and violence against women.

Objective 15.24: *Discuss problems with involuntary commitment and deinstitutionalization.*

People believed to be mentally ill and dangerous to themselves or others can be involuntarily committed to mental hospitals for diagnosis and treatment. Abuses of involuntary commitments and other problems associated with state mental hospitals have led many states to practice *deinstitutionalization*—discharging as many patients as possible and discouraging admissions. Community services such as community mental health (CMH) centers try to cope with the problems of deinstitutionalization.

Objective 15.25: *Is therapy effective, and how can we find a good therapist?*

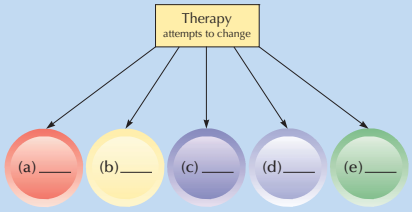
Research on the effectiveness of psychotherapy has found that 40 to 80 percent of those who receive treatment are better off than those who do not receive treatment. When searching for a good therapist, it's good to "shop around," and to consult your psychology instructor or college counselors for referrals. If you're in a crisis, get immediate help through hospital emergency rooms or telephone hotlines.

Objective 15.26: *Briefly summarize how to deal with someone who's seriously depressed.*

When talking to someone who's clinically depressed, you should not trivialize the disease, be a cheerleader/"fix-it," or equate it with normal down times. Instead, you should educate yourself, be Rogerian, and get help!

Questions

1. Label the five most common goals of therapy on the figure below.



2. Match the following therapists with their primary emphasis:
   ___ psychoanalysts
   ___ humanistic therapists
   ___ biomedical therapists
   ___ cognitive therapists
   ___ behavior therapists
   (a) faulty thinking and belief patterns
   (b) unconscious thoughts
   (c) biological disorders
   (d) negative emotions
   (e) maladaptive behaviors
3. Name the six features of therapy that are culturally universal.
4. A Japanese therapy designed to help clients discover personal guilt for having been ungrateful and troublesome to others and to develop gratitude toward those who have helped them is known as _____. (a) Kyoto therapy; (b) Okado therapy; (c) Naikan therapy; (d) Nissan therapy
5. What are the five major concerns about women in therapy?
6. The policy of discharging as many people as possible from state hospitals and discouraging admissions is called _____. (a) disengagement; (b) reinstitutionalization; (c) maladaptive restructuring; (d) deinstitutionalization

Check your answers in Appendix B.

Click & Review
for additional assessment options:
wiley.com/college/huffman

Assessment
KEY TERMS

*To assess your understanding of the **Key Terms** in Chapter 15, write a definition for each (in your own words), and then compare your definitions with those in the text.*

psychotherapy (p. 510)

Insight Therapies
active listening (p. 519)
client-centered therapy (p. 518)
cognitive-behavior therapy (p. 514)
cognitive restructuring (p. 514)
cognitive therapy (p. 514)
dream analysis (p. 511)
empathy (p. 518)
free association (p. 511)
genuineness (p. 519)
group therapy (p. 521)
humanistic therapy (p. 518)
interpretation (p. 511)
psychoanalysis (p. 510)
psychodynamic therapy (p. 512)
rational-emotive behavior therapy (REBT) (p. 514)
resistance (p. 511)
self-help group (p. 521)
self-talk (p. 514)
transference (p. 511)
unconditional positive regard (p. 518)

Behavior Therapies
aversion therapy (p. 524)
behavior therapy (p. 524)
modeling therapy (p. 527)
systematic desensitization (p. 524)

Biomedical Therapies
antianxiety drugs (p. 528)
antidepressant drugs (p. 528)
antipsychotic drugs (p. 528)
biomedical therapy (p. 528)
electroconvulsive therapy (ECT) (p. 530)
lobotomy (p. 530)
mood stabilizer drugs (p. 528)
psychopharmacology (p. 528)
psychosurgery (p. 530)
repetitive transcranial magnetic stimulation (rTMS) (p. 531)
tardive dyskinesia (p. 530)

Therapy and Critical Thinking
eclectic approach (p. 533)

Achievement
WEB RESOURCES

Huffman Book Companion Site
wiley.com/college/huffman

This site is loaded with free Interactive Self-Tests, Internet Exercises, Glossary and Flashcards for key terms, web links, Handbook for Non-Native Speakers, and other activities designed to improve your mastery of the material in this chapter.

Chapter 15 Visual Summary

Insight Therapies

Description/Major Goals

- **Psychoanalysis/psychodynamic therapies:** Bring unconscious conflicts inyo conscious awareness.
- **Cognitive therapies:** Analyze faulty thought processes, beliefs, and negative **self-talk,** and change these destructive thoughts with **cognitive restructuring. Cognitive-behavior therapy:** Focuses on changing faulty thoughts and behaviors.
- **Humanistic therapies:** Work to facilitate personal growth.
- **Group, family, and marital therapies:** Several clients meet with one or more therapists to resolve personal problems.

Techniques/Methods

Five major techniques:

- **Free association**
- **Dream analysis**
- **Resistance**
- **Transference**
- **Interpretation**

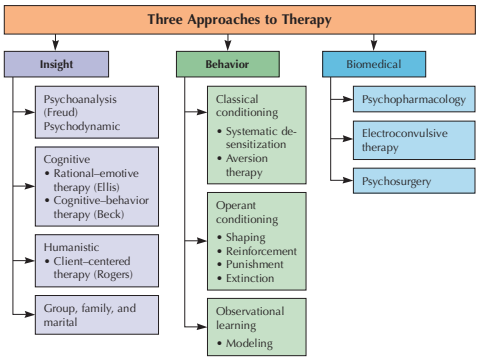
Ellis's **rational-emotive behavior therapy (REBT)** replaces irrational beliefs with rational beliefs and accurate perceptions of the world.
Beck's **cognitive therapy** emphasizes change in both thought processes and behavior.

Rogers's **client-centered therapy** offers **empathy, unconditional positive regard, genuineness,** and **active listening** to facilitate personal growth.

Provide group support, feedback, information, and opportunities for behavior-rehearsal.

- **Self-help groups** (like Alcoholics Anonymous) are sometimes considered group therapy, but professional therapists do not conduct them.
- **Family therapies:** Work to change maladaptive family interaction patterns.

David Young Wolff/PhotoEdit



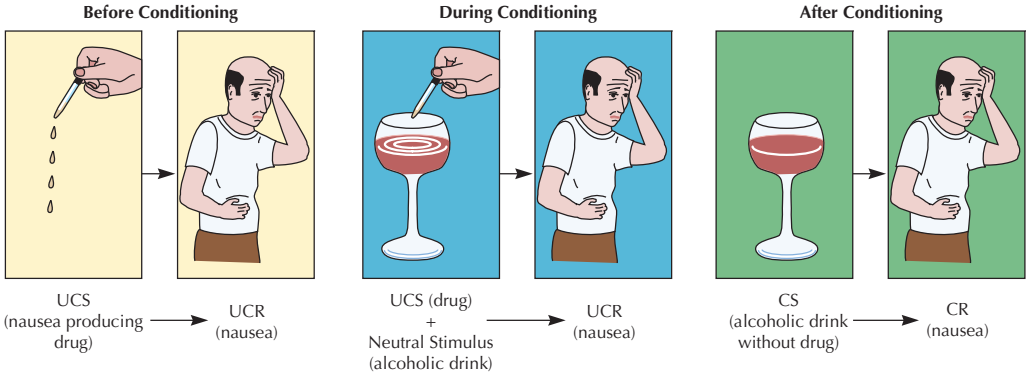
Behavior Therapies

Description/Major Goals

Behavior therapies: Use learning principles to eliminate maladaptive behaviors and substitute healthy ones.

Techniques/Methods

- Classical conditioning techniques, including **systematic desensitization** (client replaces anxiety with relaxation) and **aversion therapy** (an aversive stimulus is paired with a maladaptive behavior)
- Operant conditioning techniques, including shaping and reinforcement.
- Observational learning techniques, including **modeling therapy** (clients watch and imitate positive role models).



Biomedical Therapies

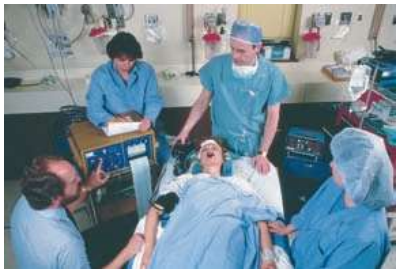
Description/Major Goals

- **Biomedical therapies:** Use biological techniques to relieve psychological disorders.

Techniques/Methods

Drug therapy is the most common biomedical treatment.

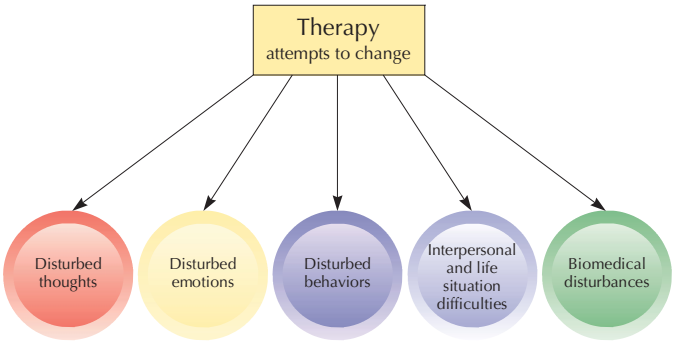
- **Antianxiety drugs** used to treat anxiety disorders.
- **Antipsychotic drugs** relieve symptoms of psychosis.
- **Mood stabilizers** help stabilize bipolar disorder.
- **Antidepressants** used to treat depression.



James P. Wilson/Woodfin Camp & Associates

Electroconvulsive therapy (ECT) used primarily to relieve serious depression, when medication fails.
Psychosurgeries, such as a **lobotomy**, are seldom used today.

Therapy and Critical Thinking



Women in Therapy

Higher rate of diagnosis and treatment of mental disorders due to stresses of poverty, multiple roles, aging, and violence against women.

WireImageStock/Masterfill

Cultural Issues

Common features of therapy in all cultures: Naming a problem, qualities of the therapist, establishing credibility, placing the problem in a familiar framework, applying techniques to bring relief, and a special time and place.
Differences in therapy between cultures: Individualistic cultures emphasize the "self" and control over one's life. However, therapies in collectivist cultures, like Japan's Naikan therapy, emphasize interdependence.

Seeking Therapy

Forty to 80 percent of those who receive treatment are better off than those who do not.
Take time to "shop around," but a crisis requires immediate help.
If others' problems affect you, get help yourself.

Institutionalization

People believed to be mentally ill and dangerous to themselves or others can be involuntarily committed to mental hospitals for diagnosis and treatment.
Abuses of involuntary commitment and other problems led to *deinstitutionalization*—discharging as many patients as possible and discouraging admissions.
Community services such as Community Mental Health (CMH) centers offset some problems of deinstitutionalization.