

Methods of Treatment



CHAPTER OUTLINE

TYPES OF HELPING PROFESSIONALS 104 PSYCHOTHERAPY 104–125

Psychodynamic Therapy
Behavior Therapy
Humanistic Therapy
Cognitive Therapy
Cognitive-Behavioral Therapy
Eclectic Therapy
Group, Family, and Couple Therapy
Evaluating Methods of Psychotherapy
Multicultural Issues in Psychotherapy

BIOMEDICAL THERAPIES 126–130

Drug Therapy
Electroconvulsive Therapy
Psychosurgery
Evaluation of Biological Approaches

HOSPITALIZATION AND COMMUNITY-BASED CARE 131–137

Roles for Hospitalization
The Community Mental Health Center

Ethnic Group Differences in Use of Mental Health Services
Racial Stereotyping and the Mental Health System
Evaluation of Deinstitutionalization

SUMMING UP 137–138



Susanna—"A Girl, Interrupted"

Suicide is a form of murder—premeditated murder. It isn't something you do the first time you think of doing it. It takes getting used to. And you need the means, the opportunity, the motive. . . .

My motives were weak: an American-history paper I didn't want to write and the question I'd asked months earlier, Why not kill myself? Dead, I wouldn't have to write the paper. Nor would I have to keep debating the question. . . .

Anything I thought or did was immediately drawn into the debate. Made a stupid remark—why not kill myself? Missed the bus—better put an end to it all. Even the good got in there. I liked that movie—maybe I shouldn't kill myself.

Actually, it was only part of myself I wanted to kill: the part that wanted to kill herself, that dragged me into the suicide debate and made every window, kitchen implement, and subway station a rehearsal for tragedy.

I didn't figure this out, though, until after I'd swallowed the fifty aspirin.

I had a boyfriend named Johnny who wrote me love poems—good ones. I called him up, said I was going to kill myself, left the phone off the hook, took my fifty aspirin, and realized it was a mistake. Then I went out to get some milk, which my mother had asked me to do before I took the aspirin.

Johnny called the police. They went to my house and told my mother what I'd done. She turned up in the A&P on Mass. Ave, just as I was about to pass out over the meat counter.

As I walked the five blocks to the A&P I was gripped by humiliation and regret. I'd made a mistake and I was going to die because of it. I began to cry about my death. For a moment, I felt compassion for myself and all the unhappiness I contained. Then things started to blur and whiz. By the time I reached the store, the world had been reduced to a narrow, throbbing tunnel. I'd lost my peripheral vision, my ears were ringing, my pulse was pounding. The bloody chops and steaks straining against the plastic wrapping were the last things I saw clearly.

Having my stomach pumped brought me around. They took a long tube and put it slowly up my nose and down the back of my throat. That was like being choked to death. Then they began to pump. That was like having blood drawn on a massive scale—the suction, the sense of tissue collapsing and touching itself in a way it shouldn't, the nausea as all that was inside was pulled out. It was a good deterrent. Next time, I decided, I certainly wouldn't take aspirin.

But when they were done, I wondered if there would be a next time. I felt good. I wasn't dead, yet something was dead. Perhaps I'd managed my peculiar objective of partial suicide. I was lighter, airier than I'd been in years. . . .

The only odd thing was that suddenly I was a vegetarian. I associated meat with suicide, because of passing out at the meat counter. But I know there was more to it.

The meat was bruised, bleeding, and imprisoned in a tight wrapping. And, though I had a six-month respite from thinking about it, so was I.

—From *Girl, Interrupted* by Susanna Kaysen, copyright © 1993 by Susanna Kaysen.
Used by permission of Turtle Bay Books, a division of Random House, Inc.

TRUTH or FICTION

T **F** Some psychologists have been trained to prescribe drugs. (p. 105)

T **F** In many states people can set up shop as a psychotherapist without any kind of license or credentials. (p. 106)

T **F** In classical psychoanalysis, clients are asked to express whatever thought happens to come to mind, no matter how seemingly trivial or silly. (p. 108)

T **F** Psychotherapy is no more effective than simply letting time take its course. (p. 120)

T **F** Antidepressants are used only to treat depression. (p. 127)

T **F** Sending jolts of electricity into a person's brain can often help relieve severe depression. (p. 128)

EIGHTEEN-YEAR-OLD SUSANNA KAYSEN SPENT TWO YEARS ON A PSYCHIATRIC WARD AFTER THIS halfhearted suicide attempt. Twenty-five years later she chronicled her experience as a psychiatric patient in her autobiographical book, *Girl, Interrupted*. Like Kaysen, many people who attempt or commit suicide have ambivalent feelings about taking their own lives. Kaysen called her boyfriend, giving him the opportunity to intervene. She survived, was able to get on with her life, and eventually wrote two novels and her memoir, which later became the subject of a motion picture of the same name. Unfortunately, many people who attempt suicide fail to get a second chance on life.



Girl, Interrupted. The memoir and movie of the same name chronicles the experiences of a young woman (played in the movie by actress Winona Ryder) who is hospitalized in a mental hospital after a halfhearted suicide attempt.

This chapter focuses on ways of helping people like Susanna who are struggling with psychological problems. Some forms of help involve outpatient treatment, such as psychotherapy or drug therapy. In more severe cases, such as with people who make suicide attempts or are suffering acute episodes of schizophrenia, treatment typically involves a period of inpatient care.

The treatment an individual receives depends not only on the particular problem but also on the therapeutic orientation and training of the helping professional. Consider someone suffering from depression. A psychiatrist might recommend a course of antidepressant medication, perhaps in combination with psychotherapy. A cognitively oriented psychologist might suggest cognitive therapy to help identify faulty thinking patterns that underlie depression, whereas a psychodynamic therapist might probe for unconscious conflicts believed to lie at the root of the person's problems.

In this chapter we focus on these and other ways of treating psychological disorders. About one out of seven people in the United States receives mental health treatment in any given year (USDHHS, 1999a). Yet, despite

the widespread availability of mental health services, there remains a large unmet need, as most people with diagnosed mental disorders remain either untreated or under-treated (Kessler et al., 2005c; Wang et al., 2005).

In later chapters we examine the kinds of treatment approaches applied to particular disorders, but here we focus on the treatments themselves. We will see that the biological and psychological perspectives have spawned corresponding approaches to treatment. First, however, we consider the major types of mental health professionals who treat psychological or mental disorders and the different roles they play.

TYPES OF HELPING PROFESSIONALS

Many people are confused about the differences in qualifications and training of the various types of professionals who provide mental health care. It is little wonder people are confused, as there are different types of mental health professionals who represent a wide range of training backgrounds and areas of practice. For example, clinical psychologists and counseling psychologists have completed advanced graduate training in psychology and obtained a license to practice psychology. Psychiatrists are medical doctors who specialize in the diagnosis and treatment of emotional disorders. The major professional groupings of helping professionals, including clinical and counseling psychologists, psychiatrists, social workers, nurses, and counselors, are described in Table 4.1.

Unfortunately, many states do not limit the use of the titles *therapist* or *psychotherapist* to trained professionals. In such states, anyone can set up shop as a psychotherapist and practice “therapy” without a license. Thus, people seeking help are advised to inquire about the training and licensure of helping professionals. If you or someone you know should seek the services of a psychologist, how would you find one? The *A Closer Look* feature, “How Do I Find Help?,” offers some suggestions.

We now consider the major types of psychotherapy and their relationships to the theoretical models from which they are derived.

psychotherapy A structured form of treatment derived from a psychological framework that consists of one or more verbal interactions or treatment sessions between a client and a therapist.

PSYCHOTHERAPY

Psychotherapy is a systematic interaction between a client and a therapist that draws on psychological principles to help bring about changes in the client's behaviors, thoughts, and feelings. Psychotherapy is used to help clients overcome abnormal

TABLE 4.1
Major Types of Helping Professionals

Type	Description
Clinical psychologists	Have earned a doctoral degree in psychology (either a Ph.D., or Doctor of Philosophy; a Psy.D., or Doctor of Psychology; or an Ed.D., or Doctor of Education) from an accredited college or university. Training in clinical psychology typically involves 4 years of graduate coursework, followed by a year-long internship and completion of a doctoral dissertation. Clinical psychologists specialize in administering psychological tests, diagnosing psychological disorders, and practicing psychotherapy. Until recently, they were not permitted to prescribe psychiatric drugs. However, as of this writing, two states (New Mexico and Louisiana) had enacted laws granting prescription privileges to psychologists who complete specialized training programs (Comas-Díaz, 2006; Practice Directorate Staff, 2005). Whether other states will follow suit remains to be seen. Moreover, the granting of prescription privileges to psychologists remains a hotly contested issue between psychologists and psychiatrists and within the field of psychology itself.
Counseling psychologists	Also hold doctoral degrees in psychology and have completed graduate training preparing them for careers in college counseling centers and mental health facilities. They typically provide counseling to people with psychological problems falling in a milder range of severity than those treated by clinical psychologists, such as difficulties adjusting to college or uncertainties regarding career choices.
Psychiatrists	Have earned a medical degree (M.D.) and completed a residency program in psychiatry. Psychiatrists are physicians who specialize in the diagnosis and treatment of psychological disorders. As licensed physicians, they can prescribe psychiatric drugs and may employ other medical interventions, such as electroconvulsive therapy (ECT). Many also practice psychotherapy based on training they receive during their residency programs or in specialized training institutes.
Clinical or psychiatric social workers	Have earned a master's degree in social work (M.S.W.) and use their knowledge of community agencies and organizations to help people with severe mental disorders receive the services they need. For example, they may help people with schizophrenia make a more successful adjustment to the community once they leave the hospital. Many clinical social workers practice psychotherapy or specific forms of therapy, such as marital or family therapy.
Psychoanalysts	Typically are either psychiatrists or psychologists who have completed extensive additional training in psychoanalysis. They are required to undergo psychoanalysis themselves as part of their training.
Counselors	Have typically earned a master's degree by completing a graduate program in a counseling field. Counselors work in many settings, including public schools, college testing and counseling centers, and hospitals and health clinics. Many specialize in vocational evaluation, marital or family therapy, rehabilitation counseling, or substance abuse counseling. Counselors may focus on providing psychological assistance to people with milder forms of disturbed behavior or those struggling with a chronic or debilitating illness or recovering from a traumatic experience. Some are clergy members who are trained in pastoral counseling programs to help parishioners cope with personal problems.
Psychiatric nurses	Typically are R.N.s who have completed a master's program in psychiatric nursing. They may work in a psychiatric facility or in a group medical practice where they treat people suffering from severe psychological disorders.


Source: Adapted from Nevid, J. S. (2007). *Psychology: Concepts and applications* (2nd ed.). Boston: Houghton Mifflin.

behavior, solve problems in living, or develop as individuals. Let us take a closer look at these features of psychotherapy:

- 1. *Systematic interaction.* “Systematic” means that therapists structure their interactions with clients in ways that reflect their theoretical points of view.
- 2. *Psychological principles.* Psychotherapists draw on psychological principles, research, and theory in their practice.

TRUTH OR FICTION

Some psychologists have been trained to prescribe drugs.

 **TRUE.** Some psychologists have received specialized training that prepares them to prescribe psychiatric medications.

3. *Behavior, thoughts, and feelings.* Psychotherapy may be directed at behavioral, cognitive, and emotional domains to help clients overcome psychological problems and lead more satisfying lives.
4. *Abnormal behavior, problem solving, and personal growth.* At least three groups of people are assisted by psychotherapy. First are people with abnormal behavior problems such as mood disorders, anxiety disorders, or schizophrenia. Second are people who seek help for personal problems that are not regarded as abnormal, such as social shyness or confusion about career choices. Third are people who seek personal growth. For them, psychotherapy is a means of self-discovery that may help them reach their potentials as, for example, parents, creative artists, performers, or athletes.

Psychotherapies share other features as well. For one, they are all “talking therapies”—psychologically based treatment involving verbal interchanges between clients and therapists. In some cases, there is a continuous back-and-forth dialogue between the client and therapist. In others, such as traditional psychoanalysis, the client does virtually all the talking. Skillful therapists are also active listeners: They listen intently to what clients are saying to understand as clearly as possible what they are experiencing and attempting to convey. Therapists also express interest in what the client is saying through words as well as nonverbal gestures, such as establishing eye contact and leaning forward when the client is speaking. Skillful therapists are also sensitive to clients’ nonverbal cues, such as gestures that may indicate underlying feelings or conflicts. Therapists also seek to convey empathy, or accurate understanding of the client’s feelings and experiences. Therapist empathy is a consistent predictor of therapy outcome. Clients of therapists who are perceived as warmer and more empathic show greater improvement than clients of other therapists, regardless of the type of therapy.

TRUTH or FICTION

In many states people can set up shop as a psychotherapist without any kind of license or credentials.

TRUE. It is legal in many states to use the title “psychotherapist” or to practice psychotherapy without a license or credentials.



A CLOSER LOOK

How Do I Find Help?

In most areas in the United States and Canada, there are pages upon pages of psychologists and other mental health professionals in the telephone directory. Many people have no idea whom to call for help. If you don’t know where to go or whom to see, there are a number of steps you can take to ensure that you receive appropriate care:

1. *Seek recommendations from respected sources, such as your family physician, course instructor, clergy person, or college health service.*
2. *Seek a consultation with your college counseling center or health services center.* Most colleges and universities offer psychological assistance to students, generally without charge.
3. *Seek a referral from a local medical center or local community mental health center.* When making inquiries, ask about the services that are available or about opportunities for referral to qualified treatment providers in the area.
4. *Contact professional organizations for recommendations.* Many local or national organizations maintain a referral list of qualified treatment providers in your area. If you would like to consult a psychologist, contact the American Psychological Association in Washington, DC, by telephone at 202-336-5650 or on the Internet at www.apa.org. At the Web site, click on the links to “Find a Psychologist” for a listing of psychologists in your particular area. Alternatively, you can call your local or state psychology association in the United States or your provincial or territorial psychological association in Canada.
5. *Let your fingers do the walking—but be careful!* Look under “Psychologists,” “Physicians,” “Social Workers,” or “Social and Human Services” in your local Yellow Pages. However, be wary of professionals who take out large ads and claim to be experts in treating many different kinds of problems.
6. *Make sure the treatment provider is a licensed member of a recognized mental health profession, such as psychology, medicine, counseling, or social work.* In many states, anyone can set up practice as a “therapist,” even as a “psychotherapist.” These titles may not be limited by law to

licensed practitioners. Licensed professionals clearly display their licenses and other credentials in their offices, usually in plain view. If you have any questions about the licensure status of a treatment provider, contact the licensing board in your state, province, or territory.

7. *Inquire about the type of therapy being provided (e.g., psychoanalysis, family therapy, behavior therapy).* Ask the treatment provider to explain how his or her particular type of therapy is appropriate to treating the problems you are having.
8. *Inquire about the treatment provider’s professional background.* Ask about the person’s educational background, supervised experience, and credentials. An ethical practitioner will not hesitate to provide this information.
9. *Inquire whether the treatment provider has had experience treating other people with similar problems.* Ask about their results and how they were measured.
10. *Once the treatment provider has had the opportunity to conduct a formal evaluation of your problem, discuss the diagnosis and treatment plan before making any commitments to undertake treatment.*
11. *Ask about costs and insurance coverage.* Ask what types of insurance the provider accepts and whether copayments are required on your part. Ask whether the provider will adjust his or her fees on a sliding scale that takes your income and family situation into account. If you are eligible for Medicaid or Medicare, inquire whether the treatment provider accepts these types of coverage. College students may also be covered by their parents’ health insurance plans or by student plans offered by their colleges. Find out if the treatment provider participates in any health maintenance organization to which you may belong.
12. *Find out about the treatment provider’s policies regarding charges for missed or canceled sessions.*
13. *If medication is to be prescribed, find out how long a delay is expected before it starts working.* Also inquire about possible side effects, and about

(continued)

which side effects should prompt you to call with questions. Don't be afraid to seek a second opinion before undergoing any course of medication.

- 14.** *If the treatment recommendations don't sound quite right to you, discuss your concerns openly.* An ethical professional will be willing to address your concerns rather than feel insulted.

- 15.** *If you still have any doubts, request a second opinion.* An ethical professional will support your efforts to seek a second opinion. Ask the treatment provider to recommend other professionals—or select your own.

Source: Adapted from Nevid, J. S., *Psychology: Concepts and Applications*, Second Edition (Boston: Houghton Mifflin, 2007), p. 56. Reprinted by permission.

Another common feature among different psychotherapies is the instilling in clients of a sense of hope of improvement. Clients generally enter therapy with expectations of receiving help to overcome their problems. Responsible therapists do not promise results or guarantee cures; however, they do instill hope that they can help clients deal with their problems. Positive expectancies can become a type of self-fulfilling prophecy by leading clients to mobilize their efforts toward overcoming their problems. Responses to positive expectancies are termed *placebo effects* or *expectancy effects*.

These common features that cut across different approaches to psychotherapy, such as the encouragement of hope and the display of empathy and attentiveness on the part of the therapist, are called **nonspecific treatment factors**. These factors may have therapeutic benefits in themselves, quite apart from the specific benefits associated with particular forms of therapy. We will discuss these factors in greater detail in the section on evaluating psychotherapy.

Psychodynamic Therapy

Sigmund Freud was the first theorist to develop a psychological model—the *psychodynamic model*—of abnormal behavior (see Chapter 2). He was also the first to develop a model of psychotherapy, which he called **psychoanalysis**, to help people who suffered from psychological disorders. Psychoanalysis was the first **psychodynamic therapy**. Psychodynamic therapy helps individuals gain insight into, and resolve, the unconscious conflicts believed to lie at the root of abnormal behavior. Working through these conflicts, the ego would be freed of the need to maintain defensive behaviors—such as phobias, obsessive-compulsive behaviors, hysterical complaints, and the like—that shield it from recognition of inner turmoil.

Freud summed up the goal of psychoanalysis by saying, “Where id was, there shall ego be.” This meant, in part, that psychoanalysis could help shed the light of awareness, represented by the conscious ego, on the inner workings of the id. Through this process a man might come to realize that unresolved anger toward his dominating or rejecting mother has sabotaged his intimate relationships with women during his adulthood. A woman with a loss of sensation in her hand that could not be explained medically might come to see that she harbored guilt over urges to masturbate. The loss of sensation might have prevented her from acting on these urges. Through confronting hidden impulses and the conflicts they produce, clients learn to sort out their feelings and find more constructive and socially acceptable ways of handling their impulses and wishes. The ego is then freed to focus on more constructive interests.

The major methods that Freud used to accomplish these goals were free association, dream analysis, and analysis of the transference relationship.

Free Association **Free association** is the process of uttering uncensored thoughts as they come to mind. Free association is believed to gradually break down the defenses that block awareness of

nonspecific treatment factors Factors not specific to any one form of psychotherapy, such as therapist attention and support, and creating positive expectancies of change.

psychoanalysis The method of psychotherapy developed by Sigmund Freud.

psychodynamic therapy Therapy that helps individuals gain insight into, and resolve, unconscious conflicts.

free association The method of verbalizing thoughts as they occur without a conscious attempt to edit or censor them.



The therapeutic relationship. In the course of successful psychotherapy, a therapeutic relationship is forged between the therapist and patient. Therapists use attentive listening to understand as clearly as possible what the client is experiencing and attempting to convey. Skillful therapists are also sensitive to clients' nonverbal cues, such as gestures and posture, that may indicate underlying feelings or conflicts.

TRUTH or FICTION

In classical psychoanalysis, clients are asked to express whatever thought happens to come to mind, no matter how seemingly trivial or silly.

TRUE. In classical psychoanalysis, clients are asked to report any thoughts that come to mind. The technique is called free association.

transference relationship In psychoanalysis, the client's transfer or generalization to the analyst of feelings and attitudes the client holds toward important figures in his or her life.

countertransference In psychoanalysis, the transfer of feelings or attitudes that the analyst holds toward other persons in her or his life onto the client.



Dream analysis. Freud believed that dreams represent the “royal road to the unconscious.” Dream interpretation was one of the principal techniques that Freud used to uncover unconscious material.

unconscious processes. Clients are told not to censor or screen out thoughts, but to let their minds wander “freely” from thought to thought. Psychoanalysts do not believe that the process of free association is truly free. Repressed impulses press for expression or release, leading to a *compulsion to utter*. Although free association may begin with small talk, the compulsion to utter eventually leads the client to disclose more meaningful material.

The ego, however, continues to try to avert the disclosure of threatening impulses and conflicts. Consequently, clients may show *resistance*, an unwillingness or inability to recall or discuss disturbing or threatening material. Clients may report that their minds suddenly go blank when they venture into sensitive areas, such as hateful feelings toward family members or sexual yearnings. They may switch topics abruptly or accuse the analyst of trying to pry into material that is too personal or embarrassing to talk about. Or they may conveniently “forget” the next appointment after a session in which sensitive material is touched upon. The analyst monitors the dynamic conflict between the compulsion to utter and resistance. Signs of resistance are often suggestive of meaningful material. Now and then, the analyst brings interpretations of this material to the attention of the client to help the client gain better insight into deep-seated feelings and conflicts.

Dream Analysis To Freud, dreams represented the “royal road to the unconscious.” During sleep, the ego's defenses are lowered and unacceptable impulses find expression in dreams. Because the defenses are not completely eliminated, the impulses take a disguised or symbolized form. In psychoanalytic theory, dreams have two levels of content:

1. *Manifest content*: the material of the dream the dreamer experiences and reports
2. *Latent content*: the unconscious material the dream symbolizes or represents

A man might dream of flying in an airplane. Flying is the apparent or manifest content of the dream. Freud believed that flying may symbolize erection, so perhaps the latent content of the dream reflects unconscious issues related to fears of impotence. Because such symbols may vary from person to person, analysts ask clients to free-associate to the manifest content of the dream to provide clues to the latent content. Although dreams may have a psychological meaning, as Freud believed, there remains no independent way of determining what dreams mean (Squier & Domhoff, 1998).

Transference Freud found that clients responded to him not only as an individual but also in ways that reflected their feelings and attitudes toward other important people in their lives. A young female client might respond to him as a father figure, displacing, or transferring, onto Freud her feelings toward her own father. A man might also view him as a father figure, responding to him as a rival in a manner that Freud believed might reflect the man's unresolved Oedipus complex.

The process of analyzing and working through the **transference relationship** is considered an essential component of psychoanalysis. Freud believed that the transference relationship provides a vehicle for the reenactment of childhood conflicts with parents. Clients may react to the analyst with the same feelings of anger, love, or jealousy they felt toward their own parents. Freud termed the enactment of these childhood conflicts the *transference neurosis*. This “neurosis” had to be successfully analyzed and worked through for clients to succeed in psychoanalysis.

Childhood conflicts usually involve unresolved feelings of anger, rejection, or need for love. For example, a client may interpret any slight criticism by the therapist as a devastating blow, transferring feelings of self-loathing that the client had repressed from childhood experiences of parental rejection. Transference may also distort or color the client's relationships with others, such as a spouse or employer. A client might relate to a spouse as to a parent, perhaps demanding too much or unjustly accusing the spouse of being insensitive or uncaring. Or a client who had been mistreated by a past lover might not give new friends or lovers the benefit of a fair chance. The analyst helps the client recognize transference relationships, especially the therapy transference, and work through the residues of childhood feelings and conflicts that lead to self-defeating behavior in the present.

According to Freud, transference is a two-way street. Freud felt he transferred his underlying feelings onto his clients, perhaps viewing a young man as a competitor or a woman as a rejecting love interest. Freud referred to the feelings that he projected onto clients as **countertransference**. Psychoanalysts in training are expected to undergo

psychoanalysis themselves to help them uncover motives that might lead to countertransferences in their therapeutic relationships. In their training, psychoanalysts learn to monitor their own reactions in therapy, so as to become better aware of when and how countertransferences intrude on the therapy process.

Although the analysis of transference is a crucial element of psychoanalytic therapy, it generally takes months or years for a transference relationship to develop and be resolved. This is one reason why psychoanalysis is typically a lengthy process.

Modern Psychodynamic Approaches Although some psychoanalysts continue to practice traditional psychoanalysis in much the same manner as Freud, briefer and less-intensive forms of psychodynamic treatment have emerged. They are able to reach clients who are seeking briefer and less costly forms of treatment, perhaps once or twice a week (Grossman, 2003).

Like Freudian psychoanalysis, the newer psychodynamic approaches aim to uncover unconscious motives and break down resistances and psychological defenses. Yet they focus more on the client's present relationships and encourage the client to make adaptive behavior changes. Many contemporary psychodynamic therapists draw more heavily on the ideas of Erik Erikson, Karen Horney, and other theorists than on Freud's ideas. Treatment entails a more open dialogue and direct exploration of the client's defenses and transference relationships than was traditionally the case (Messer, 2001b). The client and therapist generally sit facing each other, and the therapist engages in more frequent verbal give-and-take with the client, as in the following vignette. Note how the therapist uses interpretation to help the client, Mr. Arianes, achieve insight into how his relationship with his wife involves a transference of his childhood relationship with his mother:



Modern psychodynamic psychotherapy.

Modern psychodynamic therapists engage in more direct, face-to-face interactions with clients than do traditional Freudian psychoanalysts. Modern psychodynamic approaches are also generally briefer and focus more on the direct exploration of clients' defenses and transference relationships.

Offering an Interpretation

MR. ARIANES: *I think you've got it there, Doc. We weren't communicating. I wouldn't tell her [his wife] what was wrong or what I wanted from her. Maybe I expected her to understand me without saying anything.*

THERAPIST: *Like the expectations a child has of its mother.*

MR. ARIANES: *Not my mother!*

THERAPIST: *Oh?*

MR. ARIANES: *No, I always thought she had too many troubles of her own to pay attention to mine. I remember once I got hurt on my bike and came to her all bloodied up. When she saw me she got mad and yelled at me for making more trouble for her when she already had her hands full with my father.*

THERAPIST: *Do you remember how you felt then?*

MR. ARIANES: *I can't remember, but I know that after that I never brought my troubles to her again.*

THERAPIST: *How old were you?*

MR. ARIANES: *Nine. I know that because I got that bike for my ninth birthday. It was a little too big for me still, that's why I got hurt on it.*

THERAPIST: *Perhaps you carried this attitude into your marriage.*

MR. ARIANES: *What attitude?*

THERAPIST: *The feeling that your wife, like your mother, would be unsympathetic to your difficulties. That there was no point in telling her about your experiences because she was too preoccupied or too busy to care.*

MR. ARIANES: *But she's so different from my mother. I come first with her.*

THERAPIST: *On one level you know that. On another, deeper level there may well be the fear that people—or maybe only women, or maybe only women you're close to—are all the same, and you can't take a chance at being rejected again in your need.*

MR. ARIANES: *Maybe you're right, Doc, but all that was so long ago, and I should be over that by now.*

THERAPIST: *That's not the way the mind works. If a shock or a disappointment is strong enough, it can permanently freeze our picture of ourselves and our expectations of the world. The rest of us grows up—that is, we let ourselves learn about life from experience and from what we see, hear, or read of the experiences of others, but that one area where we really got hurt stays unchanged. So what I mean when I say you might be carrying that attitude into your relationship with your wife is that when it comes to your hopes of being understood and catered to when you feel hurt or abused by life, you still feel very much like that nine-year-old boy who was rebuffed in his need and gave up hope that anyone would or could respond to him.*

—Offering an Interpretation, from M. F. Basch, *Doing Psychotherapy* (Basic Books, 1980), pp. 29–30. Reprinted by permission of Basic Books, a member of Perseus Books Group.

Some modern psychodynamic therapists focus more on the role of the ego and less on the role of the id. These therapists, such as Heinz Hartmann, are generally described as *ego analysts*. Other modern psychoanalysts, such as Margaret Mahler, are identified with *object-relations* approaches to psychodynamic therapy. They focus on helping people separate their own ideas and feelings from the elements of others they have incorporated or *introjected* within themselves. Clients can then develop more as individuals—as their own persons, rather than trying to meet the expectations they believe others have of them.

Though psychodynamic therapy is no longer the dominant force in the field that it once was, it is still practiced widely. A recent survey of 177 practicing psychologists found that nearly half (45%) reported using psychodynamic techniques along with cognitive-behavioral techniques in their practice (Holloway, 2003; PracticeNet, 2003). Let's now turn to other forms of therapy, beginning with behavior therapy.

Behavior Therapy

behavior therapy The therapeutic application of learning-based techniques.

Behavior therapy is the systematic application of the principles of learning to the treatment of psychological disorders. Because the focus is on changing behavior—not on personality change or deep probing into the past—behavior therapy is relatively brief, lasting typically from a few weeks to a few months. Behavior therapists, like other therapists, seek to develop warm therapeutic relationships with clients, but they believe the special efficacy of behavior therapy derives from the learning-based techniques rather than from the nature of the therapeutic relationship.

Behavior therapy first gained widespread attention as a means of helping people overcome fears and phobias, problems that had proved resistant to insight-oriented therapies. Among the methods used are systematic desensitization, gradual exposure, and modeling. **Systematic desensitization** involves a therapeutic program of exposure (in imagination or by means of pictures or slides) to progressively more fearful stimuli while one remains deeply relaxed. First the person uses a relaxation technique, such as progressive relaxation (discussed in Chapter 5), to become deeply relaxed. The client is then instructed to imagine (or perhaps view, as through a series of slides) progressively more anxiety-arousing scenes. If fear is evoked, the client focuses on restoring relaxation. The process is repeated until the client can tolerate the scene without anxiety. The client then progresses to the next scene in the *fear-stimulus hierarchy*. The procedure is continued until the person can remain relaxed while imagining the most distressing scene in the hierarchy.

In **gradual exposure** (also called *in vivo*, meaning “in life,” exposure), people troubled by phobias purposely expose themselves to the stimuli that evoke their fear. Like systematic desensitization, the person progresses at his or her own pace through a hierarchy of progressively more anxiety-evoking stimuli. The person with a fear of snakes, for example, might first look at a harmless, caged snake from across the room and then gradually approach and interact with the snake in a step-by-step process, progressing to each new step only when feeling completely calm at the prior step. Gradual expo-

systematic desensitization A behavior therapy technique for overcoming phobias by means of exposure to progressively more fearful stimuli while one remains deeply relaxed.

gradual exposure A behavior therapy technique for overcoming fears through direct exposure to increasingly fearful stimuli.

sure is often combined with cognitive techniques that focus on replacing anxiety-arousing irrational thoughts with calming rational thoughts.

In **modeling**, individuals learn desired behaviors by observing others perform them (Braswell & Kendall, 2001). For example, the client may observe and then imitate others who interact with fear-evoking situations or objects. After observing the model, the client may be assisted or guided by the therapist or the model in performing the target behavior. The client receives ample reinforcement from the therapist for each attempt. Modeling approaches were pioneered by Albert Bandura and his colleagues, who had remarkable success using modeling techniques with children to treat various phobias, especially fears of animals, such as snakes and dogs (Bandura, Jeffery, & Wright, 1974; Braswell & Kendall, 2001).

Behavior therapists also use reinforcement techniques based on operant conditioning to shape desired behavior. For example, parents and teachers may be trained to systematically reinforce children for appropriate behavior by showing appreciation and to extinguish inappropriate behavior by ignoring it. In institutional settings, **token economy** systems seek to increase adaptive behavior by rewarding patients with tokens for performing appropriate behaviors, such as self-grooming and making their beds. The tokens can eventually be exchanged for desired rewards. Token systems have also been used to treat children with conduct disorders.

Other techniques of behavior therapy discussed in later chapters include *aversive conditioning* (used in the treatment of substance abuse problems such as smoking and alcoholism), and *social skills training* (used in the treatment of social anxiety and skills deficits associated with schizophrenia).

Humanistic Therapy

Psychodynamic therapists tend to focus on unconscious processes, such as internal conflicts. By contrast, humanistic therapists focus on clients' subjective, conscious experiences. Like behavior therapists, humanistic therapists also focus more on what clients are experiencing in the present—the here and now—than on the past. But there are also similarities between the psychodynamic and humanistic therapies. Both assume that the past affects present behavior and feelings and both seek to expand clients' self-insight. The major form of humanistic therapy is **person-centered therapy** (also called *client-centered therapy*), which was developed by the psychologist Carl Rogers.

Person-Centered Therapy Rogers (1951) believed that people have natural motivational tendencies toward growth, fulfillment, and health. In Rogers's view, psychological disorders develop largely from the roadblocks that other people place in the path toward self-actualization. When others are selective in their approval of our childhood feelings and behavior, we may disown the criticized parts of ourselves. To earn social approval, we may don social masks or facades. We learn "to be seen and not heard" and may become deaf even to our own inner voices. Over time, we may develop distorted self-concepts that are consistent with others' views of us but are not of our own making and design. As a result, we may become poorly adjusted, unhappy, and confused as to who and what we are.

Well-adjusted people make choices and take actions consistent with their personal values and needs. Person-centered therapy creates conditions of warmth and acceptance in the therapeutic relationship that help clients become more aware and accepting of their true selves. Rogers did not believe therapists should impose their own goals or values on their clients. His focus of therapy, as the name implies, is the person.

Person-centered therapy is *nondirective*. The client, not the therapist, takes the lead and directs the course of therapy. The therapist uses *reflection*—the restating or paraphrasing of the client's expressed feelings without interpreting them or passing judgment on them. This encourages the client to further explore his or her feelings and get in touch with deeper feelings and parts of the self that had become disowned because of social condemnation.

modeling A behavior therapy technique for helping an individual acquire a new behavior by means of having a therapist or another individual demonstrate a target behavior that is then imitated by the client.

token economy Behavioral treatment program in which a controlled environment is constructed such that people are reinforced for desired behaviors by receiving tokens that may be exchanged for desired rewards.

person-centered therapy The establishment of a warm, accepting therapeutic relationship that frees clients to engage in self-exploration and achieve self-acceptance.



"You say 'off with her head,' but what I'm hearing is, 'I feel neglected.'"

Drawing by Mike Ewers. Reprinted by permission.

Rogers stressed the importance of creating a warm therapeutic relationship that would encourage the client to engage in self-exploration and self-expression. The effective therapist should possess four basic qualities or attributes: *unconditional positive regard*, *empathy*, *genuineness*, and *congruence*. First, the therapist must be able to express **unconditional positive regard** for clients. In contrast to the conditional approval the client may have received from parents and others in the past, the therapist must be unconditionally accepting of the client as a person, even if the therapist sometimes objects to the client's choices or behaviors. Unconditional positive regard provides clients with a sense of security that encourages them to explore their feelings without fear of disapproval. As clients feel accepted or prized for themselves, they are encouraged to accept themselves in turn. To Rogers, every human being has intrinsic worth and value. Rogers believed that people are basically good and are motivated to pursue *prosocial* goals.

Therapists who display **empathy** are able to reflect or mirror accurately their clients' experiences and feelings. Therapists try to see the world through their clients' eyes or frames of reference. They listen carefully to clients and set aside their own judgments and interpretations of events. Showing empathy encourages clients to get in touch with feelings of which they may be only dimly aware.

Genuineness is the ability to be open about one's feelings. Rogers admitted he had negative feelings at times during therapy sessions, typically boredom, but he attempted to express these feelings openly rather than hide them (Bennett, 1985).

Congruence refers to the fit between one's thoughts, feelings, and behavior. The congruent person is one whose behavior, thoughts, and feelings are integrated and consistent. Congruent therapists serve as models of psychological integrity to their clients.

Here Rogers (C. R.) uses reflection to help a client focus more deeply on her inner feelings:

Rogers Demonstrates Reflection

JILL: *I'm having a lot of problems dealing with my daughter. She's 20 years old; she's in college; I'm having a lot of trouble letting her go. And I have a lot of guilt feelings about her; I have a real need to hang on to her.*

C.R.: *A need to hang on so you can kind of make up for the things you feel guilty about. Is that part of it?*

JILL: *There's a lot of that. Also, she's been a real friend to me, and filled my life. And it's very hard . . . a lot of empty places now that she's not with me.*

C.R.: *The old vacuum, sort of, when she's not there.*

JILL: *Yes. Yes. I also would like to be the kind of mother that could be strong and say, you know, "Go and have a good life," and this is really hard for me, to do that.*

C.R.: *It's very hard to give up something that's been so precious in your life, but also something that I guess has caused you pain when you mentioned guilt.*

JILL: *Yeah. And I'm aware that I have some anger toward her that I don't always get what I want. I have needs that are not met. And, uh, I don't feel I have a right to those needs. You know . . . she's a daughter; she's not my mother. Though sometimes I feel as if I'd like her to mother me . . . it's very difficult for me to ask for that and have a right to it.*

C.R.: *So, it may be unreasonable, but still, when she doesn't meet your needs, it makes you mad.*

JILL: *Yeah I get very angry, very angry with her.*

C.R.: *(Pause) You're also feeling a little tension at this point, I guess.*

JILL: *Yeah. Yeah. A lot of conflict . . . (C.R.: M-hm.). A lot of pain.*

C.R.: *A lot of pain. Can you say anything more about what that's about?*

—From Farber, Brink, & Raskin, 1996, *The psychotherapy of Carl Rogers: Cases and commentary*, pp. 74–75. Reprinted with permission of The Guilford Press.

unconditional positive regard The expression of unconditional acceptance of another person's basic worth as a person.

empathy The ability to understand someone's experiences and feelings from that person's point of view.

genuineness The ability to recognize and express one's true feelings.

congruence The fit between one's thoughts, behaviors, and feelings.

Cognitive Therapy

There is nothing either good or bad, but thinking makes it so.

—Shakespeare, *Hamlet*

In these words, Shakespeare did not mean to imply that misfortunes or ailments are painless or easy to manage. His point, rather, was that the ways in which we evaluate upsetting events can heighten or diminish our discomfort and affect our ability to cope. Several hundred years later, cognitive therapists such as Aaron Beck and Albert Ellis adopted this simple but elegant expression as a kind of motto for their approach to therapy.

Cognitive therapists focus on helping clients identify and correct faulty thinking, distorted beliefs, and self-defeating attitudes that create or contribute to emotional problems. They argue that negative emotions such as anxiety and depression are caused by interpretations we place on troubling events, not on events themselves. Here we focus on two prominent types of **cognitive therapy**: Albert Ellis's rational emotive behavior therapy and Aaron Beck's cognitive therapy.

Rational Emotive Behavior Therapy Albert Ellis (1977b, 1993, 2001; Dryden & Ellis, 2001) believed that negative emotions such as anxiety and depression are caused by the irrational ways in which we interpret or judge negative events, not by negative events themselves. Consider the irrational belief that we must have the approval almost all the time of the people who are important to us. Ellis finds it understandable to want other people's approval and love, but he argues that it is irrational to believe we cannot survive without it. Another irrational belief is that we must be thoroughly competent and achieving in virtually everything we seek to accomplish. We are doomed to eventually fall short of these irrational expectations, and when we do, we may experience negative emotional consequences, such as depression and lowered self-esteem. Emotional difficulties such as anxiety and depression are not directly caused by negative events, but rather by how we distort their meaning by viewing them through the dark-colored glasses of self-defeating beliefs. In Ellis's **rational emotive behavior therapy (REBT)**, therapists actively *dispute* clients' irrational beliefs and the premises on which they are based and help clients to develop alternative, adaptive beliefs in their place.

Ellis and Dryden (1987) describe the case of a 27-year-old woman, Jane, who was socially inhibited and shy, particularly with attractive men. Through REBT, Jane identified some of her underlying irrational beliefs, such as "I must speak well to people I find attractive" and "When I don't speak well and impress people as I should, I'm a stupid, inadequate person!" (p. 68). REBT helped Jane discriminate between these irrational beliefs and rational alternatives, such as "If people do reject me for showing them how anxious I am, that will be most unfortunate, but I can stand it" (p. 68). REBT encouraged Jane to debate or dispute irrational beliefs by posing challenging questions to herself: (1) "Why must I speak well to people I find attractive?" and (2) "When I don't speak well and impress people, how does that make me a *stupid and inadequate person*?" (p. 69). Jane learned to form rational responses to her self-questioning. For example, (1) "There is no reason I must speak well to people I find attractive, but it would be desirable if I do so, so I shall make an effort—but not kill myself—to do so," and (2) "When I speak poorly and fail to impress people, that only makes me a *person who spoke unimpressively this time*—not a *totally stupid or inadequate person*" (p. 69). After 9 months of REBT, Jane was able to talk comfortably to men she found attractive and was preparing to take a job as a teacher, a position she had previously avoided due to fear of facing a class.

Rational emotive behavior therapists help clients substitute more effective interpersonal behavior for self-defeating or maladaptive behavior. Ellis often gave clients specific tasks or homework assignments, such as disagreeing with an overbearing relative or asking someone for a date. He assisted them in practicing or rehearsing adaptive behaviors.

cognitive therapy A form of therapy that helps clients identify and correct faulty cognitions (thoughts, beliefs, and attitudes) believed to underlie their emotional problems and maladaptive behavior.

rational emotive behavior therapy (REBT) A therapeutic approach that focuses on helping clients replace irrational, maladaptive beliefs with alternative, more adaptive beliefs.

Beck's Cognitive Therapy Psychiatrist Aaron Beck and his colleagues (Beck et al., 1979; DeRubeis, Tang, & Beck, 2001) developed cognitive therapy, which, like REBT, focuses on people's faulty thoughts and beliefs. Cognitive therapists encourage clients to recognize and change errors in their thinking, called *cognitive distortions*, such as tendencies to magnify negative events and minimize personal accomplishments, that affect their moods and impair their behavior.

Cognitive therapists have clients record the thoughts that are prompted by upsetting events and note the connections between their thoughts and their emotional responses. They then help clients to dispute distorted thoughts and replace them with rational alternatives. Therapists also use behavioral homework assignments, such as encouraging depressed clients to fill their free time with structured activities, such as gardening or completing work around the house. Carrying out such tasks counteracts the apathy and loss of motivation that often characterize depression and may also provide concrete evidence of competence, which helps combat self-perceptions of helplessness and inadequacy.

Another type of homework assignment involves *reality testing*, whereby clients are asked to test their negative beliefs in the light of reality. For example, a depressed client who feels unwanted by everyone might be asked to call two or three friends on the phone to gather data about the friends' reactions to the calls. The therapist might then ask the client to report on the assignment: "Did they immediately hang up the phone, or did they seem pleased you called? Did they express any interest at all in talking to you again or getting together sometime? Does the evidence support the conclusion that *no one* has any interest in you?" Such exercises help clients replace distorted beliefs with rational alternatives.

Consider this case in which a depressed man was encouraged to test his belief that he was about to be fired from his job. The case also illustrates several cognitive distortions or errors in thinking, such as selectively perceiving only one's flaws (in this case, self-perceptions of laziness) and expecting the worst (expectations of being fired).

Kyle Tests His Beliefs

Kyle, a 35-year-old frozen foods distributor, had suffered from chronic depression since his divorce 6 years earlier. During the past year the depression had worsened, and he found it increasingly difficult to call upon customers or go to the office. Each day that he avoided working made it more difficult for him to go to the office and face his boss. He was convinced that he was in imminent danger of being fired because he had not made any sales calls for more than a month. Because he had not earned any commissions in a while, he felt he was not adequately supporting his two daughters and was concerned that he wouldn't have the money to send them to college. He was convinced that his basic problem was laziness, not depression. His therapist pointed out the illogic in his thinking. First of all, there was no real evidence that his boss was about to fire him. His boss had actually encouraged him to get help and was paying for part of the treatment. His therapist also pointed out that judging himself as lazy was unfair because it overlooked the fact that he had been an industrious, successful salesman before he became depressed. Although not fully persuaded, the client agreed to a homework assignment in which he was to call his boss and also make a sales call to one of his former customers. His boss expressed support and reassured him that his job was secure. The customer ribbed him about "being on vacation" during the preceding 6 weeks but placed a small order. The client discovered that the small unpleasantness he experienced in facing the customer and being teased paled in comparison to the intense depression he felt at home while he was avoiding work. Within the next several weeks he gradually worked himself back to a normal routine, calling upon customers and making future plans. This process of viewing himself and the world from a fresh perspective led to a general improvement in his mood and behavior.

—Adapted from Burns & Beck, 1978, pp. 124–126

TABLE 4.2 Overview of Major Types of Psychotherapy

TYPE OF THERAPY	Major Figure(s)	Goal	Length of Treatment	Therapist's Approach	Major Techniques
Classical psychoanalysis	Sigmund Freud	Gaining insight and resolving unconscious psychological conflicts	Lengthy, typically lasting several years	Passive, interpretive	Free association, dream analysis, interpretation
Modern psychodynamic approaches	Erik Erikson Harry Stack Sullivan Heinz Hartmann Melanie Klein Margaret Mahler	Focus on developing insight, but with greater emphasis on ego functioning, current interpersonal relationships, and adaptive behavior than traditional psychoanalysis	Briefer than traditional psychoanalysis	More direct probing of client defenses; more back-and-forth discussion	Direct analysis of client's defenses and transference relationships
Behavior therapy	Various	Directly changing problem behavior through use of learning-based techniques	Relatively brief, typically lasting 10 to 20 sessions	Directive, active problem solving	Systematic desensitization, gradual exposure, modeling, reinforcement techniques
Humanistic, client-centered therapy	Carl Rogers	Self-acceptance and personal growth	Varies, but briefer than traditional psychoanalysis	Nondirective, allowing client to take the lead, with therapist serving as an empathic listener	Use of reflection, creation of a warm, accepting therapeutic relationship
Ellis's rational emotive behavior therapy	Albert Ellis	Replacing irrational beliefs with rational alternative beliefs; making adaptive behavioral changes	Relatively brief, typically lasting 10 to 20 sessions	Direct, sometimes confrontational challenging of client's irrational beliefs	Identifying and challenging irrational beliefs, behavioral homework assignments
Beck's cognitive therapy	Aaron Beck	Identify and correcting distorted or self-defeating thoughts and beliefs; making adaptive behavioral changes	Relatively brief, typically lasting 10 to 20 sessions	Collaboratively engaging client in process of logically examining thoughts and beliefs and testing them out	Identifying and correcting distorted thoughts; behavioral homework including reality testing
Cognitive-behavioral therapy	Various	Use of cognitive and behavioral techniques to change maladaptive behaviors and cognitions	Relatively brief, typically lasting 10 to 20 sessions	Direct, active problem solving	Combination of cognitive and behavioral techniques

REBT and Beck's cognitive therapy have much in common, especially the focus on helping clients replace self-defeating thoughts and beliefs with more rational ones. Perhaps the major difference between the two approaches is therapeutic style. REBT therapists tend to be more confrontational and forceful in their approach to disputing clients' irrational beliefs. Cognitive therapists tend to adopt a more gentle, collaborative approach in helping clients discover and correct the distortions in their thinking.

The therapies developed by Beck and Ellis can be classified as forms of *cognitive-behavioral therapy*, which is the treatment approach we turn to next. We will then turn to consider a growing movement among therapists toward incorporating principles and techniques derived from different schools of therapy. Before reading further, you may wish to review Table 4.2, which summarizes the major approaches to psychotherapy.

cognitive-behavioral therapy (CBT)

A learning-based approach to therapy incorporating cognitive and behavioral techniques.

Cognitive-Behavioral Therapy

Today, most behavior therapists identify with a broader model of behavior therapy called **cognitive-behavioral therapy (CBT)** (also called *cognitive-behavior therapy*). Cognitive-behavioral therapy attempts to integrate therapeutic techniques that help individuals make changes not only in their overt behavior but also in their underlying thoughts, beliefs, and attitudes. Cognitive-behavioral therapy draws on the assumption that thinking patterns and beliefs affect behavior and that changes in these cognitions can produce desirable behavioral and emotional changes (Dobson & Dozois, 2001; McGinn & Sanderson, 2001). Cognitive-behavioral therapists focus on helping clients identify and correct the maladaptive beliefs and negative, automatic thoughts that may underlie their emotional problems.

Cognitive-behavioral therapists use an assortment of cognitive techniques and behavioral techniques. The following case illustration shows how behavioral techniques (exposure to fearful situations) and cognitive techniques (changing maladaptive thoughts) were used in the treatment of a case of *agoraphobia*, a type of anxiety disorder characterized by excessive fears of venturing out in public.

Mrs. X Uses CBT to Overcome Agoraphobia

Mrs. X was a 41-year-old woman with a 12-year history of agoraphobia. She feared venturing into public places alone and required her husband or children to accompany her from place to place. In vivo (actual) exposure sessions were arranged in a series of progressively more fearful encounters (a fear-stimulus hierarchy). The first step in the hierarchy, for example, involved taking a shopping trip while accompanied by the therapist. After accomplishing this task, Mrs. X gradually moved upward in the hierarchy. By the third week of treatment, she was able to complete the last step in her hierarchy: shopping by herself in a crowded supermarket.

Cognitive restructuring was conducted along with the exposure training. Mrs. X was asked to imagine herself in various fearful situations and to report the self-statements she experienced. The therapist helped her identify disruptive self-statements, such as, "I am going to make a fool of myself." The therapist questioned this particular self-statement by asking whether it was realistic to believe that she would actually lose control and, secondly, by disputing the belief that the consequences of losing control, were it to happen, would truly be disastrous. Mrs. X progressed rapidly with treatment and became capable of functioning more independently, but she still worried about future relapses. The therapist focused at this point on deeper cognitive structures involving her fears of abandonment by the people she loved if she were to relapse and be unable to attend to their needs. In challenging these beliefs, the therapist helped Mrs. X realize that she was not as helpless as she perceived herself to be and that she was loved for other reasons than her ability to serve others. She also explored the question, "Who am I improving for?" She realized that she needed to find reasons to overcome her phobia that were related to meeting her own personal needs, not simply the needs of her loved ones. At a follow-up interview 9 months after treatment, she was functioning independently, which allowed her to pursue her own interests, such as taking night courses and seeking a job.

—Adapted from Biran, 1988, pp. 173–176

Cognitive-behavioral therapy has produced impressive results in treating a wide range of emotional disorders, including depression, panic disorder, generalized anxiety disorder, social phobia, posttraumatic stress disorder, agoraphobia, and obsessive-compulsive disorder, as well as other disorders such as bulimia and personality disorders (e.g., Bockting et al., 2005; Butler et al., 2006; DeRubeis et al., 2005; Heimberg, Turk, & Mennin, 2004; Hollon et al., 2005, 2006; Lilienfeld, 2007; Norton & Price, 2007). Yet, like other forms of treatment, including drug therapy, CBT is not effective in all cases; perhaps as many 30–40% of patients fail to respond to treatment (David & Szentagotai, 2006).

Eclectic Therapy

Each of the major psychological models of abnormal behavior—the psychodynamic, behaviorist, humanistic, and cognitive approaches—has spawned its own approaches to psychotherapy. Although many therapists identify with one or another of these schools of therapy, an increasing number of therapists practice **eclectic therapy**, in which they draw on techniques and teachings of multiple therapeutic approaches. Eclectic therapists seek to enhance their therapeutic effectiveness by incorporating principles and techniques from different therapeutic orientations. An eclectic therapist might use behavior therapy techniques to help a client change specific maladaptive behaviors, for example, along with psychodynamic techniques to help the client gain insight into the childhood roots of the problem.

A greater percentage of clinical and counseling psychologists identify with an eclectic or integrative orientation than any other therapeutic orientation (Bechtoldt et al., 2001; see Figure 4.1). Therapists who adopt an eclectic approach tend to be older and more experienced (Beitman, Goldfried, & Norcross, 1989). Perhaps they have learned through experience of the value of drawing on diverse contributions to the practice of therapy.

Eclecticism has different meanings for different therapists. Some therapists are *technical eclectics*. They draw on techniques from different schools of therapy without necessarily adopting the theoretical positions that spawned the techniques (Beutler, Harwood, & Caldwell, 2001; Lazarus, 1992). They assume a pragmatic approach in using techniques from different therapeutic approaches that they believe are most likely to work with a given client.

Other eclectic therapists are *integrative eclectics*. They attempt to synthesize and integrate diverse theoretical approaches—to bring together different theoretical concepts and therapeutic approaches under the roof of one integrated model of therapy (Beutler, Harwood, & Caldwell, 2001; Stricker & Gold, 2001). Although various approaches to integrative psychotherapy have been proposed, there is as yet no clear agreement as to the principles and practices that constitute therapeutic integration (Garfield, 1994). Perhaps multiple approaches are needed (Safran & Messer, 1997).

Not all therapists subscribe to the view that therapeutic integration is a desirable or achievable goal. They believe that combining elements of different therapeutic approaches will lead to a hodgepodge of techniques that lack a cohesive conceptual framework. Still, interest in the professional community in therapeutic integration is growing, and we expect to see new models emerging that aim to tie together the contributions of different approaches.

eclectic therapy An approach to psychotherapy that incorporates principles or techniques from various systems or theories.

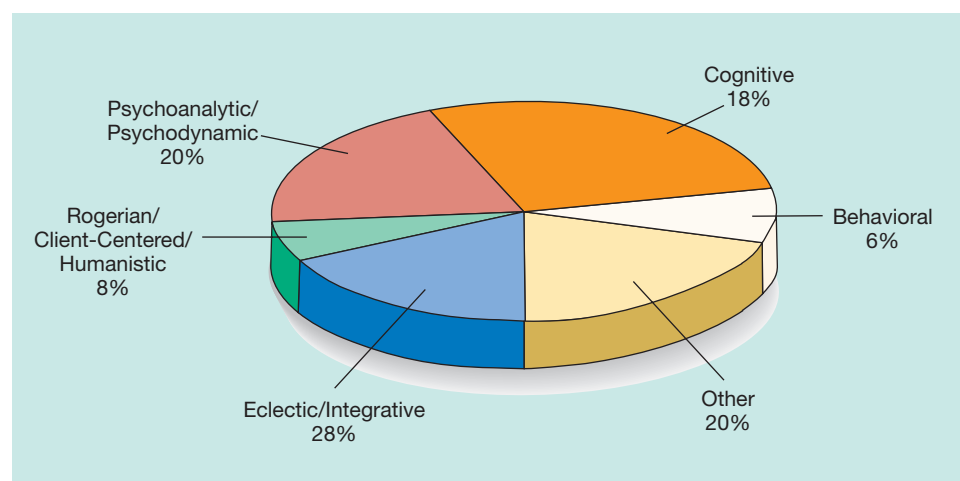


FIGURE 4.1 Therapeutic orientations of clinical and counseling psychologists.

An eclectic/integrative orientation is the most widely endorsed therapeutic orientation among clinical and counseling psychologists today.

Source: Adapted from Bechtoldt et al. (2001).



Group therapy. What are some of the advantages of group therapy over individual therapy? What are some of its disadvantages?

group therapy A form of therapy in which a group of clients meets together with a therapist.



Family therapy. In family therapy, the family, not the individual, is the unit of treatment. Family therapists help family members communicate more effectively with one another, for example, to air their disagreements in ways that are not hurtful to individual members. Family therapists also try to prevent one member of the family from becoming the scapegoat for the family's problems.

family therapy A form of therapy in which the family, not the individual, is the unit of treatment.

couple therapy A form of therapy that focuses on resolving conflicts in distressed couples.

Group, Family, and Couple Therapy

Some approaches to therapy expand the focus of treatment to include groups of people, families, and couples.

Group Therapy In **group therapy**, a group of clients meets together with a therapist or a pair of therapists. Group therapy has several advantages over individual treatment. For one, group therapy is less costly to individual clients, because several clients are treated at the same time. Many clinicians also believe that group therapy is more effective in treating groups of clients who have similar problems, such as complaints relating to anxiety, depression, lack of social skills, or adjustment to divorce or other life stresses.

Clients learn how people with similar problems cope and receive social support from the group as well as the therapist. Group therapy also provides members with opportunities to work through their problems in relating to others. For example, the therapist or other members may point out to a particular member patterns of behavior that mirror the client's behavior outside the group. Group members may also rehearse social skills with one another in a supportive atmosphere.

Despite these advantages, clients may prefer individual therapy for various reasons. For one, clients might not wish to disclose their problems in a group. Some clients prefer the individual attention of the therapist. Others are too socially inhibited to feel comfortable in a group setting. Because of such concerns, group therapists require that group disclosures be kept confidential, that group members relate to each other supportively and nondestructively, and that group members receive the attention they need.

Family Therapy In **family therapy**, the family, not the individual, is the unit of treatment. Family therapy aims to help troubled families resolve their conflicts and problems so the family functions better as a unit and individual family members are subjected to less stress from family conflicts. In family therapy, family members learn to communicate more effectively and to air their disagreements constructively. Family conflicts often emerge at transitional points in the life cycle, when family patterns are altered by changes in one or more members. Conflicts between parents and children, for example, often emerge when adolescent children seek greater independence or autonomy. Family members with low self-esteem may be unable to tolerate different attitudes or behaviors from other members of the family and may resist their efforts to change or become more independent. Family therapists work with families to resolve these conflicts and help them adjust to life changes.

Family therapists are sensitive to tendencies of families to scapegoat one family member as the source of the problem, or the "identified client." Disturbed families seem to adopt a sort of myth: Change the identified client, the "bad apple," and the "barrel," or family, will once again become functional. Family therapists encourage families to work together to resolve their disputes and conflicts, instead of scapegoating one member.

Many family therapists adopt a *systems approach* to understanding the workings of the family and problems that may arise within the family. They see problem behaviors of individual family members as representing a breakdown in the system of communications and role relationships within the family. For example, a child may feel in competition with other siblings for a parent's attention and develop enuresis, or bed-wetting, as a means of securing attention. Operating from a systems perspective, the family therapist may focus on helping family members understand the hidden messages in the child's behavior and make changes in their relationships to meet the child's needs more adequately.

Couple Therapy **Couple therapy** focuses on resolving conflicts in distressed couples, including married and unmarried couples (Christensen et al., 2004). Like family therapy, couple therapy focuses on improving communication and analyzing role relation-



CONTROVERSIES IN ABNORMAL PSYCHOLOGY

Online Therapy: A New Therapeutic Tool, or Pandora's Box?

You can do almost anything on the Internet these days, from ordering concert tickets to downloading music (legally, of course) or whole books. You can also receive counseling or therapy services from an online therapist. As the numbers of online counseling services continues to increase, so does the controversy concerning their use.

When we last commented upon the use of Internet-based psychological services in the last edition of this textbook, we noted that many professionals had voiced significant concerns about the clinical, ethical, and legal issues of these treatments. These concerns remain. One problem is that although psychologists are licensed in particular states, Internet communications easily cross state and international borders. It remains unclear whether psychologists or other mental health professionals can legally provide online services to residents of states in which they are not licensed. Ethical problems and liability issues arise when psychologists and other helping professionals offer services to clients they never meet in person. Many therapists also express concerns that interacting with a client only by computer would prevent them from evaluating nonverbal cues and gestures that might signal deeper levels of distress than are verbally reported or typed on a keyboard.

Yet another problem is that online therapists living at great distances from their clients may not be able to provide the more intensive services clients need during times of emotional crisis. Professionals also express concern about the potential for unsuspecting clients to be victimized by unqualified practitioners or “quacks.” We don’t yet have a system to ensure that only licensed and qualified practitioners offer online therapeutic services.

On the other hand, many professionals argue that online consultation and counseling services can have therapeutic value (e.g., Chang & Yeh, 2003; Taylor & Luce, 2003). One advantage of these Internet-based services is that they require fewer therapist resources than standard face-to-face therapy (Litz et al., 2005). They may also be able to reach people who have avoided seeking help because of shyness or embarrassment. Online consultation may also make people feel more comfortable about receiving help, making it a first step toward meeting a therapist in person. Online therapy may also provide treatment services people might not otherwise receive because they lack mobility or live in remote areas.

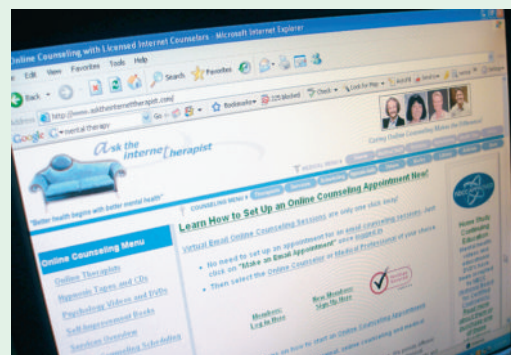
Far from writing off so-called e-therapy, psychologists are seeking responsible ways of using the Internet and other forms of electronically delivered psychological services, or *psychotechnology*, as this new field was recently called (Comas-Diaz, 2006). Evidence is mounting that Internet-based treatments can yield therapeutic benefits in treating anxiety disorders such as posttraumatic stress disorder (PTSD), panic disorder, and social phobia, as well as helping people quit smoking and overcome insomnia and even test anxiety (Andersson et al., 2006; Carlbring et al., 2006; Litz et al., 2005;

Orbach, Lindsay, & Grey, 2007; Walters, Wright, & Shegog, 2006). Online support groups may also be helpful to people who are depressed and have few social outlets (Houston et al., 2002).

We should also note that other technologies hold great promise for expanding services and for training opportunities. For example, teleconferencing is being used to help rural clinicians further develop their skills by providing them access to training and consultation with specialists (Schopp, Johnstone, & Reid-Arndt, 2005). In other cases, investigators report significant improvements in depression among patients who participated in a cognitive-behavioral treatment program administered by telephone (Mohr et al., 2005). Added to the mix are computerized versions of cognitive-behavioral therapy designed to increase access to therapy and reduce costs associated with traditional therapy (McCrone et al., 2004; Proudfoot et al., 2004). In one recent example, investigators found that a computer-assisted cognitive therapy program produced effects that were comparable to standard cognitive therapy in treating depression (Wright et al., 2005).

Critical Thinking

- What ethical and practical problems do therapists who offer online therapy face?
- What are the potential benefits of online therapy? What are the potential risks?



Internet Therapy. Online therapeutic services are popping up on the Internet. Although Internet-based counseling or therapy services may have therapeutic benefits, many mental health professionals express concerns about potential clinical, ethical, and legal issues associated with these services.

ships. For example, one partner may play a dominant role and resist any request to share power. The couple therapist helps bring these role relationships into the open, so that partners can explore alternative ways of relating to one another that would lead to a more satisfying relationship.

Evaluating Methods of Psychotherapy

What, then, of the effectiveness of psychotherapy? Does psychotherapy work? Are some forms of therapy more effective than others? Are some forms of therapy more effective for some types of clients or for some types of problems than for others?

The effectiveness of psychotherapy receives strong support from the research literature. Reviews of the scientific literature often utilize a statistical technique called *meta-analysis*, which averages the results of a large number of studies to determine an overall level of effectiveness.

TRUTH or FICTION

Psychotherapy is no more effective than simply letting time take its course.

FALSE. There is ample evidence that psychotherapy produces better results than control treatments in which people are placed on waiting lists that allow time to take its course.

In the most frequently cited meta-analysis of psychotherapy research, M. L. Smith and Glass (1977) analyzed the results of some 375 controlled studies comparing various types of therapies (psychodynamic, behavioral, humanistic, etc.) against control groups. The results of their analyses showed that the average psychotherapy client in these studies was better off than 75% of the clients who remained untreated. A larger analysis based on 475 controlled outcome studies showed the average person who received therapy was better off at the end of treatment than 80% of those who did not (M. L. Smith, Glass, & Miller, 1980).

Other meta-analyses also show positive outcomes for psychotherapy, including analyses of cognitive-behavioral therapy, brief psychodynamic therapy, child and adolescent psychotherapy, group psychotherapy, and behavioral marital therapy (e.g., Butler et al., 2006; McDermut, Miller, & Brown, 2001; McLeod & Weisz, 2004; Shadish & Baldwin, 2005). Psychotherapy is effective not only in the confines of clinical research centers, but also in settings that are more typical of ordinary clinical practice (Shadish et al., 2000).

The greatest gains in psychotherapy typically occur in the first several months of treatment (Barkham et al., 1996). At least 50% of patients in controlled research studies show clinically significant improvement in about 13 treatment sessions; by 26 sessions, this figure rises to more than 80% (E. M. Anderson & Lambert, 2001; Hanson et al., 2002; Messer, 2001a). Yet we should recognize that many clients drop out prematurely, before therapeutic benefits are achieved.

Studies using the technique of meta-analysis show that different forms of therapy produce about the same size or magnitude of effects when they are compared to control groups (Wampold, 2001). This suggests that the effectiveness of different forms of psychotherapy may have more to do with nonspecific factors they have in common than with the specific techniques that set them apart. Nonspecific or common factors include expectations of improvement and features of the therapist–client relationship, including the following: (1) empathy, support, and attention shown by the therapist; (2) *therapeutic alliance*, or the attachment the client develops toward the therapist and the therapy process; and (3) the *working alliance*, or the development of an effective working relationship in which the therapist and client work together to identify and confront the important issues and problems the client faces (Busseri & Tyler, 2003; Klein et al., 2003; Westra, Dozois, & Marcus, 2007).

Should we conclude that different therapies are about equally effective? Not necessarily. Different therapies may be more or less equivalent in their effects overall, but some may be more effective for some patients or some types of problems. We should also allow that the effectiveness of therapy may have more to do with effectiveness of the therapist than with the particular form of therapy (Wampold, 2001).

All in all, the question of whether some forms of therapy are more effective than others remains unresolved. Perhaps the time has come for investigators to turn more of their attention to examining the active ingredients that make some therapists more effective than others, such as interpersonal skills, empathy, and ability to develop a good therapeutic relationship or alliance (Hanna, 2003; Karver et al., 2006). A stronger therapeutic alliance, especially an alliance formed early in therapy, is associated with better treatment outcomes (Constantino et al., 2005; Loeb et al., 2005; Strauss et al., 2006; Zuroff, & Blatt, 2006). The personal qualities that therapists bring to the therapeutic relationship, such as flexibility, honesty, warmth, and trustworthiness, impact their ability to form effective therapeutic alliances (Ackerman & Hilsenroth, 2003).

Another approach to determining which therapies are effective in treating which particular problems is the effort undertaken by a task force of psychologists to designate evidence-based practices (EBPs), which are also called *empirically supported treatments* or ESTs (APA Presidential Task Force on Evidence-Based Practice, 2006; Deegear & Lawson, 2003; Wells & Miranda, 2006). ESTs are specific psychological treatments that have demonstrated their effectiveness in treating specific problem behaviors or disorders in carefully designed clinical studies (see the listing in Table 4.3) (Chambless & Ollendick, 2001). We should note that the designation of empirically supported treatments is a work in progress, as other treatments may eventually be

TABLE 4.3
Examples of Empirically Supported Treatments (ESTs)

Treatment	Conditions for Which Treatment Is Effective
Cognitive therapy	(Chapter in text where treatment is discussed is shown in parentheses.) Headache (Chapter 5) Depression (Chapter 8)
Behavior therapy or behavior modification	Depression (Chapter 8) Persons with developmental disabilities (Chapter 14) Enuresis (Chapter 14)
Cognitive-behavioral therapy	Panic disorder with and without agoraphobia (Chapter 6) Generalized anxiety disorder (Chapter 6) Bulimia (Chapter 10)
Exposure treatment	Agoraphobia and specific phobia (Chapter 6)
Exposure and response prevention	Obsessive-compulsive disorder (Chapter 6)
Interpersonal psychotherapy	Depression (Chapter 8)
Parent training programs	Children with oppositional behavior (Chapter 14)

added to the list as scientific evidence of their efficacy in treating specific types of problems becomes available.

The attempt to designate evidence-based treatments may help address the problem of clients receiving mental health treatments that are not known to be effective (Thase, 2006). We should caution, however, that the inclusion of a particular treatment does not guarantee it is effective in every case. We also need to point out that methods and criteria used to determine which treatments are considered empirically supported remains a point of controversy in the field (see Crits-Christoph, Wilson, & Hollon, 2005; Weisz, Weersing, & Henggeler, 2005; Westen, Novotny, & Thompson-Brenner, 2004, 2005). This topic is explored further in the accompanying *Controversies in Abnormal Psychology* feature.

Let us conclude by noting that it is thus insufficient to ask which therapy works best. Instead, we must ask, Which therapy works best for which type of problem? Which clients are best suited for which type of therapy? What are the advantages and limitations of particular therapies? Although the effort to identify empirically supported treatments moves us in the direction of matching treatments to particular disorders, the process of determining which treatment, practiced by whom, and under what conditions is most effective for a given client remains a challenge.



CONTROVERSIES IN ABNORMAL PSYCHOLOGY

The Controversy Over Evidence-Based Practice: Repairing the Rift

—WILLIAM C. SANDERSON

When you make a visit to your physician with a particular ailment, it is safe to assume that whatever treatment you are given is the one most likely to be effective. You expect that the doctor's decision about which treatment approach to use is guided by clinical evidence, rather than personal preference. Increasingly, medical professionals are drawing upon *evidence-based treatments* as the basis for making treatment choices.

Is the same process used by psychologists in selecting a particular psychotherapy approach? Let's say a person suffering from panic disorder

consults a psychologist for treatment. What is the likelihood the person will receive the therapeutic intervention having the most supporting evidence for its efficacy? Unfortunately, the fact is that most people receiving treatment for panic disorder fail to receive the particular treatment that has received the strongest support in the research literature—cognitive-behavioral therapy. (See Chapter 6 for further discussion of cognitive-behavioral treatment of panic disorder.) Let us consider some of the reasons why evidence-based practices are not used more widely. But first, what do we mean by the term *evidence-based practices*?

(continued)

(continued)

WHAT ARE EVIDENCE-BASED PRACTICES?

Evidence-based practices (EBPs) (also called *empirically supported treatments* or ESTs) are treatments that have been shown to be effective in well-conducted controlled research trials (that is, in trials that randomize participants to treatment conditions, use a control or comparison group, and rely on a treatment manual that specifically describes the treatment protocol). The initial, and perhaps the most influential, effort to identify EBPs was undertaken in 1993 by a task force commissioned by The Society of Clinical Psychology (Division 12) of the American Psychological Association (APA). For a treatment to be considered evidence-based, the task force determined that it must have been shown to be either (a) equivalent to an already established treatment, or (b) superior to a placebo drug or psychotherapy placebo condition in at least two separate well-controlled studies. The task force was transformed into a standing committee of the division in 1999 (i.e., the Committee on Science and Practice) and continues its efforts today.

WHY IS THERE CONTROVERSY OVER EBPs?

In principle, psychologists are likely to agree on the necessity of providing empirical support for treatment interventions they use. It is also reasonable to assume that consumers of mental health treatment expect to receive a treatment whose effectiveness has been proven when one is available. Therefore, one would expect clinicians to embrace EBPs. However, psychologists are split on the EBP movement. I believe that with the possible exception of the controversy over prescription privileges for psychologists, there is probably no issue more hotly debated among practicing psychologists today. Why? I will briefly summarize the main arguments against the use of EBPs.

First, many clinicians claim that EBPs essentially favor cognitive-behavioral therapies because these represent the kinds of standardized treatments that can be tested more readily in controlled clinical trials. As a result, they believe that viable alternative treatments (e.g., psychodynamic therapy), which cannot be as easily standardized, will fail to measure up to the EBP criteria, even though they may be effective in clinical practice. Second, it has been argued that most studies supportive of EBPs fail to capture the complexity and uniqueness of patients seen in “actual” practice. Consequently, these clinicians question the applicability of these manualized treatments to patients seen in the community. Third, many clinicians have a negative reaction to being “told what to do” by researchers who generate these data. This is part of an ongoing tension between scientists and practitioners as to who “knows best” about treatment decisions—those who generate the research findings or those who provide clinical treatment in actual practice?

FUTURE DIRECTIONS

Division 12’s interest in identifying EBPs is part of a larger worldwide movement to make findings from applied medical research more available to clinicians in practice, a movement generally known as *evidence-based medicine*. The

basic aim of this effort is to improve the quality of patient care by making it easier for practitioners to use empirical evidence to inform their choice of medical services. As a result, the issue of EBPs in psychology will need to be resolved if psychologists expect to have their roles as health-care providers taken seriously within the health-care community.

In my opinion, the future of the EBP movement will primarily be focused on repairing the rift between scientists and practitioners so they can work together to deal with this important issue. In particular, researchers must address the concerns of clinicians, noted briefly before. First, treatments clinicians believe are effective must be subject to empirical investigations to support their legitimacy. Second, more attention needs to be paid to evaluating EBPs in true clinical settings (known as *effectiveness research*) rather than only in clinical research centers. Third, researchers should work with clinicians to form a collaborative effort in disseminating EBPs in clinical practice, rather than having one group impose them on another. I believe that these issues are beginning to be addressed in the psychology community and am confident that psychologists will move together toward acceptance and dissemination of evidence-based practices.



William C. Sanderson, Ph.D., is Professor of Psychology at Hofstra University and Editor of the APA Division 12 publication, *The Clinical Psychologist*. Dr. Sanderson was a member of the original Division 12 Task Force on evidence-based treatment and served as Chair of the committee for several years.

Critical Thinking

- Evidence-based treatments exist for many, but not all, psychological disorders. What do you think a clinician should do if no evidence-based guidance exists for a particular disorder?
- Demonstrating that evidence-based treatments work in actual clinical settings is an essential area of future research. What may be some reasons for concern that these treatments may not be as effective as those tested in clinical trials in research centers or universities?

(For further information of the present status of EBPs in psychology, see the following publication: Bruce, T. J., & Sanderson, W. C. (2004). Evidence-based psychosocial practices: The past, present, and future. In C. Stout & R. Hayes (Eds.), *Evidence-based practice: Methods, models and tolls for mental health professionals* (pp. 220–243). New York: John Wiley and Sons.)

managed care systems Health care delivery systems that impose limits on the number of treatment sessions they will approve for payment and the fees they will allow for reimbursement.

All in all, psychotherapy is a complex process that incorporates common features along with specific techniques that foster adaptive change. We need to take into account the contributions to therapeutic change of both specific and nonspecific factors, as well as their interactions.

Managed Care or Managed Costs? This is an appropriate juncture to note that the practice of psychotherapy has been influenced by changes in the general health-care environment in recent years, especially the increasing role of **managed care systems**, such as health maintenance organizations (HMOs). Managed care systems typically impose limits on the number of treatment sessions they will approve for payment and the fees they will allow for reimbursement. Consequently, there is greater emphasis today on briefer, more direct forms of treatment, including cognitive-behavioral therapy and shorter-term psychodynamic therapies. Moreover, managed care has curbed costly inpatient mental health treatment, primarily through limiting the lengths of stay of patients in psychiatric hospitals (USDHHS, 1999a).

Though managed care may help trim costs, many people express concerns about the risks of sacrificing quality of care in the interests of cutting costs. A recent study found that quality of mental health care is lacking in many HMOs (Druss et al., 2002). Consumers rank autonomy in treatment decisions (not having a particular treatment turned down for reimbursement by a managed care company), choice of therapists, copayment amounts, limits to confidentiality, and ease of access to care as the most important elements of psychotherapy service plans offered by managed care companies (Kremer & Gesten, 2003).

Though health-care providers understand the need to curtail the spiraling costs of care, they are understandably concerned that the cost-cutting emphasis of managed care plans may discourage people with identifiable psychological disorders from seeking help or receiving adequate care (Landerman et al., 1994). According to a Surgeon General's report, "Excessively restrictive cost-containment strategies and financial incentives to providers and facilities to reduce specialty referrals, hospital admissions, or length or amount of treatment may ultimately contribute to lowered access and quality of care" (cited in USDDHS, 1999a).

Overzealous cost-cutting policies may also be financially shortsighted because the failure to provide adequate mental health care when problems arise may lead to a need for more expensive care later. Evidence shows that for people with severe psychological disorders, such as schizophrenia, bipolar disorder, and borderline personality disorder, psychotherapy actually reduces health-care costs by reducing the need for hospitalization and work impairment (Fraser, 1996; Gabbard et al., 1997).



"IT'S YOUR INSURANCE COMPANY,
THEY SAY YOU'RE CURED."

Managed care or managed costs?

From the Wall Street Journal—permission, Cartoon Features Syndicate.

Multicultural Issues in Psychotherapy

We live in an increasingly diverse, multicultural society in which people bring to therapy not only their personal backgrounds and individual experiences but also their cultural learning, norms, and values. Normal and abnormal behaviors occur in a context of culture and community. Clearly, therapists need to be culturally competent to provide appropriate services to people of varied backgrounds (Hall, 2005; Stuart, 2004).

Therapists need to be sensitive to cultural differences and how they affect the therapeutic process. Cultural sensitivity involves more than good intentions. Therapists must also have accurate knowledge of cultural factors, as well as the ability to use that knowledge effectively in developing culturally sensitive approaches to treatment (Cardemil & Battle, 2003; Muñoz & Mendelson, 2005). Moreover, they need to avoid ethnic stereotyping and demonstrate sensitivity to the values, languages, and cultural beliefs of members of racial or ethnic groups that are different than their own. Perhaps it shouldn't surprise us that clients who rate their therapists high on multicultural competence also tend to perceive them as having skills of empathy and general competence (Fuentes & Brobst, 2002). However, a recent survey of professional psychologists showed that they applied relatively few of the recommended multicultural psychotherapy competencies in their practices (Hansen et al., 2006).

We must also recognize that just because a given therapy works with one population does not mean that it will necessarily work with another population (Hwang, 2006). We need evidence that speaks directly to whether particular therapies are effective with different populations (Muñoz, & Mendelson, 2005). We also need to learn more about how racial and gender differences between patients and therapists affect the development of the therapeutic alliance (Karlsson, 2005; Wintersteen, Mensinger, & Diamond, 2005).

Let us touch on some of the issues involved in treating members of the major ethnic minority groups in our society: African Americans, Asian Americans, Hispanic Americans, and Native Americans.



Cultural sensitivity. Therapists need to be sensitive to cultural differences and how they may affect the therapeutic process. They also need to avoid ethnic stereotyping and to demonstrate sensitivity to the values, languages, and cultural beliefs of members of racial or ethnic groups that are different than their own. Clients who are not fluent in English profit from having therapists who can conduct therapy in their own languages.

African Americans The cultural history of African Americans must be understood in the context of extreme racial discrimination (Boyd-Franklin, 1989; Greene, 1990). African Americans have needed to develop coping mechanisms for managing the pervasive racism they encounter in such areas as employment, housing, education, and access to health care (Greene, 1993a, 1993b). For example, the sensitivity of many African Americans to the potential for maltreatment and exploitation is a survival tool and may take the form of a heightened level of suspiciousness or reserve (Greene, 1986). Therapists need to be aware of the tendency of African American clients to minimize their vulnerability by being less self-disclosing, especially in early stages of therapy (Ridley, 1984). Therapists should not confuse such suspiciousness with paranoia (Boyd-Franklin, 1989; Greene, 1986).

In addition to whatever psychological problems African American clients may present, therapists often need to help their clients develop coping mechanisms to deal with racial barriers they encounter in daily life. Therapists also need to be attuned to tendencies of some African Americans to internalize the negative stereotypes about Blacks that are perpetuated in the dominant culture (Greene, 1985, 1992a, 1992b; Nickerson, Helms, & Terrell, 1994; Pinderhughes, 1989).

To be culturally competent, therapists not only must understand the cultural traditions and languages of the groups with which they work, but also must recognize their own racial and ethnic attitudes and how these underlying attitudes affect their clinical practice (Greene, 1985, 1992a, 1992b; Nickerson, Helms, & Terrell, 1994; Pinderhughes, 1989). Therapists are exposed to the same negative stereotypes about African Americans as other people in society and must recognize how these stereotypes, if left unexamined, can become destructive to the therapeutic relationships they form with African American clients. In effect, therapists must be willing to confront their own racism and prejudices and replace these attitudes with more realistic appraisals of African Americans (Mays, 1985).

Therapists must also be aware of the cultural characteristics of African American families, such as strong kinship bonds, often including people who are not biologically related (for example, a close friend of a parent may have some parenting role and may be addressed as “aunt”), strong religious and spiritual orientation, multigenerational households, adaptability and flexibility of gender roles (African American women have a long history of working outside the home), and distribution of child-care responsibilities among different family members (Boyd-Franklin, 1989; Collins, 1990; Ferguson-Peters, 1985; Greene, 1990; USDHHS, 1999a).

Asian Americans Culturally sensitive therapists not only understand the beliefs and values of other cultures but also integrate this knowledge within the therapy process. Generally speaking, Asian cultures, including Japanese culture, value restraint in talking about oneself and one’s feelings. Public expression of emotions is also discouraged in Asian cultures, which may inhibit Asian clients from revealing their feelings in therapy. In traditional Asian cultures, the failure to keep one’s feelings to oneself, especially negative feelings, may be perceived as reflecting poorly on one’s upbringing. Asian clients who appear passive or emotionally restrained when judged by Western standards may be responding in ways that are culturally appropriate and should not be judged as shy, uncooperative, or avoidant by therapists (Hwang, 2006).

Clinicians also note that Asian clients often express psychological complaints in terms of physical symptoms. However, this tendency to *somaticize* emotional problems may be attributed in part to differences in communication styles (Zane & Sue, 1991). That is, Asians may use somatic terms to convey emotional distress.

In some cases, the goals of therapy may conflict with the values of a particular culture. Therapists need to recognize that the individualism of American society, which is expressed in therapeutic interventions that focus on development of the self, may con-

flict with the group- and family-centered values of Asian cultures. Framing the therapy process in culturally appropriate terms may help build bridges, such as by emphasizing the strong links in Asian cultures between mind, body, and spirit (Hwang, 2006).

Hispanic Americans Although Hispanic American subcultures differ in various respects, many share certain cultural values and beliefs, such as adherence to a strong patriarchal (male-dominated) family structure and strong kinship ties. De la Cancela and Guzman (1991) identify some other values shared by many Hispanic Americans:

One's identity is in part determined by one's role in the family. The male, or *macho*, is the head of the family, the provider, the protector of the family honor, and the final decision maker. The woman's role (*marianismo*) is to care for the family and the children. Obviously, these roles are changing, with women entering the work force and achieving greater educational opportunities. Cultural values of *respeto* (respect), *confianza* (trust), *dignidad* (dignity), and *personalismo* (personalism) are highly esteemed and are important factors in working with many [Hispanic Americans] (p. 60).

Therapists need to recognize that the traditional Hispanic American value of interdependency within the family may conflict with the values of independence and self-reliance that are stressed in the mainstream U.S. culture (De la Cancela & Guzman, 1991). Psychotherapeutic interventions should respect differences in values rather than attempt to impose values of majority cultures. Therapists should also be trained to reach beyond the confines of their offices to work within the Hispanic American community itself, in settings that have an impact on the daily lives of Hispanic Americans, such as social clubs, *bodegas* (neighborhood groceries), and neighborhood beauty and barber shops. We can further break down barriers that may impede utilization of mental health services by Hispanic Americans by recruiting bicultural/bilingual staff and creating a welcoming therapeutic atmosphere that is accepting of Hispanic American cultural values (Guarnaccia & Rodriguez, 1996).

Native Americans Traditionally underserved groups, including people of color, have the greatest unmet needs for mental health treatment services (Wang et al., 2005). A case in point are Native Americans, who are underserved by mental health professionals partly as the result of the cultural gap between providers and recipients (Duran et al., 2005). Commenting upon this gap, Kahn (1982) suggests that if mental health professionals are to be successful in helping Native Americans, they must do so within a context that is relevant and sensitive to Native Americans' customs, culture, and values. For example, many Native Americans expect the therapist will do most of the talking and they will play a passive role in treatment. These expectations are in keeping with the traditional healer role but conflict with the client-focused approach of many forms of conventional therapy. There may yet be other differences in gestures, eye contact, facial expression, and other modes of nonverbal expression that can impede effective communication between therapist and client (Renfrey, 1992).

Psychologists recognize the importance of bringing elements of tribal culture into mental health programs for Native Americans (Rabasca, 2000a). For example, therapists can use indigenous ceremonies that are part of the client's cultural or religious traditions. Purification and cleansing rites are therapeutic for many Native American peoples in the United States and elsewhere, as *Santeria* is among the African Cuban community, *umbanda* for the Brazilian community, and *vodoun* in the Haitian community (Lefley, 1990). Cleansing rites are often sought by people who believe their problems are caused by failure to placate malevolent spirits or to perform mandatory ritual.

Respect for cultural differences is a key feature of culturally sensitive therapies. Training in multicultural therapy is becoming more widely integrated into training programs for therapists. Culturally sensitive therapies adopt a respectful attitude that encourages people to tell their own personal story as well as the story of their culture (Coronado & Peake, 1992).

psychopharmacology The field of study that examines the effects of therapeutic or psychiatric drugs.

antianxiety drugs Drugs that combat anxiety and reduce states of muscle tension.

tolerance Physical habituation to use of a drug.

BIOMEDICAL THERAPIES

There is a growing emphasis in American psychiatry on biomedical therapies, especially the use of *psychotropic drugs* (also called psychiatric drugs). Biomedical therapies are generally administered by medical doctors, many of whom have specialized training in psychiatry or **psychopharmacology**. Many family physicians or general practitioners also prescribe psychotherapeutic drugs for their patients.

Biomedical approaches have had dramatic success in treating some forms of abnormal behavior, although they also have their limitations. For one, drugs may have unwelcome or dangerous side effects. There is also the potential for abuse. One of the most commonly prescribed minor tranquilizers, Valium, has become a major drug of abuse among people who become psychologically and physiologically dependent on it. Psychosurgery has been all but eliminated as a form of treatment because of serious harmful effects of earlier procedures.

Drug Therapy

Different classes of psychotropic drugs are used in treating many types of psychological disorders. But all the drugs in these classes act on neurotransmitter systems in the brain, affecting the delicate balance of chemicals that ferry nerve impulses from neuron to neuron (Snyder, 2002). The major classes of psychiatric drugs are antianxiety drugs, antipsychotic drugs, and antidepressants, as well as lithium, which is used to treat mood swings in people with bipolar disorder. The use of other psychotropic drugs, such as stimulants, will be discussed in later chapters.

Antianxiety Drugs **Antianxiety drugs** (also called *anxiolytics*, from the Greek *anxietas*, meaning “anxiety,” and *lysis*, meaning “bringing to an end”) combat anxiety and reduce states of muscle tension. They include mild tranquilizers, such as those of the *benzodiazepine* class of drugs, including *diazepam* (Valium) and *alprazolam* (Xanax), as well as hypnotic-sedatives, such as *triazolam* (Halcion) and *flurazepam* (Dalmane).

Antianxiety drugs depress the level of activity in certain parts of the central nervous system (CNS). In turn, the CNS decreases the level of sympathetic nervous system activity, reducing the respiration rate and heart rate and lessening states of anxiety and tension. Mild tranquilizers such as Valium grew in popularity when physicians became concerned about the use of more potent depressants, such as barbiturates, which are highly addictive and extremely dangerous when taken in overdoses or mixed with alcohol. Unfortunately, it has become clear that these tranquilizers also can, and often do, lead to physiological dependence (addiction). People who are dependent on Valium may go into convulsions when they abruptly stop taking it. Deaths have been reported among people who mix mild tranquilizers with alcohol or who are unusually sensitive to them.

Side effects of using antianxiety drugs include fatigue, drowsiness, and impaired motor coordination that can impair the ability to function or to operate an automobile. Regular usage of these drugs can also produce **tolerance**, a physiological sign of dependence, which refers to the need over time for increasing dosages of a drug to achieve the same effect. When used on a short-term basis, antianxiety drugs can be safe and effective in treating anxiety and insomnia. Yet drugs by themselves do not teach people more adaptive ways of solving their problems and may encourage them to rely on a chemical agent to cope with stress rather than to develop active means of coping. Drug therapy is thus often combined with psychotherapy to help people with anxiety complaints. However, combining drug therapy and psychotherapy may present special problems and challenges. For one, drug-induced relief from anxiety may reduce clients’ motivation to try to solve their problems. For another, medicated clients who develop skills for coping with stress in psychotherapy may fail to retain what they have learned once the tranquilizers are discontinued or find themselves too tense to employ their newly acquired skills.

Rebound anxiety is another problem associated with regular use of tranquilizers. Many people who regularly use antianxiety drugs report that anxiety or insomnia returns in a more severe form once they discontinue them. For some, this may represent a fear of not having the drugs to depend on. For others, rebound anxiety might reflect changes in biochemical processes that are not well understood at present.

Antipsychotic Drugs Antipsychotic drugs, also called *neuroleptics*, are commonly used to treat the more flagrant features of schizophrenia and other psychotic disorders, such as hallucinations, delusions, and states of confusion. Introduced during the 1950s, many of these drugs, including *chlorpromazine* (Thorazine), *thioridazine* (Mellaril), and *fluphenazine* (Prolixin), belong to the *phenothiazine* class of chemicals. Phenothiazines appear to control psychotic features by blocking the action of the neurotransmitter dopamine at receptor sites in the brain. Although the underlying causes of schizophrenia remain unknown, researchers suspect an irregularity in the dopamine system in the brain may be involved (see Chapter 12). *Clozapine* (Clozaril), a neuroleptic of a different chemical class than the phenothiazines, is effective in treating many people with schizophrenia whose symptoms were unresponsive to other neuroleptics (see Chapter 12). The use of clozapine must be carefully monitored, however, because of potentially dangerous side effects.

The use of neuroleptics has greatly reduced the need for more restrictive forms of treatment for severely disturbed patients, such as physical restraints and confinement in padded cells, and has lessened the need for long-term hospitalization. The introduction of the first generation of antipsychotic drugs in the mid-1950s was one of the major factors that led to a massive exodus of chronic mental patients from state institutions. Many formerly hospitalized patients have been able to resume family life and hold jobs while continuing to take their medications.

Neuroleptics are not without their problems, including potential side effects such as muscular rigidity and tremors. Although these side effects are generally controllable by use of other drugs, long-term use of antipsychotic drugs (possibly excepting *clozapine*) can produce a potentially irreversible and disabling motor disorder called *tardive dyskinesia* (see Chapter 12), which is characterized by uncontrollable eye blinking, facial grimaces, lip smacking, and other involuntary movements of the mouth, eyes, and limbs. Researchers are experimenting with lowered dosages, intermittent drug regimens, and new medications to reduce the risk of such complications.

Antidepressants We have three major classes of antidepressants in use today: *tricyclics* (TCAs), *monoamine oxidase (MAO) inhibitors*, and *selective serotonin-reuptake inhibitors* (SSRIs). Tricyclics and MAO inhibitors increase the availability of the neurotransmitters norepinephrine and serotonin in the brain. Some of the more common tricyclics are *imipramine* (Tofranil), *amitriptyline* (Elavil), and *doxepin* (Sinequan). The MAO inhibitors include such drugs as *phenelzine* (Nardil). Tricyclic antidepressants (TCAs) are favored over MAO inhibitors because they cause fewer potentially serious side effects.

The third class of antidepressants, selective serotonin-reuptake inhibitors, or SSRIs, have more specific effects on serotonin function in the brain. Drugs in this class include *fluoxetine* (Prozac) and *sertraline* (Zoloft). They increase the availability of serotonin in the brain by interfering with its reuptake by the transmitting neuron.

Slightly more than half of depressed patients treated with antidepressants of the tricyclic class respond favorably (Depression Guideline Panel, 1993b). Bear in mind that a favorable response to treatment does not mean depression is relieved, however. Overall, the effects of antidepressants appear to be modest at best, with full remission of symptoms in only about one in three patients treated in the first round of antidepressant medication (Lespérance et al., 2007; Rush et al., 2006). Perhaps another 5% to 10% of patients will show remission if then switched to other antidepressant drugs (Nelson, 2006). Nor is any particular antidepressant clearly more effective than any other (Depression Guideline Panel, 1993b). Even Prozac, which some hailed as a

rebound anxiety The experiencing of strong anxiety following withdrawal from a tranquilizer.

antipsychotic drugs Drugs used to treat schizophrenia or other psychotic disorders.

antidepressants Drugs used to treat depression that affect the availability of neurotransmitters in the brain.

TRUTH or FICTION

Antidepressants are used only to treat depression.

✓ **FALSE.** Antidepressants have many psychiatric uses, including treatment of many anxiety disorders and bulimia.



Electroconvulsive therapy (ECT). ECT is helpful in many cases of severe or prolonged depression that do not respond to other forms of treatment. Still, its use remains controversial.

electroconvulsive therapy (ECT) A method of treating severe depression by administering electrical shock to the head.

TRUTH OR FICTION

Sending jolts of electricity into a person's brain can often help relieve severe depression.

✓ **TRUE.** Severely depressed people who have failed to respond to other treatments often show rapid improvement from electroconvulsive therapy.

“wonder drug,” produces about the same level of therapeutic benefit as the older generation of antidepressants, the TCAs. Prozac and other SSRIs may be preferred, however, because they are associated with fewer side effects, such as weight gain, and have a lower risk of lethal overdoses than the older tricyclics.

Antidepressants also have beneficial effects in treating a wide range of psychological disorders, including panic disorder, social phobia, obsessive–compulsive disorder (see Chapter 6), and bulimia, a type of eating disorder (see Chapter 10). As research into the underlying causes of these disorders continues, we may find that irregularities of neurotransmitter functioning in the brain plays a key role in their development.

Lithium Lithium carbonate, a salt of the metal lithium in tablet form, helps stabilize the dramatic mood swings in many cases of people with bipolar disorder (formerly *manic depression*) (see Chapter 8). People with bipolar disorder may have to continue using lithium indefinitely to control the disorder. Because of potential toxicity associated with lithium, the blood levels of patients maintained on the drug must be carefully monitored.

Table 4.4 lists psychotropic drugs according to their drug class and category.

Electroconvulsive Therapy

In 1939, the Italian psychiatrist Ugo Cerletti introduced the technique of **electroconvulsive therapy (ECT)** in psychiatric treatment. Cerletti had observed the practice in some slaughterhouses of using electric shock to render animals unconscious. He observed that the shocks also produced convulsions. Cerletti incorrectly believed, as did other researchers in Europe at the time, that convulsions of the type found in epilepsy were incompatible with schizophrenia and that a treatment method that induced convulsions might be used to cure schizophrenia.

After the introduction of the phenothiazines in the 1950s, the use of ECT became generally limited to the treatment of severe depression. The introduction of antidepressants has limited the use of ECT even further today. However, evidence indicates that many people with major depression who have failed to respond to antidepressants do show significant improvement following ECT (Ebmeier, Donaghey, & Steele, 2006; UK ECT Review Group, 2003).

ECT remains a source of controversy for several reasons. First, many people, including many professionals, are uncomfortable about the idea of passing an electric shock through a person's head, even if the level of shock is closely regulated and the convulsions are controlled by drugs. Second, ECT carries potential side effects, including some memory loss. Permanent loss of memory may occur for events that happen during the months that precede ECT and for several weeks afterwards (Glass, 2001). Third, the relative effectiveness of ECT, as compared to antidepressant drugs and to alternative treatments, such as cognitive-behavioral therapy, remains under study. Fourth, no one yet knows why ECT works, although it is suspected that it might help correct neurotransmitter imbalances in the brain. Finally, ECT is associated with a high rate of relapse following treatment (Sackeim et al., 2001, 2004).

Although controversies concerning the use of ECT persist, increasing evidence supports its effectiveness in helping people with severe depression, including cases in which depressed people fail to respond to psychotherapy or antidepressant medication (Sackeim et al., 2001). ECT is generally considered a treatment of last resort, after less-intrusive methods have been tried and failed.

TABLE 4.4

Major Psychotropic Drugs

	Generic Name	Brand Name	Clinical Uses	Possible Side Effects or Complications
Antianxiety Drugs	Diazepam Chlordiazepoxide Lorazepam Alprazolam	Valium Librium Ativan Xanax	Treatment of anxiety and insomnia	Drowsiness, fatigue, impaired coordination, nausea
Antidepressant Drugs	Tricyclics			
	Imipramine Desipramine Amitriptyline Doxepin	Tofranil Norpramin Elavil Sinequan	Depression, bulimia, panic disorder	Changes in blood pressure, heart irregularities, dry mouth, confusion, skin rash
	MAO Inhibitors			
	Phenelzine	Nardil	Depression	Dizziness, headache, sleep disturbance, agitation, anxiety, fatigue
	Selective Serotonin-Reuptake Inhibitors			
	Fluoxetine Sertraline Paroxetine Citalopram	Prozac Zoloft Paxil Celexa	Depression, bulimia, panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder (Zoloft), social anxiety (Paxil)	Nausea, diarrhea, anxiety, insomnia, sweating, dry mouth, dizziness, drowsiness
	Other Antidepressant Drugs			
	Bupropion	Wellbutrin, Zyban	Depression, nicotine dependence	Dry mouth, insomnia, headaches, nausea, constipation, tremors
	Venlafaxine	Effexor	Depression	Nausea, constipation, dry mouth, drowsiness, insomnia, dizziness, anxiety
Antipsychotic Drugs	Phenothiazines			
	Chlorpromazine Thioridazine Trifluoperazine Fluphenazine	Thorazine Mellaril Stelazine Prolixin	Schizophrenia and other psychotic disorders	Movement disorders (e.g., tardive dyskinesia), drowsiness, restlessness, dry mouth, blurred vision, muscle rigidity
	Other Antipsychotic Drugs			
	Haloperidol	Haldol	Schizophrenia and other psychotic disorders	Similar to phenothiazines
	Clozapine	Clozaril	Schizophrenia and other psychotic disorders	Potentially lethal blood disorder, seizures, fast heart rate, drowsiness, dizziness, nausea
	Risperidone	Risperdal	Schizophrenia and other psychotic disorders	Feeling unable to sit still, constipation, dizziness, drowsiness, weight gain
	Olanzapine	Zyprexa	Schizophrenia and other psychotic disorders	Low blood pressure, dizziness, drowsiness, heart palpitations, fatigue, constipation, weight gain
Antimanic Drugs	Lithium carbonate	Eskalith	Manic episodes and stabilization of mood swings associated with bipolar disorder	Tremors, thirst, diarrhea, drowsiness, weakness, lack of coordination
	Divalproex sodium	Depakote		Nausea, vomiting, dizziness, abdominal cramps, sleeplessness
Stimulant Drugs	Methylphenidate Amphetamine with dextroamphetamine	Ritalin Concerta Adderall	Childhood hyperactivity	Nervousness, insomnia, nausea, dizziness, heart palpitations, headache; may temporarily retard growth

Source: From Nevid, J. S., *Psychology: Concepts and Applications*, Second Edition (Boston: Houghton Mifflin, 2007), p. 574. Reprinted by permission.

Psychosurgery

Psychosurgery is yet more controversial than ECT and is rarely practiced today. Although no longer performed today, the most common form of psychosurgery was the *prefrontal lobotomy*. This procedure involved surgical severing of nerve pathways linking the thalamus to the prefrontal lobes of the brain. The operation was based on the theory that extremely disturbed patients suffer from overexcitation of emotional impulses emanating from lower brain centers, such as the thalamus and hypothalamus. It was believed that by severing the connections between the thalamus and the higher brain centers in the frontal lobe of the cerebral cortex, the patient's violent or aggressive tendencies could be controlled. The prefrontal lobotomy was developed by the Portuguese neurologist António Egas Moniz and was introduced to the United States in the 1930s. More than 1,000 mental patients received the operation by 1950. Although the operation did reduce violent and agitated behavior in many cases, it was not always successful. In a cruel ironic twist, a patient whom Moniz had treated later shot him, leaving him paralyzed from a bullet that lodged in his spine. The procedure was abandoned, in large part because it often produced serious complications and even deaths, and also because of the advent in the 1950s of psychiatric drugs that could be used to control violent or disruptive behavior.

Today, more sophisticated psychosurgery techniques have been introduced. Guided by a better understanding of brain circuitry involved in certain disorders, such as obsessive-compulsive disorder, these surgical techniques target smaller parts of the brain and produce less damage than the prefrontal lobotomy (Wichmann & Delong, 2005). These techniques have been used in treating some patients with severe forms of obsessive-compulsive disorder, bipolar disorder, and major depression that have not responded to other treatments (Kopell, Machado, & Rezai, 2005). Yet a debate continues over both the safety and efficacy of these procedures, so it is best to continue to classify them as experimental treatments (Anderson & Booker, 2006; Bejerot, 2003). Before leaving this topic, let us underscore that psychosurgery should only be considered as a treatment of last resort.

Evaluation of Biological Approaches

There is little doubt that biological treatments have helped many people with severe psychological problems. Many thousands of people with schizophrenia who were formerly hospitalized are able to function in the community because of antipsychotic drugs. Antidepressant drugs have helped relieve depression in many cases and have shown therapeutic benefits in treating other disorders, such as panic disorder, obsessive-compulsive disorder, and eating disorders. ECT is helpful in relieving depression in many people who have been unresponsive to other treatments.

On the other hand, some forms of psychotherapy may be as effective as drug therapy in treating anxiety disorders and depression (see Chapters 6 and 8). Moreover, problems such as side effects persist. In addition, antianxiety drugs, such as Valium, often become drugs of abuse among people who become dependent on them for relieving the effects of stress. Medical practitioners have often been too quick to use their prescription pads to help people with anxiety complaints, rather than to help them examine their lives or refer them for psychological treatment. Physicians often feel pressured, of course, by patients who seek a chemical solution to their life problems.

Although we continue to learn more about the biological foundations of abnormal behavior patterns, the interface between biology and behavior can be construed as a two-way street. Researchers have uncovered links between psychological factors and many physical disorders and conditions (see Chapter 5). Researchers are also investigating whether the combination of psychological and drug treatments for such problems as depression, anxiety disorders, and substance abuse disorders, among others, may increase the therapeutic benefits of either of the two approaches alone.

HOSPITALIZATION AND COMMUNITY-BASED CARE

People receive mental health services within various settings, including hospitals, outpatient clinics, community mental health centers, and private practices. In this section we explore the purposes of hospitalization and the movement toward community-based care. Due to **deinstitutionalization**—the policy of shifting the burden of care from state hospitals to community-based treatment settings—an exodus has taken place from state mental hospitals. We will see that deinstitutionalization has had a profound impact on the delivery of mental health services as well as on the larger community.

Roles for Hospitalization

Different types of hospitals provide different types of mental health treatment. State mental hospitals provide care to people with severe psychological problems. Municipal and community-based hospitals tend to focus on short-term care for people with serious psychological problems who need a structured hospital environment to help them through a crisis. In these kinds of cases, psychotropic drugs and other biological treatments, such as ECT for severe cases of depression, are often used in combination with short-term psychotherapy. Hospitalization may be followed by outpatient treatment. Many private psychiatric hospitals provide longer-term care or are specialized to help people withdraw safely from alcohol or drugs. Susanna, whose case opened this chapter, was treated in such a hospital for nearly two years.

Most state hospitals today are better managed and provide more humane care than those of the 19th and early 20th centuries, but here and there deplorable conditions persist. Today's state hospital is generally more treatment oriented and focuses on preparing residents to return to community living. State hospitals today often function as part of an integrated, comprehensive approach to treatment. They provide a structured environment for people who are unable to function in a less-restrictive community setting. When hospitalization restores patients to a higher level of functioning, the patients are reintegrated in the community and given follow-up care and transitional residences, if needed, to help them adjust to community living. Patients may be rehospitalized as needed in a state hospital if a community-based hospital is not available or if they require more extensive care. For younger and less intensely disturbed people, the state hospital stay is typically briefer than it was in the past, lasting only until their condition allows them to reenter society. Older chronic patients may be unprepared to handle the most rudimentary tasks (shopping, cooking, cleaning, and so on) of independent life, however—in part because the state hospital may be the only home such patients have known as adults.

The Community Mental Health Center

Community mental health centers (CMHCs) perform many functions in the effort to reduce the need for hospitalization of new patients and rehospitalization of formerly hospitalized patients. A primary function of the CMHC is to help discharged mental patients adjust to the community by providing continuing care and closely monitoring their progress. Unfortunately, not enough CMHCs have been established to serve the needs of the hundreds of thousands of formerly hospitalized patients and to prevent the need to hospitalize new patients by providing intervention services and day hospital programs. Patients in *day hospitals* attend structured therapy and vocational rehabilitation programs in a hospital setting during the day, but are returned to their families or homes at night. Many CMHCs also administer transitional treatment facilities in the community, such as *halfway houses*. Halfway houses provide a sheltered living environment to help discharged mental patients gradually adjust to the community as well as to offer people in crisis an alternative to hospitalization. CMHCs also provide consultative services to other professionals, such as training police officers to handle disturbed people. One of the major functions of the community mental health center is

deinstitutionalization The policy of shifting care for patients with severe or chronic mental health problems from inpatient facilities to community-based facilities.



The Mental hospital. Under the policy of deinstitutionalization, mental hospitals today provide a range of services, including short-term treatment of people in crisis or in need of a secure treatment setting. They also provide long-term treatment in a structured environment for people who are unable to function in less-restrictive community settings.

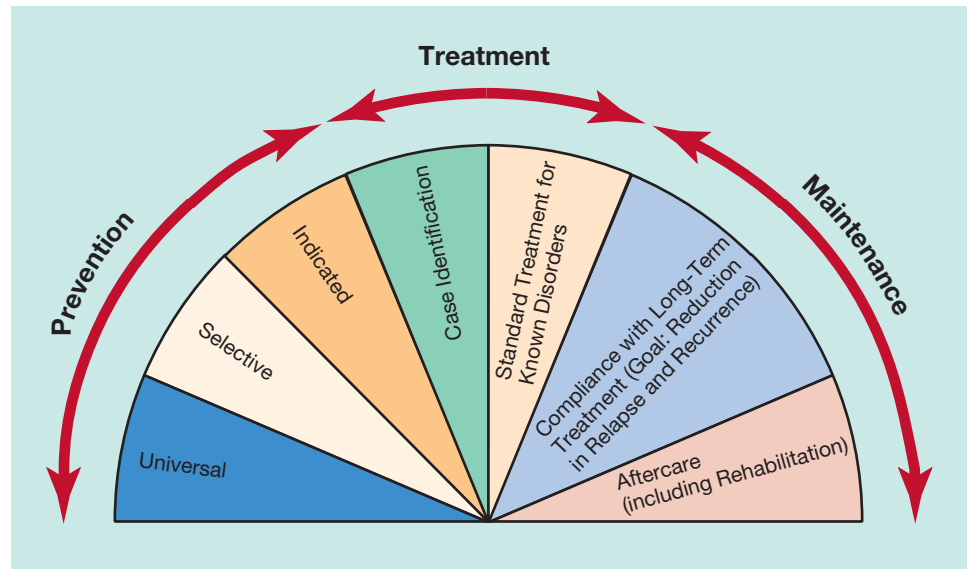


FIGURE 4.2 The mental health intervention spectrum for mental disorders.

Source: Mazrek, P. J., & Haggerty, R. J., *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Copyright © 1994 by the National Academy of Sciences. Courtesy of the National Academy Press, Washington, DC. Reprinted with permission.

prevention. “An ounce of prevention is worth a pound of cure,” so goes the saying. In medical science, vaccines prevent people from contracting such diseases as smallpox and polio. In the mental health system, however, resources are generally directed toward treating mental health problems rather than attempting to prevent them from developing. However, a report by the prestigious Institute of Medicine (IOM) called for increased support for research on prevention and for programs to promote psychological well-being and reduce the risks of mental health disorders (Muñoz, Mrazek, & Haggerty, 1996).

The Spectrum of Prevention Traditionally, the term *prevention* has been applied to interventions that run the gamut from programs designed to prevent the onset of mental disorders to those that attempt to reduce the impact of disorders once they develop. The IOM report limits the term *prevention* to interventions that occur before the onset of a diagnosable disorder. Interventions focusing on lessening the impact of already developed disorders are classified as *treatment interventions* rather than prevention.

The IOM report conceptualizes a mental health spectrum of interventions ranging from prevention efforts through treatment and maintenance interventions (see Figure 4.2). Three categories of prevention programs are identified: universal, selective, and indicated.

Universal preventive interventions are targeted toward the whole population or general public, and include programs designed to enhance prenatal health or childhood nutrition. *Selective preventive interventions* are targeted toward individuals or groups known to be at higher than average risk of developing mental disorders, such as children of schizophrenic parents. **Primary prevention** efforts—programs designed to prevent problems from arising—can be either universal or selective, depending on whether they are focused on the general population or “at-risk” groups.

Indicated preventive interventions are directed toward individuals with early signs or symptoms that foreshadow the development of a mental disorder but don’t yet meet diagnostic criteria for the particular disorder. This form of prevention, commonly called **secondary prevention**, attempts to nip in the bud developing problems. For example, secondary preventive programs aimed at changing the drinking habits of

primary prevention Efforts designed to prevent problems from arising.

secondary prevention Efforts to ameliorate existing problems at an early stage.

high-risk drinkers or early problem drinkers may forestall the onset of more severe alcohol-related problems or alcohol dependence (Botelho & Richmond, 1996; Marlatt et al., 1998).

We now have ample evidence supporting the effectiveness of prevention interventions across a range of problem outcomes of concern to society (Barrar & Sandler, 2006; Cuijpers, Van Straten, & Smit, 2005). For example, evidence supports the benefits of prevention interventions in the following:

- Reducing depression in at-risk teens (Lynch et al., 2005);
- Preventing problems in children from divorced families (Tein et al., 2004)
- Reducing risks of eating disorder in college-age women (Stice et al., 2007; Taylor et al., 2006)
- Reducing risk of HIV transmission in at-risk population groups (Albarracín, Durantini, & Ear, 2006; DiClemente et al., 2004; Durantini et al., 2006)

Psychologist Martin Seligman and his colleagues have shown that teaching cognitive skills involved in disputing catastrophic, negative thoughts reduced the risk of depression in both college students and school-age children (Jaycox et al., 1994; Seligman, 1998). Still, we have much to learn about developing effective prevention programs to prevent psychological disorders. To develop effective preventive programs we must expand our knowledge of the underlying causes of these disorders as well as mount controlled investigations to examine ways of preventing them.

The challenge of preventing psychological disorders is before us. The question is whether the nation can muster the political will and financial resolve to meet the challenge.

Ethnic Group Differences in Use of Mental Health Services

A report by the U.S. Surgeon General concluded that members of racial and ethnic minority groups typically have less access to mental health care and receive lower-quality care than do other Americans (USDHHS, 2001; see Table 4.5). A major reason for this disparity is that a disproportionate number of minority group members remain



An ounce of prevention. Obtaining good prenatal care can help prevent health problems in both the mother and the fetus. Mental health professionals face the challenge of developing programs to reduce the risks of psychological disorders.

TABLE 4.5

Culture, Race, Ethnicity, and Mental Health: Major Findings of the Surgeon General’s Report

<ul style="list-style-type: none">• The percentage of African Americans receiving needed care for mental health problems is only half that of non-Hispanic Whites. African Americans have less access to mental health care than Whites, partly because a greater percentage of African Americans lack health insurance.
<ul style="list-style-type: none">• Of all American ethnic groups, Hispanic Americans are the least likely to have health insurance. Moreover, the limited availability of Spanish-speaking mental health professionals means that many Hispanic Americans who speak little or no English lack the opportunity to receive care from linguistically similar treatment providers.
<ul style="list-style-type: none">• Largely because of lingering stigma and shame associated with mental illness, Asian Americans/Pacific Islanders often fail to seek care until their problems are more advanced than is the case with other groups. Moreover, accessibility is limited by scarcity of treatment providers with appropriate language skills.
<ul style="list-style-type: none">• American Indians/Alaska Natives have a suicide rate that is 50% higher than the national average, but little is known about how many people within these groups receive needed care. In addition, the rural, isolated locations in which many Native Americans live places a severe constraint on the availability of mental health services.

Source: Adapted from Stenson, 2001a; USDHHS, 2001.

uninsured or underinsured, leaving them unable to afford mental health care. Consequently, minorities shoulder a greater burden of mental health problems that go undiagnosed and untreated (Neighbors et al., 2007; Stenson, 2001a).

Cultural factors are yet another reason for underutilization of mental health services by minority groups (Sanders Thompson et al., 2004). Mental health clinics are not typically the first places where African Americans go for help for emotional problems. They are more likely to turn first to the church and second to the emergency room of the local general hospital (Lewis-Hall, 1992). The National Survey of African Americans found that slightly more than half (54%) of those who reported experiencing feelings of a “nervous breakdown” failed to consult any type of professional for help with their problems (Neighbors, 1992). Another study found that only about 1 in 10 African Americans in a community-based sample who experienced major depression consulted a mental health professional (D. R. Brown, Ahmed, Gary, & Milburn, 1995).

Latinos who encounter emotional problems are more likely to seek assistance from friends and relatives or from spiritualists than to reach out to mental health facilities, which they perceive as cold and impersonal (De La Cancela & Guzman, 1991). Latinos are also more likely to seek assistance for emotional problems from primary-care physicians than from psychologists or psychiatrists, in part to avoid the perceived stigma of consulting a mental health provider (Kouyoumdjian, Zamboanga, & Hansen, 2003). Asian Americans/Pacific Islanders are also less likely than Euro Americans to seek help from mental health providers (Breau, Matsuoka, & Ryujin, 1995).

We may better understand low rates of utilization of outpatient mental health services by ethnic minorities by examining the barriers that exist to receiving treatment, which include the following (adapted from Cheung, 1991; USDHHS, 1999a; Woodward, Dwinell, & Arons, 1992):

1. *Cultural mistrust.* People from minority groups often fail to use mental health services because of a lack of trust (Sanders Thompson et al., 2004). Mistrust may stem from a cultural or personal history of oppression, discrimination, or experiences in which service providers were unresponsive to their needs. When ethnic minority clients perceive majority therapists and the institutions in which they work to be cold or impersonal, they are less likely to place their trust in them.
2. *Institutional barriers.* Facilities may be inaccessible to minority group members because they are located at a considerable distance from their homes or because of lack of public transportation. Most facilities operate only during daytime work hours, which means they are inaccessible to working people. Moreover, minority group members feel staff members often make them feel stupid for not being familiar with clinic procedures, and their requests for assistance often become tangled in red tape.
3. *Cultural barriers.* Many recent immigrants, especially those from Southeast Asian countries, have had little, if any, previous contact with mental health professionals. They may hold different conceptions of mental health problems or view mental health problems as less severe than physical problems. In some ethnic minority subcultures, the family is expected to take care of members who have psychological problems and may resist seeking outside assistance. Other cultural barriers include cultural differences between typically lower socioeconomic strata minority group members and mostly White, middle-class staff members and incongruence between the cultural practices of minority group members and techniques used by mental health professionals. For example, Asian immigrants may find little value in talking about their problems or may be uncomfortable expressing their feelings to strangers. In many ethnic minority groups, personal and interpersonal problems are brought to trusted elders in the family or religious leaders, not to outside professionals. In light of these fac-

tors, it is not surprising to find evidence that East Asian immigrants who are willing to seek psychological treatment tend to be older, more assimilated, and have better proficiency in English than their peers (Barry & Grilo, 2002).

4. *Language barriers.* Differences in language make it difficult for minority group members to describe their problems or obtain needed services. Many mental health facilities lack staff members who can communicate in the languages used by ethnic minority residents in their communities (Biever et al., 2002).
5. *Economic and accessibility barriers.* As mentioned earlier, financial burdens are often a major barrier to utilization of mental health services by ethnic minorities, many of whom live in economically distressed areas (Sanders Thompson et al., 2004). Moreover, many minority group members live in rural or isolated areas where mental health services may be lacking or inaccessible (USDHHS, 2001).

Cheung (1991) concludes that greater utilization of mental health services will depend to a great extent on the ability of the mental health system to develop programs that take cultural factors into account and build staffs that consist of culturally sensitive providers, including minority mental health professionals and paraprofessionals. Cultural mistrust of the mental health system among minority group members may be grounded in the perception that many mental health professionals are racially biased in how they evaluate and treat members of minority groups. Let's take a closer look at whether the evidence bears out this perception.

Racial Stereotyping and the Mental Health System

If you are African American, you are more likely to be admitted to a mental hospital and more likely to be involuntarily committed than if you are White (Lindsey & Paul, 1989). You are also more likely to be diagnosed with schizophrenia (Coleman & Baker, 1994; USDHHS, 1999a). The question is, *why*?

Relationships between ethnicity and diagnostic and admission practices are complex. They depend in part on differences in rates of mental disorders among different ethnic groups. If the rate of a given disorder is higher in a particular group, then it stands to reason that more members of the group will be diagnosed with the disorder. We know that African Americans as a group are no more likely to develop schizophrenia, a severe psychological disorder that often leads to hospitalization, than are Euro Americans of the same socioeconomic level (USDHHS, 1999a). However, we also know that African Americans are overrepresented among lower socioeconomic groups in our society, and people in the lower strata on the socioeconomic ladder are more likely to have severe psychological disorders, such as schizophrenia. Thus, differences in socioeconomic backgrounds offer at least a partial explanation of ethnic/racial differences in diagnostic practices and rates of psychiatric hospitalization.

Ethnic stereotyping by mental health professionals may also contribute to an overdiagnosis of severe psychological problems requiring hospitalization. For example, although African Americans and Hispanic Americans are more likely than Euro Americans to be diagnosed with schizophrenia, independent assessment of patients does not justify such differences in rates of diagnosis (Garb, 1997; Lawson et al., 1994). This evidence strongly suggests that bias comes into play in diagnosing members of ethnic minority groups. African Americans are also more likely than Euro Americans to receive psychiatric medication, including antipsychotic medication (Segal, Bola, & Watson, 1996). Investigators believe that clinician biases rather than clinical criteria may account for differences in prescription patterns (Frackiewicz et al., 1999).

How might bias affect a clinician's clinical judgments? As the Surgeon General's report on mental health points out, diagnostic and treatment decisions in mental health settings are based more on behavioral signs and patient reporting of symptoms than on more objective laboratory tests (USDHHS, 1999a). Consequently, clinician judgment plays an important role in determining whether someone receives a schizophrenia diagnosis and is deemed to be in need of hospitalization or antipsychotic medication.

Evaluation of Deinstitutionalization

Let us return to the issue of deinstitutionalization. Has this policy achieved its goal of successfully reintegrating mental patients into society, or does it remain a promise that is largely unfulfilled? Deinstitutionalization has often been criticized for failing to live up to its expectations. The criticism seems to be well founded. Among the most frequent criticisms is the charge that many hospital patients were merely dumped into the community and not provided with the community-based services they needed to adjust to demands of community living. A 1998 national study found that fewer than half of patients with schizophrenia were receiving adequate care (Winerip, 1999).

Though the community mental health movement has had some successes, a great many patients with severe and persistent mental health problems fail to receive the range of mental health and social services they need to adjust to life in the community (Jacobs, Newman, & Burns, 2001). One of the major challenges facing the community mental system is the problem of psychiatric homelessness (Folsom et al., 2005).

Deinstitutionalization and the Psychiatric Homeless Population The federal government estimates that about one-third of homeless adults in the United States suffer from severe psychological disorders (NIH, 2003). Many formerly hospitalized mental patients were essentially dumped into local communities after discharge and left with little if any support. Lacking adequate support, they often face more dehumanizing conditions on the street, under deinstitutionalization, than they did in the hospital. Many compound their problems by turning to illegal street drugs such as crack. Also, some of the younger psychiatric homeless population might have been hospitalized in earlier times but are now, in the wake of deinstitutionalization, directed toward community support programs when they are available.

The lack of available housing and transitional care facilities and effective case management plays an important role in homelessness among people with psychiatric problems (Folsom et al., 2005). Some homeless people with severe psychiatric problems are repeatedly hospitalized for brief stays in community-based hospitals during acute episodes. They move back and forth between the hospital and the community as though caught in a revolving door. Frequently, they are released from the hospital with inadequate arrangements for housing and community care. Some are left essentially to fend for themselves. Although many state hospitals closed their doors and others slashed the number of beds, the states never funded the support services in the community that were supposed to replace the need for long-term hospitalization (Winerip, 1999).

Problems of homelessness are especially severe for children. Not surprisingly, homeless children tend to have more behavior problems than housed children (Schteingart et al., 1995). The problem of psychiatric homelessness is not limited to urban areas, although it is on our city streets that the problem is most visible. The pattern in rural areas tends to be one of inconsistent housing and unstable living arrangements, rather than outright homelessness (Drake et al., 1991).

The mental health system alone does not have the resources to resolve the multifaceted problems faced by the psychiatric homeless population. Helping the psychiatric



The problem of psychiatric homelessness. Many homeless people have severe psychological problems but fall through the cracks of the mental health and social service systems.

homeless escape from homelessness requires an integrated effort involving mental health and alcohol and drug abuse programs; access to decent, affordable housing; and provision of other social services (Rosenheck, Kaspro et al., 2003). It also requires effective means of evaluating the mental health needs of homeless people and matching services to their specific needs (Jacobs, Newman, & Burns, 2001; Tolomiczenko, Sota, & Goering, 2000).

Another difficulty in meeting the challenge of psychiatric homelessness is that homeless people with severe psychological problems typically do not seek out mental health services. More intensive outreach and intervention efforts that focus on helping homeless people connect with the services they need are likely to produce the best outcomes (Coldwell & Bender, 2007; Rosenheck, 2000). All in all, the problems of the psychiatric homeless population remain complex, vexing problems for the mental health system and society at large.

Deinstitutionalization: A Promise as Yet Unfulfilled Although the net results of deinstitutionalization may not yet have lived up to expectations, a number of successful community-oriented programs are available. However, they remain underfunded and unable to reach many people needing ongoing community support. If deinstitutionalization is to succeed, patients need continuing care and opportunities for decent housing, gainful employment, and training in social and vocational skills.

New, promising services exist to improve community-based care for people with chronic psychological disorders—for example, psychosocial rehabilitation centers, family psychoeducational groups, supportive housing and work programs, and social skills training. Unfortunately, too few of these services exist to meet the needs of many patients who might benefit from them. The community mental health movement continues to need expanded community support and adequate financial resources if it is to succeed in fulfilling its original promise.

SUMMING UP

Types of Helping Professionals

How do the three major groups of mental health professionals—clinical psychologists, psychiatrists, and psychiatric social workers—differ in their training backgrounds? Clinical psychologists complete graduate training in clinical psychology, typically at the doctoral level. Psychiatrists are medical doctors who specialize in psychiatry. Psychiatric social workers are trained in graduate schools of social work or social welfare, generally at the master's level.

Psychotherapy

What is psychotherapy? Psychotherapy involves a systematic interaction between a therapist and clients that incorporates psychological principles to help clients overcome abnormal behavior, solve problems in living, or develop as individuals.

What is psychodynamic therapy? Psychodynamic therapy originated with psychoanalysis, the approach to treatment developed by Freud. Psychoanalysts use techniques such as free association and dream analysis to help people gain insight into their unconscious conflicts and work through them in the light of their

adult personalities. Contemporary psychodynamic therapy is typically briefer and more direct in its approach to exploring the patient's defenses and transference relationships.

What is behavior therapy? Behavior therapy applies the principles of learning to help people make adaptive behavioral changes. Behavior therapy techniques include systematic desensitization, gradual exposure, modeling, operant conditioning approaches, and social skills training. Cognitive-behavioral therapy integrates behavioral and cognitive approaches in treatment.

What is humanistic therapy? Humanistic therapy focuses on the client's subjective, conscious experience in the here and now. Rogers's person-centered therapy helps people increase their awareness and acceptance of inner feelings that had met with social condemnation and been disowned. The effective person-centered therapist possesses the qualities of unconditional positive regard, empathy, genuineness, and congruence.

What are two major approaches to cognitive therapy? Cognitive therapy focuses on modifying the maladaptive cognitions believed to underlie emotional problems and self-defeating

behavior. Ellis's rational emotive behavior therapy focuses on disputing irrational beliefs that occasion emotional distress and substituting adaptive beliefs and behavior. Beck's cognitive therapy focuses on helping clients identify, challenge, and replace distorted cognitions, such as tendencies to magnify negative events and minimize personal accomplishments.

What is cognitive-behavioral therapy? Cognitive-behavioral therapy is a broader form of behavior therapy that integrates cognitive and behavioral techniques in treatment.

What are the two major forms of eclectic therapy? These are technical eclecticism, a pragmatic approach that draws on techniques from different schools of therapy without necessarily subscribing to the theoretical positions represented by these schools, and integrative eclecticism, an approach that attempts to synthesize and integrate diverse theoretical approaches in an integrative model of therapy.

What are the general aims of group therapy, family therapy, and couple therapy? Group therapy provides opportunities for mutual support and shared learning experiences within a group setting to help individuals overcome psychological difficulties and develop more adaptive behaviors. Family therapists work with conflicted families to help them resolve their differences. Family therapists focus on clarifying family communications, resolving role conflicts, guarding against scapegoating individual members, and helping members develop greater autonomy. Couple therapists focus on helping couples improve their communications and resolve their differences.

Does psychotherapy work? Evidence from meta-analyses of psychotherapy outcome studies that compare psychotherapy with control groups supports the value of various approaches to psychotherapy. The question of whether there are differences in the effectiveness of different types of psychotherapy remains under study.

Biomedical Therapies

What are the major biomedical approaches to treating psychological disorders, and how effective are they? The

major biomedical therapies are drug therapy and electroconvulsive therapy (ECT). Antianxiety drugs, such as Valium, may relieve short-term anxiety but do not directly help people solve their problems or cope with stress. Antipsychotic drugs help control flagrant psychotic symptoms, but regular use of these drugs is associated with the risk of serious side effects. Antidepressants can help relieve depression, and lithium is helpful in many cases in stabilizing mood swings in people with bipolar disorder. ECT often leads to dramatic relief from severe depression. Psychosurgery has all but disappeared as a form of treatment because of adverse consequences.

Hospitalization and Community-Based Care

What roles do mental hospitals and community mental health centers play in the mental health system? Mental hospitals provide structured treatment environments for people in acute crisis and for those who are unable to adapt to community living. Community mental health centers seek to prevent the need for psychiatric hospitalization by providing intervention services and alternatives to full hospitalization.

What factors account for underutilization of mental health services by racial or ethnic minorities in the United States? These include cultural factors regarding preferences for other forms of help, cultural mistrust of the mental health system, cultural barriers, linguistic barriers, and economic and accessibility barriers.

How successful is the policy of deinstitutionalization? Deinstitutionalization has greatly reduced the population of state mental hospitals, but it has not yet fulfilled its promise of providing the quality of care needed to restore discharged patients to a reasonable quality of life in the community. One example of the challenges yet to be met are the many homeless people with severe psychological problems who are not receiving adequate care in the community.

KEY TERMS

psychotherapy (p. 104)
nonspecific treatment factors (p. 107)
psychoanalysis (p. 107)
psychodynamic therapy (p. 107)
free association (p. 107)
transference relationship (p. 108)
countertransference (p. 108)
behavior therapy (p. 110)
systematic desensitization (p. 110)
gradual exposure (p. 110)
modeling (p. 111)
token economy (p. 111)
person-centered therapy (p. 111)

unconditional positive regard (p. 112)
empathy (p. 112)
genuineness (p. 112)
congruence (p. 112)
cognitive therapy (p. 113)
rational emotive behavior therapy (REBT) (p. 113)
cognitive-behavioral therapy (CBT) (p. 116)
eclectic therapy (p. 117)
group therapy (p. 118)
family therapy (p. 118)
couple therapy (p. 118)

managed care systems (p. 122)
psychopharmacology (p. 126)
antianxiety drugs (p. 126)
tolerance (p. 126)
rebound anxiety (p. 127)
antipsychotic drugs (p. 127)
antidepressants (p. 127)
electroconvulsive therapy (ECT) (p. 128)
deinstitutionalization (p. 131)
primary prevention (p. 132)
secondary prevention (p. 132)

MEDIA TOOLS

A variety of digital and online learning tools are available to enrich your learning experience and help you succeed in the course. These resources include:

- **MyPsychLab**, an online learning system for your course in abnormal psychology that allows you to test your mastery of concepts in the book by using chapter-by-chapter diagnostic tests. Results from the diagnostic tests help you build a customized study plan. To access **MyPsychLab**, visit www.prenhall.com/mypsychlab and follow the instructions on the site.
- **“Speaking Out” Patient Interviews**, a set of video case examples of actual patients you can access on the companion CD-ROM included with the text. Icons in the margins of the chapter highlight the video case examples included on the CD-ROM.
- **Companion Web site**, an online study center that offers computer-scored quizzes you can use to test your knowledge, along with other study tools and links to related sites to enhance your learning of abnormal psychology. To access the companion Web site, visit www.prenhall.com/nevid and use the various tabs and links on the site to access these learning resources.