



## *Gateway* THEME

Psychotherapies are based on a common core of therapeutic principles. Medical therapies treat the physical causes of psychological disorders. In many cases, these approaches are complementary.

# Therapies

## Paddle Like a Duck

**Joe stared at some ducks** through the blinds in his psychology professor's office. They were quacking as they explored the campus pond. As psychologists, we meet many students with personal problems. Still, Joe's teacher was surprised to see him at her office door. His excellent work in class and his healthy, casual appearance left her unprepared for his first words. "I feel like I'm losing my mind," he said. "Can I talk to you?"

Over the next hour, Joe described his own personal hell. In a sense, he was like the ducks outside, appearing peaceful on the surface, but madly paddling underneath. He was working hard to hide a world of crippling fear, anxiety, and depression. At work, he was deathly afraid of talking to coworkers and customers. His social phobia led to frequent absenteeism and embarrassing behavior. At school, Joe felt "different" and was sure that other students could tell he was "weird." Several disastrous romances had left him terrified of women. Lately, he had been so depressed that he thought of suicide.

Joe's request for help was a turning point. At a time when he was becoming his own worst enemy, Joe realized he needed help. In Joe's case, that person was a talented clinical psychologist to whom his teacher referred him. With psychotherapy (and some temporary help from an antidepressant medication), the psychologist was able to help Joe come to grips with his emotions and regain his balance.

This chapter discusses methods used to alleviate problems like Joe's. We will begin with a look at the origins of modern therapy before describing therapies that emphasize the value of viewing personal problems with *insight* and *changing thought patterns*. Then, we will focus on *behavior therapies*, which directly change troublesome actions. After that, we will explore *medical therapies*, which are based on psychiatric drugs and other physical treatments. We conclude with a look at some contemporary issues in therapy.

## Gateway QUESTIONS

- |  |   |
|--|---|
| 15.1 How did psychotherapy originate?                          | 15.8 How do psychiatrists treat psychological disorders?  |
| 15.2 Is Freudian psychoanalysis still used?                    | 15.9 Are various psychotherapies effective, and what do they have in common?                                    |
| 15.3 How do psychotherapies differ?                            | 15.10 What will therapy be like in the future?  |
| 15.4 What are the major humanistic therapies?                  | 15.11 How are behavioral principles applied to everyday problems and how could a person find professional help? |
| 15.5 How does cognitive therapy change thoughts and emotions?  |   |
| 15.6 What is behavior therapy?                                 |   |
| 15.7 What role do operant principles play in behavior therapy? |   |

## Origins of Therapy— Bored Out of Your Skull

### Gateway Question 15.1: How did psychotherapy originate?

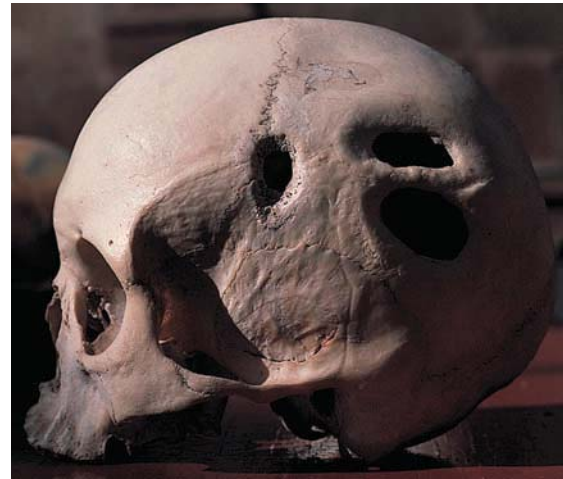
Fortunately, the odds are that you will *not* experience problems as serious as those of Joe, the student we just met. But if you did, what help is available? In most cases, it would be some form of **psychotherapy**, a psychological technique that can bring about positive changes in personality, behavior, or personal adjustment. It might, as with Joe, also include a medical therapy. Let's begin with a brief history of mental health care, including a discussion of psychoanalysis, the first fully developed psychotherapy.

Early treatments for mental problems give good reasons to appreciate modern therapies (Sharf, 2012). Archaeological findings dating to the Stone Age suggest that most primitive approaches were marked by fear and superstitious belief in demons, witchcraft, and magic. If Joe were unlucky enough to have been born several thousand years ago, his “treatment” might have left him feeling “bored.” You see, one of the more dramatic “cures” practiced by primitive “therapists” was a process called *trepanning* (treh-PAN-ing), also sometimes spelled *trephining* (Terry, 2006). In modern usage, trepanning is any surgical procedure in which a hole is bored in the skull. In the hands of primitive therapists, it meant boring, chipping, or bashing holes in a patient's head. Presumably, this was done to relieve pressure or release evil spirits (● Figure 15.1).

Joe would not have been much better off during the Middle Ages. Then, treatments for mental illness in Europe focused on **demonology**, the study of demons and persons plagued by spirits. Medieval “therapists” commonly blamed abnormal behavior on supernatural forces, such as possession by the devil, or on curses from witches and wizards. As a cure, they used exorcism to “cast out evil spirits.” For the fortunate, exorcism was a religious ritual. More often, physical torture was used to make the body an inhospitable place for the devil to reside.

One reason for the rise of demonology may lie in *ergotism* (AIR-got-ism), a psychotic-like condition caused by ergot poisoning. In the Middle Ages, rye (grain) fields were often infested with ergot fungus. Ergot, we now know, is a natural source of LSD and other mind-altering chemicals. Eating tainted bread could have caused symptoms that were easily mistaken for bewitchment or madness. Pinching sensations, muscle twitches, facial spasms, delirium, and hallucinations are all signs of ergot poisoning (Matossian, 1982). Modern analyses of “demonic possession” suggest that many victims may have been suffering from epilepsy, schizophrenia (Mirsky & Duncan, 2005), dissociative disorders (van der Hart, Lierens, & Goodwin, 1996), and depression (Thase, 2006). Thus, many people “treated” by demonologists may have been doubly victimized.

Then, in 1793, a French doctor named Philippe Pinel changed the Bicêtre Asylum in Paris from a squalid “madhouse” into a mental hospital by unchaining the inmates (Harris, 2003). Finally, the emotionally disturbed were



Danielle Pellegrini/Photo Researchers, Inc.

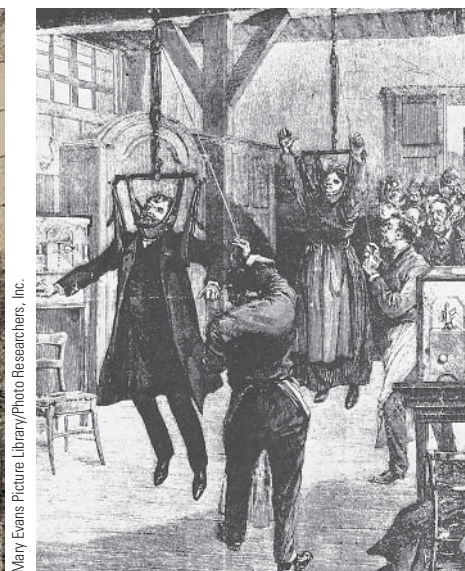
● **Figure 15.1** Primitive “treatment” for mental disorders sometimes took the form of boring a hole in the skull. This example shows signs of healing, which means the “patient” actually survived the treatment. Many didn't.

regarded as “mentally ill” and given compassionate treatment. Although it has been more than 200 years since Pinel began more humane treatment, the process of improving care continues today.

*When was psychotherapy developed?* The first true psychotherapy was created by Sigmund Freud little more than 100 years ago (Jacobs, 2003). As a physician in Vienna, Freud was intrigued by cases of **hysteria**. People suffering from hysteria have physical symptoms (such as paralysis or numbness) for which no physical causes can be found.

#### BRIDGES

Such problems are now called **somatoform disorders**, as discussed in Chapter 14, pages 499–501.



Many Events Picture Library/Photo Researchers, Inc.

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(left) Many early asylums were no more than prisons with inmates held in chains. (right) One late 19th-century “treatment” was based on swinging the patient in a harness—presumably to calm the patient's nerves.

Slowly, Freud became convinced that hysteria was related to deeply hidden unconscious conflicts and developed psychoanalysis in order to help patients gain insight into those conflicts (Knafo, 2009). Because it is the “granddaddy” of more modern therapies, let’s examine psychoanalysis in some detail.

## ▶ Psychoanalysis—Expedition into the Unconscious

**Gateway Question 15.2:** *Is Freudian psychoanalysis still used?*

*Isn’t psychoanalysis the therapy for which the patient lies on a couch?* Freud’s patients usually reclined on a couch during therapy, while Freud sat out of sight taking notes and offering interpretations. This procedure was supposed to encourage a free flow of thoughts and images from the unconscious. However, it is the least important element of psychoanalysis, and many modern analysts have abandoned it.

*How did Freud treat emotional problems?* Freud’s theory stressed that “neurosis” and “hysteria” are caused by repressed memories, motives, and conflicts—particularly those stemming from instinctual drives for sex and aggression. Although they are hidden, these forces remain active in the personality and cause some people to develop rigid ego defenses and compulsive, self-defeating behavior. Thus, the main goal of **psychoanalysis** is to reduce internal conflicts that lead to emotional suffering (Fayek, 2010).

Freud developed four basic techniques to uncover the unconscious roots of neurosis (Freud, 1949). These are *free association*, *dream analysis*, *analysis of resistance*, and *analysis of transference*.



Pioneering psychotherapist Sigmund Freud’s famous couch.

### Free Association

The basis for **free association** is saying whatever comes to mind without worrying whether ideas are painful, embarrassing, or illogical. Thoughts are simply allowed to move freely from one idea to the next, without self-censorship. The purpose of free association is to lower defenses so that unconscious thoughts and feelings can emerge (Hoffer & Youngren, 2004).

### Dream Analysis

Freud believed that dreams disguise consciously unacceptable feelings and forbidden desires in dream form (Rock, 2004). The psychoanalyst can use this “royal road to the unconscious” to help the patient work past the obvious, visible meaning of the dream (its *manifest content*) to uncover the hidden, symbolic meaning (its *latent content*). This is achieved by analyzing dream symbols (images that have personal or emotional meanings).

Suppose that a young man dreams of pulling a pistol from his waistband and aiming at a target as his wife watches. The pistol repeatedly fails to discharge, and the man’s wife laughs at him. Freud might have seen this as an indication of repressed feelings of sexual impotence, with the gun serving as a disguised image of the penis.

#### BRIDGES

See Chapter 5, pages 178–179 and 198–199, for more information of Freudian dream theory.

### Analysis of Resistance

When free associating or describing dreams, patients may *resist* talking about or thinking about certain topics. Such **resistances** (blockages in the flow of ideas) reveal particularly important unconscious conflicts. As analysts become aware of resistances, they bring them to the patient’s awareness so the patient can deal with them realistically. Rather than being roadblocks in therapy, resistances can be clues and challenges (Engle & Arkowitz, 2006).

- Psychotherapy** Any psychological technique used to facilitate positive changes in a person’s personality, behavior, or adjustment.
- Demonology** In medieval Europe, the study of demons and the treatment of persons “possessed” by demons.
- Hysteria** (now called somatoform disorders) An outdated term describing people with physical symptoms (such as paralysis or numbness) for which no physical causes can be found.
- Psychoanalysis** A Freudian therapy that emphasizes the use of free association, dream interpretation, resistances, and transference to uncover unconscious conflicts.
- Free association** In psychoanalysis, the technique of having a client say anything that comes to mind, regardless of how embarrassing or unimportant it may seem.
- Resistance** A blockage in the flow of free association; topics the client resists thinking or talking about.

## Analysis of Transference

**Transference** is the tendency to “transfer” feelings to a therapist similar to those the patient had for important persons in his or her past. At times, the patient may act as if the analyst is a rejecting father, an unloving or overprotective mother, or a former lover, for example. As the patient re-experiences repressed emotions, the therapist can help the patient recognize and understand them. Troubled persons often provoke anger, rejection, boredom, criticism, and other negative reactions from others. Effective therapists learn to avoid reacting as others do and playing the patient’s habitual resistance and transference “games.” This, too, contributes to therapeutic change (Fayek, 2010).

## Psychoanalysis Today

*What is the status of psychoanalysis today?* Traditional psychoanalysis was open-ended, calling for three to five therapy sessions a week, often for many years. Today, most patients are seen only once or twice per week, but treatment may still go on for years (Friedman et al., 1998). Because of the huge amounts of time and money this requires, psychoanalysts have become relatively rare. Nevertheless, psychoanalysis made a major contribution to modern therapies by highlighting the importance of unconscious conflicts (Friedman, 2006).

Many therapists have switched to doing time-limited **brief psychodynamic therapy**, which uses direct questioning to reveal unconscious conflicts (Binder, 2004). Modern therapists also actively provoke emotional reactions that will lower defenses and provide insights. Interestingly, brief therapy appears to accelerate recovery. Patients seem to realize that they need to get to the heart of their problems quickly (Messer & Kaplan, 2004).

## Interpersonal Psychotherapy

One example of a brief dynamic therapy is **interpersonal psychotherapy (IPT)**, which was first developed to help depressed people improve their relationships with others (Teyber & McClure, 2011). Research has confirmed that IPT is effective for depressive disorders, as well as eating disorders, substance abuse, social phobias, and personality disorders (Fiore et al., 2008; Hoffart, 2005; Prochaska & Norcross, 2010; Talbot & Gamble, 2008).

Liona’s therapy is a good example of IPT (Brown & Barlow, 2011). Liona was suffering from depression that a therapist helped her trace to a conflict with her parents. When her father was absent, Liona adopted the role of her mother’s protector and friend. However, when her father was home, she was expected to resume her role as a daughter. She was angry with her father for frequently abandoning her mother and upset about having to switch roles so often. Liona’s IPT sessions (which sometimes included her mother) focused on clarifying Liona’s family roles. Her mood improved a lot after her mother urged her to “stick to being herself.”

## Is Traditional Psychoanalysis Effective?

The development of newer, more streamlined dynamic therapies is in part due to questions about whether traditional psychoanalysis “works.” In a classic criticism, Hans Eysenck (1994) suggested that

psychoanalysis simply takes so long that patients experience a **spontaneous remission** of symptoms (improvement due to the mere passage of time).

*How seriously should the possibility of spontaneous remission be taken?* It’s true that problems ranging from hyperactivity to anxiety do improve with the passage of time. Regardless, researchers have confirmed that psychoanalysis does, in fact, produce improvement in a majority of patients (Doidge, 1997).

The real value of Eysenck’s critique is that it encouraged psychologists to try new ideas and techniques. Researchers began to ask, “When psychoanalysis works, why does it work? Which parts of it are essential and which are unnecessary?” Modern therapists have given surprisingly varied answers to these questions. Let’s move on to survey some of the ways modern therapies differ. Later, we will acquaint you with some of the therapies currently in use.

## ➤ Dimensions of Therapy— ➤ Let Me Count the Ways

### Gateway Question 15.3: How do psychotherapies differ?

In contrast to *medical therapies*, which are physical in nature, *psychotherapy* refers to any psychological technique that can bring about positive changes in personality, behavior, or personal adjustment. Psychotherapy is usually based on a dialogue between therapists and their clients, although some therapists also use learning principles to directly alter troublesome behaviors (Corsini & Wedding, 2011).

Therapists have many approaches to choose from: psychoanalysis, which we just discussed, as well as client-centered therapy, Gestalt therapy, cognitive therapy, and behavior therapy—to name but a few. As we will see throughout the chapter, each therapy emphasizes different concepts and methods. For this reason, the best approach for a particular person or problem may vary (Prochaska & Norcross, 2010).

## Dimensions of Psychotherapy

The terms in the list that follows describe some basic aspects of various psychotherapies (Prochaska & Norcross, 2010; Sharf, 2012). Notice that more than one term may apply to a particular therapy. For example, it is possible to have a directive, action-oriented, open-ended group therapy or a nondirective, individual, insight-oriented, time-limited therapy:

- **Insight vs. action therapy:** Does the therapy aim to bring clients to a deeper understanding of their thoughts, emotions, and behavior? Or is it designed to bring about direct changes in troublesome thoughts, habits, feelings, or behavior, without seeking insight into their origins or meanings?
- **Directive vs. nondirective therapy:** Does the therapist provide strong guidance and advice? Or does the therapist merely assist clients, who are responsible for solving their own problems?

- **Individual vs. group therapy:** Does the therapy involve one therapist with one client? Or do several clients participate at the same time?
- **Open-ended vs. time-limited therapy:** Is the therapy open-ended? Or is it begun with the expectation that it will last only a limited number of sessions?

### Myths

Psychotherapy has often been depicted as a complete personal transformation—a sort of “major overhaul” of the psyche. But therapy is *not* equally effective for all problems. Chances of improvement are fairly good for phobias, low self-esteem, some sexual problems, and marital conflicts. More complex problems can be difficult to solve and may, as in Joe’s case, require medical treatment as well. The most extreme cases may not respond to psychotherapy at all, leaving a medical therapy as the only viable treatment option.

In short, it is often unrealistic to expect psychotherapy to undo a person’s entire past. For many people, the major benefit of psychotherapy is that it provides comfort, support, and a way to make constructive changes (Bloch, 2006; Burns, 2010). Yet, even when problems are severe, therapy may help a person gain a new perspective or learn behaviors to better cope with life. Psychotherapy can be hard work for both clients and therapists, but when it succeeds, few activities are more worthwhile.

It’s also a mistake to think that psychotherapy is used only to solve problems or end a crisis. Even if a person is already doing well, therapy can be a way to promote personal growth (Bloch, 2006). Therapists in the positive psychology movement are developing ways to help people make use of their personal strengths. Rather than trying to fix what is “wrong” with a person, they seek to nurture positive traits and actively solve problems (Compton, 2005). ■ Table 15.1 lists some of the elements of positive mental health that therapists seek to restore or promote. Before we dig deeper into some of the different types of psychotherapy, let’s enhance your positive academic health with a short review.

**TABLE 15.1** Elements of Positive Mental Health

- Personal autonomy and independence
- A sense of identity
- Feelings of personal worth
- Skilled interpersonal communication
- Sensitivity, nurturance, and trust
- Genuineness and honesty with self and other
- Self-control and personal responsibility
- Committed and loving personal relationships
- Capacity to forgive others and oneself
- Personal values and a purpose in life
- Self-awareness and motivation for personal growth
- Adaptive coping strategies for managing stresses and crises
- Fulfillment and satisfaction in work
- Good habits of physical health

Adapted from Bergin, 1991; Bloch, 2006.

8. An approach that is incompatible with insight therapy is  
 a. individual therapy b. action therapy c. nondirective therapy d. time-limited psychotherapy

### REFLECT

#### Think Critically

9. According to Freud’s concept of *transference*, patients “transfer” their feelings onto the psychoanalyst. In light of this idea, to what might the term *countertransference* refer?

#### Self-Reflect

The use of trepanning, demonology, and exorcism all implied that the mentally ill are “cursed.” To what extent are the mentally ill rejected and stigmatized today?

Try to free associate (aloud) for 10 minutes. How difficult was it? Did anything interesting surface?

Can you explain, in your own words, the role of dream analysis, resistances, and transference in psychoanalysis?

Make a list describing what you think it means to be mentally healthy. How well does your list match the items in ■ Table 15.1?

**Answers:** 1. a 2. F 3. d 4. C 5. A 6. D 7. B 8. d 9. Psychoanalysts (and therapists in general) are also human. They may transfer their own unresolved, unconscious feelings onto their patients. This sometimes hampers the effectiveness of therapy (Kim & Gray, 2009).

### Knowledge Builder

## Treating Psychological Distress

### RECITE

1. One modern scientific explanation of medieval “possessions” by “demons” is related to the effects of  
 a. ergot poisoning b. trepanning c. exorcism d. unconscious transference
2. Pinel is famous for his use of exorcism. T or F?
3. In psychoanalysis, an emotional attachment to the therapist is called:  
 a. free association b. manifest association c. resistance d. transference

Match:

- |                                 |                                       |
|---------------------------------|---------------------------------------|
| 4. _____ Directive therapies    | A. Change behavior                    |
| 5. _____ Action therapies       | B. Place responsibility on the client |
| 6. _____ Insight therapies      | C. The client is guided strongly      |
| 7. _____ Nondirective therapies | D. Seek understanding                 |

**Transference** The tendency of patients to transfer feelings to a therapist that correspond to those the patient had for important persons in his or her past.

**Brief psychodynamic therapy** A modern therapy based on psychoanalytic theory but designed to produce insights more quickly.

**Interpersonal psychotherapy (IPT)** A brief dynamic psychotherapy designed to help people by improving their relationships with other people.

**Spontaneous remission** Improvement of symptoms due to the mere passage of time.

## Humanistic Therapies— Restoring Human Potential

**Gateway Question 15.4:** *What are the major humanistic therapies?*

When most people picture psychotherapists at work, they imagine them talking with their clients. Let's sample a variety of talk-oriented approaches. *Humanistic therapies* tend to be insight therapies intended to help clients gain deeper insight into their thoughts, emotions, and behavior. In contrast, *cognitive therapies* tend to be action therapies less concerned with insight than with helping people change harmful thinking patterns. Let's start with some insight.

Better self-knowledge was the goal of traditional psychoanalysis. However, Freud claimed that his patients could expect only to change their “hysterical misery into common unhappiness!” Humanistic therapists are more optimistic, believing that humans have a natural urge to seek health and self-growth. Most assume that it is possible for people to use their potentials fully and live rich, rewarding lives. In this section, we'll discuss three of the most common humanistic therapies: client-centered therapy, existential therapy, and Gestalt therapy.

### Client-Centered Therapy

*What is client-centered therapy? How is it different from psychoanalysis?* Whereas psychoanalysis is directive and based on insights from the *unconscious*, **client-centered therapy** (also called **person-centered therapy**) is nondirective and based on insights from *conscious* thoughts and feelings (Brodley, 2006; Wampold, 2007). The psychoanalyst tends to take a position of authority, stating what dreams, thoughts, or memories “mean.” In contrast, Carl Rogers (1902–1987), who originated client-centered therapy, believed that what is right or valuable for the therapist may be wrong for the client. (Rogers preferred the term “*client*” to “*patient*” because “*patient*” implies that a person is “sick” and needs to be “cured.”) Consequently, in client-centered therapy, the client determines what will be discussed during each session.

Psychotherapist Carl Rogers,  
who originated client-  
centered therapy.



Courtesy of Dr. Natalie Rogers

*If the client runs things, what does the therapist do?* The therapist cannot “fix” the client. Instead, the client must actively seek to solve his or her problems (Whitton, 2003). The therapist’s job is to create a safe “atmosphere of growth” by providing opportunities for change.

*How do therapists create such an atmosphere?* Rogers believed that effective therapists maintain four basic conditions. First, the therapist offers the client **unconditional positive regard** (unshakable personal acceptance). The therapist refuses to react with shock, dismay, or disapproval to anything the client says or feels. Total acceptance by the therapist is the first step to self-acceptance by the client.

Second, the therapist attempts to achieve genuine **empathy** by trying to see the world through the client’s eyes and feeling some part of what the client is feeling.

As a third essential condition, the therapist strives to be **authentic** (genuine and honest). The therapist must not hide behind a professional role. Rogers believed that phony fronts destroy the growth atmosphere sought in client-centered therapy.

Fourth, the therapist does not make interpretations, propose solutions, or offer advice. Instead, the therapist **reflects** (rephrases, summarizes, or repeats) the client’s thoughts and feelings. This enables the therapist to act as a psychological “mirror” so clients can see themselves more clearly. Rogers theorized that a person armed with a realistic self-image and greater self-acceptance will gradually discover solutions to life’s problems.

### Existential Therapy

According to the existentialists, “being in the world” (existence) creates deep anxiety. Each of us must deal with the realities of death. We must face the fact that we create our private world by making choices. We must overcome isolation on a vast and indifferent planet. Most of all, we must confront feelings of meaninglessness (Schneider, Galvin, & Serlin, 2009).

*What do these concerns have to do with psychotherapy?* **Existential therapy** focuses on the problems of existence, such as meaning, choice, and responsibility. Like client-centered therapy, it promotes self-knowledge. However, there are important differences. Client-centered therapy seeks to uncover a “true self” hidden behind a screen of defenses. In contrast, existential therapy emphasizes free will, the human ability to make choices. Accordingly, existential therapists believe you can *choose to become* the person you want to be.

Existential therapists try to give clients the *courage* to make rewarding and socially constructive choices. Typically, therapy focuses on *death, freedom, isolation, and meaninglessness*, the “ultimate concerns” of existence (van Deurzen & Kenward, 2005). These universal human challenges include an awareness of one’s mortality, the responsibility that comes with freedom to choose, being alone in your own private world, and the need to create meaning in your life.

One example of existential therapy is Victor Frankl’s *logotherapy*, which emphasizes the need to find and maintain meaning in

life. Frankl (1904–1997) based his approach on experiences he had as a prisoner in a Nazi concentration camp. In the camp, Frankl saw countless prisoners break down as they were stripped of all hope and human dignity (Frankl, 1955). Those who survived with their sanity did so because they managed to hang on to a sense of meaning (*logos*). Even in less dire circumstances, a sense of purpose in life adds greatly to psychological well-being (Prochaska & Norcross, 2010).

*What does the existential therapist do?* The therapist helps clients discover self-imposed limitations in personal identity. To be successful, the client must fully accept the challenge of changing his or her life (Bretherton & Orner, 2004). Interestingly, Buddhists seek a similar state that they call “radical acceptance” (Brach, 2003).

A key aspect of existential therapy is *confrontation*, in which clients are challenged to be mindful of their values and choices and to take responsibility for the quality of their existence (Claessens, 2009). An important part of confrontation is the unique, intense, here-and-now *encounter* between two human beings. When existential therapy is successful, it brings about a renewed sense of purpose and a reappraisal of what’s important in life. Some clients even experience an emotional rebirth, as if they had survived a close brush with death. As Marcel Proust wrote, “The real voyage of discovery consists not in seeing new landscapes but in having new eyes.”

## Gestalt Therapy

Gestalt therapy is based on the idea that perception, or *awareness*, is disjointed and incomplete in maladjusted persons. The German word *Gestalt* means “whole,” or “complete.” **Gestalt therapy** helps people rebuild thinking, feeling, and acting into connected wholes. This is achieved by expanding personal awareness; by accepting responsibility for one’s thoughts, feelings, and actions; and by filling in gaps in experience (Masquelier, 2006).

*What are “gaps in experience”?* Gestalt therapists believe that we often shy away from expressing or “owning” upsetting feelings. This creates a gap in self-awareness that may become a barrier to personal growth. For example, a person who feels anger after the death of a parent might go for years without fully expressing it. This and similar threatening gaps may impair emotional health.

The Gestalt approach is more directive than client-centered or existential therapy, and it is less insight-oriented and instead emphasizes immediate experience. Working either one-to-one or in a group setting, the Gestalt therapist encourages clients to become more aware of their moment-to-moment thoughts, perceptions, and emotions (Staemmler, 2004). Rather than discussing *why* clients feel guilt, anger, fear, or boredom, the therapist encourages them to have these feelings in the “here and now” and become fully aware of them. The therapist promotes awareness by drawing attention to a client’s posture, voice, eye movements, and hand gestures. Clients may also be asked to exaggerate vague feelings until they become clear. Gestalt therapists believe that expressing such feelings allows people to “take care of unfinished business” and break through emotional impasses (O’Leary, 2006).

Gestalt therapy is often associated with the work of Fritz Perls (1969). According to Perls, emotional health comes from knowing what you *want* to do, not dwelling on what you *should* do, *ought* to do, or *should want* to do (Brownell, 2010). In other words, emotional health comes from taking full responsibility for one’s feelings and actions. For example, it means changing “I can’t” to “I won’t,” or “I must” to “I choose to.”

*How does Gestalt therapy help people discover their real wants?* Above all else, Gestalt therapy emphasizes *present* experience (Yontef, 2007). Clients are urged to stop intellectualizing and talking *about* feelings. Instead, they learn to live now; live here; stop imagining; experience the real; stop unnecessary thinking; taste and see; express rather than explain, justify, or judge; give in to unpleasantness and pain just as to pleasure; and surrender to being as you are. Gestalt therapists believe that, paradoxically, the best way to change is to become who you really are (Brownell, 2010).

## Cognitive Therapy—Think Positive!

**Gateway Question 15.5:** *How does cognitive therapy change thoughts and emotions?*

Whereas humanistic therapies usually seek to foster insight, cognitive therapies usually try to directly change what people think, believe, and feel, and, as a consequence, how they act. In general, **cognitive therapy** helps clients change thinking patterns that lead to troublesome emotions or behaviors (Davey, 2008; Power, 2010).

*In practice, how does cognitive therapy differ from humanistic therapy?* Janice is a hoarder whose home is crammed full with things she has acquired over two decades. If she seeks help from a therapist concerned with insight, she will try to better understand why she began collecting stuff. In contrast, if she seeks help from a cognitive

- Client-centered (or person-centered) therapy** A nondirective therapy based on insights gained from conscious thoughts and feelings; emphasizes accepting one’s true self.
- Unconditional positive regard** An unqualified, unshakable acceptance of another person.
- Empathy** A capacity for taking another’s point of view; the ability to feel what another is feeling.
- Authenticity** In Carl Rogers’s terms, the ability of a therapist to be genuine and honest about his or her own feelings.
- Reflection** In client-centered therapy, the process of rephrasing or repeating thoughts and feelings expressed by clients so they can become aware of what they are saying.
- Existential therapy** An insight therapy that focuses on the elemental problems of existence, such as death, meaning, choice, and responsibility; emphasizes making courageous life choices.
- Gestalt therapy** An approach that focuses on immediate experience and awareness to help clients rebuild thinking, feeling, and acting into connected wholes; emphasizes the integration of fragmented experiences.
- Cognitive therapy** A therapy directed at changing the maladaptive thoughts, beliefs, and feelings that underlie emotional and behavioral problems.



therapist, she may spend little time examining her past. Instead, she will work to actively change her thoughts and beliefs about hoarding. With either approach, the goal is to give up hoarding. Further, in practice, humanistic therapies often also result in active change and cognitive therapies often also yield deeper insight.

Cognitive therapy has been successfully used as a remedy for many problems, ranging from generalized anxiety disorder and post-traumatic stress disorder to marital distress and anger (Butler et al., 2006). For example, compulsive hand washing can be greatly reduced by changing a client's thoughts and beliefs about dirt and contamination (Jones & Menzies, 1998). Cognitive therapy has been especially successful in treating depression (Hollon, Stewart, & Strunk, 2006). Joe's clinical psychologist relied on cognitive therapy to help lift Joe (who could forget Joe?) out of his depression.

### Cognitive Therapy for Depression

As you may recall from Chapter 13, cognitive psychologists believe that negative, self-defeating thoughts underlie depression. According to Aaron Beck (1991), depressed persons see themselves, the world, and the future in negative terms because of major distortions in thinking. The first is **selective perception**, which refers to perceiving only certain stimuli in a larger array. If five good things and three bad things happen during the day, depressed people focus only on the bad. A second thinking error in depression is **overgeneralization**, the tendency to think that an upsetting event applies to other, unrelated situations. An example would be Joe's considering himself a total failure, or completely worthless, if he were to lose a part-time job or fail a test. To complete the picture, depressed persons tend to magnify the importance of undesirable events by engaging in **all-or-nothing thinking**: they see events as completely good or bad, right or wrong, and themselves as either successful or failing miserably (Lam & Mok, 2008).

*How do cognitive therapists alter such patterns?* Cognitive therapists make a step-by-step effort to correct negative thoughts that lead to depression or similar problems. At first, clients are taught to recognize and keep track of their own thoughts. The client and therapist then look for ideas and beliefs that cause depression, anger, and avoidance. For example, here's how Joe's therapist began to challenge his all-or-nothing thinking:

**Joe:** I'm feeling really depressed today. No one wants to hire me, and I can't even get a date. I feel completely incompetent!

**Therapist:** I see. The fact that you are currently unemployed and don't have a girlfriend proves that you are completely and utterly incompetent?

**Joe:** Well...I can see that doesn't add up.

Next, clients are asked to gather information to test their beliefs. For instance, a depressed person might list his or her activities for a week. The list is then used to challenge all-or-nothing thoughts, such as "I had a terrible week" or "I'm a complete failure." With more coaching, clients learn to alter their thoughts in ways that improve their moods, actions, and relationships.

Cognitive therapy is at least as effective as drugs for treating many cases of depression (Butler et al., 2006; Eisendrath, Chartier, & McLane, 2011). More importantly, people who have adopted new thinking patterns are less likely to become depressed again—a benefit that drugs can't impart (Dozois & Dobson, 2004; Hollon, Stewart, & Strunk, 2006).

In an alternate approach, cognitive therapists look for an *absence* of effective coping skills and thinking patterns, not for the *presence* of self-defeating thoughts (Dobson, Backs-Dermott, & Dozois, 2000). The aim is to teach clients how to cope with anger, depression, shyness, stress, and similar problems. Stress inoculation, which was described in Chapter 13, is a good example of this approach. Joe used it to weaken his social phobia.

Cognitive therapy is a rapidly expanding specialty. Before we leave the topic, let's explore another widely used cognitive therapy.

### Rational-Emotive Behavior Therapy

**Rational-emotive behavior therapy (REBT)** attempts to change irrational beliefs that cause emotional problems. According to Albert Ellis (1913–2007), the basic idea of REBT is as easy as A-B-C (Ellis, 1995, Ellis & Ellis, 2011). Ellis assumes that people become unhappy and develop self-defeating habits because they have unrealistic or faulty *beliefs*.

*How are beliefs important?* Ellis analyzes problems in this way: The letter A stands for an *activating experience*, which the person assumes to be the cause of C, an *emotional consequence*. For instance, a person who is rejected (the activating experience) feels depressed, threatened, or hurt (the consequence). Rational-emotive behavior therapy shows the client that the real problem is what comes between A and C: In between is B, the client's irrational and unrealistic *beliefs*. In this example, an unrealistic belief leading to unnecessary suffering is, "I must be loved and approved by everyone at all times." REBT holds that events do not *cause* us to have feelings. We feel as we do because of our beliefs (Dryden, 2011; Kottler & Shepard, 2011). (For some examples, see "Ten Irrational Beliefs—Which Do You Hold?")

#### BRIDGES

The REBT explanation of emotional distress is related to the effects of emotional appraisals. See Chapter 10, pages 359–360.

Ellis (1979, Ellis & Ellis, 2011) says that most irrational beliefs come from three core ideas, each of which is unrealistic:

1. I *must* perform well and be approved of by significant others. If I don't, then it is awful, I cannot stand it, and I am a rotten person.
2. You *must* treat me fairly. When you don't, it is horrible, and I cannot bear it.
3. Conditions *must* be the way I want them to be. It is terrible when they are not, and I cannot stand living in such an awful world.

Discovering Psychology

## Ten Irrational Beliefs—Which Do You Hold?

**Rational-emotive behavior therapists** have identified numerous beliefs that commonly lead to emotional upsets and conflicts. See if you recognize any of the following irrational beliefs:

1. I must be loved and approved by almost every significant person in my life or it's awful and I'm worthless.  
*Example:* "One of my classmates doesn't seem to like me. I must be a big loser."
2. I should be completely competent and achieving in all ways to be a worthwhile person.  
*Example:* "I don't understand my physics class. I guess I really am just stupid."
3. It's terribly upsetting when things don't go my way.  
*Example:* "I should have gotten a B in that class. The teacher is a total creep."

4. It's not my fault I'm unhappy; I can't control my emotional reactions.  
*Example:* "You make me feel awful. I would be happy if it weren't for you."
5. I should never forget it if something unpleasant happens.  
*Example:* "I'll never forget the time my boss insulted me. I think about it every day at work."
6. It is easier to avoid difficulties and responsibilities than to face them.  
*Example:* "I don't know why my girlfriend is angry. Maybe it will just pass if I ignore it."
7. A lot of people I have to deal with are bad. I should severely punish them for it.  
*Example:* "The students renting next door are such a pain. I'm going to play my stereo even louder the next time they complain."

8. I should depend on others who are stronger than me.  
*Example:* "I couldn't survive if she left me."
9. Because something once strongly affected me, it will do so forever.  
*Example:* "My girlfriend dumped me during my junior year in college. I can never trust a woman again."
10. There is always a perfectly obvious solution to human problems, and it is immoral if this solution is not put into practice.  
*Example:* "I'm so depressed about politics in this country. It all seems hopeless."\*

If any of the listed beliefs sound familiar, you may be creating unnecessary emotional distress for yourself by holding on to unrealistic expectations.

\*Adapted from Dryden, 2011; Ellis & Ellis, 2011; Teyber & McClure, 2011).

It's easy to see that such beliefs can lead to much grief and needless suffering in a less than perfect world. Rational-emotive behavior therapists are very directive in their attempts to change a client's irrational beliefs and "self-talk." The therapist may directly attack clients' logic, challenge their thinking, confront them with evidence contrary to their beliefs, and even assign "homework." Here, for instance, are some examples of statements that dispute irrational beliefs (adapted from Dryden, 2011; Ellis & Ellis, 2011; Kottler & Shepard, 2011):

- "Where is the evidence that you are a loser just because you didn't do well this one time?"
- "Who said the world should be fair? That's your rule."
- "What are you telling yourself to make yourself feel so upset?"
- "Is it really terrible that things aren't working out as you would like? Or is it just inconvenient?"

Many of us would probably do well to give up our irrational beliefs. Improved self-acceptance and a better tolerance of daily annoyances are the benefits of doing so (see "Overcoming the Gambler's Fallacy").

The value of cognitive approaches is further illustrated by three techniques (*covert sensitization*, *thought stopping*, and *covert reinforcement*) described in this chapter's *Psychology in Action* section. A little later you can see what you think of them.

Knowledge Builder

### Humanistic and Cognitive Therapies

RECITE

Match:

- |   |   |
|---|---|
| 1. _____ Client-centered therapy  | <b>A.</b> Changing thought patterns     |
| 2. _____ Gestalt therapy  | <b>B.</b> Unconditional positive regard |
| 3. _____ Existential therapy  | <b>C.</b> Gaps in awareness             |
| 4. _____ REBT   | <b>D.</b> Choice and becoming           |
| 5. The Gestalt therapist tries to <i>reflect</i> a client's thoughts and feelings. T or F?  |   |
| 6. Confrontation and encounter are concepts of existential therapy. T or F?   |   |
| 7. According to Beck, selective perception, overgeneralization, and _____ thinking are cognitive habits that underlie depression. |   |

Continued

**Selective perception** Perceiving only certain stimuli among a larger array of possibilities.

**Overgeneralization** Blowing a single event out of proportion by extending it to a large number of unrelated situations.

**All-or-nothing thinking** Classifying objects or events as absolutely right or wrong, good or bad, acceptable or unacceptable, and so forth.

**Rational-emotive behavior therapy (REBT)** An approach that states that irrational beliefs cause many emotional problems and that such beliefs must be changed or abandoned.

## The Clinical File

# Overcoming the Gambler's Fallacy

**Seventeen-year-old Jonathan** just lost his shirt again. This time, he did it playing on-line Blackjack. Jonathan started out making \$5 bets and then doubled his bet over and over. Surely, he thought, his luck would eventually change. However, he ran out of money after just eight straight hands, having lost more than \$1000. Last week, he lost a lot of money playing Texas Hold 'Em. Now Jonathan is in tears—he has lost most of his summer earnings, and he is worried about having to drop out of school and tell his parents about his losses. Jonathan has had to admit that he is part of the growing ranks of underage gambling addicts (LaBrie & Shaffer, 2007; Wilber & Potenza, 2006).

Like many problem gamblers, Jonathan suffers from several cognitive distortions related to gambling. Here are some of his mistaken beliefs (adapted from adapted from Toneatto, 2002; Wickwire, Whelan, & Meyers, 2010):

**Magnified gambling skill:** Your self-confidence is exaggerated, despite the fact that you lose persistently.

**Attribution errors:** You ascribe your wins to skill but blame losses on bad luck.

**Gambler's fallacy:** You believe that a string of losses soon must be followed by wins.

**Selective memory:** You remember your wins but forget your losses.

**Overinterpretation of cues:** You put too much faith in irrelevant cues such as bodily sensations or a feeling that your next bet will be a winner.

**Luck as a trait:** You believe that you are a "lucky" person in general.

**Probability biases:** You have incorrect beliefs about randomness and chance events.

Do you have any of these mistaken beliefs? Taken together, Jonathan's cognitive distortions created an illusion of control. That is, he believed that if he worked hard enough, he could figure out how to win. Fortunately, a cognitive therapist helped Jonathan *cognitively restructure* his beliefs. He now no longer believes he can control chance events. Jonathan still gambles a bit, but he does so only recreationally, keeping his losses within his budget and enjoying himself in the process.



Gambling addiction is a growing problem among young people (LaBrie & Shaffer, 2007).

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8. The B in the A-B-C of REBT stands for  
a. behavior b. belief c. being d. Beck

### REFLECT

#### Think Critically

9. How might using the term *patient* affect the relationship between an individual and a therapist?  
10. In Aaron Beck's terms, a belief such as "I must perform well or I am a rotten person" involves two thinking errors. What are they?

#### Self-Reflect

You are going to play the role of a therapist for a classroom demonstration. How would you act if you were a client-centered therapist? An existential therapist? A Gestalt therapist?

What would an existential therapist say about the choices you have made so far in your life? Should you be choosing more "courageously"?

We all occasionally engage in negative thinking. Can you remember a time recently when you engaged in selective perception? Overgeneralization? All-or-nothing thinking?

Answers: 1. B 2. C 3. D 4. A 5. F 6. T 7. all-or-nothing 8. b 9. The terms *doctor* and *patient* imply a large gap in status and authority between the individual and his or her therapist. Client-centered therapy attempts to narrow this gap by making the person the final authority concerning solutions to his or her problems. Also, the word *patient* implies that a person is "sick" and needs to be "cured." Many regard this as an inappropriate way to think about human problems. 10. Overgeneralization and all-or-nothing thinking.

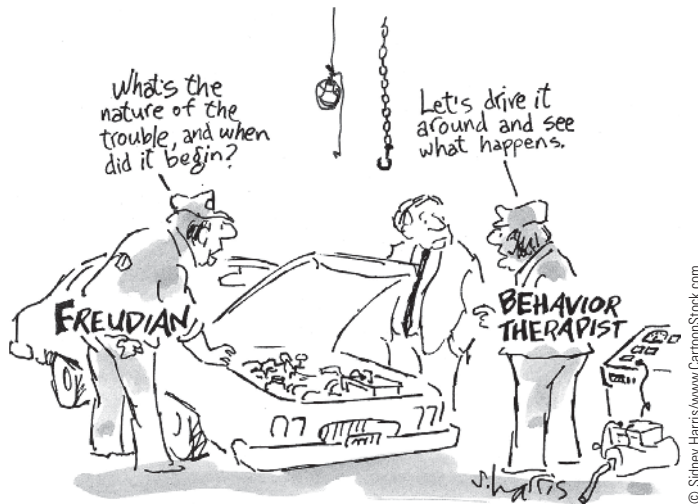
## Therapies Based on Classical Conditioning—Healing by Learning

### Gateway Question 15.6: What is behavior therapy?

Jay repeatedly and vividly imagined himself going into a store to steal something. He then pictured himself being caught and turned over to the police, who handcuffed him and hauled him off to jail. Once there, he imagined calling his wife to tell her he had been arrested for shoplifting. He became very distressed as he faced her anger and his son's disappointment (Kohn & Antonuccio, 2002).

*Why would anyone imagine such a thing?* Jay's behavior is not as strange as it may seem. His goal was self-control: Jay is a *kleptomaniac* (a compulsive thief). The method he chose (called *covert sensitization*) is a form of behavior therapy (Prochaska & Norcross, 2010).

*In general, how does behavior therapy work?* A breakthrough occurred when psychologists realized they could use learning principles to solve human problems. **Behavior therapy** is an action therapy that uses learning principles to make constructive changes in behavior. Behavior therapists believe that deep insight into one's problems is often unnecessary for improvement. Instead, they try to directly alter troublesome actions and thoughts. Jay



didn't need to probe into his past or his emotions and conflicts; he simply wanted to break his shoplifting habit. This and the next section describe some innovative—and very successful—behavioral therapies.

Behavior therapists assume that people have *learned* to be the way they are. If they have learned responses that cause problems, then they can change them by *relearning* more appropriate behaviors. Broadly speaking, **behavior modification** refers to any use of classical or operant conditioning to directly alter human behavior (Miltenberger, 2011; Spiegler & Guevremont, 2010). (Some therapists prefer to call this approach *applied behavior analysis*.) Behavioral approaches include aversion therapy, desensitization, token economies, and other techniques (Forsyth & Savsevitz, 2002).

*How does classical conditioning work? I'm not sure I remember.* Perhaps a brief review would be helpful. Classical conditioning is a form of learning in which simple responses (especially reflexes) are associated with new stimuli. In classical conditioning, a neutral stimulus is followed by an *unconditioned stimulus (US)* that consistently produces an unlearned reaction, called the *unconditioned response (UR)*. Eventually, the previously neutral stimulus begins to produce this response directly. The response is then called a *conditioned response (CR)*, and the stimulus becomes a *conditioned stimulus (CS)*. Thus, for a child the sight of a hypodermic needle (CS) is followed by an injection (US), which causes anxiety or fear (UR). Eventually, the sight of a hypodermic (the conditioned stimulus) may produce anxiety or fear (a conditioned response) *before* the child gets an injection.

### BRIDGES

For a more thorough review of classical conditioning, return to Chapter 6, pages 207–212.

*What does classical conditioning have to do with behavior modification?* Classical conditioning can be used to associate discomfort with a bad habit, as Jay did to deal with his kleptomania. More powerful versions of this approach are called aversion therapy.

## Aversion Therapy

Imagine that you are eating an apple. Suddenly, you discover that you just bit a large green worm in half. You vomit. Months later, you cannot eat an apple again without feeling ill. It's apparent that you have developed a conditioned aversion to apples. (A *conditioned aversion* is a learned dislike or negative emotional response to some stimulus.)

*How are conditioned aversions used in therapy?* In **aversion therapy**, an individual learns to associate a strong aversion to an undesirable habit such as smoking, drinking, or gambling. Aversion therapy has been used to cure hiccups, sneezing, stuttering, vomiting, nail-biting, bed-wetting, compulsive hair-pulling, alcoholism, and the smoking of tobacco, marijuana, or crack cocaine. Actually, aversive conditioning happens every day. For example, not many physicians who treat lung cancer patients are smokers, nor do many emergency room doctors drive without using their seat belts (Eifert & Lejuez, 2000).

## Puffing Up an Aversion

The fact that nicotine is toxic makes it easy to create an aversion that helps people give up smoking. Behavior therapists have found that electric shock, nauseating drugs, and similar aversive stimuli are not required to make smokers uncomfortable. All that is needed is for the smoker to smoke—rapidly, for a long time, at a forced pace. During rapid smoking, clients are told to smoke continuously, taking a puff every 6 to 8 seconds. Rapid smoking continues until the smoker is miserable and can stand it no more. By then, most people are thinking, “I never want to see another cigarette for the rest of my life.”

Rapid smoking has long been known as an effective behavior therapy for smoking (McRobbie & Hajek, 2007). Nevertheless, anyone tempted to try rapid smoking should realize that it is very unpleasant. Without the help of a therapist, most people quit too soon for the procedure to succeed. In addition, rapid smoking can be dangerous. It should be done only with professional supervision. (An alternative method that is more practical is described in the *Psychology in Action* section of this chapter.)

## Aversive Therapy for Drinking

Another excellent example of aversion therapy was pioneered by Roger Vogler and his associates (1977). Vogler worked with alcoholics who were unable to stop drinking and for whom aversion therapy was a last chance. While drinking an alcoholic beverage, clients receive a painful (although not injurious) electric shock to the hand. Most of the time, these shocks occur as the client is beginning to take a drink of alcohol.

These *response-contingent shocks* (shocks that are linked to a response) obviously take the pleasure out of drinking. Shocks also

- Behavior therapy** Any therapy designed to actively change behavior.
- Behavior modification** The application of learning principles to change human behavior, especially maladaptive behavior.
- Aversion therapy** Suppressing an undesirable response by associating it with aversive (painful or uncomfortable) stimuli.

## Discovering Psychology

## Feeling a Little Tense? Relax!

**The key to desensitization** is relaxation. To inhibit fear, you must *learn* to relax. One way to voluntarily relax is by using the **tension-release method**. To achieve deep muscle relaxation, try the following exercise:

Tense the muscles in your right arm until they tremble. Hold them tight as you slowly count to ten and then let go. Allow your hand and arm to go limp and to relax completely. Repeat the procedure. Releasing tension two or three times will allow you to feel whether your arm

muscles have relaxed. Repeat the tension-release procedure with your left arm. Compare it with your right arm. Repeat until the left arm is equally relaxed. Apply the tension-release technique to your right leg; to your left leg; to your abdomen; to your chest and shoulders. Clench and release your chin, neck, and throat. Wrinkle and release your forehead and scalp. Tighten and release your mouth and face muscles. As a last step, curl your toes and tense your feet. Then release.

If you carried out these instructions, you should be noticeably more relaxed than you were before you began. Practice the tension-release method until you can achieve complete relaxation quickly (5 to 10 minutes). After you have practiced relaxation once a day for a week or two, you will begin to be able to tell when your body (or a group of muscles) is tense. Also, you will begin to be able to relax on command. This is a valuable skill that you can apply in any situation that makes you feel tense or anxious.

cause the alcohol abuser to develop a conditioned aversion to drinking. Normally, the misery caused by alcohol abuse comes long after the act of drinking—too late to have much effect. But if alcohol can be linked with *immediate* discomfort, then drinking will begin to make the individual very uncomfortable.

*Is it really acceptable to treat clients this way?* People are often disturbed (shocked?) by such methods. However, clients usually *volunteer* for aversion therapy because it helps them overcome a destructive habit. Indeed, commercial aversion programs for overeating, smoking, and alcohol abuse have attracted many willing customers. More important, aversion therapy can be justified by its long-term benefits. As behaviorist Donald Baer put it, “A small number of brief, painful experiences are a reasonable exchange for the interminable pain of a lifelong maladjustment.”

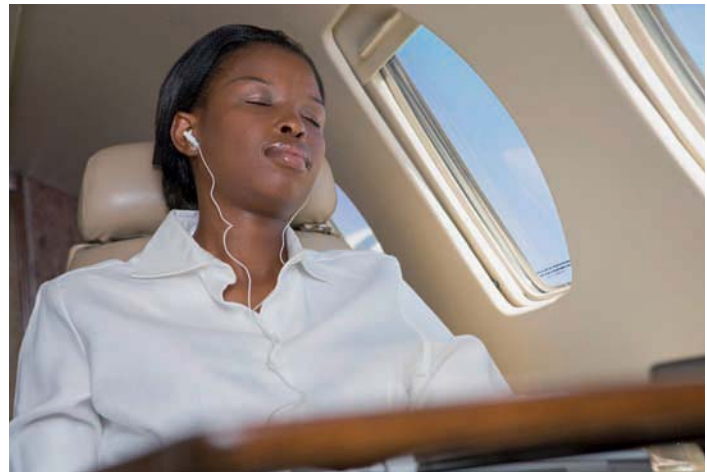
## Desensitization

*How is behavior therapy used to treat phobias, fears, and anxieties?* Suppose you want to help Curtis overcome fear of the high diving board. How might you proceed? Directly forcing Curtis off the high board could be a psychological disaster. A better approach would be to begin by teaching him to dive off the edge of the pool. Then he could be taught to dive off the low board, followed by a platform 6 feet above the water and then an 8-foot platform. As a last step, Curtis could try the high board.

## Who’s Afraid of a Hierarchy?

This rank-ordered series of steps (called a **hierarchy**) allows Curtis to undergo *adaptation*. Gradually, he adapts to the high dive and overcomes his fear. When Curtis has conquered his fear, we can say that *desensitization* (dee-SEN-sih-tih-ZAY-shun) has occurred (Spiegler & Guevremont, 2010).

Desensitization is also based on **reciprocal inhibition** (using one emotional state to block another) (Heriot & Pritchard, 2004).



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Programs for treating fears of flying combine relaxation, systematic desensitization, group support, and lots of direct and indirect exposure to airliners. Many such programs conclude with a brief flight, so that participants can “test their wings.”

For instance, it is impossible to be anxious and relaxed at the same time. If we can get Curtis onto the high board in a relaxed state, his anxiety and fear will be inhibited. Repeated visits to the high board should cause fear to disappear in this situation. Again, we would say that Curtis has been desensitized. Typically, **systematic desensitization** (a guided reduction in fear, anxiety, or aversion) is attained by gradually approaching a feared stimulus while maintaining relaxation.

*What is desensitization used for?* Desensitization is used primarily to help people unlearn phobias (intense, unrealistic fears) or strong anxieties. For example, each of these people might be a candidate for desensitization: a teacher with stage fright; a student with test anxiety; a salesperson who fears people; or a newlywed with an aversion to sexual intimacy.

## Performing Desensitization

*How is desensitization done?* First, the client and the therapist *construct a hierarchy*. This is a list of fear-provoking situations, arranged from least disturbing to most frightening. Second, the client is taught *exercises that produce deep relaxation* (see “Feeling a Little Tense? Relax!”). Third, once the client is relaxed, she or he tries to *perform the least disturbing item* on the list. For a fear of heights (acrophobia), this might be: “(1) Stand on a chair.” The first item is repeated until no anxiety is felt. Any change from complete relaxation is a signal that clients must relax again before continuing. Slowly, clients move up the hierarchy: “(2) Climb to the top of a small stepladder”; “(3) Look down a flight of stairs”; and so on, until the last item is performed without fear: “(20) Fly in an airplane.”

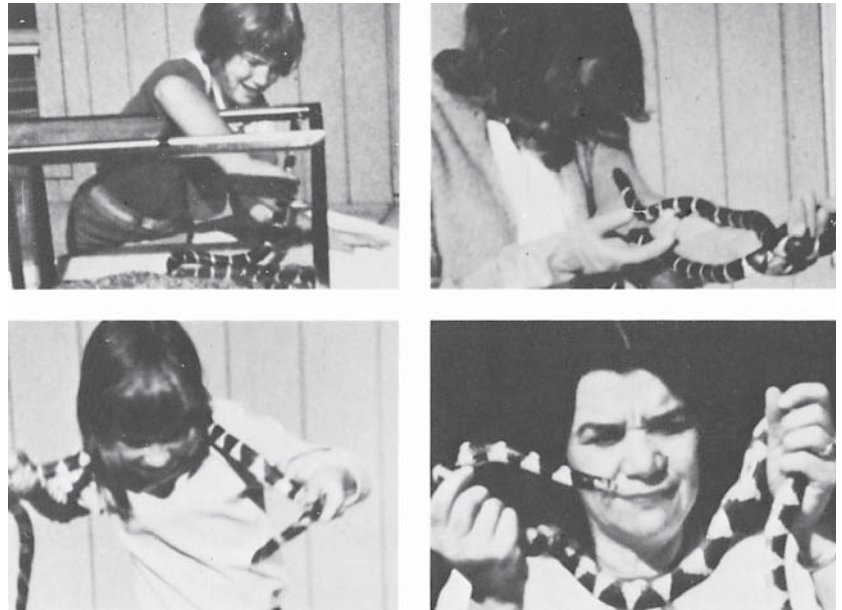
For many phobias, desensitization works best when people are directly exposed to the stimuli and situations they fear (Bourne, 2010; Miltenberger, 2011). For something like a simple spider phobia, this exposure can even be done in groups. Also, for some fears (such as fear of riding an elevator, or fear of spiders) desensitization may be completed in a single session (Müller et al., 2011; Sturges & Sturges, 1998).

## Vicarious Desensitization

*What if it's not practical to directly act out the steps of a hierarchy?* For a fear of heights, the steps of the hierarchy might be acted out. However, if this is impractical, as it might be in the case of a fear of flying, the problem can be handled by having clients observe *models* who are performing the feared behavior (Eifert & Lejuez, 2000; Bourne, 2010; ● Figure 15.2). A model is a person (either live or filmed) who serves as an example for observational learning. If such **vicarious desensitization** (secondhand learning) can't be used, there is yet another option. Fortunately, desensitization works almost as well when a person *vividly imagines* each step in the hierarchy (Yahnke, Sheikh, & Beckman, 2003). If the steps can be visualized without anxiety, fear in the actual situation is reduced. Because imagining feared stimuli can be done at a therapist's office, it is the most common way of doing desensitization.

## Virtual Reality Exposure

Desensitization is an *exposure therapy*. Similar to other such therapies, it involves exposing people to feared stimuli until their fears extinguish. In an important recent development, psychologists are now also using virtual reality to treat phobias. Virtual reality is a computer-generated, three-dimensional “world” that viewers enter by wearing a head-mounted video display. **Virtual reality exposure** presents computerized fear stimuli to clients in a realistic, yet carefully controlled fashion (Wiederhold & Wiederhold, 2005; Riva, 2009). It has already been used to treat fears of flying, driving, and public speaking as well as acrophobia (fear of heights),



● **Figure 15.2** Treatment of a snake phobia by vicarious desensitization. These classic photographs show models interacting with snakes. To overcome their own fears, phobic subjects observed the models (Bandura, Blanchard, & Ritter, 1969).

Photos courtesy of Albert Bandura.

claustrophobia, and spider phobias (Arbona et al., 2004; Giuseppe, 2005; Lee et al., 2002; Meyerbröker & Emmelkamp, 2010; Müller et al., 2011; see ● Figure 15.3.). Virtual reality exposure has also been used to create immersive distracting environments for help patients reduce the experience of pain (Malloy & Milling, 2010).

Desensitization has been one of the most successful behavior therapies. A relatively new technique may provide yet another way to lower fears, anxieties, and psychological pain.

## Eye Movement Desensitization

Traumatic events produce painful memories. Disturbing flashbacks often haunt victims of accidents, disasters, molestations, muggings, rapes, or emotional abuse. To help ease traumatic memories and post-traumatic stress, Dr. Francine Shapiro developed **eye movement desensitization and reprocessing (EMDR)**.

**Hierarchy** A rank-ordered series of higher and lower amounts, levels, degrees, or steps.

**Reciprocal inhibition** The presence of one emotional state can inhibit the occurrence of another, such as joy preventing fear or anxiety inhibiting pleasure.

**Systematic desensitization** A reduction in fear, anxiety, or aversion brought about by planned exposure to aversive stimuli.

**Tension-release method** A procedure for systematically achieving deep relaxation of the body.

**Vicarious desensitization** A reduction in fear or anxiety that takes place vicariously (“secondhand”) when a client watches models perform the feared behavior.

**Virtual reality exposure** Use of computer-generated images to present fear stimuli. The virtual environment responds to a viewer's head movements and other inputs.

**Eye movement desensitization and reprocessing (EMDR)** A technique for reducing fear or anxiety; based on holding upsetting thoughts in mind while rapidly moving the eyes from side to side.



Images courtesy of Virtually Better.

● **Figure 15.3** (top) Dr. Larry Hodges (in the head-mounted display) and Dr. Page Anderson show how a virtual reality system is used to expose people to feared stimuli. (bottom) A computer image from a virtual Iraq or Afghanistan. Veterans suffering from post-traumatic stress disorder (PTSD) can re-experience their traumas. For example, someone whose Humvee was destroyed by an improvised explosive device can relive that moment complete with sights, sounds, vibrations, and even smells. Successive exposures result in a reduction of PTSD symptoms (Gerardi et al., 2008).

In a typical EMDR session, the client is asked to visualize the images that most upset her or him. At the same time, a pencil (or other object) is moved rapidly from side to side in front of the person's eyes. Watching the moving object causes the person's eyes to dart swiftly back and forth. After about 30 seconds, clients describe any memories, feelings, and thoughts that emerged and discuss them with the therapist. These steps are repeated until troubling thoughts and emotions no longer surface (Shapiro, 2001; Shapiro & Forrest, 2004).

A number of studies suggest that EMDR lowers anxieties and takes the pain out of traumatic memories (Seidler & Wagner, 2006). However, EMDR is highly controversial (Albright & Thyer, 2010). Some studies, for example, have found that eye movements

add nothing to the treatment. The apparent success of EMDR may simply be based on gradual exposure to upsetting stimuli, as in other forms of desensitization (Davidson & Parker, 2001). On the other hand, some researchers continue to find that EMDR is superior to traditional therapies (Greenwald, 2006; Solomon, Solomon, & Heide, 2009).

Is EMDR a breakthrough? Given the frequency of traumas in modern society, it shouldn't be long before we find out.

## ▶ Operant Therapies—All the World Is a Skinner Box?

**Gateway Question 15.7:** What role do operant principles play in behavior therapy?

*Aversion therapy and desensitization are based on classical conditioning. Where does operant conditioning fit in?* As you may recall, operant conditioning refers to learning based on the consequences of making a response. The operant principles most often used by behavior therapists to deal with human behavior are:

1. **Positive reinforcement.** Responses that are followed by reinforcement tend to occur more frequently. If children whine and get attention, they will whine more frequently. If you get A's in your psychology class, you may become a psychology major.
2. **Nonreinforcement and Extinction.** A response that is not followed by reinforcement will occur less frequently. If a response is not followed by reward after it has been repeated many times, it will extinguish entirely. After winning three times, you pull the handle on a slot machine 30 times more without a payoff. What do you do? You go away. So does the response of handle pulling (for that particular machine, at any rate).
3. **Punishment.** If a response is followed by discomfort or an undesirable effect, the response will be suppressed (but not necessarily extinguished).
4. **Shaping.** Shaping means reinforcing actions that are closer and closer approximations to a desired response. For example, to reward an intellectually disabled child for saying "ball," you might begin by reinforcing the child for saying anything that starts with a *b* sound.
5. **Stimulus control.** Responses tend to come under the control of the situation in which they occur. If you set your clock 10 minutes fast, it may be easier to leave the house on time in the morning. Your departure is under the stimulus control of the clock, even though you know it is fast.
6. **Time out.** A time-out procedure usually involves removing the individual from a situation in which reinforcement occurs. Time out is a variation of response cost: It prevents reward from following an undesirable response. For example, children who fight with each other can be sent to separate rooms and allowed out only when they are able to behave more calmly.

**BRIDGES**

For a more thorough review of operant learning, return to Chapter 6, pages 212–229.

As simple as these principles may seem, they have been used very effectively to overcome difficulties in work, home, school, and industrial settings. Let's see how.

### Nonreinforcement and Extinction

An extremely overweight mental patient had a persistent and disturbing habit: She stole food from other patients. No one could persuade her to stop stealing or to diet. For the sake of her health, a behavior therapist assigned her a special table in the ward dining room. If she approached any other table, she was immediately removed from the dining room. Any attempt to steal from others caused the patient to miss her own meal (Ayllon, 1963). Because her attempts to steal food went unrewarded, they rapidly disappeared.

*What operant principles did the therapist in this example use?* The therapist used *nonreward* to produce *extinction*. The most frequently occurring human behaviors lead to some form of reward. An undesirable response can be eliminated by *identifying* and *removing* the rewards that maintain it. But people don't always do things for food, money, or other obvious rewards. Most of the rewards maintaining human behavior are subtler. *Attention, approval, and concern* are common yet powerful reinforcers for humans (● Figure 15.4).

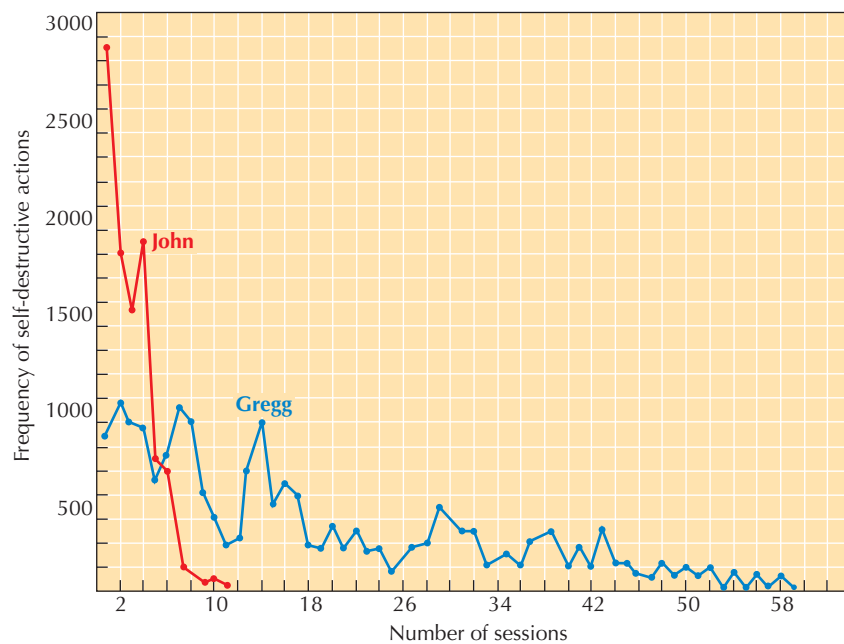
Nonreward and extinction can eliminate many problem behaviors, especially in schools, hospitals, and institutions. Often, diffi-

culties center on a limited number of particularly disturbing responses. Time out is a good way to remove such responses, usually by refusing to pay attention to a person who is misbehaving. For example, 14-year-old Terrel periodically appeared in the nude in the activity room of a training center for disturbed adolescents. This behavior always generated a great deal of attention from staff and other patients. As an experiment, the next time he appeared nude, counselors and other staff members greeted him normally and then ignored him. Attention from other patients rapidly subsided. Sheepishly, he returned to his room and dressed.

### Reinforcement and Token Economies

A distressing problem therapists sometimes face is how to break through to severely disturbed patients who won't talk. Conventional psychotherapy offers little hope of improvement for such patients.

*What can be done for them?* One widely used approach is based on *tokens* (symbolic rewards that can be exchanged for real rewards). Tokens may be printed slips of paper, check marks, points, or gold stars. Whatever form they take, tokens serve as rewards because they may be exchanged for candy, food, cigarettes, recreation, or privileges, such as private time with a therapist, outings, or watching television. Tokens are used in mental hospitals, halfway houses, schools for the intellectually disabled, programs for delinquents, and ordinary classrooms. They usually produce improvements in behavior (Dickerson, Tenhula, & Green-Paden, 2005; Matson & Boisjoli, 2009).



● **Figure 15.4** This graph shows extinction of self-destructive behavior in two autistic boys. Before extinction began, the boys received attention and concern from adults for injuring themselves. During extinction, the adults were taught to ignore the boys' self-damaging behavior. As you can see, the number of times that the boys tried to injure themselves declined rapidly. (Adapted from Lovaas & Simmons, 1969.)

**BRIDGES**

Tokens provide an effective way to change behavior because they are secondary reinforcers. See Chapter 6, pages 218–220.

By using tokens, a therapist can *immediately reward* positive responses. For maximum impact, therapists select specific *target behaviors* (actions or other behaviors the therapist seeks to modify). Target behaviors are then reinforced with tokens. For example, a mute mental patient might first be given a token each time he or she says a word. Next, tokens may be given for speaking a complete sentence. Later, the patient could gradually be required to speak more often, then to answer questions, and eventually to carry on a short conversation in order to receive tokens. In this way, deeply withdrawn patients have been returned to the world of normal communication.

The full-scale use of tokens in an institutional setting produces a *token economy*. In a **token economy**,

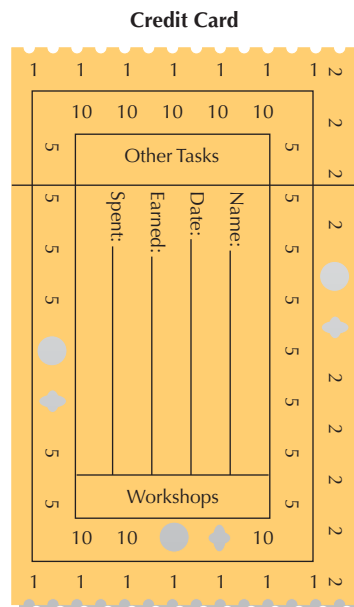
**Token economy** A therapeutic program in which desirable behaviors are reinforced with tokens that can be exchanged for goods, services, activities, and privileges.



patients are rewarded with tokens for a wide range of socially desirable or productive activities (Spiegler & Guevremont, 2010). They must *pay* tokens for privileges and when they engage in problem behaviors (● Figure 15.5). For example, tokens are given to patients who dress themselves, take required medication, arrive for meals on time, and so on. Constructive activities, such as gardening, cooking, or cleaning, may also earn tokens. Patients must *exchange* tokens for meals and private rooms, movies, passes, off-ward activities, and other privileges. They are *charged* tokens for disrobing in public, talking to themselves, fighting, crying, and similar target behaviors (Morisse et al., 1996; Spiegler & Guevremont, 2010).

Token economies can radically change a patient's overall adjustment and morale. Patients are given an incentive to change, and they are held responsible for their actions. The use of tokens may seem manipulative, but it actually empowers patients. Many "hopelessly" intellectually disabled, mentally ill, and delinquent people have been returned to productive lives by means of token economies (Field et al., 2004).

By the time they are ready to leave, patients may be earning tokens on a weekly basis for maintaining sane, responsible, and productive behavior (Miltenberger, 2011). Typically, the most effective token economies are those that gradually switch from tokens to *social rewards* such as praise, recognition, and approval. Such rewards are what patients will receive when they return to family, friends, and community.



● **Figure 15.5** Shown here is a token used in one token economy system. In this instance, the token is a card that records the number of credits earned by a patient. Also pictured is a list of credit values for various activities. Tokens may be exchanged for items or for privileges listed on the board. (After photographs by Robert P. Liberman.)

OXNARD DAY TREATMENT CENTER CREDIT INCENTIVE SYSTEM				
EARN CREDITS BY			SPEND CREDITS FOR	
MONITOR	DAILY	15	COFFEE	5
MENU PLANNING	CHAIRMAN	50	LUNCH	10
PARTICIPATE		5	EXCEPT THURSDAY	15
BUY FOOD AT STORE		10	BUS TRIP	5
COOK FOR/PREPARE LUNCH		5	BOWLING	8
WIPE OFF KITCHEN TABLE		3	GROUP THERAPY	5
WASH DISHES		5-10	PRIVATE STAFF TIME	5
DRY AND PUT AWAY DISHES		5	DAY OFF	5-20
MAKE COFFEE AND CLEAN URN		15	WINDOW SHOPPING	5
CLEAN REFRIGERATOR		20	REVIEW WITH DR.	10
ATTEND PLANNING CONFERENCE		1	DOING OWN THING	1
OT PREPARATION		1-5	LATE 1 PER EVERY 10 MIN	
COMPLETE OT PROJECT		5	PRESCRIPTION FROM DR.	10
RETURN OT PROJECT		2		
DUST AND POLISH TABLES		5		
PUT AWAY GROCERIES		3		
CLEAN TABLE		5		
CLEAN 6 ASH TRAYS		2		
CLEAN SINK		5		
CARRY OUT CUPS & BOTTLES		5		
CLEAN CHAIRS		5		
CLEAN KITCHEN CUPBOARDS		5		
ASSIST STAFF		5		
ARRANGE MAGAZINES NEATLY		3		
BEING ON TIME		5		
MONITOR-ANN				

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## Knowledge Builder

## Behavior Therapies

### RECITE

1. What two types of conditioning are used in behavior modification? \_\_\_\_\_ and \_\_\_\_\_
2. Shock, pain, and discomfort play what role in conditioning an aversion?
  - a. conditioned stimulus
  - b. unconditioned response
  - c. unconditioned stimulus
  - d. conditioned response
3. If shock is used to control drinking, it must be \_\_\_\_\_ contingent.
4. When desensitization is carried out through the use of live or filmed models, it is called
  - a. cognitive therapy
  - b. flooding
  - c. covert desensitization
  - d. vicarious desensitization
5. The three basic steps in systematic desensitization are: constructing a hierarchy, flooding the person with anxiety, and imagining relaxation. T or F?
6. In EMDR therapy, computer-generated virtual reality images are used to expose clients to fear-provoking stimuli. T or F?

7. Behavior modification programs aimed at extinction of an undesirable behavior typically make use of what operant principles?
  - a. punishment and stimulus control
  - b. punishment and shaping
  - c. nonreinforcement and time out
  - d. stimulus control and time out
8. Attention can be a powerful \_\_\_\_\_ for humans.
9. Tokens basically allow the operant shaping of desired responses or "target behaviors." T or F?

### REFLECT

#### Think Critically

10. Alcoholics who take a drug called Antabuse become ill after drinking alcohol. Why, then, don't they develop an aversion to drinking?
11. A natural form of desensitization often takes place in hospitals. Can you guess what it is?

#### Self-Reflect

Can you describe three problems for which you think behavior therapy would be an appropriate treatment?

A friend of yours has a dog that goes berserk during thunderstorms. You own a CD of a thunderstorm. How could you use the CD to desensitize the dog? (Hint: The CD player has a volume control.)

Have you ever become naturally desensitized to a stimulus or situation that at first made you anxious (for instance, heights, public speaking, or driving on freeways)? How would you explain your reduced fear?

See if you can give a personal example of how the following principles have affected your behavior: positive reinforcement, extinction, punishment, shaping, stimulus control, and time out.

**Answers:** 1. classical (or respondent), operant 2. c. response 4. d. 5. F 6. F 7. c. 8. reinforced 9. T 10. Committing alcoholics may actually "drink through it" and learn to tolerate the nauseating effects. 11. Doctors and nurses learn to relax and remain calm at the sight of blood and other bodily fluids because of their frequent exposure to them.

**TABLE 15.2** Commonly Prescribed Psychiatric Drugs

Class	Examples (Trade Names)	Effects	Main Mode of Action
Anxiolytics (minor tranquilizers)	Ativan, Halcion, Librium, Restoril, Valium, Xanax	Reduce anxiety, tension, fear	Enhance effects of GABA
Antidepressants	Anafranil, Elavil, Nardil, Norpramin, Parnate, Paxil, Prozac, Tofranil, Zoloft	Counteract depression	Enhance effects of serotonin or dopamine
Antipsychotics (major tranquilizers)	Clozaril, Haldol, Mellaril, Navane, Risperdal, Thorazine	Reduce agitation, delusions, hallucinations, thought disorders	Reduce effects of dopamine

Source: Adapted from Freberg, 2010; Julien, 2008; Kalat, 2009.

## Medical Therapies— Psychiatric Care

**Gateway Question 15.8:** *How do psychiatrists treat psychological disorders?*

Psychotherapy may be applied to anything from a brief crisis to a full-scale psychosis. However, most psychotherapists *do not* treat patients with major depressive disorders, schizophrenia, or other severe conditions. Major mental disorders are more often treated medically, although combinations of medication and psychotherapy are also often helpful (Beck, et al., 2009).

Three main types of **somatic** (bodily) **therapy** are *pharmacotherapy*, *electrical stimulation therapy*, and *psychosurgery*. Somatic

therapy is often done in the context of psychiatric hospitalization. All the somatic approaches have a strong medical slant and are typically administered by psychiatrists, who are trained as medical doctors.

### Drug Therapies

The atmosphere in psychiatric wards and mental hospitals changed radically in the mid-1950s with the widespread adoption of **pharmacotherapy** (FAR-meh-koe-THER-eh-pea), the use of drugs to treat psychopathology. Drugs may relieve the anxiety attacks and other discomforts of milder psychological disorders. More often, however, they are used to combat schizophrenia and major mood disorders (Julien, 2008).

*What sort of drugs are used in pharmacotherapy?* Three major types of drugs are used. All achieve their effects by influencing the activity of different brain neurotransmitters (Freberg, 2010). **Anxiolytics** (ANG-zee-eh LIT-iks), such as Valium, produce relaxation or reduce anxiety. **Antidepressants**, such as Prozac, are mood-elevating drugs that combat depression. **Antipsychotics** (also called **major tranquilizers**), such as Risperdal, have tranquilizing effects and reduce hallucinations and delusions. See ■ Table 15.2 for examples of each class of drugs.

*Are drugs a valid approach to treatment?* Yes. Drugs have shortened hospital stays, and they have greatly improved the chances that people will recover from major psychological disorders. Drug therapy has also made it possible for many people to return to the community, where they can be treated on an outpatient basis.

### Limitations of Drug Therapy

Regardless of their benefits, all drugs involve risks as well. For example, 15 percent of patients taking major tranquilizers for long periods develop a neurological disorder that causes rhythmic facial



Courtesy of Rodger Casier

The work of artist Rodger Casier illustrates the value of psychiatric care. Despite having a form of schizophrenia, Casier produces artwork that has received public acclaim and has been featured in professional journals.

- Somatic therapy** Any bodily therapy, such as drug therapy, electroconvulsive therapy, or psychosurgery.
- Pharmacotherapy** The use of drugs to treat psychopathology.
- Anxiolytics** Drugs (such as Valium) that produce relaxation or reduce anxiety.
- Antidepressants** Mood-elevating drugs.
- Antipsychotics (major tranquilizers)** Drugs that, in addition to having tranquilizing effects, also tend to reduce hallucinations and delusional thinking.

and mouth movements (Chakos et al., 1996). Similarly, although the drug *clozapine* (Clozaril) can relieve the symptoms of schizophrenia, 2 out of 100 patients taking the drug suffer from a potentially fatal blood disease (Ginsberg, 2006).

*Is the risk worth it?* Many experts think it is, because chronic schizophrenia robs people of almost everything that makes life worth living. It's possible, of course, that newer drugs will improve the risk/benefit ratio in the treatment of severe problems like schizophrenia. For example, the drug risperidone (Risperdal) appears to be as effective as Clozaril, without the same degree of lethal risk.

But even the best new drugs are not cure-alls. They help some people and relieve some problems, but not all. It is noteworthy that for serious mental disorders a combination of medication and psychotherapy almost always works better than drugs alone (Manber et al., 2008). Nevertheless, when schizophrenia and major mood disorders are concerned, drugs will undoubtedly remain the primary mode of treatment (Vasa, Carlino, & Pine, 2006; Walker et al., 2004).

## Electrical Stimulation Therapy

In contrast to drug therapies, electrical stimulation therapies achieve their effects by altering the electrical activity of the brain. Electroconvulsive therapy is the first, and most dramatic, of these therapies. Widely used since the 1940s, it remains controversial to this day (Hirshbein & Sarvananda, 2008).

### Electroshock

In **electroconvulsive therapy (ECT)**, a 150-volt electrical current is passed through the brain for slightly less than a second. This rather drastic medical treatment for depression triggers a convulsion and causes the patient to lose consciousness for a short time. Muscle relaxants and sedative drugs are given before ECT to soften its impact. Treatments are given in a series of sessions spread over several weeks or months.

In electroconvulsive therapy, electrodes are attached to the head and a brief electrical current is passed through the brain. ECT is used in the treatment of severe depression.



Witt & Dent/McIntyre/Photo Researchers, Inc.

*How does shock help?* Actually, it is the seizure activity that is believed to be helpful. Proponents of ECT claim that shock-induced seizures alter or “reset” the biochemical and hormonal balance in the brain and body, bringing an end to severe depression and suicidal behavior (Medda et al., 2009) as well as improving long-term quality of life (McCall et al., 2006). Others have charged that ECT works only by confusing patients so they can't remember why they were depressed.

Not all professionals support the use of ECT. However, most experts seem to agree on the following: (1) At best, ECT produces only temporary improvement—it gets the patient out of a bad spot, but it must be combined with other treatments; (2) ECT can cause memory loss in some patients (Sienaert et al., 2010); (3) ECT should be used only after other treatments have failed; and (4) to lower the chance of a relapse, ECT should be followed by antidepressant drugs (Sackeim et al., 2001). All told, ECT is considered by many to be a valid treatment for selected cases of depression—especially when it rapidly ends wildly self-destructive or suicidal behavior (Medda et al., 2009; Pagnin et al., 2004). It's interesting to note that most ECT patients feel that the treatment helped them. Most, in fact, would have it done again (Bernstein et al., 1998; Smith et al., 2009).

## Implanted Electrodes

Unlike ECT, implanting electrodes requires surgery but allows for electrical stimulation of precisely targeted brain regions. In some studies, depressed patients who hadn't benefited from drug therapy and ECT improved when a specific brain region was stimulated (Mayberg et al., 2005; Sartorius et al., 2010). Stimulating pleasure centers in the brains of another group of patients also relieved depression (Schlaepfer et al., 2008). Also, unlike ECT, implanted electrodes can be used to treat disorders other than depression, such as obsessive-compulsive disorder (Haq et al., 2010).

### BRIDGES

Electrical stimulation of the brain is one of several methods used to investigate the brain's inner workings. **For more information, see Chapter 2, pages 60–63.**

## Psychosurgery

**Psychosurgery** (any surgical alteration of the brain) is the most extreme medical treatment. The oldest and most radical psychosurgery is the lobotomy. In *prefrontal lobotomy*, the frontal lobes are surgically disconnected from other brain areas. This procedure was supposed to calm persons who didn't respond to any other type of treatment.

When the lobotomy was first introduced in the 1940s, there were enthusiastic claims for its success. But later studies suggested that some patients were calmed, some showed no change, and some became mental “vegetables.” Lobotomies also produced a high rate of undesirable side effects, such as seizures, blunted emotions, major personality changes, and stupor. At about the same time that

such problems became apparent, the first antipsychotic drugs became available. Soon after, the lobotomy was abandoned (Mashour, Walker, & Martuza, 2005).

*To what extent is psychosurgery used now?* Psychosurgery is still considered valid by many neurosurgeons. However, most now use *deep lesioning*, in which small target areas are destroyed in the brain's interior. The appeal of deep lesioning is that it can have value as a remedy for some very specific disorders (Mashour, Walker, & Martuza, 2005). For instance, patients suffering from a severe type of obsessive-compulsive disorder may be helped by psychosurgery (Dougherty et al., 2002).

**BRIDGES**

Deep lesioning is another method used to study the brain. See Chapter 2, pages 60–63.

It is worth remembering that psychosurgery cannot be reversed. Whereas a drug can be given or taken away and electrical stimulation can be turned off, you can't take back psychosurgery. Critics argue that psychosurgery should be banned altogether; others continue to report success with brain surgery. Nevertheless, it may have value as a remedy for some very specific disorders (Mashour, Walker, & Martuza, 2005; Sachdev & Chen, 2009).

**Hospitalization**

In 2008, about 3 million Americans received inpatient treatment for a mental health problem (National Institute of Mental Health, 2011a). **Mental hospitalization** involves placing a person in a protected setting where medical therapy is provided. Hospitalization, by itself, can be a form of treatment. Staying in a hospital takes patients out of situations that may be sustaining their problems. For example, people with drug addictions may find it nearly impossible to resist the temptations for drug abuse in their daily lives. Hospitalization can help them make a clean break from their self-destructive behavior patterns (André et al., 2003).

At their best, hospitals are sanctuaries that provide diagnosis, support, refuge, and therapy. This is frequently true of psychiatric units in general hospitals and private psychiatric hospitals. At worst, confinement to an institution can be a brutal experience that leaves people less prepared to face the world than when they arrived. This is more often the case in large state mental hospitals. In most instances, hospitals are best used as a last resort, after other forms of treatment within the community have been exhausted.

Another trend in treatment is **partial hospitalization**. In this approach, some patients spend their days in the hospital but go home at night. Others attend therapy sessions during the evening. A major advantage of partial hospitalization is that patients can go home and practice what they've been learning. Overall, partial hospitalization can be just as effective as full hospitalization (Drymalski & Washburn, 2011; Kiser, Heston, & Paavola, 2006).



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Depending on the quality of the institution, hospitalization may be a refuge or a brutalizing experience. Many state “asylums” or mental hospitals are antiquated and in need of drastic improvement.

**Deinstitutionalization**

In the last 50 years, the population in large mental hospitals has dropped by two thirds. This is largely a result of **deinstitutionalization**, or reduced use of full-time commitment to mental institutions. Long-term “institutionalization” can lead to dependency, isolation, and continued emotional disturbance (Novella, 2010). Deinstitutionalization was meant to remedy this problem

*How successful has deinstitutionalization been?* In truth, its success has been limited (Talbot, 2004). Many states reduced mental hospital populations primarily as a way to save money. The upsetting result is that many chronic patients have been discharged to hostile communities without adequate care. Many former patients have joined the ranks of the homeless. Others are repeatedly jailed for minor crimes. Sadly, patients who trade hospitalization for unemployment, homelessness, and social isolation all too often end up rehospitalized or in jail (Markowitz, 2011).

Large mental hospitals may no longer be warehouses for society's unwanted, but many former patients are no better off in bleak nursing homes, single-room hotels, board-and-care homes, shelters, or jails. For every mentally ill American in a hospital, three are trapped in the criminal justice system (National Institute of Mental Health, 2010a). These figures suggest that jails are replacing mental hospitals as our society's “solution” for mental illness (Markowitz, 2011). Yet, ironically, high-quality care is

- Electroconvulsive therapy (ECT)** A treatment for severe depression, consisting of an electric shock passed directly through the brain, which induces a convulsion.
- Psychosurgery** Any surgical alteration of the brain designed to bring about desirable behavioral or emotional changes.
- Mental hospitalization** Placing a person in a protected, therapeutic environment staffed by mental health professionals.
- Partial hospitalization** An approach in which patients receive treatment at a hospital during the day, but return home at night.
- Deinstitutionalization** Reduced use of full-time commitment to mental institutions to treat mental disorders.



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A well-run halfway house can be a humane and cost-effective way to ease former mental patients back into the community (Soyez & Broekaert, 2003).

available in almost every community. As much as anything, a simple lack of money prevents large numbers of people from getting the help they need (Torrey, 1996).

Halfway houses may be a better way to ease a patient's return to the community (Soyez & Broekaert, 2003). **Halfway houses** are short-term group living facilities for people making the transition from an institution (mental hospital, prison, and so forth) to independent living. Typically, they offer supervision and support, without being as restricted and medically oriented as hospitals. They also keep people near their families. Most important, halfway houses can reduce a person's chances of being readmitted to a hospital (Coursey, Ward-Alexander, & Katz, 1990; Soyez & Broekaert, 2003).

## Community Mental Health Programs

**Community mental health centers**, which offer a wide range of mental health services and psychiatric care and are a bright spot in the area of mental health care. Such centers try to help people avoid hospitalization and find answers to mental health problems (Burns, 2004; Teed et al., 2007). Typically, they do this by providing short-term treatment, counseling, outpatient care, emergency services, and suicide prevention.

Mental health centers are also concerned with *prevention*. Consultation, education, and **crisis intervention** (skilled management of a psychological emergency) are used to prevent problems before they become serious. Also, some centers attempt to raise the general level of mental health in a community by combating unemployment, delinquency, and drug abuse (Tausig, Michello, & Subedi, 2004).

*Have community mental health centers succeeded in meeting their goals?* In practice, they have concentrated much more on providing clinical services than they have on preventing problems. This appears to be primarily the result of wavering government support (translation: money). Overall, community mental health centers have succeeded in making psychological services more accessible

than ever before. Many of their programs rely on **paraprofessionals** (individuals who work in a near-professional capacity under the supervision of more highly trained staff). Some paraprofessionals are ex-addicts, ex-alcoholics, or ex-patients who have “been there.” Many more are persons (paid or volunteer) who have skills in tutoring, crafts, or counseling or who are simply warm, understanding, and skilled at communication. Often, paraprofessionals are more approachable than “doctors.” This encourages people to seek mental health services that they might otherwise be reluctant to use (Everly, 2002).

### Knowledge Builder

## Medical Therapies

### RECITE

- Major tranquilizers are also known as
  - anxiolytics
  - antipsychotics
  - antidepressants
  - prefrontal sedatives
- ECT is a modern form of pharmacotherapy. T or F?
- Currently, the frontal lobotomy is the most widely used form of psychosurgery. T or F?
- Deinstitutionalization is an advanced form of partial hospitalization. T or F?

### REFLECT

#### Think Critically

- Residents of Berkeley, California, once voted on a referendum to ban the use of ECT within city limits. Do you think that the use of certain psychiatric treatments should be controlled by law?

#### Self-Reflect

Keeping in mind that all therapies, and especially medical therapies, have side effects (see, e.g., Casselle, 2009), when is it appropriate to use a medical therapy to treat someone with a mental illness? Why not use psychotherapy instead?

Why might you choose to combine a medical therapy and psychotherapy? Can you frame your reasons in terms of the stress-vulnerability model introduced in Chapter 14?

**Answers:** 1. b 2. F 3. F 4. F 5. The question of who can prescribe drugs, perform surgery, and administer ECT is controlled by law. However, psychiatrists strongly object to residents, city councils, or government agencies making medical decisions.

## Therapies—Human to the Core

**Gateway Question 15.9:** *Are various psychotherapies effective, and what do they have in common?*

In this section, let's ask whether the psychotherapies work and what, if anything, they have in common. We have put this section *after* the section on medical therapies to stress that human relations are at the core of healing. Whether or not a patient under medical care is receiving a somatic treatment, that treatment is administered in a human context. In that sense, it doesn't matter if the healer is a psychotherapist, psychiatrist, social worker, hospital worker, or whatever. No matter what helping specialty you might be considering as a career, information you'll encounter in this section might prove invaluable.

**Critical Thinking****How Do We Know Therapy Actually Works?**

**Why is it risky to believe people** who say their therapy was effective? An old joke among doctors is that a cold lasts a week without treatment and seven days with it. Perhaps the same is true of therapy. Someone who feels better after 6 months of therapy may have experienced a spontaneous remission—they just feel better because so much time has passed. Or perhaps the crisis that triggered the therapy is now nearly forgotten. Or maybe some sort of therapy placebo effect has occurred. Also, it's possible that the person has received help from other people, such as family, friends, or clergy.

To find out if therapy works, we could randomly place clients in an experimental group that receives therapy and a control group that does not. When this is done, the control group may show some improvement, even without receiving therapy (Lambert & Ogles, 2002; Schuck, Keijsers, & Rinck, 2011). Thus, we can conclude that the therapy is effective only if people in the experimental group improve more than those in the control group.

*But isn't it unethical to withhold treatment from someone who really needs therapy?* That's right. One way to deal with this is to

use a *waiting-list control group*. In this case, people who are waiting to see a therapist are compared with those who receive therapy. Later, those on the waiting list will eventually also receive therapy.

If we combine the results of many experiments, it becomes clear that therapy is effective (Lipsey & Wilson, 1993). In addition, studies have revealed that some therapies work best for specific problems (Bradley et al., 2005; Eddy et al., 2004). For example, behavioral, cognitive, and drug therapies are most helpful in treating obsessive-compulsive disorder.

*OK. So how effective is psychotherapy?* Judging the outcome of therapy is tricky. In a national survey, 9 out of 10 people who have sought mental health care say their lives improved as a result of the treatment (Consumer Reports, 2010; Kotkin, Daviet, & Gurin, 1996). Unfortunately you can't just take people's word for it (see "How Do We Know Therapy Actually Works?").

Psychologists are making steady progress in identifying "empirically supported" (or "evidence-based") therapies (Westen & Bradley, 2005). Rather than just relying on intuition, clinicians are seeking guidance from research experiments and guidelines developed through clinical practice (Carroll & Rounsaville, 2007; Miller & Binder, 2002). The end result is a better understanding of which therapies "work" best for specific types of problems. This trend is also helping to weed out fringe "therapies" that have little or no value.

Fortunately, there is direct evidence that therapy is beneficial. Hundreds of studies show a strong pattern of positive effects for psychotherapy, counseling, and other psychological treatments (Barlow, 2004; Lambert & Cattani-Thompson, 1996; Moras, 2002). Of course, results vary in individual cases. For some people, therapy is immensely helpful; for others, it is unsuccessful. Overall, it is effective for more people than not. Speaking more subjectively, a real success, in which a person's life is changed for the better, can be worth the frustration of several cases in which little progress is made.

Although it is common to think of therapy as a long, slow process, this is not normally the case (Shapiro et al., 2003). Research shows that about 50 percent of all clients feel better after between 13 and 18 weekly 1-hour therapy sessions (Howard et al., 1986). This means that the majority of clients improve after 6 months of therapy. Such rapid improvement is impressive in view of the fact that people often suffer for several years before seeking help. Unfortunately, because of high costs and limited insurance coverage, the average client receives only 5 therapy sessions, after which only 20 percent of all patients feel better (Hansen, Lambert, & Forman, 2002).

**Core Features of Psychotherapy**

*What do psychotherapies have in common?* We have sampled only a few of the many therapies in use today. For a summary of major differences among psychotherapies, see ■ Table 15.3. To add to your understanding, let's briefly summarize what all techniques have in common.

Psychotherapies of various types share all or most of the following goals: restoring hope, courage, and optimism; gaining insight; resolving conflicts; improving one's sense of self; changing unacceptable patterns of behavior; finding purpose; mending interpersonal relations; and learning to approach problems rationally (Frank & Frank, 2004; Seligman, 1998). To accomplish these goals, psychotherapies offer the following:

1. Effective therapy provides a **therapeutic alliance**, a *caring relationship* that unites the client and therapist as they work together to solve the client's problems. The strength of this alliance has a major impact on whether therapy succeeds (Kozart, 2002; Meier et al., 2006). The basis for this relationship is emotional rapport, warmth, friendship, understanding, acceptance, and empathy.

**Halfway house** A community-based facility for individuals making the transition from an institution (mental hospital, prison, and so forth) to independent living.

**Community mental health center** A facility offering a wide range of mental health services, such as prevention, counseling, consultation, and crisis intervention.

**Crisis intervention** Skilled management of a psychological emergency.

**Paraprofessional** An individual who works in a near-professional capacity under the supervision of a more highly trained person.

**Therapeutic alliance** A caring relationship that unites a therapist and a client in working to solve the client's problems.

**TABLE 15.3** Comparison of Psychotherapies

	Insight or Action?	Directive or Nondirective?	Individual or Group?	Therapy's Strength
Psychoanalysis	Insight	Directive	Individual	Searching honesty
Brief psychodynamic therapy	Insight	Directive	Individual	Productive use of conflict
Client-centered therapy	Insight	Nondirective	Both	Acceptance, empathy
Existential therapy	Insight	Both	Individual	Personal empowerment
Gestalt therapy	Insight	Directive	Both	Focus on immediate awareness
Behavior therapy	Action	Directive	Both	Observable changes in behavior
Cognitive therapy	Action	Directive	Individual	Constructive guidance
Rational-emotive behavior therapy	Action	Directive	Individual	Clarity of thinking and goals
Psychodrama	Insight	Directive	Group	Constructive re-enactments
Family therapy	Both	Directive	Group	Shared responsibility for problems

Source: Adapted from Corsini & Wedding, 2011; Prochaska & Norcross, 2010.

- Therapy offers a *protected setting* in which emotional *catharsis* (release) can take place. Therapy is a sanctuary in which the client is free to express fears, anxieties, and personal secrets without fearing rejection or loss of confidentiality.
- All therapies to some extent offer an *explanation* or *rationale* for the client's suffering. Additionally, they propose a line of action that will end this suffering.
- Therapy provides clients with a *new perspective* about themselves and their situations and a chance to practice *new behaviors* (Crencavage & Norcross, 1990; Prochaska & Norcross, 2010). Insights gained during therapy can bring about lasting changes in clients' lives (Grande et al., 2003).

## Master Therapists

Because therapies have much in common, a majority of psychologists have become *eclectic* in their work (Kopta et al., 1999). Eclectic therapists use whatever methods best fit a particular problem (Norcross, 2005). In addition, some seek to combine the best elements of various therapies to broaden their effectiveness.

*What do the most capable therapists have in common?* One study of master therapists found that they share several characteristics (Jennings & Skovholt, 1999). The most effective therapists:

- Are enthusiastic learners
- Draw on their experience with similar problems
- Value complexity and ambiguity
- Are emotionally open
- Are mentally healthy and mature
- Nurture their own emotional well-being
- Realize that their emotional health affects their work
- Have strong social skills
- Cultivate a working alliance
- Expertly use their social skills in therapy

Notice that this list also could describe the kind of person most of us would want to talk to when facing a life crisis. But what if someone else turns to you for help?

## Basic Counseling Skills

If you are ever called upon to comfort a person in distress, such as a troubled friend or relative, here are some general helping skills that can be distilled from the various approaches to therapy (Kottler & Shepard, 2011; Sharf, 2012; ■ Table 15.4).

### Active Listening

People frequently talk “at” each other without really listening. A person with problems needs to be heard. Make a sincere effort to listen to and understand the person. Try to accept the person's message without judging it or leaping to conclusions. Let the person know you are listening, through eye contact, posture, your tone of voice, and your replies (Kottler & Shepard, 2011).

### Reflect Thoughts and Feelings

One of the best things you can do when offering support to another person is to give feedback by simply restating what is said. This is also a good way to encourage a person to talk. If your friend

**TABLE 15.4** Helping Behaviors

To help another person gain insight into a personal problem, it is valuable to keep the following comparison in mind:

Behaviors That Help	Behaviors That Hinder
Active listening	Probing painful topics
Acceptance	Judging/moralizing
Reflecting feelings	Criticism
Open-ended questioning	Threats
Supportive statements	Rejection
Respect	Ridicule/sarcasm
Patience	Impatience
Genuineness	Placing blame
Paraphrasing	Opinionated statements

Adapted from Kottler & Shepard, 2011.

seems to be at a loss for words, *restate* or *paraphrase* his or her last sentence. Here's an example:

*Friend:* I'm really down about school. I can't get interested in any of my classes. I flunked my Spanish test, and somebody stole my notebook for psychology.

*You:* You're really upset about school, aren't you?

*Friend:* Yeah, and my parents are hassling me about my grades again.

*You:* That sucks.

*Friend:* Yeah.

*You:* That must make you angry.

As simple as this sounds, it is very helpful to someone trying to sort out feelings. Try it. If nothing else, you'll develop a reputation as a fantastic conversationalist!

## Silence

Counselors tend to wait longer before responding than do people in everyday conversations. Pauses of 5 seconds or more are not unusual, and interrupting is rare. Listening patiently lets the person feel unhurried and encourages her or him to speak freely.

## Questions

Because your goal is to encourage free expression, *open-ended questions* tend to be the most helpful. A *closed question* is one that can be answered yes or no. Open-ended questions call for an open-ended reply. Say, for example, that a friend tells you, "I feel like my boss has it in for me at work." A closed question would be, "Oh yeah? So, are you going to quit?" Open-ended questions such as "Do you want to talk about it?" or "How do you feel about it?" are more likely to be helpful.

### BRIDGES

Open-ended questions are an effective way to begin and sustain a conversation. See Chapter 12, page 436.

## Clarify the Problem

People who have a clear idea of what is wrong in their lives are more likely to discover solutions. Try to understand the problem from the person's point of view. As you do, check your understanding often. For example, you might ask, "Are you saying that you feel depressed just at school? Or in general?" Remember, a problem well defined is often half solved.

## Focus on Feelings

Feelings are neither right nor wrong. By focusing on feelings, you can encourage the outpouring of emotion that is the basis for catharsis. Passing judgment on what is said just makes people defensive. For example, a friend confides that he has failed a test. Perhaps you know that he studies very little. If you say, "Just study more and you will do better," he will probably become defensive or hostile. Much more can be accomplished by saying, "You must feel very frustrated" or simply, "How do you feel about it?"



Teams of psychologists and counselors are often assembled to provide support to victims of major accidents and natural disasters. Because their work is stressful and often heart wrenching, relief workers also benefit from on-site counseling. Expressing emotions and talking about feelings are major elements of disaster counseling.

## Avoid Giving Advice

Many people mistakenly think that they must solve problems for others. Remember that your goal is to provide understanding and support, not solutions. Of course, it is reasonable to give advice when you are asked for it, but beware of the trap of the "Why don't you...? Yes, but..." game. According to psychotherapist Eric Berne (1964), this "game" follows a pattern: Someone says, "I have this problem." You say, "Why don't you do thus and so?" The person replies, "Yes, but..." and then tells you why your suggestion won't work. If you make a new suggestion, the reply will once again be, "Yes, but..." Obviously, the person either knows more about his or her personal situation than you do or he or she has reasons for avoiding your advice. The student described earlier knows he needs to study. His problem is to understand why he doesn't *want* to study.

## Accept the Person's Frame of Reference

Because we all live in different psychological worlds, there is no "correct" view of a life situation. A person who feels that his or her viewpoint has been understood feels freer to examine it objectively and to question it. Understanding another person's perspective is especially important when cultural differences may create a barrier between a client and therapist (Draguns, Gielen, & Fish, 2004). (See "Therapy and Culture—A Bad Case of 'Ifufunyané.'")

## Maintain Confidentiality

Your efforts to help will be wasted if you fail to respect the privacy of someone who has confided in you. Put yourself in the person's place. Don't gossip.

These guidelines are not an invitation to play "junior therapist." Professional therapists are trained to approach serious problems with skills far exceeding those described here. However, the points



## Human Diversity

# Therapy and Culture—A Bad Case of “Ifufunyane”

**At the age of 23**, the patient was clearly suffering from “ifufunyane,” a form of bewitchment common in the Xhosa culture of South Africa. However, he was treated at a local hospital by psychiatrists, who said he had schizophrenia and gave him antipsychotic drugs. The drugs helped, but his family shunned his fancy medical treatment and took him to a traditional healer who gave him herbs for his ifufunyane. Unfortunately, he got worse and was readmitted to the hospital. This time, the psychiatrists included the patient’s family in his treatment. Together, they agreed to treat him with a combination of antipsychotic drugs *and* traditional herbs. This time, the patient got much better and his ifufunyane was alleviated, too (Niehaus et al., 2005).

As this example illustrates, **culturally skilled therapists** are trained to work with clients from various cultural backgrounds. To be culturally skilled, a counselor must be able to do all of the following (American Psychological Association, 2003, 2008; Brammer, 2012; Fowers & Davidov, 2006):

- Adapt traditional theories and techniques to meet the needs of clients from non-European ethnic or racial groups.
- Be aware of his or her own cultural values and biases.
- Establish rapport with a person from a different cultural background.
- Be open to cultural differences without resorting to stereotypes.

- Treat members of racial or ethnic communities as individuals.
- Be aware of a client’s ethnic identity and degree of acculturation to the majority society.
- Use existing helping resources within a cultural group to support efforts to resolve problems.

Cultural awareness has helped broaden our ideas about mental health and optimal development (Brammer, 2012). It is also worth remembering that cultural barriers apply to communication in all areas of life, not just therapy. Although such differences can be challenging, they are also frequently enriching (Uwe et al., 2006).

made help define the qualities of a therapeutic relationship. They also emphasize that each of us can supply two of the greatest mental health resources available at any cost: friendship and honest communication.

## ➤ The Future of Therapy— ➤ Magnets, Groups, and Smartphones

**Gateway Question 15.10:** *What will therapy be like in the future?*

Therapy has come a long way since the days of trepanning and demonology. Still, the search for ways to improve therapy remains an urgent challenge for those who devote their lives to helping others. Therapy in the future will likely include some things old and some things new (Norcross, Hedges, & Prochaska, 2002):

- More therapy provided by lower cost master’s-level practitioners (counselors, social workers, and psychiatric nurses).
- Greater use of short-term therapy and solution-focused, problem-solving approaches.
- More precisely targeted medical therapies with fewer side effects.
- Greater reliance on group therapies and self-help groups run by paraprofessionals.
- Increased use of Internet services and telephone counseling to distribute mental health services.

As you might imagine, many of these predicted changes are based on pressures to reduce the cost of mental health services. Psychiatrists

and clinical psychologists are expensive to train. There are too few to take on primary responsibility in all cases. Similarly, longer-term insight-oriented therapies, in particular psychoanalysis, are an expensive luxury.

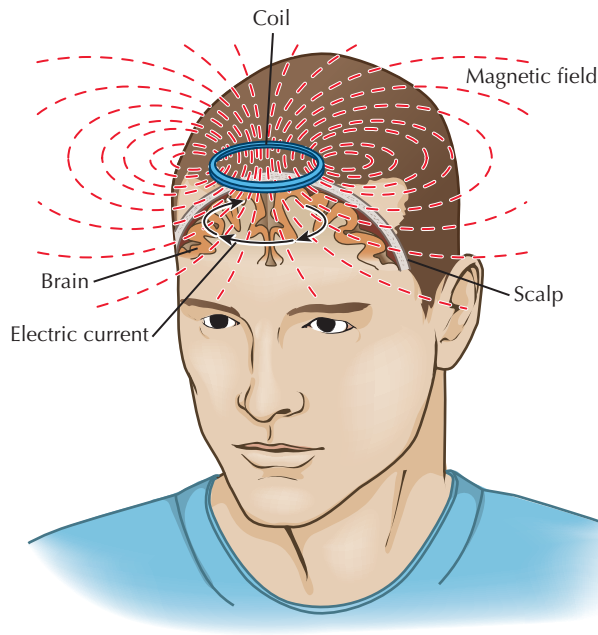
## New Medical Therapies

Neuroscience research continues to probe the functioning of the brain and its various parts in ever-greater detail (Freberg, 2010). As a result, more precisely targeted medical therapies with fewer side effects will continue to be discovered (Morgan & Ricke, 2008). For example, a new technique called **transcranial magnetic stimulation (TMS)** uses magnetic pulses to temporarily block activity in specific parts of the brain. Unlike surgical lesioning, TMS is non-invasive and is reversible (see • Figure 15.6).

By applying TMS to parts of the frontal lobe, Paulo Boggio and his colleagues (2010) were able to change the way people made decisions while gambling. It is not a long stretch to imagine that this technique might become a powerful adjunct therapy together with cognitive therapy to treat compulsive gambling (Ladouceur, Lachance, & Fournier, 2009). Similarly, patients with obsessive-compulsive disorder have shown marked improvement when TMS disrupted brain areas involved in compulsive behavior (Mantovani et al., 2010).

## Group Therapy

Because it is cost-effective, **group therapy**, psychotherapy done with more than one person, will become more common in the future. This is a trend that began some 50 years ago when psychologists first worked with groups because there was a shortage of



● **Figure 15.6** Transcranial magnetic stimulation (TMS) uses a small coil held near the surface of the scalp to create magnetic pulses that induce electrical activity in the underlying brain tissue. The result is a temporary blockage of normal brain activity. TMS can be used to study brain function and has already been applied as a medical therapy (Mantovani et al., 2010).

therapists. Many of the therapies we have discussed can be adapted for use in groups (Corey, 2012). Surprisingly, group therapy has turned out to be just as effective as individual therapy and has some special advantages (Burlingame, Fuhriman, & Mosier, 2003).

*What are the advantages?* In group therapy, a person can *act out* or directly experience problems. Doing so often produces insights that might not occur from merely talking about an issue. In addition, other group members with similar problems can offer support and useful input. Group therapy is especially good for helping people understand their personal relationships (McCluskey, 2002). For reasons such as these, a number of specialized groups have emerged. Because they range from Alcoholics Anonymous to Marriage Encounter, we will sample only a few examples.

## Psychodrama

One of the first group therapies was developed by Jacob L. Moreno (1953), who called his technique psychodrama. In **psychodrama**, clients act out personal conflicts with others who play supporting roles (Blatner, 2006). Through role-playing, the client re-enacts incidents that cause problems in real life. For example, Don, a disturbed teenager, might act out a typical family fight, with the therapist playing his father and with other clients playing his mother, brothers, and sisters. Moreno believed that insights gained in this way transfer to real life situations.

Therapists using psychodrama often find that role reversals are helpful. A **role reversal** involves taking the part of another person to learn how he or she feels. For instance, Don might role-play his father or mother, to better understand their feelings. A

related method is the **mirror technique**, in which clients observe another person re-enact their behavior. Thus, Don might briefly join the audience and watch as another group member plays his role. This would allow him to see himself as others do. Later, the group may summarize what happened and reflect on its meaning (Turner, 1997).

## Family and Couples Therapy

Family relationships are the source of great pleasure and, all too often, of great pain. In **family therapy**, husband, wife, and children work as a group to resolve the problems of each family member. This is also called *couples therapy* when children are not involved (Scheinkman, 2008). Family and couples therapy tends to be time limited and focused on specific problems, such as frequent fights or a depressed teenager. For some types of problems, family therapy may be superior to other approaches (Capuzzi, 2003; Eisler et al., 2007).



A group therapy session. Group members offer mutual support while sharing problems and insights.

- Culturally skilled therapist** A therapist who has the awareness, knowledge, and skills necessary to treat clients from diverse cultural backgrounds.
- Transcranial magnetic stimulation (TMS)** Use of magnetic pulses to temporarily block activity in specific parts of the brain.
- Group therapy** Psychotherapy conducted in a group setting to make therapeutic use of group dynamics.
- Psychodrama** A therapy in which clients act out personal conflicts and feelings in the presence of others who play supporting roles.
- Role reversal** Taking the role of another person to learn how one's own behavior appears from the other person's perspective.
- Mirror technique** Observing another person re-enact one's own behavior, like a character in a play; designed to help persons see themselves more clearly.
- Family therapy** Technique in which all family members participate, both individually and as a group, to change destructive relationships and communication patterns.

Family therapists believe that a problem experienced by one family member is really the whole family's problem (Teyber & McClure, 2011). If the entire pattern of behavior in a family doesn't change, improvements in any single family member may not last. Family members, therefore, work together to improve communication, to change destructive patterns, and to see themselves and each other in new ways (Goldenberg & Goldenberg, 2004; Griffin, 2002).

*Does the therapist work with the whole family at once?* Family therapists treat the family as a unit, but they may not meet with the entire family at each session (Eisler et al., 2007). If a family crisis is at hand, the therapist may first try to identify the most resourceful family members, who can help solve the immediate problem. The therapist and family members may then work on resolving more basic conflicts and on improving family relationships (Griffin, 2002).

### Group Awareness Training

During the 1960s and 1970s, the human potential movement led many people to seek personal growth experiences. Often, their interest was expressed by participation in sensitivity training or encounter groups.

*What is the difference between sensitivity groups and encounter groups?* Sensitivity groups tend to be less confrontational than encounter groups. Participants in **sensitivity groups** take part in exercises that gently enlarge self-awareness and sensitivity to others. For example, in a "trust walk," participants expand their confidence in others by allowing themselves to be led around while blindfolded.

**Encounter groups** are based on an honest expression of feelings, and intensely personal communication may take place. Typically, the emphasis is on tearing down defenses and false fronts. Because there is a danger of hostile confrontation, participation is safest when members are carefully screened and a trained leader guides the group. In business settings, psychologists still use the basic principles of sensitivity and encounter groups—truth, self-awareness, and self-determination—to improve employee relationships. Specially designed encounter groups for married couples are also widely held (Harway, 2004).

There has also been much public interest in various forms of large group awareness training. **Large group awareness training** refers to programs that claim to increase self-awareness and facilitate constructive personal change. The Garden Company, Lifespring, the Forum, the Hoffman Quadrinity Process, and similar commercial programs are examples. Like the smaller groups that preceded them, large-group training combines psychological exercises, confrontation, new viewpoints, and group dynamics to promote personal change.

*Are sensitivity, encounter, and awareness groups really psychotherapies?* These experiences tend to be positive, but they produce only moderate benefits (Faith, Wong, & Carpenter, 1995). Moreover, many of the claimed benefits may result simply from a kind of **therapy placebo effect**, in which improvement is based on a client's belief that therapy will help. Positive expectations, a break in

daily routine, and an excuse to act differently can have quite an impact. Also, less ambitious goals may be easier to attain. For example, one program succeeded in teaching stress-management techniques in a large group setting (Timmerman, Emmelkamp, & Sanderman, 1998). Because of their low cost and versatility, groups undoubtedly will continue to grow in popularity as tools for solving problems and improving lives (Corey, 2012).

### Therapy at a Distance

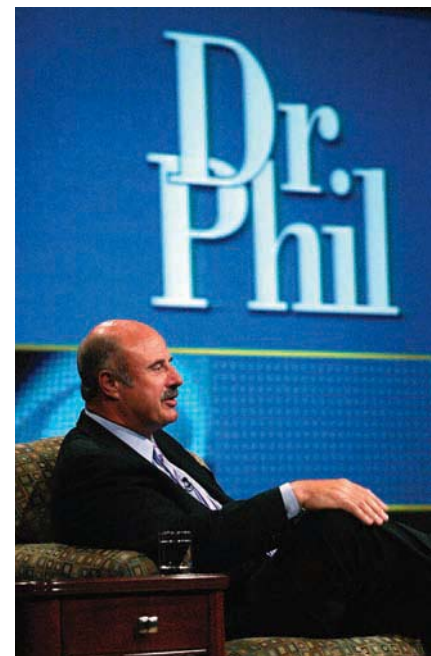
For better or worse, high-tech psychotherapy and counseling are rapidly becoming commonplace (Ormay, 2006). Today, psychological services are available through radio, telephone, e-mail, Internet chat rooms, and videoconferencing (Maheu et al., 2004). What are the advantages and disadvantages of getting help at a distance?

### Media Psychologists

By now you have probably heard a phone-in radio psychologist or watched one on television. On a typical program, participants describe problems arising from child abuse, loneliness, love affairs, phobias, sexual adjustment, or depression. The media psychologist then offers reassurance, advice, or suggestions for getting help. Such talk-radio and television programs may seem harmless, but they raise some important questions. For instance, is it reasonable to give advice without knowing anything about a person's background? Could the advice do harm? What good can a psychologist do in 3 minutes or even an hour?

In their own defense, media psychologists point out that listeners and viewers may learn solutions to their problems by hearing others talk. Many also stress that their work is educational, not therapeutic. The well-known media psychologist Dr. Phil McGraw

Media psychologists have been urged to educate without actually doing therapy. Some overstep this boundary, however. Do you think popular TV psychologist Dr. Phil sometimes goes too far?



Frederick M. Brown/Getty Images

has even been awarded a President's Citation from the American Psychological Association for his work in publicizing mental health issues (Meyers, 2006).

Nevertheless, the question arises: When does advice become therapy? The American Psychological Association urges media psychologists to discuss problems only of a general nature instead of actually counseling anyone. For example, if a caller complains about insomnia, the radio psychologist should talk about insomnia in general, not probe the caller's personal life. A good guide for anyone tempted to call a radio psychologist or accept advice from a TV psychologist might be "let the consumer beware."

## Telephone and Internet Therapists

The same caution applies to commercial telephone and Internet therapists. A key feature of successful face-to-face therapy is the establishment of an effective *therapeutic alliance*, a continuing relationship between two people. In this regard, distance therapies are more or less limited by a lack of interpersonal cues, such as facial expressions and body language. For example, brief e-mail messages are no way to make a diagnosis. And forget about facial expressions or body language—not even tone of voice reaches the e-mail therapist. Typing emotional icons (called *emoticons*) like little smiley faces (☺) or frowns (☹) is a poor substitute for real human interaction.

Of special concern is the fact that distance therapists may or may not be trained professionals (Bloom, 1998). And even if they are, questions exist about whether a psychologist licensed in one state can legally do therapy in another state via the telephone or the Internet.

Regardless, distance counseling and therapy services do have some advantages. For one thing, clients can more easily remain anonymous. (But beware that e-mail counseling may not be completely confidential and could be intercepted and misused.) Thus, a person who might hesitate to see a psychologist can seek help privately, on the phone or online. Likewise, people who live in rural areas can more easily work with psychologists living in large cities. And, compared with traditional office visits, distance therapies are less expensive.

Under the right circumstances, distance therapies can be successful (Day & Schneider, 2002). For example, in one study, telephone counseling helped improve success rates for smokers who wanted to quit (Rabius et al., 2004). Other studies have shown that depressed people benefit from telephone therapy (Mohr et al., 2005; Simon et al., 2004). Psychologists have also demonstrated success in providing therapy over the Internet, at least for certain types of problems (Carlbring et al., 2007; Chester & Glass, 2006; Klein, Richards, & Austin, 2006).

## The Ever-Evolving Internet

The Internet continues to provide new communication tools that blend voice, text, graphics, and video. Widely available and inexpensive technologies, such as Skype, make it easy to create two-way audio-video links that allow a client and therapist to see one another on computer monitors and to talk via speakerphones. Doing therapy this way still lacks the close personal contact of

face-to-face interaction. However, it does remove many of the objections to doing therapy at a distance. It's very likely that distance services will continue to evolve (Riva & Wiederhold, 2006) and become a major source of mental health care in coming years (Schopp, Demiris, & Glueckauf, 2006).

Another interesting cost-saving measure is the idea that computer software may be able to treat some relatively minor problems (Craske et al., 2009). In one study, clients worked through ten computer-guided sessions that helped them identify a problem, form a plan of action, and work through carrying out the plan. Most were satisfied with the help they received (Jacobs et al., 2001).

## Implications

As you can see, psychological services that rely on electronic communication may serve some useful purposes. However, the value of therapy offered by commercial telephone "counselors" and Internet "therapists" remains open to question. The very best advice given by media psychologists, telephone "counselors," or Internet "therapists" may be, "If at all possible, you should consider discussing this problem with a psychologist or counselor in your own community."

## A Look Ahead

In the *Psychology in Action* section that follows, we will return briefly to behavioral approaches. There you will find a number of useful techniques that you may be able to apply to your own behavior. You'll also find a discussion of when to seek professional help and how to find it. Here's your authors' professional advice: This is information you won't want to skip.

### Knowledge Builder

## Contemporary Issues in Therapy

### RECITE

- Emotional rapport, warmth, understanding, acceptance, and empathy are the core of
  - the therapeutic alliance
  - large-group awareness training
  - role reversals
  - action therapy
- Culturally skilled therapists do all but one of the following; which does *not* apply?
  - Are aware of the client's degree of acculturation
  - Use helping resources within the client's cultural group
  - Adapt standard techniques to match cultural stereotypes
  - Are aware of their own cultural values

*Continued*

**Sensitivity group** A group experience consisting of exercises designed to increase self-awareness and sensitivity to others.

**Encounter group** A group experience that emphasizes intensely honest interchanges among participants regarding feelings and reactions to one another.

**Large group awareness training** Any of a number of programs (many of them commercialized) that claim to increase self-awareness and facilitate constructive personal change.

**Therapy placebo effect** Improvement caused not by the actual process of therapy but by a client's expectation that therapy will help.

3. In psychodrama, people attempt to form meaningful wholes out of disjointed thoughts, feelings, and actions. T or F?
4. Most large-group awareness trainings make use of Gestalt therapy. T or F?
5. The mirror technique is frequently used in  
a. exposure therapy b. psychodrama c. family therapy d. ECT
6. To date, the most acceptable type of “distance therapy” is  
a. media psychology b. commercial telephone counseling c. Internet-based cybertherapy d. based on videoconferencing

### REFLECT

#### Think Critically

7. In your opinion, do psychologists have a duty to protect others who may be harmed by their clients? For example, if a patient has homicidal fantasies about his ex-wife, should she be informed?

### Relate

What lies at the “heart” of psychotherapy? How would you describe it to a friend?

Which of the basic counseling skills do you already use? Which would improve your ability to help a person in distress (or even just have an engaging conversation)?

Would you rather participate in individual therapy or group therapy?

What advantages and disadvantages do you think each has?

A neighbor of yours is thinking about getting counseling on the Internet. What would you tell her about the pros and cons of distance therapy?

**Answers:** 1. a. 2. c. 3. F. 4. F. 5. b. 6. d. 7. According to the law, there is a duty to protect others when a therapist could, with little effort, prevent serious harm. However, this duty can conflict with a client's rights to confidentiality and with client-therapist trust. Therapists often must make difficult choices in such situations.

## Psychology in Action



## Self-Management and Seeking Professional Help

**Gateway Question 15.11:** *How are behavioral principles applied to everyday problems and how could a person find professional help?*

As mentioned elsewhere in this book, you should seek professional help when a significant problem exists. For lesser difficulties you may want to try applying behavioral principles yourself (Martin & Pear, 2011; Watson & Tharp, 2007). (See also Chapter 6.)

### Covert Reward and Punishment—Boosting Your “Willpower”

Behavior therapy is not a cure-all. Its use is often quite complicated and requires a great deal of expertise. Still, behavior therapy offers a straightforward solution to many problems.

Let's see how this might be done:

**Therapist:** “Have you ever decided to quit smoking cigarettes, watching television too much, eating too much, drinking too much, or driving too fast?”

**Client:** “Well, one of those applies. I have decided several times to quit smoking.”

**Therapist:** “When have you decided?”

**Client:** “Usually after I am reminded of how dangerous smoking is—like when I heard that

my uncle had died of lung cancer. He smoked constantly.”

**Therapist:** “If you have decided to quit ‘several times,’ I assume you haven’t succeeded.”

**Client:** “No, the usual pattern is for me to become upset about smoking and then to cut down for a day or two.”

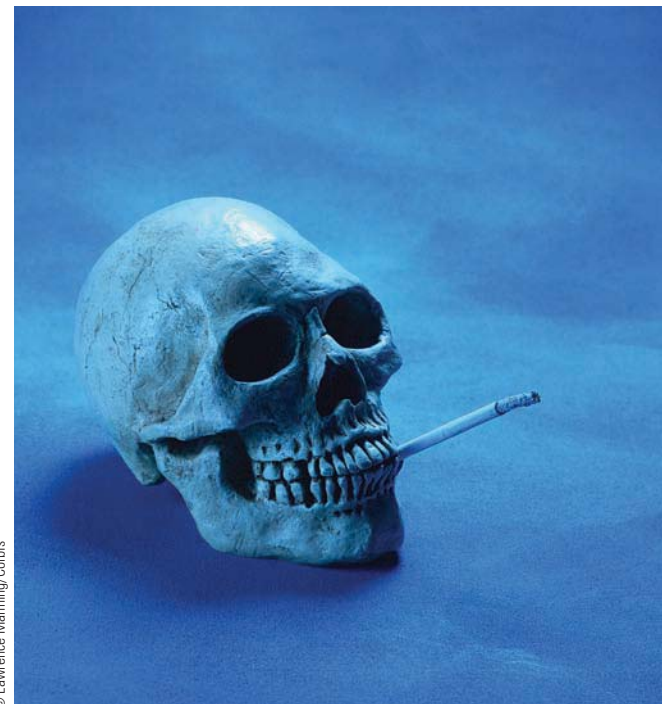
**Therapist:** “You forget the disturbing image of your uncle’s death, or whatever, and start smoking again.”

**Client:** “Yes. I suppose if I had an uncle die every day or so, I might actually quit!”

The use of intensive behavioral principles, such as electric shock, to condition an aversion seems remote from everyday problems. Even naturally aversive actions are difficult to apply to personal behavior. As mentioned earlier, for instance, rapid smoking is difficult for most smokers to carry out on their own. And what about a problem like overeating? Indeed, it would be difficult to eat enough to create a lasting aversion to overeating (although it’s sometimes tempting to try).

In view of such limitations, psychologists have developed an alternative procedure that can be used to curb smoking, overeating, and other habits (Kearney, 2006; Watson & Tharp, 2007).

**Covert Sensitization** In **covert sensitization**, aversive imagery is used to reduce the occurrence of an undesired response. Here’s how it’s done: Obtain six 3 by 5 cards and on each write a brief description of a scene related to the habit you wish to control. The scene should be so *disturbing* or *disgusting* that



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thinking about it would temporarily make you very uncomfortable about indulging in the habit. For smoking, the cards might read:

- “I am in a doctor’s office. The doctor looks at some reports and tells me I have lung cancer. She says a lung will have to be removed and sets a date for the operation.”
- “I am in bed under an oxygen tent. My chest feels caved in. There is a tube in my throat. I can barely breathe.”
- “I wake up in the morning and smoke a cigarette. I begin coughing up blood.”
- “My lover won’t even kiss me because my breath smells bad.”

Other cards would continue along the same line.

For overeating the cards might read like this:

- “I am at the beach. I get up to go for a swim and I overhear people whispering to each other, ‘Isn’t that fat disgusting?’”
- “I am at a store buying clothes. I try on several things that are too small. The only things that fit look like rumpled sacks. Salespeople are staring at me.”
- “I can’t fit into my seat at the movies.”

The trick is to get yourself to imagine or picture vividly each of these disturbing scenes *several times* a day. Imagining the scenes can be accomplished by placing them under *stimulus control*. Simply choose something you do *frequently* each day (such as getting a cup of coffee or getting up from your chair). Next make a rule: Before you can get a cup of coffee or get up from your chair, or whatever you have selected as a cue, you must take out your cards and *vividly picture* yourself engaging in the action you wish to curb (eating or smoking, for example). Then *vividly picture* the scene described on the top card. Imagine the scene for 30 seconds.

After visualizing the top card, move it to the bottom so the cards are rotated. Make up new cards each week. The scenes can be made much more upsetting than the samples given here, which are toned down to keep you from being “grossed out.”

Covert sensitization can also be used directly in situations that test your self-control. If you are trying to lose weight, for instance, you might be able to turn down a tempting dessert in this way: As you look at the dessert, visualize maggots crawling all over it. If you make this image as vivid and nauseat-

ing as possible, losing your appetite is almost a certainty. If you want to apply this technique to other situations, be aware that vomiting scenes are especially effective. Covert sensitization may sound as if you are “playing games with yourself,” but it can be a great help if you want to cut down on a bad habit (Kearney, 2006). Try it!

**Thought Stopping** As discussed earlier, behavior therapists accept that thoughts, like visible responses, can also cause trouble. Think of times when you have repeatedly “put yourself down” mentally or when you have been preoccupied by needless worries, fears, or other negative and upsetting thoughts. If you would like to gain control over such thoughts, thought stopping may help you do it.

In **thought stopping**, aversive stimuli are used to interrupt or prevent upsetting thoughts (Bakker, 2009). The simplest thought-stopping technique makes use of mild punishment to suppress upsetting mental images and internal “talk.” Simply place a large, flat rubber band around your wrist. As you go through the day apply this rule: Each time you catch yourself thinking the upsetting image or thought, pull the rubber band away from your wrist and snap it. You need not make this terribly painful. Its value lies in drawing your attention to how often you form negative thoughts and in interrupting the flow of thoughts.

A second thought-stopping procedure requires only that you interrupt upsetting thoughts each time they occur. Begin by setting aside time each day during which you will deliberately think the unwanted thought. As you begin to form the thought, shout “Stop!” aloud, with conviction. (Obviously, you should choose a private spot for this part of the procedure!)

Repeat the thought-stopping procedure 10 to 20 times for the first 2 or 3 days. Then switch to shouting “Stop!” covertly (to yourself) rather than aloud. Thereafter, thought stopping can be carried out throughout the day, whenever upsetting thoughts occur. After several days of practice, you should be able to stop unwanted thoughts whenever they occur.

**Covert Reinforcement** Earlier we discussed how punishing images can be used to decrease undesirable responses, such as smoking or overeating. Many people also find it helpful to covertly *reinforce* desired actions. **Covert reinforcement** is the use of positive imagery

to reinforce desired behavior. For example, suppose your target behavior is, once again, not eating dessert. If this were the case, you could do the following (Kearney, 2006; Watson & Tharp, 2007):

Imagine that you are standing at the dessert table with your friends. As dessert is passed, you politely refuse and feel good about staying on your diet.

These images would then be followed by imagining a pleasant, reinforcing scene:

Imagine that you are your ideal weight. You look really slim in your favorite color and style. Someone you really like says to you, “Gee, you’ve lost weight. I’ve never seen you look so good.”

For many people, of course, actual direct reinforcement is the best way to alter behavior. Nevertheless, covert or “visualized” reinforcement can have similar effects. To make use of covert reinforcement, choose one or more target behaviors and rehearse them mentally. Then follow each rehearsal with a vivid, rewarding image.

#### BRIDGES

Direct reinforcement is described in the *Psychology in Action* section of Chapter 6, pages 234–236.

### Self-Directed Desensitization—Overcoming Common Fears

You have prepared for 2 weeks to give a speech in a large class. As your turn approaches, your hands begin to tremble. Your heart pounds and you find it difficult to breathe. You say to your body, “Relax!” What happens? Nothing! That’s why the first step in desensitization is learning to relax voluntarily by using the tension-release method described earlier in this chapter. As an alternative, you might want to try imagining a very safe, pleasant, and relaxing scene. Some people find such images as relaxing as the tension-release method (Rosenthal, 1993). Another helpful technique

**Covert sensitization** Use of aversive imagery to reduce the occurrence of an undesired response.

**Thought stopping** Use of aversive stimuli to interrupt or prevent upsetting thoughts.

**Covert reinforcement** Using positive imagery to reinforce desired behavior.

is to do some deep breathing. Typically, a person who is breathing deeply is relaxed. Shallow breathing involves little movement of the diaphragm. If you place your hand on your abdomen, it will move up and down if you are breathing deeply.

Once you have learned to relax, the next step is to identify the fear you would like to control and construct a hierarchy.

**Procedure for Constructing a Hierarchy** Make a list of situations (related to the fear) that make you anxious. Try to list at least 10 situations. Some should be very frightening and others only mildly frightening. Write a short description of each situation on a separate 3-by-5 card. Place the cards in order from the least disturbing situation to the most disturbing. Here is a sample hierarchy for a student afraid of public speaking:

1. Being given an assignment to speak in class.
2. Thinking about the topic and the date the speech must be given.
3. Writing the speech; thinking about delivering the speech.
4. Watching other students speak in class the week before the speech date.
5. Rehearsing the speech alone; pretending to give it to the class.
6. Delivering the speech to my roommate; pretending my roommate is the teacher.
7. Reviewing the speech on the day it is to be presented.
8. Entering the classroom; waiting and thinking about the speech.
9. Being called; standing up; facing the audience.
10. Delivering the speech.

**Using the Hierarchy** When you have mastered the relaxation exercises and have the hierarchy constructed, set aside time each day to work on reducing your fear. Begin by performing the relaxation exercises. When you are completely relaxed, visualize the scene on the first card (the least frightening scene). If you can *vividly* picture and imagine yourself in the first situation twice *without a noticeable increase in muscle tension*, proceed to the next card. Also, as you progress, relax yourself between cards.

Each day, stop when you reach a card that you cannot visualize without becoming tense in three attempts. Each day, begin one or two

cards before the one on which you stopped the previous day. Continue to work with the cards until you can visualize the last situation without experiencing tension (techniques are based on Wolpe, 1974).

By using this approach you should be able to reduce the fear or anxiety associated with things such as public speaking, entering darkened rooms, asking questions in large classes, heights, talking to members of the opposite sex, and taking tests (Watson & Tharp, 2007). Even if you are not always able to reduce a fear, you will have learned to place relaxation under voluntary control. This alone is valuable because controlling unnecessary tension can increase energy and efficiency.

### Seeking Professional Help— When, Where, and How?

Chances are good that at some point you or someone in your family will benefit from mental health services of one kind or another. In one survey, 13.4 percent of all Americans received treatment for a mental health concern during the preceding year (National Institute of Mental Health, 2011a).

*How would I know if I should seek professional help at some point in my life?* Although there is no simple answer to this question, the following guidelines may be helpful:

1. If your level of psychological discomfort (unhappiness, anxiety, or depression, for example) is comparable to a level of physical discomfort that would cause you to see a doctor or dentist, you should consider seeing a psychologist or a psychiatrist.
2. Another signal to watch for is significant changes in behavior, such as the quality of your work (or schoolwork), your rate of absenteeism, your use of drugs (including alcohol), or your relationships with others.
3. Perhaps you have urged a friend or relative to seek professional help and were dismayed because he or she refused to do so. If you find friends or relatives making a similar suggestion, recognize that they may be seeing things more clearly than you are.
4. If you have persistent or disturbing suicidal thoughts or impulses, you should seek help immediately.

**Locating a Therapist** *If I wanted to talk to a therapist, how would I find one?* Here are some suggestions that could help you get started:

1. **Colleges and universities.** If you are a student, don't overlook counseling services offered by a student health center or special student counseling facilities.
2. **Workplaces.** If you have a job, check with your employer. Some employers have employee assistance programs that offer confidential free or low-cost therapy for employees.
3. **Community or county mental health centers.** Most counties and many cities offer public mental health services. (These are listed in the phone book.) Public mental health centers usually provide counseling and therapy services directly, and they can refer you to private therapists.
4. **Mental health associations.** Many cities have mental health associations organized by concerned citizens. Groups such as these usually keep listings of qualified therapists and other services and programs in the community.
5. **The Yellow Pages.** Psychologists are listed in the telephone book or on the Internet under "Psychologists," or in some cases under "Counseling Services." Psychiatrists are generally listed as a sub-heading under "Physicians." Counselors are usually found under the heading "Marriage and Family Counselors." These listings will usually put you in touch with individuals in private practice.
6. **Crisis hotlines.** The typical crisis hotline is a telephone service staffed by community volunteers. These people are trained to provide information concerning a wide range of mental health problems. They also have lists of organizations, services, and other resources in the community where you can go for help.

■ Table 15.5 summarizes all the sources for psychotherapy, counseling, and referrals we have discussed, as well as some additional possibilities.

**Options** *How would I know what kind of a therapist to see? How would I pick one?* The choice between a psychiatrist and a psycholo-

**TABLE 15.5** Mental Health Resources

- Family doctors (for referrals to mental health professionals)
- Mental health specialists, such as psychiatrists, psychologists, social workers, and mental health counselors
- Religious leaders/counselors
- Health maintenance organizations (HMOs)
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- University—or medical school—affiliated programs
- State hospital outpatient clinics
- Family service/social agencies
- Private clinics and facilities
- Employee assistance programs
- Local medical, psychiatric, or psychological societies

National Institute of Mental Health (2010b).

gist is somewhat arbitrary. Both are trained to do psychotherapy and can be equally effective as therapists (Seligman, 1995). Although a psychiatrist can administer somatic therapy and prescribe drugs, so can psychologists in New Mexico and Louisiana (Munsey, 2006). Besides, a psychologist can work in conjunction with a physician if such services are needed.

Fees for psychiatrists are usually higher, averaging about \$160 to \$200 an hour. Psychologists average about \$100 an hour. Counselors and social workers typically charge about \$80 per hour. Group therapy averages only about \$40 an hour because the therapist's fee is divided among several people.

Be aware that most health insurance plans will pay for psychological services. If fees are a problem, keep in mind that many therapists charge on a sliding scale, or ability-to-pay basis, and that community mental health centers almost always charge on a sliding scale. In one way or another, help is almost always available for anyone who needs it.

Some communities and college campuses have counseling services staffed by sympathetic paraprofessionals or peer counselors. These services are free or very low cost. As mentioned earlier, paraprofessionals are people who work in a near-professional capacity under professional supervision. **Peer counselors** are non-

professional persons who have learned basic counseling skills. There is a natural tendency, perhaps, to doubt the abilities of paraprofessionals. However, many studies have shown that paraprofessional counselors are often as effective as professionals (Christensen & Jacobson, 1994).

Also, don't overlook self-help groups, which can add valuable support to professional treatment. Members of a self-help group typically share a particular type of problem, such as eating disorders or coping with an alcoholic parent. **Self-help groups** offer members mutual support and a chance to discuss problems. In many instances, helping others also serves as therapy for those who give help (Burlingame & Davies, 2002). For some problems, self-help groups may be the best choice of all (Fobair, 1997; Galanter et al., 2005).

**Qualifications** You can usually find out about a therapist's qualifications simply by asking. A reputable therapist will be glad to reveal his or her background. If you have any doubts, credentials may be checked and other helpful information can be obtained from local branches of any of the following organizations. You can also browse the websites listed here:

American Association for Marriage and Family Therapy ([www.aamft.org](http://www.aamft.org))

American Family Therapy Academy ([www.afta.org](http://www.afta.org))

American Psychiatric Association ([www.psych.org](http://www.psych.org))

American Psychological Association ([www.apa.org](http://www.apa.org))

Association of Humanistic Psychology ([www.ahpweb.org](http://www.ahpweb.org))

Canadian Psychiatric Association ([www.cpa-apc.org](http://www.cpa-apc.org))

Canadian Psychological Association ([www.cpa.ca](http://www.cpa.ca))

Mental Health America ([www.nmha.org](http://www.nmha.org))

The question of how to pick a particular therapist remains. The best way is to start with a short consultation with a respected psychiatrist, psychologist, or counselor. This will allow the person you consult to evaluate your difficulty and recommend a type of therapy or a therapist who is likely to be helpful.

As an alternative you might ask the person teaching this course for a referral.

**Evaluating a Therapist** *How would I know whether to quit or ignore a therapist?* A balanced look at psychotherapies suggests that all *techniques* can be equally successful (Wampold et al., 1997). However, all *therapists* are not equally successful. Far more important than the approach used are the therapist's personal qualities (Okiishi et al., 2003; Prochaska & Norcross, 2010). The most consistently successful therapists are those who are willing to use whatever method seems most helpful for a client. They are also marked by personal characteristics of warmth, integrity, sincerity, and empathy. Former clients consistently rate the person doing the therapy as more important than the type of therapy used (Elliott & Williams, 2003).

It is perhaps most accurate to say that at this stage of development, psychotherapy is an art, not a science. The *relationship* between a client and therapist is the therapist's most basic tool (Hubble, Duncan, & Miller, 1999; Prochaska & Norcross, 2010). This is why you must trust and easily relate to a therapist for therapy to be effective. Here are some danger signals to watch for in psychotherapy:

- Sexual advances by therapist
- Therapist makes repeated verbal threats or is physically aggressive
- Therapist is excessively blaming, belittling, hostile, or controlling
- Therapist makes excessive small talk; talks repeatedly about his/her own problems
- Therapist encourages prolonged dependence on him/her
- Therapist demands absolute trust or tells client not to discuss therapy with anyone else

Clients who like their therapist are generally more successful in therapy (Talley, Strupp, & Morey, 1990). An especially important part of the therapeutic alliance is agreement about the goals of therapy (Meier et al., 2006). It is, therefore, a good idea to think about what you would like to accomplish by entering therapy.

**Peer counselor** A nonprofessional person who has learned basic counseling skills.

**Self-help group** A group of people who share a particular type of problem and provide mutual support to one another.



Write down your goals and discuss them with your therapist during the first session. Your first meeting with a therapist should also answer all of the following questions (Somberg, Stone, & Claiborn, 1993):

- Will the information I reveal in therapy remain completely confidential?
- What risks do I face if I begin therapy?
- How long do you expect treatment to last?
- What form of treatment do you expect to use?
- Are there alternatives to therapy that might help me as much or more?

It's always tempting to avoid facing up to personal problems. With this in mind, you should give a therapist a fair chance and not give up too easily. But don't hesitate to change therapists or to terminate therapy if you lose confidence in the therapist or if you don't relate well to the therapist as a person.

### Knowledge Builder

## Self-Management and Seeking Professional Help

### RECITE

1. Covert sensitization and thought stopping combine aversion therapy and cognitive therapy. T or F?
2. Like covert aversion conditioning, covert reinforcement of desired responses is also possible. T or F?
3. Exercises that bring about deep-muscle relaxation are an essential element in covert sensitization. T or F?
4. Items in a desensitization hierarchy should be placed in order from the least disturbing to the most disturbing. T or F?
5. The first step in desensitization is to place the visualization of disturbing images under stimulus control. T or F?
6. Persistent emotional discomfort is a clear sign that professional psychological counseling should be sought. T or F?
7. Community mental health centers rarely offer counseling or therapy themselves; they only do referrals. T or F?
8. In many instances, a therapist's personal qualities have more of an effect on the outcome of therapy than does the type of therapy used. T or F?

### REFLECT

#### Critical Thinking

9. Would it be acceptable for a therapist to urge a client to break all ties with a troublesome family member?

#### Self-Reflect

How could you use covert sensitization, thought stopping, and covert reinforcement to change your behavior? Try to apply each technique to a specific example.

Just for practice, make a fear hierarchy for a situation you find frightening. Does vividly picturing items in the hierarchy make you tense or anxious? If so, can you intentionally relax using the tension-release method?

Assume that you want to seek help from a psychologist or other mental health professional. How would you proceed? Take some time to actually find out what mental health services are available to you.

**Answers:** 1. T, 2. T, 3. F, 4. T, 5. F, 6. T, 7. F, 8. T, 9. Such decisions must be made by clients themselves. Therapists can help clients evaluate important decisions and feelings about significant persons in their lives. However, actively urging a client to sever a relationship borders on unethical behavior.



## Chapter in Review Gateways to Therapies

### Gateway QUESTIONS REVISITED

#### 15.1 How did psychotherapy originate?

**15.1.1** Early approaches to mental illness were dominated by superstition and moral condemnation.

**15.1.2** Demonology attributed mental disturbance to demonic possession and prescribed exorcism as the cure.

**15.1.3** In some instances, the actual cause of bizarre behavior may have been ergot poisoning.

**15.1.4** More humane treatment began in 1793 with the work of Philippe Pinel in Paris.

#### 15.2 Is Freudian psychoanalysis still used?

**15.2.1** As the first true psychotherapy, Freud's psychoanalysis gave rise to modern psychodynamic therapies.

**15.2.2** The psychoanalyst uses free association, dream analysis, and analysis of resistance and transference to reveal health-producing insights.

**15.2.3** Some critics argue that traditional psychoanalysis receives credit for spontaneous remissions of symptoms. However, psychoanalysis is successful for many patients.

**15.2.4** Psychoanalysts have become relatively rare because psychoanalysis is expensive and time intensive. Brief psychodynamic therapy (which relies on psychoanalytic theory but is brief and focused) is as effective as other major therapies. One example is interpersonal psychotherapy.

### 15.3 *How do psychotherapies differ?*

**15.3.1** All psychotherapy aims to facilitate positive changes in personality, behavior, or adjustment.

**15.3.2** Psychotherapies may be classified as insight, action, directive, nondirective, and combinations of these.

**15.3.3** Therapies may be conducted either individually or in groups, and they may be time limited.

### 15.4 *What are the major humanistic therapies?*

**15.4.1** Client-centered (or person-centered) therapy is non-directive, based on insights gained from conscious thoughts and feelings, and dedicated to creating an atmosphere of growth.

**15.4.2** Unconditional positive regard, empathy, authenticity, and reflection are combined to give the client a chance to solve his or her own problems.

**15.4.3** Existential therapies focus on the end result of the choices one makes in life. Clients are encouraged through confrontation and encounter to exercise free will and to take responsibility for their choices.

**15.4.4** Gestalt therapy emphasizes immediate awareness of thoughts and feelings. Its goal is to rebuild thinking, feeling, and acting into connected wholes and to help clients break through emotional blockages.

### 15.5 *How does cognitive therapy change thoughts and emotions?*

**15.5.1** Cognitive therapy emphasizes changing thought patterns that underlie emotional or behavioral problems. Changing the thought patterns can have a positive impact on emotions and behavior.

**15.5.2** Aaron Beck's cognitive therapy focuses on changing several major distortions in thinking: selective perception, overgeneralization, and all or nothing thinking.

**15.5.3** In a variation of cognitive therapy called rational-emotive behavior therapy (REBT), clients learn to recognize and challenge the irrational beliefs that are at the core of their maladaptive thinking patterns.

### 15.6 *What is behavior therapy?*

**15.6.1** Behavior therapists use the learning principles of classical or operant conditioning to directly change human behavior.

**15.6.2** In aversion therapy, classical conditioning is used to associate maladaptive behavior (such as smoking or drinking) with pain or other aversive events in order to inhibit undesirable responses.

**15.6.3** In desensitization, gradual adaptation and reciprocal inhibition break the link between fear and particular situations.

**15.6.4** Typical steps in desensitization are: Construct a fear hierarchy; learn to produce total relaxation; and perform items on the hierarchy (from least to most disturbing).

**15.6.5** Desensitization may be carried out with real settings or it may be done by vividly imagining the fear hierarchy or by watching models perform the feared responses.

**15.6.6** In some cases, virtual reality exposure can be used to present fear stimuli in a controlled manner.

**15.6.7** A newer technique called eye movement desensitization and reprocessing (EMDR) shows promise as a treatment for traumatic memories and stress disorders. At present, however, EMDR is highly controversial.

### 15.7 *What role do operant principles play in behavior therapy?*

**15.7.1** Operant principles, such as positive reinforcement, nonreinforcement, extinction, punishment, shaping, stimulus control, and time out, are used to extinguish undesirable responses and to promote constructive behavior.

**15.7.2** Nonreward can extinguish troublesome behaviors. Often this is done by simply identifying and eliminating reinforcers, particularly attention and social approval.

**15.7.3** To apply positive reinforcement and operant shaping, tokens are often used to reinforce selected target behaviors.

**15.7.4** Full-scale use of tokens in an institutional setting produces a token economy. Toward the end of a token economy program, patients are shifted to social rewards such as recognition and approval.

### 15.8 *How do psychiatrists treat psychological disorders?*

**15.8.1** Medical approaches to mental disorders, such as drugs, surgery, and hospitalization, are similar to medical treatments for physical ailments. All medical treatments for psychological disorders have pros and cons. Overall, however, their effectiveness is improving.

**15.8.2** Three medical, or somatic, approaches to treatment are pharmacotherapy, electrical stimulation therapy (including electroconvulsive therapy [ECT]), and psychosurgery.

**15.8.3** Community mental health centers seek to avoid or minimize mental hospitalization. They also seek to prevent mental health problems through education, consultation, and crisis intervention.

### 15.9 *Are various psychotherapies effective, and what do they have in common?*

**15.9.1** Effective psychotherapies are based on the therapeutic alliance, a protected setting, catharsis, insights, new perspectives, and a chance to practice new behaviors.

**15.9.2** Psychotherapy is generally effective, although no single form of therapy is superior to others.

**15.9.3** All of the following are helping skills that can be learned: active listening, acceptance, reflection, open-ended questioning, support, respect, patience, genuineness, and paraphrasing.

**15.9.4** The culturally skilled counselor must be able to establish rapport with a person from a different cultural background and adapt traditional theories and techniques to meet the needs of clients from non-European ethnic groups.

### 15.10 What will therapy be like in the future?

**15.10.1** Therapy can be done with groups of people based on a simple extension of individual methods or based on techniques developed specifically for groups.

**15.10.2** In psychodrama, individuals enact roles and incidents resembling their real-life problems. In family therapy, the family group is treated as a unit.

**15.10.3** Sensitivity and encounter groups encourage positive personality change. Large-group awareness training attempts to do the same, but the benefits of such programs are questionable.

**15.10.4** Media psychologists, telephone counselors, and cybertherapists may, on occasion, do some good. However, each has drawbacks, and the effectiveness of telephone counseling and cybertherapy has not been established.

**15.10.5** Therapy by videoconferencing shows more promise as a way to provide mental health services at a distance.

### 15.11 How are behavioral principles applied to everyday problems and how could a person find professional help?

**15.11.1** Some personal problems can be successfully treated using self-management techniques, such as covert reinforcement, covert sensitization, thought stopping, and self-directed desensitization.

**15.11.2** In covert sensitization, aversive images are used to discourage unwanted behavior. Thought stopping uses mild punishment to prevent upsetting thoughts. Covert reinforcement is a way to encourage desired responses by mental rehearsal.

**15.11.3** Desensitization pairs relaxation with a hierarchy of upsetting images in order to lessen fears.

**15.11.4** In most communities, a competent and reputable therapist can be located with public sources of information or through a referral.

**15.11.5** Practical considerations such as cost and qualifications enter into choosing a therapist. However, the therapist's personal characteristics are of equal importance.

## MEDIA RESOURCES

### Web Resources

*Internet addresses frequently change. To find an up-to-date list of URLs for the sites listed here, visit your Psychology CourseMate.*

**Pre-Columbian Trephination** Read about the first psychosurgery as a treatment for mental illness.

**Philippe Pinel** Read about Pinel's contribution to the history of the treatment of mental illness.

**Freud and Psychoanalysis** Read about the history of psychoanalysis.

**Existential Therapy** Explore this extensive website about existential therapy.

**The Beck Institute** Read about cognitive therapy and visit the rest of the Beck Institute website.

**Albert Ellis Institute** Read about Albert Ellis and his Rational-Emotive Behavior Therapy.

**Systematic Desensitization** Explore this self-administered procedure.

**Virtual Reality Therapy** Learn more about VR therapy.

**Token Economies** Read about the use of token economies with autistic children.

**Medications for Mental Illness** Explore some information about different drugs used to treat mental illness.

**ECT** Read more about the pros and cons of ECT.

**Lobotomy** Read a case study of lobotomy and the history of the transorbital lobotomy procedure.

**American Association for Marriage and Family Therapy** Visit the website of the AAMFT.

**American Self-Help Group Clearinghouse** Explore this database of over 1,000 self-help groups.

**Dr. Phil** See for yourself how Dr. Phil publicizes mental health issues.

**Therapy Effectiveness** Read an article about the effectiveness of therapy.

**Finding a Therapist in Your Hometown** Use the Internet to locate a local therapist.

**Find a Therapist** Another Internet tool to help you locate a therapist.

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