Psychology in the News

Use of Dogs for Vets with PTSD Is Growing

GULFPORT, FL, June 7, 2010. Many soldiers returning from duty in Afghanistan and Iraq suffer from severe medical and emotional problems. Lt. Col. Kathryn Champion was one of them. She had served 27 years in the Army, but after a particularly horrific tour of duty in Iraq, during which five soldiers under her command died, she began to suffer the symptoms of posttraumatic stress disorder. When she returned home, she fell into deep depression: A virus she contracted in Iraq was killing her optic nerves, causing her to go blind; her Army career was finished.

Then Champion found an organization that matched her with a guide dog, a golden retriever mix named Angel. Just two weeks after their training together ended, Angel began helping Champion with her psychological problems. Champion was terrified of flying and of having a panic attack in public, but whenever her heart started racing, she would reach down and touch her dog. She was able to fly across country to visit her son before his deployment to Afghanistan.

Kathryn Champion, who suffered from posttraumatic stress disorder and anxiety attacks after returning from duty in Iraq, with her dog Angel.

Within weeks, Champion started going out again, since crowds were not bothering her as they had. She and Angel have traveled to the Grand Canyon and even to a "Space Camp" in Alabama.

Across the country, various organizations have begun providing service dogs to help soldiers recover from PTSD. Their efforts are part of a nationwide trend of animal-assisted therapy, also known as pet therapy, designed to help people with various psychological problems. Pet therapy is prominent in many hospitals, as volunteers and "certified therapy dogs" offer comfort and companionship to patients. When humans touch and play with dogs, horses, and other social animals, said Dr. Matt Zimmerman, Counseling and Psychological Services psychologist at the University of Virginia, it lowers their blood pressure and makes them less anxious. He added that animal-assisted therapy should generally be used with other forms of psychological treatment or medication.

Zimmerman says there are specific benefits of pet therapy for children with autism. "The animal serves as [a] reinforcement tool for appropriate social behavior," Zimmerman said. "If the child is being gentle and kind to the pet, then [it] stays. If the child is hitting or pulling on the animal, the pet leaves." When it comes to other disorders, however, the effectiveness of the treatment tends to depend more upon the individual in question, he said.

Kathryn Champion has started raising money to provide dogs for other veterans in trouble. She is once again engaged in life. As a spokeswoman for the program that provided her with the dog said, "Angel has been her ticket back in."

CHAPTER 12

Approaches to Treatment and Therapy

Have you ever survived a traumatic event—war, assault, violence in your family or neighborhood, the unexpected death of a loved one, or a natural disaster such as an earthquake or hurricane? Have you ever had to move away from the country or ethnic group you grew up in, to find yourself lonely and struggling in a new world? How about the pressures of being in college; do they ever make you feel depressed, worried, or perhaps panicky?

If so, what kind of therapy might help you? For most of the emotional problems that all of us suffer on occasion, the two greatest healers are time and the support of friends—including pet friends. For some people, though, time and friends are not enough, and they continue to be troubled by normal life difficulties, such as family quarrels or fear of public speaking, or by one of the disorders described in the previous chapter: depression, generalized anxiety disorder, phobias, or schizophrenia. What kind of therapy might help them?

In this chapter, we will evaluate two major approaches: (1) *Biological treatments,* primarily provided by psychiatrists or other physicians, include medications or intervention in brain function. So many people today are taking medications routinely, for emotional disorders and normal problems alike, that few consumers stop to question whether medication is always the right treatment, especially in the long run, or whether nonmedical treatments might work as well. We will assess which biological treatments are effective and for which conditions, which ones are not, and when drugs can be dangerous. (2) *Psychotherapy* covers an array of psychological interventions, and we will consider the major approaches: psychodynamic therapies, cognitive and behavior therapies, humanist therapies, and family or couples therapy. We will assess which kinds of psychotherapy work best for which problems, which ones are not helpful, and which ones might even be harmful.

YOU are about to learn...

- the types of medications used to treat psychological disorders.
- six important cautions about medications for emotional problems.
- ways of electrically stimulating the brain—and whether they work.

Biological Treatments for Mental Disorders

For hundreds of years, people have tried to identify the origins of mental illness, attributing the causes at various times to evil spirits, pressure in the skull, disease, or bad environments. Today, biological explanations and treatments are dominant, partly because of evidence that some disorders have a genetic component or involve a biochemical or neurological abnormality (see Chapter 11), and partly because physicians and pharmaceutical companies are promoting biomedical solutions, often uncritically (Angell, 2004).

The Question of Drugs

The most commonly used biological treatment is medication that alters the production of or response to neurotransmitters in the brain. Because drugs are so widely advertised and prescribed these days, both for severe disorders such as schizophrenia and for more common problems such as anxiety and depression, consumers need to understand what these drugs are, how they can best be used, and their limitations.

Drugs Commonly Prescribed for Mental Disorders

The main classes of drugs used in the treatment of mental and emotional disorders are the following:

antipsychotic drugs Drugs used primarily in the treatment of schizophrenia and other psychotic disorders; they are often used off label and inappropriately for other disorders such as dementia and impulsive aggressiveness.

antidepressant drugs Drugs used primarily in the treatment of mood disorders, especially depression and anxiety.

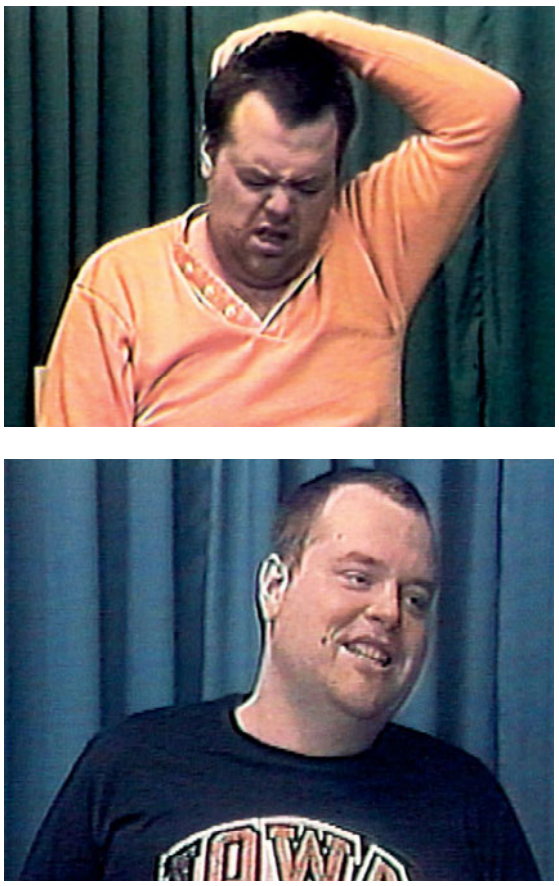
1 **Antipsychotic drugs**, also called *neuroleptics*—older ones such as Thorazine and Haldol and second-generation ones such as Clozaril, Risperdal, Zyprexa, and Seroquel—are used primarily in the treatment of schizophrenia and other psychoses. However, antipsychotic drugs are increasingly being prescribed "off label" for people with nonpsychotic disorders, such as major depression, bipolar disorder, autism, attention deficit disorder, and dementia.

Because many psychoses are thought to be caused by an excess of the neurotransmitter dopamine, most antipsychotic drugs are designed to block or reduce the sensitivity of brain receptors that respond to dopamine. Some also increase levels of serotonin, a neurotransmitter that inhibits dopamine activity. Antipsychotic drugs can reduce agitation, delusions, and hallucinations, and they can shorten schizophrenic episodes. But they offer little relief from other symptoms of schizophrenia, such as jumbled thoughts, difficulty concentrating, apathy, emotional flatness, or inability to interact with others.

Antipsychotics often cause troubling side effects, especially muscle rigidity, hand tremors, and other involuntary muscle movements that can develop into a neurological disorder. In addition, Zyprexa, Risperdal, and other antipsychotics, which manufacturers have been targeting for children and the elderly, often carry unacceptable risks for these very groups. The immediate side effect is extreme weight gain, anywhere from 24 to 100 extra pounds a year, which has led to the development of thousands of cases of diabetes. Other risks include strokes and death from sudden heart failure (Masand, 2000; Ray et al., 2009; Wallace-Wells, 2009).

Although the newer drugs now comprise 90 percent of the market for antipsychotics, a large federally funded study found that they are not significantly safer or more effective than the older, less expensive medications for schizophrenia—the only disorder for which they were originally approved (Lieberman et al., 2005; Swartz et al., 2007). And although antipsychotics are sometimes used to treat impulsive aggressiveness associated with attention deficit disorder, dementia, and mental retardation, they are ineffective for these disorders. One study followed 86 people, ages 18 to 65, who were given Risperdal, Haldol, or a placebo to treat their aggressive outbursts (Tyrer et al., 2008). The placebo group improved the most.

2 **Antidepressant drugs** are used primarily in the treatment of depression, anxiety, phobias, and obsessive-compulsive disorder. *Monoamine oxidase inhibitors* (MAOIs), such as Nardil, elevate the levels of norepinephrine and serotonin in the brain by blocking or inhibiting an enzyme that deactivates these neurotransmitters. *Tricyclic antidepressants*, such as Elavil and Tofranil, boost norepinephrine and serotonin levels by preventing the normal reabsorption, or "reuptake," of these substances by the cells that have released them. *Selective serotonin reuptake inhibitors* (SSRIs), such as Prozac, Zoloft, Lexapro, Paxil, and Celexa, work on the same principle as the tricyclics but specifically target serotonin. Cymbalta and Remeron target both



These photos show the effects of antipsychotic drugs on the symptoms of a young man with schizophrenia. In the top photo, he was unmedicated; in the bottom photo, he had taken medication. However, these drugs do not help all people with psychotic disorders.

serotonin and norepinephrine. Wellbutrin is chemically unrelated to the other antidepressants but is often prescribed for depression and sometimes as an aid to quitting smoking.

Antidepressants are nonaddictive and about equally effective, but they all tend to produce some unpleasant physical reactions, including dry mouth, headaches, constipation, nausea, restlessness, gastrointestinal problems, weight gain, and, in as many as one-third of all patients, decreased sexual desire and blocked or delayed orgasm (Hollon, Thase, & Markowitz, 2002). The specific side effects may vary with the particular drug. MAOIs interact with certain foods (such as cheese) and have the most risks, such as elevating blood pressure in some individuals to dangerously high levels, so they are prescribed least often.

3 **Antianxiety drugs (tranquilizers)**, such as Valium, Xanax, Ativan, and Klonopin, increase the activity of the neurotransmitter gamma-aminobutyric acid (GABA). Tranquilizers may temporarily help individuals who are having an acute anxiety attack, but they are not considered the treatment of choice over a long period of time. Symptoms almost always return if the medication is stopped, and a significant percentage of people who take tranquilizers overuse them and develop problems with withdrawal and tolerance (that is, they need larger and larger doses to get the same effect). *Beta-blockers*, a class of drugs primarily used to manage heart irregularities and hypertension, are sometimes prescribed to relieve acute anxiety—for example, caused by stage fright or athletic competition—which they do by slowing the heart rate and lowering blood pressure. But beta-blockers are not approved for anxiety disorders.

4 A special category of drug, a salt called **lithium carbonate**, often helps people who suffer from bipolar disorder. It may produce its effects by moderating levels of norepinephrine or by protecting brain cells from being overstimulated by another neurotransmitter, glutamate. Lithium must be given in exactly the right dose, and bloodstream levels of the drug must be carefully monitored, because too little will not help and too much is toxic; in some people, lithium produces short-term side effects (tremors) and long-term problems (kidney damage). Other drugs commonly prescribed for people with bipolar disorder include Depakote and Tegretol.

tranquilizers Drugs commonly but often inappropriately prescribed for patients who complain of unhappiness, anxiety, or worry.

lithium carbonate A drug frequently given to people suffering from bipolar disorder.

"Before Prozac, she loathed company."

TABLE 12.1

Drugs Commonly Used in the Treatment of Psychological Disorders

	Antipsychotics (Neuroleptics)	Antidepressants	Antianxiety Drugs	Lithium Carbonate
Examples	Thorazine Haldol Clozaril Risperdal Seroquel	Prozac (SSRI) Nardil (MAOI) Elavil (tricyclic) Paxil (SSRI) Wellbutrin (other) Cymbalta (other) Remeron (other)	Valium Xanax Klonapin Beta-blockers	
Primarily used for	Schizophrenia Other psychoses Impulsive anger Bipolar disorder	Depression Anxiety disorders Panic disorder Obsessive-compulsive disorder	Mood disorders Panic disorder Acute anxiety (e.g., stage fright)	Bipolar disorder

For a review of these drugs and their uses, see Table 12.1. Explore

Explore **Drugs Commonly Used to Treat Psychiatric Disorders** on **mypsychlab.com**

Some Cautions about Drug Treatments

Without question, drugs have rescued some people from emotional despair and helped countless others live with chronic problems such as obsessive-compulsive disorder and panic attacks. They have enabled severely depressed or mentally disturbed people to be released from hospitals, to function in the world, and to respond to psychotherapy. Yet many psychiatrists and drug companies are trumpeting the benefits of medication without informing the public of its limitations.

Most people are unaware of how a *publication bias*—the tendency for journals to publish positive findings rather than negative or ambiguous ones—affects what we know. Independent researchers reviewed unpublished data submitted to the U.S. Food and Drug Administration (FDA) on 12 popular antidepressants. Of the 74 studies they examined, 38 reported positive results, and all but one of those was later published. Of the remaining studies with negative or mixed results, only 14 were published—and most of them were given a positive spin (Turner et al., 2008).

Even more worrisome for the prospects of impartial research, the majority of researchers who are studying the effectiveness of medication have financial ties to the pharmaceutical industry, in the form of lucrative consulting fees, funding for their clinical trials, stock investments, and patents. Studies that are independently funded often do not get the positive results that industry-funded drug trials do (Healy, 2002; Krimsky, 2003). In this section, therefore, we want to give you an idea of what you are not hearing from the drug companies.

Thinking Critically about Drug Treatments

1 The placebo effect. New drugs often promise quick and effective cures. But the **placebo effect** ensures that many people will respond positively to a new drug just because of the enthusiasm surrounding it and because of their own expectations that the drug will make them feel better. After a while, when placebo effects decline, many drugs turn out to be neither as effective as promised nor as widely applicable. This has happened repeatedly with each new generation of tranquilizer and each new "miracle" antipsychotic drug and antidepressant (Healy, 2004; Moncrieff, 2001).

In fact, some investigators maintain that much of the effectiveness of antidepressants, especially for people who are only mildly depressed, is due to a placebo effect (Khan et al., 2003). Overall, only about half of all depressed patients respond positively to any given antidepressant medication, and of those, only about 40 percent are actually responding to the specific biological effects of the drug (Hollon, Thase, & Markowitz, 2002). In a meta-analysis of more than 5,000 patients in

placebo effect The apparent success of a medication or treatment due to the patient's expectations or hopes rather than to the drug or treatment itself.

47 clinical trials, investigators found that the placebo effect was "exceptionally large," accounting for more than 80 percent of the alleviation of symptoms. The drugs were most effective for patients with severe depression (Kirsch et al., 2008). Research in neuroscience suggests how placebos might be working: The psychological expectation of improvement actually produces some of the same brain changes that medication does (Benedetti et al., 2005).

2 High relapse and dropout rates. A person may have short-term success with antipsychotic or antidepressant drugs. However, in part because of these drugs' unpleasant side effects, anywhere from one-half to two-thirds of people stop taking them. When they do, they are likely to relapse, especially if they have not learned how to cope with their disorders (Hollon, Thase, & Maskowitz, 2002).

3 Disregard for effective, possibly better nonmedical treatments. The popularity of drugs has been fueled by pressure from insurance companies, which prefer to pay for one patient visit for a prescription rather than ten visits for psychotherapy, and by drug company marketing and advertising. In 1997, the FDA permitted pharmaceutical companies to advertise directly to the public, a practice still forbidden in Canada and Europe; sales of new drugs skyrocketed as consumers began to request them. Ads promise wonderful results for emotional and behavioral problems, yet nonmedical treatments may work just as well or better. For example, two psychologists examined data on more than 168,000 children with attention deficit disorder who had been referred for treatment to a behavioral-care facility. More than 60 percent of the boys and 23 percent of the girls were on Ritalin or another drug. But after six sessions of behavior therapy for the children and ten sessions for the parent, only 11 percent of the boys and 2 percent of the girls remained on medication (Cummings & Wiggins, 2001).

4 Dosage problems. One challenge in prescribing drugs is to find the right dose—enough but not too much. The same dose of a drug may be metabolized differently in men and women, old people and young people, and different ethnic groups. When psychiatrist Keh-Ming Lin moved from Taiwan to the United States, he was amazed to learn that the dosage of antipsychotic drugs given to American patients with schizophrenia was often ten times higher than the dose for Chinese patients. In subsequent studies, Lin and his colleagues confirmed that Asian patients require significantly lower doses of the medication for optimal treatment (Lin, Poland, & Chien, 1990). Similarly, African Americans suffering from depression or bipolar disorder seem to need lower dosages of tricyclic antidepressants and lithium than other ethnic groups do (Strickland et al., 1991, 1995). Groups may differ in the dosages they can tolerate because of variations in metabolic rates, amount of body fat, the number or type of drug receptors in the brain, or cultural practices such as smoking and eating certain foods.

5 Unknown risks over time and in combination. The effects of taking antidepressants indefinitely are still unknown, especially for vulnerable groups such as children, pregnant women, the elderly, or the generation of young adults who have been taking them since childhood or adolescence, when the brain is still developing. After British drug authorities reported that nine unpublished studies of Paxil found that it tripled the risk of suicidal thoughts and suicide attempts in adolescents who were taking the drug compared to those given a placebo (Harris, 2003), the FDA now warns against prescribing SSRIs to anyone under 18.

The reason we don't know about long-term effects until a drug has been on the market for years is that new drugs are initially tested clinically on only a few hundred people for just a few weeks or months, even when the drug is one that a person might take indefinitely (Angell, 2004). Nonetheless, many psychiatrists, understandably frustrated

"I think the dosage needs adjusting. I'm not nearly as happy as the people in the ads."

electroconvulsive therapy (ECT) A procedure used in cases of prolonged and severe major depression, in which a brief brain seizure is induced.

by the failure of existing antipsychotics and antidepressants to help all of their patients, are prescribing "cocktails" of medications—this one for anxiety, plus this one for depression, plus another to manage the side effects. They report anecdotal success in some cases, but to date, there has been virtually no research on the benefits and risks of these combination approaches.

6 Untested off-label uses. Most consumers do not realize that once the FDA approves a drug, doctors are permitted to prescribe it for other conditions and to populations other than those on which it was originally tested. As already noted, antipsychotics such as Risperdal are being used for nonpsychotic disorders. Likewise, antidepressants are being marketed for "social phobias"; Prozac, when its patent expired, was renamed Sarafem and marketed to women for "premenstrual dysphoric disorder"; Ritalin, widely given to school-aged children, is being prescribed for 2- and 3-year-olds.

The overprescription of drugs for mood disorders also occurs because of a common but mistaken assumption: If a disorder appears to have biological origins or involve biochemical abnormalities, then biological treatments must be most appropriate. In fact, however, changing your behavior and thoughts through psychotherapy or other new experiences can also change the way your brain functions. In PET-scan studies of people with obsessive-compulsive disorder, among those who were taking the SSRI Prozac, the metabolism of glucose in a critical part of the brain decreased, suggesting that the drug was having a beneficial effect by calming that area. Yet exactly the *same* brain changes occurred in patients who were getting cognitive-behavior therapy (described later in this chapter) and no medication (Baxter et al., 1992; Schwartz et al., 1996) (see Figure 12.1).

Thinking Critically about Treating the Mind "or" the Brain

In coming years, you will be hearing about "promising medications" for such common psychological problems as memory loss, eating disorders, and smoking (Miller, 2008). Every major pharmaceutical company is working on one or more of these, and you are likely to hear enthusiastic researchers claiming, "We'll have it within five years!" But we hope you will resist the impulse to jump on any new-drug bandwagon. Critical thinkers must weigh the benefits and limitations of medication for psychological problems and wait for the data on safety and effectiveness.

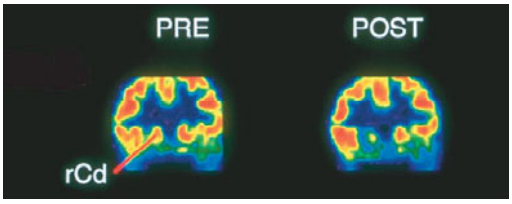


FIGURE 12.1
Psychotherapy and the Brain
These PET scans show the brain of a person with obsessive-compulsive disorder before and after behavior therapy. Before therapy, the glucose metabolic rates in the right caudate nucleus (rCd) were elevated. After therapy, this area calmed down, becoming less active, just as it did with medication (Schwartz et al., 1996).

Direct Brain Intervention

For most of human history, a person suffering from mental illness often got an extreme form of help. A well-meaning tribal healer or doctor would try to release the "psychic pressures" believed to be causing the symptoms by drilling holes in the victim's skull. It didn't work!

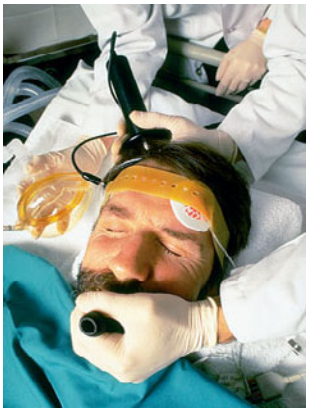
The most famous modern effort to cure mental illness by intervening directly in the brain was invented in 1935, when a Portuguese neurologist, António Egas Moniz, drilled two holes into the skull of a mental patient and used an instrument to crush nerve fibers running from the prefrontal lobes to other areas. This operation, called a *prefrontal lobotomy*, was supposed to reduce the patient's emotional symptoms without impairing intellectual ability. The procedure—which, incredibly, was never assessed or validated scientifically—was performed on more than 40,000 people in the United States. Tragically, lobotomies left many patients apathetic, withdrawn, and unable to care for themselves (Valenstein, 1986). Yet Moniz won a Nobel Prize for his work.

A different approach to altering brain function has been to stimulate the brain electrically. The oldest method is **electroconvulsive therapy (ECT)**, or "shock therapy," which is used for the treatment of severe depression, although no one knows how or why it works. An electrode is placed on one side of the head and a brief current is turned on. The current triggers a seizure that typically lasts one minute, causing the body to convulse. In the past, there were many horror stories about the misuse of ECT and its dire effects on memory. Today, however, patients are given muscle relaxants and anesthesia, so they sleep through the procedure and their convulsions are minimized. The World Psychiatric Association has endorsed ECT as safe and effective, especially for people with crippling depression and suicidal impulses and for those who have not responded to other

treatments (Shorter & Healy, 2008). Still, the mood-improving effect of ECT is usually short-lived, and the depression almost always returns within a few weeks or months (Hollon, Thase, & Markowitz, 2002). ECT is ineffective with other disorders, such as schizophrenia or alcoholism, although it is occasionally misused for these conditions.

A different method of electrically stimulating the brains of individuals suffering from severe depression, still largely experimental, is *transcranial magnetic stimulation (TMS)*, which involves the use of a pulsing magnetic coil held to a person's skull over the left prefrontal cortex, an area of the brain that is less active in people with depression. Like ECT, the benefits of TMS, when they occur, are short-lived. At present, its benefits seem to depend more on *who* is doing it than on *what* is being done, suggesting the placebo effect is at work rather than the technology itself. Until controlled studies are done, we need to tolerate some uncertainty about whether TMS will prove to be effective.

Another, riskier approach is *deep brain stimulation (DBS)*, which was originally approved for patients with Parkinson's disease and epilepsy, and now is being used for at least a dozen mental disorders, although no one knows how or why it might be helpful. DBS requires surgery to implant electrodes into the brain and to embed a small box, like a pacemaker, under the collarbone. But it also is still experimental and claims of its success are based only on patients' self-reports, so the powerful placebo effect of surgery cannot be ruled out (Lozano et al., 2008). The company that developed this $25,000-per-patient device has hired psychiatrists to lobby for it, mounted a vigorous marketing campaign to get it approved, and funded virtually all of the so-far unsuccessful efforts to show that it works (Barglow, 2008).



George Ruhe/The New York Times

A man receives ECT (left); right, a researcher demonstrates transcranial magnetic stimulation (TMS).

Quick Quiz

No amount of electric shock will stimulate test-taking ability.

A. Match these treatments with the problems for which they are typically used.

1. antipsychotic drugs	**a.** suicidal depression
2. antidepressant drugs	**b.** bipolar disorder
3. lithium carbonate	**c.** schizophrenia
4. electroconvulsive therapy	**d.** depression and anxiety
	e. obsessive-compulsive disorder

B. What are six cautions about taking medications for psychological disorders?

C. In 2006, a news story reported that scientists had high hopes for new pills that would help people quit smoking, lose weight, and kick addictions to alcohol and cocaine. The pills supposedly worked by blocking pleasure centers in the brain that make people feel good when they smoke, overeat, or drink liquor. Based on what you have read in this section, what might you expect to have read in a follow-up story two years later? Why?

Answers:

A. 1. c **2.** d, e **3.** b **4.** a **B.** Placebo effects are common; dropout and relapse rates are high; the availability of medication may prevent people from trying a possibly better nonmedical solution first; appropriate dosages can be difficult to determine and can vary by sex, age, and ethnicity; some drugs have unknown or long-term risks; and some drugs are prescribed off label for conditions for which they were never tested. **C.** You might expect to read that there were unexpected side effects of the new pills or their lack of effectiveness. One subsequent news story on this particular line of research concluded: "Now it seems the drugs may block pleasure too well, possibly raising the risk of depression and suicide." Indeed, a pill from one major drug company to help people quit smoking has been linked to dozens of reports of suicides and suicide attempts, and two obesity pills have been tied to higher rates of suicide and depression. Early reports of drugs in the testing pipeline usually promise exciting results, but many of these drugs do not pan out.

psychoanalysis A theory of personality and a method of psychotherapy, developed by Sigmund Freud, that emphasizes the exploration of unconscious motives and conflicts; modern psychodynamic therapies share this emphasis but differ from Freudian analysis in various ways.

transference In psychodynamic therapies, a critical process in which the client transfers unconscious emotions or reactions, such as emotional feelings about his or her parents, onto the therapist.

YOU are about to learn...

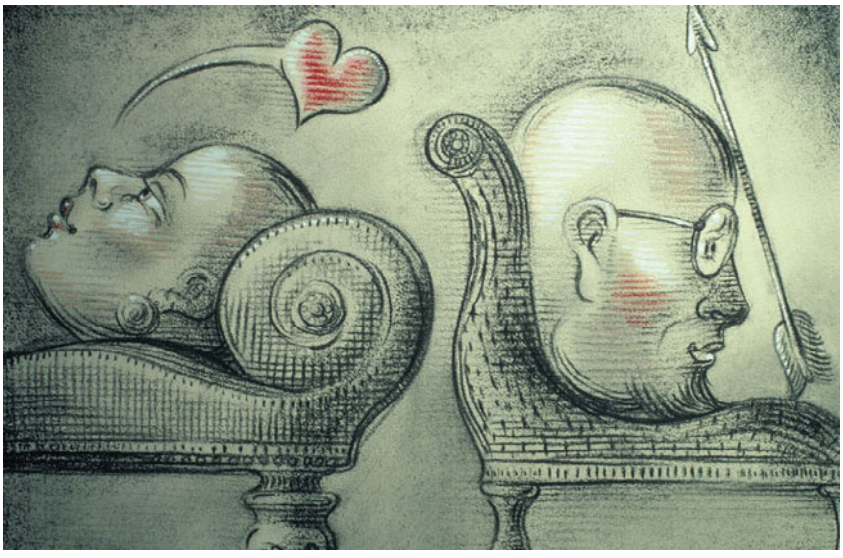
- **the major approaches to psychotherapy.**
- **how behavior therapists can help you change bad habits, and how cognitive therapists can help you get rid of self-defeating thoughts.**
- **why humanist and existential therapists focus on the "here and now" instead of the "why and how."**
- **the benefits of treating a whole family instead of only one of its members.**

Major Schools of Psychotherapy

All good psychotherapists want to help clients think about their lives in new ways and find solutions to the problems that plague them. In this section, we will consider the major schools of psychotherapy. To illustrate the philosophy and methods of each one, we will focus on a fictional fellow named Murray. Murray is a smart guy whose problem is all too familiar to many students: He procrastinates. He just can't seem to settle down and write his term papers. He keeps getting incompletes, and before long the incompletes turn to Fs. Why does Murray procrastinate, manufacturing his own misery? What kind of therapy might help him?

Psychodynamic Therapy

Sigmund Freud was the father of the "talking cure," as one of his patients called it. In his method of **psychoanalysis**, which required patients to come for treatment several days a week, often for years, patients talked not about their immediate problems but about their dreams and their memories of childhood. Freud believed that intensive analysis of these dreams and memories would give patients insight into the unconscious reasons for their symptoms. With insight and emotional release, he believed, the person's symptoms would disappear.



Psychodynamic therapists emphasize the clinical importance of transference, the process by which the client transfers emotional feelings toward other important people in his or her life (usually the parents) onto the therapist. They know that "love's arrow" isn't really intended for them!

Today, Freud's psychoanalytic method has evolved into many different forms of *psychodynamic therapy*, which share the goal of exploring the unconscious dynamics of personality, such as defenses and conflicts. Its practitioners refer to them as "depth" therapies because the purpose is to delve into the deep, unconscious processes believed to be the source of the patient's problems, rather than to concentrate on "superficial" symptoms and conscious beliefs. Modern psychodynamic therapies share certain features, including the discussion of past experience, identification of recurring themes and patterns in the client's life, exploration of fantasies, and a focus on the client's contradictory emotions and feelings (Shedler, 2010).

In addition, a major element of most psychodynamic therapies is **transference**, the client's transfer (displacement) of emotional elements of his or her inner life—usually feelings about the client's parents—outward onto the analyst. Have you ever found yourself responding to a new acquaintance with unusually quick affection or dislike, and later realized it was because the person reminded you of a relative whom you loved or loathed? That experience is similar to transference. In therapy, a woman might transfer her love for her father to the analyst, believing that she has fallen in love with the analyst. A man who is unconsciously angry at his mother for rejecting him might become furious with his analyst for going on vacation. Through analysis of transference in the therapy setting, psychodynamic therapists believe that clients can see their emotional conflicts in action and work through them (Schafer, 1992; Westen, 1998). Experimental studies have found that transference is not limited to psychotherapy; mental representations of significant others are stored in memory and are often activated in new encounters (Andersen & Berk, 1998; Andersen & Chen, 2002).

A psychodynamic therapist might help our friend Murray gain the insight that he procrastinates as an unconscious way of expressing anger toward his parents. He might realize that he is angry because they insist he study for a career he dislikes.

Behavior and Cognitive Therapy

Clinical psychologists who practice behavior therapy would get right to the problem: What are the

reinforcers in Murray's environment that are maintaining his behavior? "Mur," they would say, "forget about insight. You have lousy study habits." Clinicians who practice cognitive therapy would focus on helping Murray understand how his beliefs about studying, writing papers, and success are woefully unrealistic. Often these two approaches are combined.

Behavioral Techniques

Behavior therapy is based on principles of classical and operant conditioning that are discussed in Chapter 9. (You may want to review those principles before going on.) Here are some of these methods (Martin & Pear, 2007):

1 Exposure. The most widely used behavioral approach for treating fears and panic is **graduated exposure**. When people are afraid of some situation, object, or upsetting memory, they usually do everything they can to avoid confronting or thinking of it. Naturally, this only makes the fear worse. Exposure treatments, either in the client's imagination or in actual situations, are aimed at reversing this tendency. In graduated exposure, the client controls the degree of confrontation with the source of the fear: Someone who is trying to avoid thinking of a traumatic event might be asked to imagine the event over and over, until it no longer evokes the same degree of panic. A more dramatic form of exposure is **flooding**, in which the therapist takes the client directly into the feared situation and remains there until the client's panic and anxiety decline. Thus a person suffering from agoraphobia might be taken into a department store or a subway, an action that would normally be terrifying to contemplate.

2 Systematic desensitization. Systematic desensitization is an older behavioral method, a step-by-step process of breaking down a client's conditioned associations with a feared object or experience (Wolpe, 1958). It is based on the classical-conditioning procedure of *counterconditioning*, in which a stimulus (such as a dog) for an unwanted response (such as fear) is paired with some other stimulus or situation that elicits a response incompatible with the undesirable one (see Chapter 9). In this case, the incompatible response is usually relaxation. The client learns to relax deeply while imagining or looking at a sequence of feared stimuli, arranged in a hierarchy from the least frightening to the most frightening. The hierarchy itself is provided by the client. The sequence for a person who is terrified of spiders might be to read the classic children's story *Charlotte's Web*, then look at pictures of small, cute spiders, then look at pictures of tarantulas, then move on to observing a real spider, and so on. At each step, the person must become relaxed before going on. Eventually, the fear responses are extinguished.

Batters overcoming *bonkinogginophobia*, a fear of the ball.

Some behavior therapists have developed virtual reality (VR) programs to desensitize clients to various phobias, notably of flying, heights, spiders, and public speaking, and to help clients reduce anxiety (Gregg & Tarrier, 2007). Others are experimenting with VR to treat combat veterans who are suffering from intractable posttraumatic stress symptoms. In Virtual Iraq, vets get a combination of exposure and desensitization. They wear a helmet with video goggles and earphones to hear the sounds of war, and then play a modified version of the VR game *Full Spectrum Warrior*, adapted to the Iraq experience (Halpern, 2008).

3 Behavioral self-monitoring. Before you can change your behavior, it helps to identify the reinforcers that are supporting your unwanted habits: attention from others, temporary relief from tension or unhappiness, or tangible rewards such as money or a good meal. One way to do this is to keep a record of the behavior that you would like to change. Would you like to cut back on eating sweets? You may not be aware of how much you are eating throughout the day to relieve tension, boost

behavior therapy A form of therapy that applies principles of classical and operant conditioning to help people change self-defeating or problematic behaviors.

graduated exposure In behavior therapy, a method in which a person suffering from a phobia or panic attacks is gradually taken into the feared situation or exposed to a traumatic memory until the anxiety subsides.

flooding In behavior therapy, a form of exposure treatment in which the client is taken directly into a feared situation until his or her panic subsides.

systematic desensitization In behavior therapy, a step-by-step process of desensitizing a client to a feared object or experience; it is based on the classical-conditioning procedure of counterconditioning.

behavioral self-monitoring In behavior therapy, a method of keeping careful data on the frequency and consequences of the behavior to be changed.

In this virtual reality version of systematic desensitization, people with spider phobias are gradually exposed to computerized but extremely lifelike images of spiders in a realistic, three-dimensional environment (Wiederhold & Wiederhold, 2000).

your energy, or just to be sociable when you are hanging out; a behavioral record will show how much and when you eat. A mother might complain that her child "always" has temper tantrums; a behavioral record will show when, where, and with whom those tantrums occur. Once the unwanted behavior is identified, along with the reinforcers that have been maintaining it, a treatment program can be designed to change it. You might find other ways to reduce stress besides eating, and make sure that you are nowhere near junk food in the late afternoon, when your energy is low. The mother can learn to respond to her child's tantrum not with her attention (or a cookie to buy silence) but with a time-out: banishing the child to a corner where no positive reinforcers are available.

4 **Skills training.** It is not enough to tell someone "Don't be shy" if the person does not know how to make small talk with others, or "Don't yell!" if the person does not know how to express feelings calmly. Therefore, some behavior therapists use operant-conditioning techniques, modeling, and role-playing to teach the skills a client might lack. A shy person might learn how to converse in social settings by focusing on other people rather than on his or her own insecurity. Skills-training programs have been designed for all kinds of behavioral problems: to teach parents how to discipline their children, impulsive adults how to manage anger, autistic children how to behave appropriately, and people with schizophrenia how to hold a job. These skills are also being taught in virtual worlds, such as *Second Life*. After face-to-face sessions with a therapist, the client creates an avatar to explore a virtual environment and experiment with new behaviors; the therapist can be monitoring the client's psychological and even physiological reactions at the same time.

A behaviorist would treat Murray's procrastination in several ways. Monitoring his own behavior with a diary would let Murray know exactly how he spends his time, and how much time he should realistically allot to a project. Instead of having a vague, impossibly huge goal, such as "I'm going to reorganize my life," Murray would establish specific small goals, such as reading the two books necessary for an English paper and writing one page of an assignment. If Murray does not know how to write clearly, however, even writing one page might feel overwhelming; he might also need some skills training, such as a basic composition class. Most important, the therapist would change the reinforcers that are maintaining Murray's "procrastination behavior"—perhaps the immediate gratification of partying with friends—and replace them with reinforcers for getting the work done.

Cognitive Techniques Gloomy thoughts can generate an array of negative emotions and self-defeating behavior (see Chapter 11). The underlying

skills training In behavior therapy, an effort to teach the client skills that he or she may lack, as well as new constructive behaviors to replace self-defeating ones.

Get Involved! Cure Your Fears

In Chapter 11, a Get Involved exercise asked you to identify your greatest fear. Now see whether systematic desensitization procedures will help you conquer it. Write down a list of situations that evoke your fear, starting with one that produces little anxiety (e.g., seeing a photo of a tiny spider) and ending with the most frightening one possible (e.g., looking at live tarantulas at a pet store). Then find a quiet room where you will have no distractions or interruptions, sit in a comfortable reclining chair, and relax all the muscles of your body. Breathe slowly and deeply. Imagine the first, easiest scene, remaining as relaxed as possible. Do this until you can confront the image without becoming the least bit anxious. When that happens, go on to the next scene in your hierarchy. Do not try this all at once; space out your sessions over time. Does it work?

premise of **cognitive therapy** is that constructive thinking can do the opposite, reducing or dispelling anger, fear, and depression. Cognitive therapists help clients identify the beliefs and expectations that might be unnecessarily prolonging their unhappiness, conflicts, and other problems (Persons, Davidson, & Tompkins, 2001). They ask clients to examine the evidence for their beliefs that everyone is mean and selfish, that ambition is hopeless, or that love is doomed. Clients learn to consider other explanations for the behavior of people who annoy them: Was my father's strict discipline an attempt to control me, as I have always believed? What if he was really trying to protect and care for me? By requiring people to identify their assumptions and biases, examine the evidence, and consider other interpretations, cognitive therapy, as you can see, teaches critical thinking.

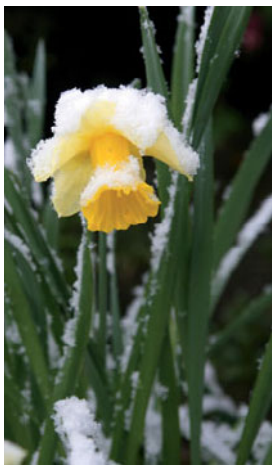
Aaron Beck (1976, 2005) pioneered in the application of cognitive therapy for depression, which often arises from specific pessimistic thoughts that the sources of your misery are permanent and that nothing good will ever happen to you again. For Beck, these beliefs are not "irrational"; rather, they are unproductive or based on misinformation. A therapist using Beck's approach would ask you to test your beliefs against the evidence. If you say, "But I *know* no one likes me," the therapist might say, "Oh, yes? How do you know? Do you really not have a single friend? Has anyone in the past year been nice to you?"

Another school of cognitive therapy is Albert Ellis's **rational emotive behavior therapy (REBT)** (Ellis, 1993; Ellis & Blau, 1998). In this approach, the therapist uses rational arguments to directly challenge a client's unrealistic beliefs or expectations. Ellis pointed out that people who are emotionally upset often *overgeneralize:* They decide that one annoying act by someone means that person is bad in every way, or that a normal mistake they made is evidence that they are rotten to the core. Many people also *catastrophize*, transforming a small problem into disaster: "I failed this test, and now I'll flunk out of school, and no one will ever like me, and even my cat will hate me, and I'll never get a job." Many people drive themselves crazy with notions of what they "must" do. The therapist challenges these thoughts directly, showing the client why they are irrational and misguided.

A cognitive therapist might treat Murray's procrastination by having Murray write down his thoughts about work, read the thoughts as if someone else had said them, and then write a rational response to each one. This technique would encourage Murray to examine the validity of his assumptions and beliefs. Many procrastinators are perfectionists; if they cannot do something perfectly, they will not do it at all. Unable to accept their limitations, they set impossible standards and catastrophize:

Negative Thought	Rational Response
If I don't get an A+ on this paper, my life will be ruined.	My life will be a lot worse if I keep getting incompletes. It's better to get a B or even a C than to do nothing.
My professor is going to think I'm an idiot when he reads this. I'll feel humiliated by his criticism.	He hasn't accused me of being an idiot yet. If he makes some criticisms, I can learn from them and do better next time.

Traditional behavioral and cognitive therapists debated whether it is most helpful to work on changing clients' thoughts or changing their behavior. But today most of them believe that thoughts



Cognitive therapists encourage clients to emphasize the positive (the early sunny signs of spring) rather than the negative (the lingering icy clutch of winter). Poet Michael Casey described the first daffodil that bravely rises through the snow as "a gleam of laughter in a sullen face."

Watch Cognitive Behavioral Therapy on **mypsychlab.com**

Get Involved! Mind over Mood Watch

See whether cognitive-therapy techniques can help you control your moods. Think of a time recently when you felt a particularly strong emotion, such as depression, anger, or anxiety. On a piece of paper, record (1) the situation—who was there, what happened, and when; (2) the intensity of your feeling at the time, from weak to strong; and (3) the thoughts that were going through your mind (e.g., "She never cares about what I want to do"; "He's going to leave me").

Now examine your thoughts. What is the worst thing that could happen if those thoughts are true? Are your thoughts accurate or are you "mind reading" another person's intentions and motives? Is there another way to think about this situation or the other person's behavior? If you practice this exercise repeatedly, you may learn how your thoughts affect your moods, and find out that you have more control over your feelings than you realized (Greenberger & Padesky, 1995).

cognitive therapy A form of therapy designed to identify and change irrational, unproductive ways of thinking and, hence, to reduce negative emotions and their self-defeating consequences.

rational emotive behavior therapy (REBT) A form of cognitive therapy devised by Albert Ellis, designed to challenge the client's unrealistic or irrational thoughts.

and behavior influence each other, which is why *cognitive-behavior therapy* (CBT) is more common than either cognitive or behavior therapy alone.

Mindfulness and Acceptance

Some CBT practitioners, inspired by Eastern philosophies such as Buddhism, have begun to question the goal of changing a client's self-defeating thoughts. They argue that it is difficult if not impossible to get rid of unwanted thoughts and feelings, especially when people have been rehearsing them for years. They therefore propose a form of CBT based on "mindfulness" and "acceptance": Clients learn to explicitly identify and accept whatever negative thoughts and feelings arise, without trying to eradicate them or letting them derail healthy behavior (Hayes, Follette, & Linehan, 2004). Instead of trying to persuade a client who is afraid of making public speeches that her fear is irrational, these therapists would encourage her to accept the anxious thoughts and feelings without judging them, or herself, harshly. Then she can focus on coping techniques and ways of giving speeches *despite* her anxiety.

Humanist and Existential Therapy

Humanist therapy, like its parent philosophy humanism, starts from the assumption that human nature is basically good and that people behave badly or develop problems when they have been warped by self-imposed limits. Humanist therapists, therefore, want to know how clients subjectively see their own situations and how they construe the world around them. They explore what is going on "here and now," not past issues of "why and how."

humanist therapy A form of psychotherapy based on the philosophy of humanism, which emphasizes the client's free will to change rather than past conflicts.

In **client-centered (nondirective) therapy**, developed by Carl Rogers, the therapist's role is to listen to the client's needs in an accepting, nonjudgmental way and to offer what Rogers called *unconditional positive regard*. Whatever the client's specific complaint is, the goal is to build the client's self-esteem and self-acceptance and help the client find a more productive way of seeing his or her problems. A Rogerian might assume that Murray's procrastination masks his low self-regard and that Murray is out of touch with his real feelings and wishes. Perhaps he is not passing his courses because he is trying to please his parents by majoring in pre-law when he would secretly rather become an artist. Rogers (1951, 1961) believed that effective therapists must be warm and genuine. For Rogerians, *empathy*, the therapist's ability to understand what the client says and identify the client's feelings, is

client-centered (nondirective) therapy A humanist approach, devised by Carl Rogers, which emphasizes the therapist's empathy with the client and the use of unconditional positive regard.

existential therapy A form of therapy designed to help clients explore the meaning of existence and face the great questions of life, such as death, freedom, alienation, and loneliness.

Humanist therapists emphasize the importance of warmth, concern, and listening empathically to what the client says.

the crucial ingredient of successful therapy: "I understand how frustrated you must be feeling, Murray, because no matter how hard you try, you don't succeed." The client, according to humanist therapists, will eventually internalize the therapist's support and become more self-accepting.

Existential therapy helps clients face the great questions of existence, such as death, freedom, loneliness, and meaninglessness. Existential therapists, like humanist therapists, believe that our lives are not inevitably determined by our pasts or our circumstances; we have the power and free will to choose our own destinies. As Irvin Yalom (1989) explained, "The crucial first step in therapy is the patient's assumption of responsibility for his or her life predicament. As long as one believes that one's problems are caused by some force or agency outside oneself, there is no leverage in therapy."

Yalom argues that the goal of therapy is to help clients cope with the inescapable realities of life and death and the struggle for meaning. However grim our experiences may be, he believes, "they contain the seeds of wisdom and redemption." Perhaps the most remarkable example of a man able to find seeds of wisdom in a barren landscape was Victor Frankl (1905–1997), who developed a form of existential therapy after surviving a Nazi concentration camp. In that pit of horror, Frankl (1955) observed, some people maintained their sanity because they were able to find meaning in the experience, shattering though it was.

Some observers believe that, ultimately, all therapies are existential. In different ways, therapy helps people determine what is important to them, what values guide them, and what changes they will have the courage to make. A humanist or existential therapist might help Murray think about the

significance of his procrastination, what his ultimate goals in life are, and how he might find the strength to reach them.

Family and Couples Therapy

Murray's situation is getting worse. His father has begun to call him Tomorrow Man, which upsets his mother, and his younger brother, the math major, has been calculating how much tuition money Murray's incompletes are costing. His older sister, Isabel, the biochemist who never had an incomplete in her life, now proposes that all of them go to a family therapist. "Murray's not the only one in this family with complaints," she says.

Family therapists would maintain that Murray's problem developed in the context of his family, that it is sustained by the dynamics of his family, and that any change he makes will affect all members of his family (Nichols & Schwartz, 2008). One of the most famous early family therapists, Salvador Minuchin (1984), compared the family to a kaleidoscope, a changing pattern of mosaics in which the pattern is larger than any one piece. In this view, efforts to isolate and treat one member of the family without the others are doomed. Only if all family members reveal their differing perceptions of each other can mistakes and misperceptions be identified. A teenager may see his mother as crabby and nagging when actually she is tired and worried. A parent may see a child as rebellious when in fact the child is lonely and desperate for attention.

Family members are usually unaware of how they influence one another. By observing the entire family, the family therapist hopes to discover tensions and imbalances in power and communication. For example, a child may have a chronic illness or a psychological problem that affects the workings of the whole family. One parent may become overinvolved with the troubled child while the other parent retreats, and each may start blaming the other. The child, in turn, may cling to the illness or disorder as a way of expressing anger, keeping the parents together, getting the parents' attention, or asserting control.

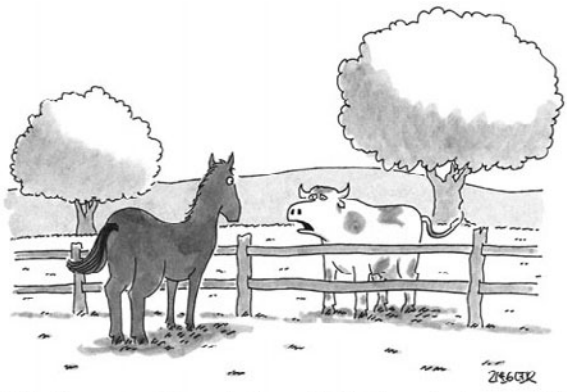
Even when it is not possible to treat the whole family, some therapists will treat individuals in a **family-systems perspective**, which recognizes that people's behavior in a family is as interconnected as that of two dancers (Bowen, 1978; Cox & Paley, 2003). Clients learn that if they change in any way, even for the better, their families may protest noisily or may send subtle messages that read, "Change back!" Why? Because when one family member changes, each of the others must change too. As the saying goes, it takes two to tango, and if one dancer stops, so must the other. But most people do not like change. They are comfortable with old patterns and habits, even those that cause them trouble. They want to keep dancing the same old dance, even if their feet hurt.

Some family therapists use photographs to help people identify themes and problems in their family histories. Does this picture convey a happy and cohesive family to you, or a divided one? Shortly after it was taken, the couple divorced. The father took custody of the children . . . and the mother kept the dog (Entin, 1992).

When a couple is arguing frequently about issues that never seem to get resolved, they may be helped by going to *couples therapy*, which is designed to help couples manage the inevitable conflicts that occur in all relationships (Christensen & Jacobson, 2000). Couples therapists generally insist on seeing both partners, so that they will hear both sides of the story. They cut through the blaming and attacking ("She never listens to me!" "He never does anything!"), and instead focus on helping the couple resolve their differences, get over hurt and blame, and make specific behavioral changes to reduce anger and conflict. Many couples therapists, like some cognitive therapists, are moving away from the "fix all the differences" approach. Instead, they are helping couples learn to accept and live with qualities in both partners that aren't going to change much (Hayes, 2004). A wife can stop trying to turn her calm, steady husband into a spontaneous adventurer ("After all, that's what I originally loved about him; he's as steady as a rock"), and a husband can stop trying to make his shy wife more assertive ("I have always loved her remarkable serenity").

family-systems perspective An approach to doing therapy with individuals or families by identifying how each family member forms part of a larger interacting system.

Family and couples therapists may use psychodynamic, behavioral, cognitive, or humanist approaches in their work; they share only a focus on the family or the couple. In Murray's case, a family therapist would observe how Murray's procrastination fits his family dynamics. Perhaps it allows Murray to get his father's attention and his mother's sympathy. Perhaps it keeps Murray from facing his greatest fear: If he finishes his work, it will not measure



"I've been a cow all my life, honey. Don't ask me to change now."

Watch Family Therapist on mypsychlab.com

up to his father's impossibly high standards. The therapist will not only help Murray change his work habits, but will also help his family deal with a changed Murray. Watch

Psychotherapy in Practice The kinds of psychotherapy that we have discussed are all quite different in theory, and so are their techniques (see Table 12.2). Yet in practice, many psychotherapists take an *integrative approach*, drawing on methods and ideas from various schools and avoiding strong allegiances to any one theory. This flexibility enables them to treat clients with whatever methods are most appropriate and effective. One Internet-based survey of more than 2,400 psychotherapists found that two-thirds said they practice cognitive-behavioral therapy—*and* that the single most influential therapist they followed was Carl Rogers *and* that they often incorporate ideas of mindfulness and acceptance (Cook, Biyanova, & Coyne, 2009).

All successful therapies, regardless of their approach, share a key element: They are able to motivate the client into wanting to change, and they replace a client's pessimistic or unrealistic life narrative with one that is more hopeful or attainable (Howard, 1991; Schafer, 1992).

TABLE 12.2
The Major Schools of Therapy Compared

	Primary Goal	Methods
Psychodynamic	Insight into unconscious motives and feelings that prolong symptoms	Probing unconscious motives and fantasies, exploring childhood experiences, identifying recurring themes in client's life; exploration of issues and emotions raised by transference
Cognitive-Behavioral		
Behavioral	Modification of self-defeating behaviors	Graduated exposure (flooding), systematic desensitization, behavioral records, skills training
Cognitive	Modification of irrational or unvalidated beliefs	Prompting the client to test beliefs against evidence; exposing the faulty reasoning in catastrophizing and mind reading; sometimes helping the client accept and live with unpleasant thoughts and feelings
Humanist and Existential		
Humanist	Insight; self-acceptance and self-fulfillment; new, optimistic perceptions of oneself and the world	Providing a nonjudgmental setting in which to discuss issues; use of empathy and unconditional positive regard by the therapist
Existential	Finding meaning in life and accepting inevitable losses	Varies with the therapist; philosophic discussions about the meaning of life, the client's goals, finding the courage to survive suffering and loss
Family and Couples		
Family	Modification of family patterns	May use any of the preceding methods to change family patterns that perpetuate problems and conflicts
Couples	Resolution of conflicts, breaking out of destructive habits	May use any of the preceding methods to help the couple communicate better, resolve conflicts, or accept differences

Quick Quiz

Don't be a procrastinator like our friend Murray; take this quiz now.

Match each method or concept with the therapy associated with it.

1. transference
2. systematic desensitization
3. facing the fear of death
4. reappraisal of thoughts
5. unconditional positive regard
6. exposure to feared situation
7. avoidance of "catastrophizing"
8. assessment of family patterns

a. cognitive therapy
b. psychodynamic therapy
c. humanist therapy
d. behavior therapy
e. family therapy
f. existential therapy

Answers:

1.b 2.d 3.f 4.a 5.c 6.d 7.a 8.e

Study and Review on mypsychlab.com

YOU are about to learn...

- **the meaning of the "scientist–practitioner gap" and why it has been widening.**
- **which form of psychotherapy is most likely to help if you are anxious or depressed.**
- **why psychotherapy can sometimes be harmful.**

Evaluating Psychotherapy

Poor Murray! He is getting a little baffled by all these therapies. He wants to make a choice soon; no sense in procrastinating about that, too! Is there any scientific evidence, he wonders, that might help him decide which therapy or therapist will be best for him?

Psychotherapy is, first and foremost, a relationship. Its success depends on the bond the therapist and client establish between them, called the **therapeutic alliance**. When both parties respect and understand one another and agree on the goals of treatment, the client is more likely to improve, regardless of the specific techniques the therapist uses (Klein et al., 2003).

Culture and the Therapeutic Alliance

Many therapists and clients work well together in spite of coming from different backgrounds. But sometimes cultural differences cause misunderstandings that result from ignorance or prejudice (Comas-Díaz, 2006; Sue et al., 2007). A lifetime of experience with racism and a general cultural distrust may keep some African Americans from revealing feelings that they believe a white therapist would not understand or accept (Whaley & Davis, 2007). Misunderstandings and prejudice may be one reason Asian-American, Latino, and African-American clients are more likely to stay in therapy when their therapists' ethnicity matches their own. When there is a cultural match, clients and psychotherapists are more likely to share perceptions of what the client's problem is, agree on the best way of coping, and have the same expectations about what therapy can accomplish (Hwang, 2006; Zone et al., 2005).

Understanding a culture's particular traditions can also help clinicians design more effective interventions for individual and community problems. In the Pacific Northwest, where substance abuse among Native Americans and Alaska Natives has widespread and devastating effects, successful approaches combine bicultural life-skills training with community involvement, which plays an essential role in native life (Hawkins, Cummins, & Marlatt, 2004).

In establishing a bond with clients, therapists must distinguish normal cultural patterns from individual psychological problems. An Irish-American family therapist, Monica McGoldrick (2005), described some problems that are typical of Irish-American families. These problems arise from Irish history and religious beliefs. "In general, the therapist cannot expect the family to turn into a physically affectionate, emotionally intimate group, or to enjoy being in therapy very much," she observed. "The notion of Original Sin—that you are guilty before you are born—leaves them with a heavy sense of burden. Someone not sensitized to these issues may see this as pathological. It is not. But it is also not likely to change and the therapist should help the family

therapeutic alliance
The bond of confidence and mutual understanding established between therapist and client, which allows them to work together to solve the client's problems.

tolerate this inner guilt rather than try to get rid of it." (Did you notice the link between her observation and acceptance-based forms of cognitive therapy?)

More and more psychotherapists are becoming "sensitized to the issues" caused by cultural differences (Arredondo et al., 2005; Sue et al., 2007). In Latin American cultures, *susto*, or "loss of the soul," is a common response to extreme grief or fright; the person believes that his or her soul has departed along with that of the deceased relative. A psychotherapist unfamiliar with this culturally determined response might conclude that the sufferer was delusional or psychotic. Latino clients are also more likely than Anglos to value harmony in their relationships, which often translates into an unwillingness to express negative emotions or confront family members or friends directly, so therapists need to help such clients find ways to communicate better within that cultural context (Arredondo & Perez, 2003). Latino clinicians, being aware of the stigma associated with psychotherapy in their culture, are also developing ways to help their clients overcome ambivalence about seeking psychological help (Añez et al., 2008).

Being aware of cultural differences, however, does not mean that the therapist should stereotype clients. After all, some Latinos do have psychoses and some Irish do not carry burdens of guilt! It does mean that therapists must ensure that their clients find them to be trustworthy and effective; and it means that clients must be aware of their own prejudices too.

The Scientist–Practitioner Gap

Now suppose that Murray has found a nice psychotherapist who seems pretty smart and friendly. Is a good alliance enough? How important is the *kind* of therapy that an individual practices?

These questions have generated a huge debate among clinical practitioners and psychological scientists. Many psychotherapists believe that trying to evaluate psychotherapy using standard empirical methods is an exercise in futility: Numbers and graphs, they say, cannot possibly capture the complex exchange that takes place between a therapist and a client. What "works" in psychotherapy is usually not a good technique but a good *relationship*. Psychotherapy, they maintain, is an art that you acquire from clinical experience; it is not a science. That's why almost any method will help most people (Wampold, 2001). Other clinicians argue that efforts to measure the effectiveness of psychotherapy oversimplify the process, because, among other reasons, many patients have an assortment of emotional problems and need therapy for a longer time than research can reasonably allow (Westen, Novotny, & Thompson-Brenner, 2004).

For their part, psychological scientists agree that therapy is often a complex process. But that is no reason, they argue, that it cannot be scientifically investigated, just like any other complex psychological process such as the development of language or personality (Crits-Christoph, Wilson, & Hollon, 2005; Kazdin, 2008). Moreover, they are concerned

"Cuento" (story) therapy is a popular form of therapy among Latino psychotherapists, building as it does on a cultural tradition of storytelling and folk heroes (Comas-Díaz, 2006). For example, most Puerto Rican children know the tales of Juan Bobo (left), a foolish child ("bobo") who is always getting into trouble. The therapists on the right have adapted these stories for Puerto Rican children who are coping with problems and ethical conflicts in America. The children and their mothers watch a videotape of the folktale, discuss it together, and role-play its major themes, such as controlling aggression and understanding right from wrong. This method has been more successful than traditional therapies in reducing the children's transitional anxieties and improving their attention spans and achievement motivation (Costantino & Malgady, 1996).

that when therapists fail to keep up with empirical findings in the field, their clients may suffer. It is crucial, scientists say, for therapists to be aware of research findings on the most beneficial methods for particular problems, on ineffective or potentially harmful techniques, and on topics relevant to their practice, such as memory, hypnosis, and child development (Lilienfeld, Lynn, & Lohr, 2003).

Over the years, the breach between scientists and therapists has widened, creating what is commonly called the *scientist–practitioner gap*. One reason for the growing split has been the rise of professional schools that are not connected to academic psychology departments and that train students solely to do therapy. Graduates of these schools sometimes know little about research methods or even about research assessing different therapy techniques.

The scientist–practitioner gap has also widened because of the proliferation of unvalidated therapies in a crowded market. Some repackage established techniques under a new name. Consider Eye Movement Desensitization and Reprocessing (EMDR), which was built on the tried-and-true behavioral techniques of desensitization and exposure for treating anxiety (Lohr, Tolin, & Lilienfeld, 1998). EMDR's founder, Francine Shapiro (1995), added eye-movement exercises: Clients move their eyes from side to side, following the therapist's moving finger, while concentrating on the memory to be desensitized. Shapiro's (1994) explanation for why such eye movements work is that "the system may become unbalanced due to a trauma or through stress engendered during a developmental window, but once appropriately catalyzed and maintained in a dynamic state by EMDR, it transmutes information to a state of therapeutically appropriate resolution." (If you do not understand that, don't worry; we don't either.) Practitioners of EMDR have claimed success in treating everything from posttraumatic stress disorder and panic attacks to eating disorders and sexual dysfunction. Yet there is no evidence from controlled studies that it is any better than standard exposure treatments or that the supposedly essential eye movements are anything other than a sciency-sounding gimmick (Goldstein et al., 2000; Lohr et al., 1999; Taylor et al., 2003).

A blue-ribbon panel of clinical scientists, convened to assess the problem of the scientist–practitioner gap for the journal *Psychological Science in the Public Interest*, reported that the current state of clinical psychology is comparable to that of medicine in the early 1900s, when physicians typically valued personal experience over scientific research. The authors concluded that a new accreditation system is necessary, one "that demands high quality science training as a central feature of doctoral training in clinical psychology" (Baker, McFall, & Shoham, 2008). The Academy of Psychological Clinical Science, an alliance of 49 clinical science graduate programs and nine clinical science internships, has begun a concerted effort to institute just such a system (Bootzin, 2009).

Problems in Assessing Therapy

Because there are so many therapies all claiming to be successful, and because of economic pressures on insurers and rising health costs, clinical psychologists are increasingly being called on to provide empirical assessments of therapy. Why can't you just ask people if the therapy helped them? The answer is that no matter what kind of therapy is involved, clients are motivated to tell you it worked. "Dr. Blitznik is a genius!" they will exclaim. "I would *never* have taken that job (or moved to Cincinnati, or found my true love) if it hadn't been for Dr. Blitznik!" Every kind of therapy ever devised produces enthusiastic testimonials from people who feel it saved their lives.

Thinking Critically about Research on Psychotherapy

The first problem with testimonials is that none of us can be our own control group. How do people know they wouldn't have taken the job, moved to Cincinnati, or found true love anyway—maybe even sooner, if Dr. Blitznik had not kept them in treatment? Second, Dr. Blitznik's success could be due to the placebo effect: The client's anticipation of success and the buzz about Dr. B.'s fabulous new method might be the active ingredients, rather than Dr. B.'s therapy itself. Third, notice that you never hear testimonials from the people who dropped out, who weren't helped, or who actually got worse. So researchers cannot be satisfied with testimonials, no matter how glowing. They know that thanks to the *justification of effort* effect (see Chapter 7), people who have put time, money, and effort into something will tell you it was worth it. No one wants to say, "Yeah, I saw Dr. Blitznik for five years, and boy, was it ever a waste of time."

To guard against these problems, some clinical researchers conduct **randomized controlled trials**, in which people with a given problem or disorder are randomly assigned to one or more treatment groups or to a control group. Sometimes the results of randomized controlled trials have been very surprising, as in the case of a form of therapy called critical incident stress debriefing (CISD). In the aftermath of any disaster, therapists often arrive on the scene to treat survivors for symptoms of

randomized controlled trials Research designed to determine the effectiveness of a new medication or form of therapy, in which people with a given problem or disorder are randomly assigned to one or more treatment groups or to a control group.

A man comforts his father after a devastating earthquake that left thousands homeless. There is a widespread belief that most survivors of any disaster will need the help of therapists to avoid developing posttraumatic stress disorder. What do randomized controlled studies show?

trauma. In CISD, survivors gather in a group for "debriefing," which generally lasts from one to three hours. Participants are expected to disclose their emotions about the traumatic experience, and the group leader warns members about traumatic symptoms that might develop.

Yet randomized controlled studies with people who have been through terrible experiences—including burns, accidents, miscarriages, violent crimes, and combat—find that posttraumatic interventions can actually *delay* recovery in some people (van Emmerik et al., 2002; McNally, Bryant, & Ehlers, 2003). In one study, victims of serious car accidents were followed for three years; some had received the CISD intervention and some had not. As you can see in Figure 12.2, almost everyone had recovered in only four months and remained fine after three years. The researchers then divided the survivors into two groups: those who had had a highly emotional reaction to the accident at the outset ("high scorers"), and those who had not. For the latter group, the intervention made no difference; they improved quickly.

Now, however, look at what happened to the people who had been the most traumatized by the accident: If they did *not* get CISD, they were fine in four months, too, like everyone else. But for those who *did* get the intervention, CISD actually blocked improvement, and they had higher stress symptoms than all the others in the study even after three years. The researchers concluded that "psychological debriefing is ineffective and has adverse long-term effects. It is not an appropriate treatment for trauma victims" (Mayou, Ehlers, & Hobbs, 2000). The World Health Organization, which deals with survivors of trauma around the world, has officially endorsed this conclusion (van Ommeren, Saxena, & Saraceno, 2005). Simulate

You can see, then, why the scientific assessment of psychotherapeutic claims and methods is so important.

Simulate **Ineffective Therapies** on **mypsychlab.com**

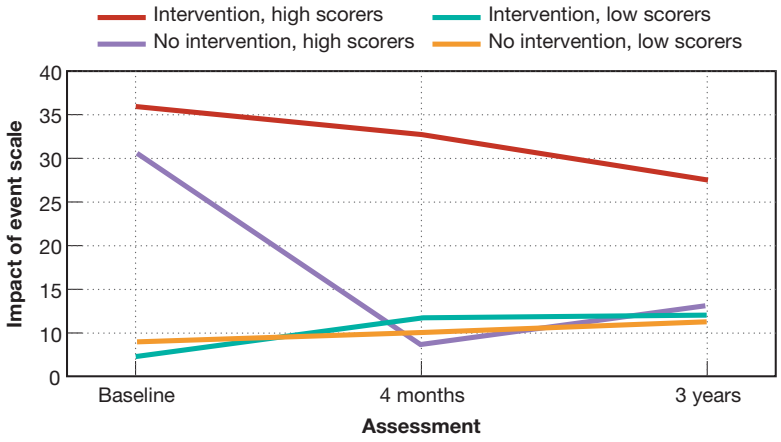


FIGURE 12.2

Do Posttraumatic Interventions Help or Harm?

In this study, victims of serious car accidents were assessed at the time of the event, four months later, and three years later. Half received a form of posttraumatic intervention called critical incident stress debriefing (CISD); half received no treatment. As you can see, almost everyone had recovered within four months, but one group had higher stress symptoms than everyone else even after three years: The people who were the most emotionally distressed right after the accident *and* who received CISD. The therapy actually impeded their recovery (Mayou et al., 2000).

When Therapy Helps

We turn now to the evidence showing the benefits of psychotherapy and which therapies work best in general, and for which disorders in particular (e.g., Chambless et al., 1998; Chambless & Ollendick, 2001). For many problems and most emotional disorders, cognitive and behavior therapies have emerged as the method of choice:

- *Depression.* Cognitive therapy's greatest success has been in the treatment of mood disorders, especially depression (Beck, 2005), and people in cognitive therapy are less likely than those on drugs to relapse when the treatment is over. The lessons learned in cognitive therapy last a long time after treatment, according to follow-ups done from 15 months to many years later (Hayes et al., 2004; Hollon, Thase, & Markowitz, 2002; Seligman et al., 1999).
- *Suicide attempts.* In a randomized controlled study of 120 adults who had attempted suicide and had been sent to an emergency room, those who were given ten sessions of cognitive therapy, in comparison to those who were simply given referrals for help, were only about half as likely to attempt suicide again in the next 18 months. They also scored significantly lower on tests of depressive mood and hopelessness (Brown et al., 2005).
- *Anxiety disorders.* Exposure techniques are more effective than any other treatment for posttraumatic stress disorder, agoraphobia, and specific phobias such as fear of dogs or flying. Cognitive-behavior therapy is often more effective than

medication for panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder (Barlow, 2004; Dalgleish, 2004; Mitte, 2005).

- *Anger and impulsive violence.* Cognitive therapy is often successful in reducing chronic anger, abusiveness, and hostility, and it also teaches people how to express anger more calmly and constructively (Deffenbacher et al., 2003).
- *Health problems.* Cognitive and behavior therapies are highly successful in helping people cope with pain, chronic fatigue syndrome, headaches, and irritable bowel syndrome; quit smoking or overcome other addictions; recover from eating disorders such as bulimia and binge eating; overcome insomnia and improve their sleeping patterns; and manage other health problems (Butler et al., 1991; Crits-Christoph, Wilson, & Hollon, 2005; Skinner et al., 1990; Stepanski & Perlis, 2000; Wilson & Fairburn, 1993).
- *Child and adolescent behavior problems.* Behavior therapy is the most effective treatment for behavior problems that range from bed-wetting to impulsive anger, and even for problems that have biological origins, such as autism. A meta-analysis of more than 100 studies of children and adolescents found that behavioral treatments worked better than others regardless of the child's age, the therapist's experience, or the specific problem (Weisz et al., 1995).
- *Relapses.* Cognitive-behavioral approaches have also been highly effective in reducing the rate of relapse among people with problems such as substance abuse, depression, sexual offending, and even schizophrenia (Hayes et al., 2004; Witkiewitz & Marlatt, 2004).

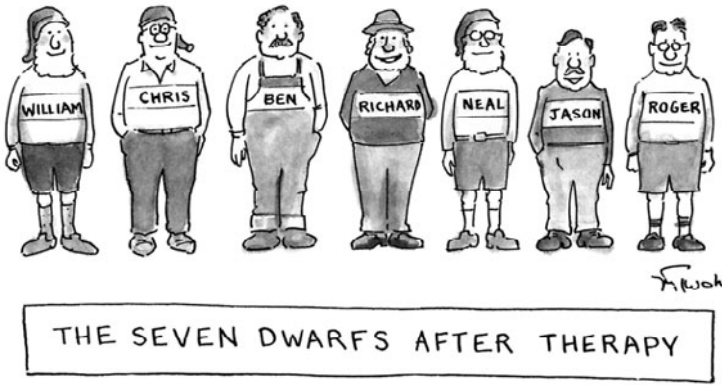
However, no single type of therapy can help everyone. In spite of their many successes, behavior and cognitive therapies have had failures, especially with people who are unmotivated to carry out a behavioral or cognitive program. Also, cognitive-behavior therapies are designed for specific, identifiable problems, but sometimes people seek therapy for less clearly defined reasons, such as wishing to introspect about their feelings or explore moral issues.

Special Problems and Populations There is also no simple rule for how long therapy needs to last. Sometimes a single session of treatment is enough to bring improvement, if it is based on sound psychotherapeutic principles. A therapy called *motivational interviewing*, which focuses on increasing a client's motivation to overcome problems such as drinking, smoking, and binge eating, has been shown to be effective in as few as one or two sessions (Burke et al., 2003; Cassin et al., 2008; Miller & Rollnick, 2002). The therapist, essentially, puts the client into a state of cognitive dissonance (see Chapter 7): "I want to be healthy and I see myself as a smart, competent person, but here I am doing something stupid and self-defeating. Do I want to feel better or not?"—and then offers the client a cognitive and behavioral strategy of improvement (Wagner & Ingersoll, 2008). Complex mental problems and personality disorders, however, are particularly difficult to treat and may respond better to long-term psychodynamic therapy than to short-term therapies (Leichsenring & Rabung, 2008; Shedler, 2010).

Further, some problems require combined approaches. Young adults with bipolar disorder or schizophrenia are best helped by combining medication with family intervention therapies that teach parents behavioral skills for dealing with their troubled children, and that educate the family about how to cope with the illness constructively (Chambless et al., 1998; Goldstein & Miklowitz, 1995; Miklowitz, 2007).

An important community intervention called *multisystemic therapy* (MST) has been highly successful in reducing teenage violence, criminal activity, drug abuse, and school problems in troubled inner-city communities. Its practitioners combine family-systems techniques with behavioral methods, but apply them in the context of forming "neighborhood partnerships" with local leaders, residents, parents, and teachers (Henggeler et al., 1998; Swenson et al., 2005). The premise of multisystemic therapy is that because aggressiveness and drug abuse are often reinforced or caused by the adolescent's family, classroom, peers, and local culture, you can't successfully treat the adolescent without also treating his or her environment. Indeed, MST has been shown to be more effective than other methods on their own (Schaeffer & Borduin, 2005).

Cognitive-behavior therapy can help people who are grumpy, bashful, and even a little dopey—as well as people who have more serious problems.



When Therapy Harms

In a tragic case that made news around the world, two social workers were convicted of recklessly causing the death of 10-year-old Candace Newmaker during a session of "rebirthing" therapy, which is supposed to help adopted children form attachments to their adoptive parents by "reliving" birth. Candace was wrapped in a blanket that supposedly simulated the womb and covered with large pillows. The therapists then pressed in on the pillows to simulate contractions and told the girl to push her way out of the blanket over her head. Candace repeatedly said that she could not breathe and felt she was going to die. Instead of unwrapping her, the therapists said, "You've got to push hard if you want to be born—or do you want to stay in there and die?" Candace lost consciousness and was rushed to a local hospital, where she died the next day.

Candace's tragic story is rare, but every treatment, including aspirin, carries some risks, and that includes psychotherapy. In a small percentage of cases, a person's symptoms may actually worsen as a result of the therapy, new symptoms may be created, the client may become too dependent on the therapist, or the client's outside relationships may deteriorate (Dimidjian & Hollon, 2010; Lilienfeld, 2007). The risks to clients increase when any of the following occurs:

Thinking Critically about the Risks of Psychotherapy

1 The use of empirically unsupported, potentially dangerous techniques. Rebirthing therapy was born (so to speak) in the 1970s, when its founder claimed that, while taking a bath, he had reexperienced his own traumatic birth. But the basic assumptions of this method—that people can recover from trauma, insecure attachment, or other psychological problems by "reliving" their emergence from the womb—are contradicted by the vast research on infancy, attachment, memory, and posttraumatic stress disorder and its treatment.

Rebirthing is one of a variety of practices, collectively referred to as "attachment therapy" (AT), that are based on the use of harsh tactics that allegedly will help children bond with their parents. These techniques include withholding food, isolating the children for extended periods, humiliating them, pressing great weights upon them, and requiring them to exercise to exhaustion (Mercer, Sarner, & Rosa, 2003). However, as we discuss in Chapter 9, abusive punishments are ineffective in treating behavior problems and often backfire, making the child angry, resentful, and withdrawn. They are hardly a way to help an adopted or emotionally troubled child feel more attached to his or her parents. And, tragically, more than 75 children and teenagers have died as a result of being in one form or another of AT.

Table 12.3 lists a number of therapies that have been shown, through randomized controlled trials or meta-analysis, to have a significant risk of harming clients.

2 Inappropriate or coercive influence that creates new symptoms. In a healthy therapeutic alliance, therapist and client come to agree on an explanation for the client's problems. Of course, the therapist will influence this explanation, according to his or her training and philosophy. Some therapists,

TABLE 12.3
Potentially Harmful Therapies

Intervention	Potential harm
Critical incident stress debriefing	Heightened risk of PTSD
Scared Straight interventions	Worsening of conduct problems
Facilitated communication	False allegations of sexual and child abuse
Attachment therapies	Death and serious injury to children
Recovered-memory techniques (e.g., dream analysis)	Induction of false memories of trauma, family breakups
"Multiple personality disorder"-oriented therapy	Induction of "multiple" personalities
Grief counseling for people with normal bereavement reactions	Increased depressive symptoms
Expressive-experiential therapies	Worsening and prolonging painful emotions
Boot-camp interventions for conduct disorder	Worsening of aggression and conduct problems
DARE (drug abuse and resistance education)	Increased use of alcohol and other drugs

Source: Lilienfeld (2007).

however, so zealously believe in the prevalence of certain disorders that they actually induce the client to produce the symptoms they are looking for (McHugh, 2008; Mazzoni, Loftus, & Kirsch, 2001; McNally, 2003; Watters & Ofshe, 1999). Therapist influence, and sometimes downright coercion, is a likely reason for the huge numbers of people who were diagnosed with multiple personality disorder in the 1980s and 1990s (see Chapter 11) and for an epidemic of alleged memories of sexual abuse during this period (see Chapter 8).

3 Prejudice or cultural ignorance on the part of the therapist. Some therapists may be prejudiced against some clients because of the client's gender, culture, religion, or sexual orientation. They may be unaware of their prejudices, yet express them in nonverbal ways that make the client feel ignored, disrespected, and devalued (Sue et al., 2007). A therapist may also try to induce a client to conform to the therapist's standards and values, even if they are not appropriate for the client or in the client's best interest.

For example, for many years, gay men and lesbians who entered therapy were told that homosexuality was a mental illness that could be cured. Some of the so-called treatments were harsh, such as electric shock for "inappropriate" arousal. Although these methods were discredited decades ago (Davison, 1976), other "reparative" therapies (whose practitioners claim they can turn gay men and lesbians into heterosexuals) still surface from time to time. But there is no reliable empirical evidence supporting these claims, and both the American Psychological Association and the American Psychiatric Association oppose reparative therapies on ethical and scientific grounds.

4 Sexual intimacies or other unethical behavior on the part of the therapist. The ethical guidelines of both APAs prohibit therapists from having any sexual intimacies with their clients or violating other professional boundaries. Occasionally, some therapists behave like cult leaders, persuading their clients that their mental health depends on staying in therapy and severing their connections to their "toxic" families (Watters & Ofshe, 1999). Such psychotherapy cults are created by the therapist's use of techniques that foster the client's isolation, prevent the client from terminating therapy, and reduce the client's ability to think critically (see Chapter 10).

To avoid these risks and benefit from what effective psychotherapy has to offer, people looking for the right therapy must become educated consumers, willing to use the critical-thinking skills we have emphasized throughout this book.

Quick Quiz

Find out whether you are an educated consumer of quizzes.

1. Which of the following is the most important predictor of successful therapy? (a) how long it lasts, (b) the insight it provides the client, (c) the bond between therapist and client, (d) whether the therapist and client are matched according to gender
2. In general, which type of psychotherapy is most effective for anxiety and depression?
3. What are four possible sources of harm in psychotherapy?
4. Ferdie is spending too much time playing softball and not enough time studying, so he signs up for "sportaholic therapy" (ST). The therapist tells him the cure for his "addiction" is to quit softball cold turkey and tap his temples three times whenever he feels the urge to play. After a few months, Ferdie announces that ST isn't helping and he's going to stop coming. The therapist gives him testimonials of clients who swear by ST, adding that Ferdie's doubts are actually a sign that the therapy is working. What is the major scientific flaw in this argument? (Bonus: What kind of therapy might help Ferdie manage his time better?)

Answers:

1. c **2.** cognitive-behavior **3.** the use of empirically unsupported techniques, inappropriate or coercive influence, the therapist's prejudice or biased treatment, and unethical behavior **4.** The therapist has violated the principle of falsifiability (see Chapter 1). If Ferdie is helped by the treatment, that shows it works; if he is not helped, that still shows it works and Ferdie is simply denying its benefits. Also, Ferdie is not hearing testimonials from people who have dropped out of ST and were not helped by it. (Bonus: A good behavioral time-management program might help, so Ferdie can play softball and get other things done, too.)

Psychology in the News REVISITED


Psychology in the News

Use of Dogs for Vets with PTSD Is Growing

GULFPORT, FL, June 7, 2010. Many soldiers returning from duty in Afghanistan and Iraq suffer from severe medical and emotional problems. Lt. Col. Kathryn Champion was one of them. She had served 27 years in the Army, but after a particularly horrific tour of duty in Iraq, during which five soldiers under her command died, she began to suffer the symptoms of posttraumatic stress disorder. When she returned home, she fell into deep depression: A virus she contracted in Iraq was killing her optic nerves, causing her to go blind; her Army career was finished.

Then Champion found an organization that matched her with a guide dog, a golden retriever mix named Angel. Just two weeks after their training together ended, Angel began helping Champion with her psychological problems. Champion was terrified of flying and of having a panic attack in public, but whenever her heart started racing, she would reach down and touch her dog. She was able to fly across country to visit her son before his deployment to Afghanistan.

Within weeks, Champion started going out again, since crowds were not bothering her as they had. She and Angel have traveled to the Grand Canyon and even to a "Space Camp" in Alabama.

Across the country, various organizations have begun providing service dogs to help soldiers recover from PTSD. Their efforts are part of a nationwide trend of animal-assisted therapy, also known as pet therapy, designed to help people with various psychological problems. Pet therapy is prominent in many hospitals, as volunteers and "certified therapy dogs" offer comfort and companionship to patients. When humans touch and play with dogs, horses, and other social animals, said Dr. Matt Zimmerman, Counseling and Psychological Services psychologist at the University of Virginia, it lowers their blood pressure and makes them less anxious. He added that animal-assisted therapy should generally be used with other forms of psychological treatment or medication.

Zimmerman says there are specific benefits of pet therapy for children with autism. "The animal serves as [a] reinforcement tool for appropriate social behavior," Zimmerman said. "If the child is being gentle and kind to the pet, then [it] stays. If the child is hitting or pulling on the animal, the pet leaves." When it comes to other disorders, however, the effectiveness of the treatment tends to depend more upon the individual in question, he said.

Kathryn Champion has started raising money to provide dogs for other veterans in trouble. She is once again engaged in life. As a spokeswoman for the program that provided her with the dog said, "Angel has been her ticket back in."

Kathryn Champion, who suffered from posttraumatic stress disorder and anxiety attacks after returning from duty in Iraq, with her dog Angel.

Now that we have reviewed the major kinds of psychotherapy, along with their successes and risks, let's return to the issues raised by the example of "pet therapy" in our opening story. Lt. Col. Kathryn Champion's success with her dog Angel, who helped her out of depression, anxiety, and even PTSD, turns out to be not just a charming anecdote. In a study of nearly 200 people with serious mental illnesses, those with pets were recovering more quickly than those without pets, and the reasons were not simply that pets provide companionship (Wisdom, Saedi, & Green, 2009). They also provide empathy, foster connections with other people, reduce their owners' blood pressure, and often make troubled individuals feel more in control of their lives, as was the case with Kathryn Champion.

Most dog owners would say, "Sure, we knew that!" But research *is* nonetheless important to verify whether pet therapy is effective, and for whom, and why. Many other therapies have been started on the basis of someone's intuitive idea that "Sure, this will work," only to have the therapy's basic premise turn out to be wrong, as in the case of post-crisis interventions, or to be horribly dangerous, as is the case with rebirthing and attachment therapies. Even when pet therapy is helpful, people suffering from serious emotional disorders may also need person-to-person psychotherapy and possibly medication.

How can consumers of psychological services distinguish between techniques that are beneficial and techniques that are useless or potentially harmful? We will offer some suggestions in "Taking Psychology with You," but for now, the research in this chapter suggests three general guidelines:

- **Make sure you are dealing with a reputable individual with appropriate credentials and training**. As we saw in Chapter 1, to become a licensed psychologist, a person must have an advanced degree and a period of supervised training. However, the word *psychotherapist* is unregulated; anyone can set up any kind of program and call it "therapy." In the United States and Canada, people can get credentialed as "experts" in various techniques and therapies simply by attending a weekend seminar or a training program lasting a week or two.
- **Ask whether the therapist practices one of the empirically supported methods described in this chapter,** and whether the basic assumptions of the therapist are likewise validated by empirical research.
- **Be realistic about what you expect of psychotherapy**. In the hands of an empathic and knowledgeable practitioner, psychotherapy can help you make decisions and clarify your values and goals. It can teach you new skills and new ways of thinking. It can help you get along better with your family and break out of destructive family patterns. It can get you through bad times when no one seems to care or to understand what you are feeling. It can teach you how to manage depression, anxiety, and anger.

However, despite its many benefits, psychotherapy cannot transform you into someone you're not. It cannot turn an introvert into an extrovert. It cannot cure an emotional disorder overnight. It cannot provide a life without problems. And it is not intended to substitute for experience—for work that is satisfying, relationships that are sustaining, activities that are enjoyable. As Socrates knew, the unexamined life is not worth living. But as we would add, the unlived life is not worth examining.

Taking Psychology with You

Becoming a Smart Consumer of Psychological Treatments

If you have a persistent problem that you do not know how to solve, one that causes you considerable unhappiness and that has lasted six months or more, it may be time to look for help. To take the lessons of this chapter with you, you might want to consider these suggestions:

Take all ads and Internet promotions for prescription drugs with a large grain of salt: Be skeptical! Remember that ads are not about educating you; they are about selling you a product. "New" is not necessarily better; many "me too" drugs simply tinker with a blockbuster drug's formula in the smallest way, and are then legally (if not medically) entitled to claim it is "new and improved." Consult your pharmacist or the FDA's website, and check out any drug you are about to take. Go to reliable sources that are not funded by the pharmaceutical industry, such as the Public Citizen's Health Research Group's consumer guide, *Worst Pills, Best Pills.*

Make an informed decision when you choose a therapist. To find a reputable individual with appropriate credentials and training, your school counseling center is a good place to start. You might also seek out a university psychology clinic, where you can get therapy with a graduate student in training; these students are closely supervised and the fees will be lower.

Choose a therapy or treatment most likely to help you. As we have seen, not all therapies are equally effective for all problems. You should not spend four years in psychodynamic therapy for panic attacks, which can generally be helped in a few sessions of cognitive-behavior therapy. Likewise, if you have a specific emotional problem, such as depression, anger, or anxiety, or if you are coping with chronic health problems, look for a cognitive or behavior therapist. However, if you mostly want to discuss your life with a wise and empathic counselor, the kind of therapy may not matter so much.

Consider a self-help group. Not all psychological problems require the aid of a professional. In the United States, an estimated 7 to 15 million adults belong to self-help groups (online and in person) for every possible problem—for alcoholics and relatives of alcoholics; people suffering from depression, anorexia, or schizophrenia; women with breast cancer; parents of murdered children; rape victims; relatives of Alzheimer's patients; and people with just about any other concern you can think of. Self-help groups can be reassuring and supportive in ways that family, friends, and psychotherapists sometimes may not be. For example, people with disabilities face unique challenges that involve coping not only with physical problems but also with the condescension and prejudice of many nondisabled people (Linton, 1998).

Nonetheless, keep your critical-thinking skills with you: Self-help groups are not regulated by law or by professional standards, and they vary widely in their philosophies and methods. Some are accepting and tolerant, offering support and spiritual guidance. Others are confrontational and coercive, and members who disagree with the premises of the group may be made to feel deviant, crazy, or "in denial."

Choose self-help books that are scientifically based and promote realistic goals. There is a self-help book available for every problem, from how to toilet train your children to how to find happiness. Critical thinkers can learn how to distinguish good ones from useless ones. To begin with, good self-help books do not promise the impossible. This rules out any that promise massive wealth, perfect love, or high self-esteem in 30 days. (Sorry!) Next, good self-help books are based on evidence and controlled studies. This rules out books that are based on the author's pseudoscientific theories, armchair observations, or personal adventures. People who have survived difficulties can tell inspirational stories, of course, but an author's own experience and vague advice to, say, "find love in your heart" or "take charge of your life" won't go far.

In contrast, when self-help books propose a specific, step-by-step empirically supported program for readers to follow, they can actually be as effective as treatment administered by a therapist, *if* readers follow through with the program (Rosen, Glasgow, & Moore, 2003). One such book is *Changing for Good* (Prochaska, Norcross, & DiClemente, 1994), which describes the ingredients of effective change that apply to people in and out of therapy.

It takes knowledge and critical thinking to know how to tell good therapies from phony ones, and the phony from the fraudulent. As long as people yearn for a magic bullet to cure their problems, quick-fix solutions will find a ready audience.

Summary

Biological Treatments for Mental Disorders

- Biological treatments for mental disorders are in the ascendance because of research findings on the genetic and biological causes of some disorders and because of economic and social factors. The medications most commonly prescribed for mental disorders include *antipsychotic drugs*, used in treating schizophrenia and other psychotic disorders and, often inappropriately, in treating dementia and aggression disorders; *antidepressants*, used in treating depression, anxiety disorders, and obsessive-compulsive disorder; tranquilizers, often prescribed for emotional

problems; and *lithium carbonate*, a salt used to treat bipolar disorder.

- Drawbacks of drug treatment include the *placebo effect*; high dropout and relapse rates among people who take medications without also learning how to cope with their problems; the difficulty of finding the correct dose for each individual, compounded by the fact that a person's ethnicity, sex, and age can influence a drug's effectiveness; and the long-term risks of medication and of possible drug interactions when several are being taken.
- The fact that a disorder appears to have biological origins or involve biochemical abnormalities does not mean that biological treatments are the only appropriate ones; psychotherapy can change brain patterns just as medication can.
- Medication can be helpful and can even save lives, but in an age in which commercial interests are heavily invested in promoting drugs for psychological problems, the public is largely unaware of drugs' limitations and potential risks.
- When drugs and psychotherapy have failed to help seriously disturbed people, some psychiatrists have intervened directly in the brain. *Prefrontal lobotomy* never had any scientific validation yet was performed on thousands of people. *Electroconvulsive therapy* (ECT), in which a brief current is sent through the brain, has been used successfully to treat suicidal depression, although its benefits rarely last. *Transcranial magnetic stimulation* (TMS), in which a magnetic coil is applied over the left prefrontal cortex, is being studied as a way of treating severe depression. *Deep brain stimulation* requires the surgical implantation of electrodes and a stimulation device, and has not been empirically validated for the treatment of depression or other emotional disorders.

Major Schools of Psychotherapy

- *Psychodynamic ("depth") therapies* stemmed from Freudian *psychoanalysis.* These therapies explore unconscious dynamics and emotions, childhood experiences, and fantasies, and focus on the process of *transference* to break through the patient's defenses.
- *Behavior therapists* draw on classical and operant principles of learning. Behavior therapists use such methods as *graduated exposure*, and sometimes immediate exposure, called *flooding*; *systematic desensitization*, based on *counterconditioning*; *behavioral self-monitoring*; and *skills training*. Some are applying these methods with virtual reality techniques.
- *Cognitive therapists* aim to change the irrational thoughts involved in negative emotions and self-defeating actions. Aaron Beck's cognitive therapy and Albert Ellis's *rational emotive behavior therapy* (REBT) are two leading approaches. *Cognitive-behavior therapy* (CBT) is now the most common approach. Some cognitive-behavioral therapists now teach clients to pay mindful attention to their negative emotions and "irrational" thoughts and learn to accept them, acting in spite of these feelings rather than constantly fighting to eradicate them.
- *Humanist therapy* holds that human nature is essentially good and attempts to help people feel better about themselves by focusing on here-and-now issues and on their capacity for change. Carl Rogers's *client-centered (nondirective) therapy* emphasizes the importance of the therapist's empathy and ability to provide *unconditional positive regard*. *Existential therapy* helps people cope with the dilemmas of existence, such as the meaning of life and the fear of death.
- *Family therapists* hold the view that individual problems develop in the context of the whole family network. In this *family-systems perspective*, any one person's behavior in the family affects everyone else. In *couples therapy*, a therapist usually sees both partners in a relationship to help them resolve ongoing quarrels and disputes or to help them accept and live with qualities that are unlikely to change.
- In practice, most therapists are *integrative*, drawing on many methods and ideas. They aim to replace a client's pessimistic or unrealistic life story with one that is more hopeful and attainable.

Evaluating Psychotherapy

- Successful therapy requires a *therapeutic alliance* between the therapist and the client, so that they understand each other and can work together. Good therapists are generally empathic and constructive. When therapist and client are of different ethnicities or cultures, the therapist must be able to distinguish normal cultural patterns from signs of mental illness, and both parties must be aware of potential prejudice and misunderstandings.
- A *scientist–practitioner gap* has developed because of the different assumptions that researchers and many clinicians hold regarding the value of empirical research for doing psychotherapy and for assessing its effectiveness. The gap has led to a proliferation of scientifically unsupported psychotherapies.
- In assessing the effectiveness of psychotherapy, researchers need to control for the placebo effect and the *justification of effort* effect. They rely on *randomized controlled trials* to determine which therapies are empirically supported. Such trials have shown that postcrisis debriefing programs are usually ineffective at best and can even slow recovery for some survivors.

- Some psychotherapies are better than others for specific problems. Behavior therapy and cognitive-behavior therapy are often the most effective for depression, anxiety disorders, anger problems, certain health problems (such as pain, insomnia, and eating disorders), and child and adolescent behavior problems. Family-systems therapies, especially when combined with behavioral techniques as in *multisystemic therapy*, are especially helpful for children with behavior problems, young adults with schizophrenia, and aggressive adolescents.
- The length of time needed for successful therapy depends on the problem and the individual. Some methods, such as *motivational interviewing*, have been able to change a client's willingness to begin a program of change in only a session or two; long-term psychodynamic therapy can be helpful for people with severe disorders and personality problems. Some problems and individuals respond best to combined therapeutic approaches.
- In some cases, therapy is harmful. A therapist may use empirically unsupported and potentially harmful techniques; inadvertently create new disorders in the client through undue influence or suggestion; hold a prejudice about the client's gender, ethnicity, religion, or sexual orientation; or behave unethically, for example by permitting a sexual relationship with the client.

Psychology in the News, Revisited

- Animal-assisted therapies are being studied empirically to assess their benefits and limitations, just as all psychotherapies should be. People who are seeking psychotherapy should make sure their psychotherapist is well trained and uses empirically validated methods, and they should have realistic expectations of what psychotherapy can do for them.

Key Terms

antipsychotic drugs (neuroleptics) **406**
antidepressant drugs **406**
monoamine oxidase inhibitors (MAOIs) **406**
tricyclic antidepressants **406**
selective serotonin reuptake inhibitors (SSRIs) **406**
tranquilizers **407**
beta-blockers **407**
lithium carbonate **407**
publication bias **408**
placebo effect **408**
prefrontal lobotomy **410**
electroconvulsive therapy (ECT) **410**
transcranial magnetic stimulation (TMS) **411**
deep brain stimulation (DBS) **411**
psychoanalysis **412**
psychodynamic ("depth") therapies **412**
transference **412**
behavior therapy **413**
graduated exposure **413**
flooding **413**
systematic desensitization **413**
counterconditioning **413**
behavioral self-monitoring **413**
skills training **414**
cognitive therapy **415**
Aaron Beck **415**
Albert Ellis **415**
rational emotive behavior therapy (REBT) **415**
cognitive-behavior therapy (CBT) **416**
humanist therapy **416**
client-centered (nondirective) therapy **416**
Carl Rogers **416**
unconditional positive regard **416**
existential therapy **416**
family therapy **417**
family-systems perspective **417**
couples therapy **417**
integrative approach to psychotherapy **418**
therapeutic alliance **419**
scientist–practitioner gap **421**
justification of effort **421**
randomized controlled trials **421**
motivational interviewing **423**
multisystemic therapy **423**

Biological Treatments for Mental Disorders

Drugs

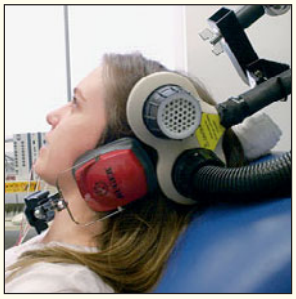
Drugs commonly prescribed for mental disorders include:
- **Antipsychotics**, used in treating schizophrenia and other psychotic disorders
- **Antidepressants**, used in treating depression, anxiety disorders, and obsessive-compulsive disorder
- **Tranquilizers**, often prescribed for emotional problems
- **Lithium carbonate**, a salt used to treat bipolar disorder

Cautions about Drug Treatments

Drawbacks of drug treatment include:
- The placebo effect
- High dropout and relapse rates
- Disregard for effective nonmedical treatments
- The difficulty of finding the correct dose
- Unknown long-term risks
- Untested off-label uses

Direct Brain Intervention

- **Electroconvulsive therapy (ECT)**, in which a brief current is sent through the brain, has been used successfully to treat suicidal depression, but its effects are short-lived and the depression almost always returns. ECT is ineffective for other disorders.
- *Transcranial magnetic stimulation*, in which a pulsing magnetic coil is held over the left prefrontal cortex, is being used with depression but its effectiveness is still uncertain.



Major Schools of Psychotherapy

Psychodynamic Therapy

Psychodynamic therapies, including Freudian **psychoanalysis** and its modern variations, explore the unconscious through techniques such as **transference**.

Humanist and Existential Therapy

Humanist therapy focuses on the capacity for self-fulfillment and self-actualization.
- Carl Rogers's **client-centered therapy** emphasizes the therapist's role in providing *unconditional positive regard* for the client.

Existential therapy helps people cope with philosophical issues such as the meaning of life.

Behavior and Cognitive Therapy

Behavior therapy applies principles of classical and operant conditioning to help change problematic behaviors. Uses such methods as:
- **Graduated exposure** and **flooding**
- **Systematic desensitization**
- **Behavioral self-monitoring**
- **Skills training**

Cognitive therapy is designed to identify irrational, unproductive ways of thinking to reduce negative emotions and their behavioral consequences. In practice, it is often combined with behavioral methods and thus called *cognitive-behavior therapy* (CBT).
- One leading approach is Albert Ellis's **rational emotive behavior therapy**.
- A current CBT approach is based on mindfulness and acceptance; clients learn to recognize and accept unwanted, unpleasant thoughts and feelings without trying to eliminate them.

Family and Couples Therapies

- Family therapies tend to share a **family-systems perspective,** understanding that one person's behavior affects the whole family.
- Couples therapy is designed to help couples understand and resolve the inevitable conflicts that occur in all relationships.

Evaluating Psychotherapy

The Scientist–Practitioner Gap

A *scientist–practitioner gap* has developed, leading to a proliferation of scientifically unsupported therapies, such as critical incident stress debriefing.

Evaluations of psychotherapy must control for:
- The placebo effect
- Justification of effort

Scientific assessments of therapy rely on **randomized controlled trials**.

- The success of psychotherapy depends on the bond between the therapist and client, called the **therapeutic alliance**.
- Therapists and clients must be alert to cultural differences between them that might cause misunderstandings.

When Therapy Helps

Cognitive-behavior therapy (CBT) is most effective for:
- Depression
- Suicide atttempts
- Anxiety disorders
- Anger problems
- Health problems
- Child and adolescent behavior problems
- Preventing relapse

Combined methods may be necessary to help particular individuals or difficult problems, such as *multisystemic therapy* for troubled, violent adolescents and combined medication and family therapy for people who are bipolar or have schizophrenia.

When Therapy Harms

Psychotherapy can be risky for clients if the therapist:
1. Uses empirically unsupported and potentially harmful techniques
2. Inadvertently creates disorders or new symptoms through suggestion
3. Is prejudiced against a client
4. Is unethical

TABLE 12.2

The Major Schools of Therapy Compared

	Primary Goal	Methods
Psychodynamic	Insight into unconscious motives and feelings that prolong symptoms	Probing unconscious motives and fantasies, exploring childhood experiences, identifying recurring themes in client's life; exploration of issues and emotions raised by transference
Cognitive-Behavioral		
Behavioral	Modification of self-defeating behaviors	Graduated exposure (flooding), systematic desensitization, behavioral records, skills training
Cognitive	Modification of irrational or unvalidated beliefs	Prompting the client to test beliefs against evidence; exposing the faulty reasoning in catastrophizing and mind reading; sometimes helping the client accept and live with unpleasant thoughts and feelings
Humanist and Existential		
Humanist	Insight; self-acceptance and self-fulfillment; new, optimistic perceptions of oneself and the world	Providing a nonjudgmental setting in which to discuss issues; use of empathy and unconditional positive regard by the therapist
Existential	Finding meaning in life and accepting inevitable losses	Varies with the therapist; philosophic discussions about the meaning of life, the client's goals, finding the courage to survive suffering and loss
Family and Couples		
Family	Modification of family patterns	May use any of the preceding methods to change family patterns that perpetuate problems and conflicts
Couples	Resolution of conflicts, breaking out of destructive habits	May use any of the preceding methods to help the couple communicate better, resolve conflicts, or accept differences