TABLE 11-1 Criteria for Empirically Validated Treatments

Well-Established Treatments

I. At least two good group design studies, conducted by different investigators, demonstrating efficacy in ***one or more of the following ways***:
   A. Superior to pill or psychological placebo or to another treatment.
   B. Equivalent to an already established treatment in studies with adequate statistical power (about 30 per group; cf. Kazdin & Bass, 1989).

OR

II. A large series of single case design studies demonstrating efficacy. These studies must have:
   A. Used good experimental designs and
   B. Compared the intervention to another treatment as in I.A.

FURTHER CRITERIA FOR BOTH I AND II:

III. Studies must be conducted with treatment manuals.
IV. Characteristics of the client samples must be clearly specified.

Probably Efficacious Treatments

I. Two studies showing the treatment is more effective than a waiting-list control group.

OR

II. Two studies otherwise meeting the well-established treatment criteria I, III, and IV, but both are conducted by the same investigator. Or one good study demonstrating effectiveness by these same criteria.

OR

III. At least two good studies demonstrating effectiveness but flawed by heterogeneity of the client samples.

OR

IV. A small series of single case design studies otherwise meeting the well-established treatment criteria II, III, and IV.

Experimental Treatments

Treatment not yet tested in trials meeting task force criteria for methodology.

SOURCE: Chambless, D. L., Baker, M., Baucom, D. H., Beutler, L. E., Calhoun, K. S., et al. (1998). Update on empirically validated therapies, II. *Clinical Psychologist, 51* (1), 3–16.

referred to as "empirically validated treatments," later discussed as "empirically supported treatments," and now more broadly referred to as "evidence-based treatments," these criteria have been used in many research studies to help determine whether certain therapeutic approaches may be especially useful for reducing mental health symptoms. These criteria have been adapted over the years, but the basic framework remains intact. Therapeutic approaches are categorized as "Well Established," "Probably Efficacious," and "Experimental" or "Possibly Efficacious." Over time, less emphasis has been placed upon the use of manuals to guide treatment, but the need for internal validity and consistency in how treatments are administered remains.

A recent example of a meta-analysis (i.e., a statistical examination of multiple studies combined; discussed in more detail below) offers a good example of work done to examine evidence-based treatments as compared to others. In 2006, John Weisz, Amanda Jensen-Doss, and Kristin Hawley combined the results from 32 clinical trials that had been conducted to understand the effects of psychotherapy with youth. In each of these clinical trials, an evidence-based therapeutic approach was compared to an alternate approach (i.e., "usual care"). Their study allowed for an examination of therapy efficacy and effectiveness, as some of the studies that were examined involved typical care in a usual setting and some involved a therapy that was administered in a research lab. These

studies also included youth who experienced psychological symptoms with a wide range of severity and samples of youth from varied ethnic backgrounds. This meta-analysis therefore allowed for an examination of whether evidence-based practice offers advantages over other therapeutic approaches, as well as whether the proposed benefits of evidence-based approaches remained even among youth who experienced severe psychopathology, among youth from ethnic minority backgrounds, and among youth who received treatment in different types of settings. Main findings included:

- Youth who received evidence-based treatment had better outcomes than 62% of youth who received usual care.
- At long-term follow-up (up to 2 years later), the better outcomes for youth who received evidence-based practice were maintained as compared to youth who received other therapeutic approaches
- The differences in effects between evidence-based treatments and other approaches were not due to the tendency for studies of evidence-based approaches to involve (1) more active homework assignments; (2) research therapists; (3) fewer comorbid samples; (4) university-based settings; (5) samples with less severe psychopathology; or (6) fewer ethnic minority youth.

Research findings such as these suggest that there are several psychological treatments that indeed seem to "work." Moreover, there is good reason to suspect that some approaches to treatment may be more efficacious than others. However, there is still much work to be done to determine whether specific treatments may be particularly effective for some individuals, diagnoses, or contexts than others (Kazdin, 2008).

FEATURES COMMON TO MANY THERAPIES

The apparent diversity among psychotherapies can sometimes lead us to overlook the marked similarities among them. One reason is that the purveyor of a new brand of psychotherapy must emphasize the special features of the new product. Bringing forth a minor variation of an old therapeutic theme would be unlikely to capture anyone's interest. Yet most psychotherapies have a great deal in common.

Hundreds of "brands" of psychotherapy have been identified. Some work, whereas others probably do not. Nevertheless, most involve a set of *common factors* that cuts across various theoretical and therapeutic boundaries. Researchers may disagree as to how influential common factors are in effecting therapeutic change in patients (Bjornsson, 2011; David & Montgomery, 2011; Wampold, 2001). For example, Wampold (2001) suggests that common factors account for the overwhelming majority of effects attributed to psychotherapy. Others, while acknowledging that common factors do play a major role in therapeutic change, argue that factors specific to particular types of intervention (e.g., changing cognitions and thoughts in cognitive-behavioral therapy for depression) are responsible for significant therapeutic change above and beyond what can be accounted for by common factors. As we mentioned previously, our focus in this chapter primarily will be on common factors, whereas factors specific to particular brands of therapy will be discussed later in their own respective chapters.

Lambert and Ogles (2004) provide a list of common factors categorized according to a sequential process that they believe is associated with positive outcome. Briefly, they propose that *supportive factors* (e.g., positive relationship, trust) lay the groundwork for changes in clients' beliefs and attitudes (*learning factors*, e.g., cognitive learning, insight), which then lead to behavioral change (*action factors*, e.g., mastery, taking risks). Although a detailed discussion of each of the common factors, such as those listed in Table 11-2, is beyond the scope of this book, it may be instructive to discuss a few of them briefly.

Relationship/Therapeutic Alliance. Research suggests that the nature of the relationship, or *therapeutic alliance*, between patient and therapist, is an

BOX 11-2 Clinical Psychologist Perspective: Dianne L. Chambless, Ph.D.

Dianne Chambless is the Merriam Term Professor of Psychology and Director of Clinical Training at the University Pennsylvania. Before coming to Penn she was a faculty member at the University of Georgia, American University, and the University of North Carolina at Chapel Hill. Professor Chambless's scholarly and professional work is focused on the psychopathology and treatment of anxiety disorders and on identification and dissemination of empirically supported psychotherapies. She chaired Division 12's original task force on empirically supported therapies (ESTs). For her work on ESTs, she has been recognized with awards, including the Florence Halpern Award for distinguished professional contributions to clinical psychology from Division 12 in 2000 and the Klaus-Grawe Award for the Advancement of Innovative Research in Clinical Psychology and Psychotherapy in 2011. Professor Chambless has served on the editorial boards of numerous journals and was associate editor of the *Journal of Consulting and Clinical Psychology.* Her research has been recognized by funding from NIMH and by a number of awards, including the Association for Advancement of Behavior Therapy's New Researcher Award in 1978 and the Aaron T. Beck Award for Significant and Enduring Contributions to Cognitive Therapy from the Academy of Cognitive Therapy in 2010.

Dr. Chambless describes her background, interests, and expertise in clinical psychology.

What originally got you interested in the field of clinical psychology?

I considered a number of majors in college (indeed, I majored in political science) and only discovered my fascination with psychology toward the end of my undergraduate years when I learned that all of psychology didn't revolve around rats. I then wavered between clinical and social psychology but eventually chose clinical because of my desire to do something that would have a beneficial impact on society. It was the 60s, and social activism was in the air. I think I chose well. I still find social psychology highly interesting, but I think I'm a better clinical researcher than I would have been a social psychology lab researcher.

Describe what activities you are involved in as a clinical psychologist.

One of the things I love about clinical psychology is the variety of activities I can engage in. I'm rarely bored, and there's always more I can learn. In my position I do administration as the director of the clinical psychology program in our department, I conduct research on treatment of anxiety disorders, I do some clinical work as part of my development of new interventions, I supervise graduate students and therapists in my treatment trials, and I teach undergraduate and doctoral students. I get to do it all! I particularly love mentoring graduate students.

What are your particular areas of expertise or interest?

I'm especially interested in psychotherapy research on anxiety disorders. Even more specifically, I'm intrigued by the family relationships of people with anxiety disorders and how these can help or hinder clients' progress in treatment. One of my current projects involves the development of an adjunctive couple/family therapy for people with anxiety disorders who are receiving cognitive-behavioral treatment, which is based on my research on family factors that influence treatment outcome. My students and I also conduct research on factors that influence therapists' willingness to obtain training in and adopt empirically supported treatments.

What are the future trends you see for clinical psychology?

There are a number of important directions in our field. I'll focus on one of these. Clinical psychologists were for some decades able to practice as they wished without being held accountable to third-party payers. That era is

important element that contributes greatly to the success of psychotherapy (Norcross & Wampold, 2011). Although not all therapists would elevate the relationship to the status of the primary "curative" agent, almost all therapists would attest to the unique importance of the relationship. Where else can patients find an accepting, nonjudgmental atmosphere in which to discuss their innermost urges, secrets, and disappointments? Discussions of this kind with a friend or relative always seem to contain an implicit aura of evaluation and often lead to unforeseen complications because the other person has a personal stake in the matters

coming to a close. The health care system cannot afford to pay for ineffective treatment or treatment of unknown efficacy. A number of forces are urging psychologists to learn and use demonstrably effective time-limited treatments with their clients. Even if they do, this will not be enough to meet the mental health needs of the population, and other effective ways of treating clients than face-to-face psychotherapy are being developed and tested, such as computer-assisted treatment and bibliotherapy. For many clients such interventions will be effective and sufficient. We need to be able to identify who will benefit from such approaches and who requires treatment with an individual therapist and to develop programs of stepped care. Training in clinical psychology is prolonged and expensive— too prolonged and expensive for doctoral-level clinicians to provide the bulk of the front-line care. I think in the future clinical psychologists will be involved less in direct care and more in developing new interventions and testing them and training and supervising master's-level providers. This new paradigm will require a different orientation to doctoral training than we presently have. This is one of the reasons I am involved with other clinical psychologists in developing a new accreditation system for scientifically oriented clinical psychology doctoral programs—the Psychological Clinical Science Accreditation System.

What are the most important next steps for evidence-based practice?

Our research indicates that psychologists already in practice are unlikely to make the investment of time and money required to learn ESTs if required to do so on their own dime and their own time. Training in ESTs needs to be infused into the graduate curriculum and supported in agencies, hospitals, and other settings where psychologists are employed, with time provided both for the initial training and follow-up supervision. There is research underway to determine how psychologists can be most efficiently trained to competency in ESTs, and it is clear that our current approaches to continuing education (e.g., attend a 3-hour or 1-day workshop at a conference) are woefully inadequate. Part of graduate training needs to be not only learning ESTs presently available but developing the habit of searching the literature to guide treatment and routinely assessing the outcomes for one's clients. Feedback about the successes and failures in their own practices should motivate psychologists to persist in the life-long learning required for ethical practice.

Dianne L. Chambless, Ph.D.

Dianne L. Chambless

discussed. Friends can easily be threatened because the content of such discussions has the potential to disturb the basis of the relationship. Can a husband discuss his abandonment fears with his wife, whose perception of her role may be disturbed by such revelations? Can a son reveal his fear of failure to a father who has been boastful of the son's achievements? Can a daughter tell her mother that she wants to give up her role as housewife in favor of a career without seeming to question her mother's values?

In psychotherapy, all of this is possible. The effective therapist is someone who can be

TABLE 11-2 Common Factors of Psychotherapy Associated with Positive Outcome

Support Factors	Learning Factors	Action Factors
Catharsis	Advice	Behavioral regulation
Identification with therapist	Affective experiencing	Cognitive mastery
Mitigation of isolation	Assimilation of problematic experiences	Encouragement of facing fears
Positive relationship	Changing expectations for personal effectiveness	Taking risks
Reassurance	Cognitive learning	Mastery efforts
Release of tension	Corrective emotional experience	Modeling
Structure	Exploration of internal frame of reference	Practice
Therapeutic alliance	Feedback	Reality testing
Therapist/client active participation	Insight	Success experience
Therapist expertness	Rationale	Working through
Therapist warmth, respect, empathy, acceptance, genuineness		
Trust		

SOURCE: Lambert and Ogles (2004).

accepting, nonjudgmental, objective, insightful, and professional all at the same time. These lavish adjectives scarcely fit all therapists all of the time. Nevertheless, the general ability of therapists to rise above their personal needs and to respond with professional skill in a nonjudgmental atmosphere of confidentiality, understanding, and warmth is probably a major reason for the success and persistence of psychotherapy in our society.

The Expert Role. It is assumed that the therapist brings to the therapy situation something more than acceptance, warmth, respect, and interest. These personal qualities are not sufficient for certification as a clinical psychologist. Conventional wisdom seems to suggest that all one needs to conduct psychotherapy is an unflagging interest in others. However, this is not enough.

In all forms of psychotherapy, patients have a right to expect that they are seeing not only a warm human being but a competent one as well. Competence can only come from a long, arduous period of training. Some may be quick to reply that the assumption of an *expert role* introduces an authoritarian element into the relationship, implying that the patient and the therapist are not equal and thus destroying the mutual respect that should exist between them. However, mutual understanding and mutual acceptance of the different roles to be played would seem sufficient to guarantee the maintenance of mutual respect. Therapists are, of course, no better than patients, and they cannot lay claim to any superior consideration in the cosmic scheme of things. However, this kind of equality need not deny the importance of training, knowledge, and experience that will assist therapists in their efforts to resolve the patient's problems.

Building Competence/Mastery. In one sense, a goal of most therapies is to make the client a more competent and effective human being. All

of the foregoing features of psychotherapy will facilitate the achievement of greater effectiveness and satisfaction. But beyond such elements as the therapeutic relationship and anxiety reduction, some forms of therapy have other features that are applicable here. For example, therapy can be a setting in which the client learns new things and corrects faulty ways of thinking. At times, some forms of therapy will take on distinct teaching overtones. The client may be "tutored" on more effective ways to find a job, or sexual information may be provided to help alleviate past sexual difficulties and promote a better sexual adjustment in the future. Therapy, then, can be more than just exorcising old psychological demons; it can also be a learning experience in the direct sense of the word. Bandura (1989) has emphasized the importance of feelings of self-efficacy in promoting a higher performance level in the individual. In short, those persons who experience a sense of *mastery*—who feel confident, expect to do well, or just feel good about themselves—are more likely to function in an effective fashion.

Nonspecific Factors. Call it faith, hope, or expectations for increased competence—successful therapy tends to be associated with such *nonspecific factors* (Kazdin, 1979). Numerous factors can conspire to promote such expectancies. First, there is often a mystique to therapy—at least in the eyes of the general public. Patients often come to therapy fully expecting to participate in a process almost guaranteed to promote mental health. Therapists often encourage such beliefs, knowing full well that a believing, motivated client is more likely to show progress than a cynical, recalcitrant one. Furthermore, nearly every therapist is committed to a theory of therapeutic change. Whether an operant theory, a theory of the unconscious, or a belief in growth potential, its ubiquitous presence in the therapist's explanations of how therapy works can ignite a confidence that helps alleviate the client's earlier feelings of despair. Although successful therapy can almost always be characterized as having rekindled the patient's hope, faith, and morale (Frank, 1973), it seems unlikely that therapy can be reduced to nothing more than what some have disparagingly referred to as a placebo effect. The expectations of the client help make even more effective the specific techniques applied in therapy. The successes of such techniques then act to further increase the client's expectations.

In Frank's (1982) description of psychotherapy, he notes that therapy involves a rationale, conceptual scheme or myth that provides a plausible explanation for the patient's difficulties and also prescribes a ritual for restoring equilibrium. Such explanations and rituals can, as Frank points out, provide the patient with a face-saving reason to abandon a symptom when ready to do so. To cease complaining or give up a cherished symptom without a good reason would imply that it was trivial. So, whatever we call it—nonspecific factor, placebo effect, or faith—it becomes an important element in the therapy process.

NATURE OF SPECIFIC THERAPEUTIC VARIABLES

It would be pleasant if psychotherapy were a simple routine in which the therapist makes a diagnosis, conveys it to the patient, gives a lecture or two, and presto, the patient is cured. Unfortunately, things do not work that way. Indeed, it is often necessary to spend considerable time correcting patients' expectations that they will be given a simple psychological prescription. Because psychotherapy is an active, dynamic process, passivity and lack of motivation can be obstacles. A number of factors involving the nature of the patient, the therapist, and the patient–therapist interaction affect the process of therapy in important ways. Often, their effects are felt over and above the specific mode of therapy employed.

The Patient or Client

Are there specific or general patient characteristics that influence the outcomes of therapy? Such a deceptively simple question really has no answer

other than "it depends." The reason is that the outcomes of therapy are exceedingly complex events that are not shaped by patient characteristics alone. They are also determined by therapist qualities and skills, the kinds of therapeutic procedures employed, the circumstances and environment of patients, and so on. Eventually, the field will have to identify specifically which kinds of patients benefit from which procedures, under which circumstances, and by which therapists (Kiesler, 1966; Paul, 1967).

With the foregoing caveat firmly in mind, we can discuss some of the more prominent patient variables that have been related to outcomes in traditional therapies.

The Degree of the Patient's Distress. A broad generalization often made by clinicians is that individuals who need therapy the least are the people who will receive the greatest benefit from it. A more sophisticated version of this relationship is reflected in Truax and Carkhuff's (1967) distinction between patients' feelings of disturbance and their overt behavioral disturbance. This distinction implies to many clinicians that a good prognosis may be expected for a patient who is experiencing distress or anxiety but is functioning well behaviorally.

Early research data on this issue were contradictory and inconsistent (which, again, probably reflects the impossibility of coming to a simple conclusion without considering many other factors). For example, one group of studies finds that greater initial distress is associated with greater improvement (e.g., Stone, Frank, Nash, & Imber, 1961). Another group of studies (e.g., Barron, 1953) finds exactly the reverse. To complicate matters further, Miller and Gross (1973) contend that the relationship between improvement and the initial disturbance is curvilinear; that is, patients with little disturbance or extreme disturbance show poorer outcomes than do moderately disturbed patients. This question remains an important issue for further exploration, even today.

Intelligence. Some therapeutic approaches require a great deal of talking, articulation of past experiences, insights, and introspection. These therapeutic approaches may rely on metaphors and complex thematic associations between one's experiences. These types of therapies require a reasonable level of intelligence (Garfield, 1994).

However, behavioral forms of therapy have often been used with considerable success with individuals across a great range of intellectual ability. A variety of behavior modification approaches are quite feasible, especially when goals involve specific behavioral changes rather than insight. Perhaps for this reason, behavioral approaches are very commonly used when working with young children and adolescents or when working on issues that involve a desire for behavioral change.

Age. Other things being equal, young adults have long been considered the best bets for therapy, as compared to older adults. In contrast, there does not seem to be a clear trend between age and psychotherapy success among youth. As compared to older adults, younger adults are presumably more flexible or less "set in their ways." Perhaps younger patients are better able to make the appropriate connections because they are closer to their childhood years, or perhaps they have been reinforced for negative behaviors less often than their older counterparts. In any event, the notion that younger persons do better in therapy is quite prevalent among clinicians. Research evidence supporting the contention that older clients have a poorer prognosis, however, is weak at best (Clarkin & Levy, 2004; Garfield, 1994; M. L. Smith et al., 1980).

It is best to consider not age alone, but rather the specific characteristics of the prospective patient. It often happens that a 55-year-old will be an active, open, introspective person who can really benefit from therapy. In short, denial of therapy to an elderly person can be construed as a form of ageism in some instances! Fortunately, research supports the efficacy of a variety of cognitive-behavioral, behavioral, and brief psychodynamic treatments with older adults suffering from anxiety and depressive disorders, two common forms of psychological problems in this age group (Ayers, Sorrell, Thorp, & Wetherell, 2007; Fiske, Wetherell, & Gatz, 2009).

Motivation. Psychotherapy is sometimes a lengthy and arduous process. It demands much from a patient. It can be fraught with anxiety, setbacks, and periods of a seeming absence of progress. Most of the work occurs outside of the therapy room through homework and challenging exercise that occur between therapy sessions. These exercises may demand that the patient engage in new behaviors that will provoke anxiety. For these and other reasons, successful psychotherapy seems to require motivation.

At some level, the patient must want psychotherapy (though there are times during psychotherapy when even highly motivated patients want out). It follows, then, that psychotherapy is a voluntary process. One cannot be forced into it. When people are forced, either openly or subtly, to become patients, they rarely profit from the experience. Therapy is not likely to be of much benefit to the prisoner who seeks therapy to impress a parole board; to the college student who, following a marijuana charge, is given the option of reporting to a counseling center or facing the prospect of jail; or to the person who undergoes therapy to protect an insurance claim.

Despite the conventional wisdom that cites client motivation as a necessary condition for positive change, research support is mixed (Garfield, 1994). One methodological problem concerns how best to assess client motivation. Studies vary widely in how they attempt to measure motivation. For example, Yoken and Berman (1987) used client payment for services as an index of client motivation. Finding relatively little difference in outcome between clients who paid the standard fees for services and those whose fees were waived, Yoken and Berman (1987) concluded that motivation appears unrelated to outcome. The lack of definitive findings, however, may simply reflect the difficulty researchers have experienced in defining and measuring client motivation.

Openness. Most therapists intuitively attach a better prognosis to patients who seem to show some respect for and optimism about the utility of psychotherapy. They are relieved when patients are willing to see their problems in psychological rather than medical terms. Such persons can be more easily "taught to be good psychotherapy patients," in contrast to patients who view their difficulties as symptoms that can be cured by an omniscient, authoritative therapist while they passively await the outcome. Thus, a kind of "openness" to the therapeutic process appears to make the patient a better bet for therapy (Zinbarg, Uliaszek, & Adler, 2009).

Gender. What is the relationship between the outcome of therapy and the gender of the patient? Many would hold that women do better in therapy than do men. However, research does not support the view that biological sex of the client is significantly related to outcome in psychotherapy (Clarkin & Levy, 2004; Garfield, 1994). Although sex of the client has not been reliably linked to outcome, it is probably true that sex or gender of the therapist may be especially important to consider in certain cases. For example, women rape victims may feel much more comfortable talking to women psychotherapists than to men psychotherapists.

Race, Ethnicity, and Social Class. For years, debate has raged over the effectiveness of therapy for ethnic minority patients—especially when they are treated by White therapists. It does appear that many therapeutic techniques have been designed and developed for White middle- and upper-class patients. Too few procedures seem to take into account the particular cultural background and expectations of patients. Banks (1972) has suggested that greater rapport and self-exploration may occur when both therapist and patient are of the same race. Others have reached the same conclusion regarding social class, background, values, and experience and have proposed that conventional therapies be abandoned in favor of more supportive techniques. Still, two decades of research have seemingly failed to show conclusively that ethnic minorities achieve differential treatment outcomes (Sue, 1988; Sue, Zane, & Young, 1994; Zane, Hall, Sue, Young, & Nunez, 2004).

Schofield (1964) described the psychotherapist's belief in the ideal patient as the YAVIS

BOX 11-3 Focus on Professional Issues: Cultural Competence

Increasingly, clinical psychologists are providing services to members of non-White multicultural groups. Therefore, the clinician must consider a number of factors when assessing and treating clients from an ethnic or socioeconomic group different from his or her own. Paniagua (1998) provides a number of general guidelines and considerations:

1. *Acculturation*. This refers to "the degree of integration of new cultural patterns into the original cultural patterns" (Paniagua, 1998, p. 8). Acculturation can be internal (e.g., moving from one region of the United States to another) or external (moving to a new country). Clinicians can estimate the level of acculturation exhibited by a client by administering brief scales that assess variables like language preference, preferred racial group with which to socialize, and generation (Paniagua, 1998).
2. *Language Barriers*. Although it is ideal to avoid the use of a translator if at all possible, in some cases a translator is necessary. Paniagua (1998) suggests using translators who share the client's cultural background. Translators should have a background in mental health and should develop some rapport with the client ahead of time. A sequential mode of translation should be used (versus concurrent translation), and the use of friends, relatives, and bilingual children as translators should be avoided. The level of acculturation of the translator should be considered as well.
3. *Overdiagnosis*. Clinicians must guard against inaccurately viewing behaviors of members of multicultural groups as pathological simply because these are unfamiliar or unusual.
4. *Extended Family*. Clinicians should rely on the client's definition of extended family (which may include nonbiological members) before enlisting others to aid in the client's treatment.
5. *Type of Theory*. Directive, active, and structured therapies are generally preferred by African Americans, Native Americans, Hispanics, and Asian Americans. Individual therapy should precede any family or marital therapy in instances where acculturation appears to play a major role in the presenting problems.
6. *Amount of Data Collected*. Clinicians should avoid collecting massive amounts of data early on in the assessment or treatment process. Otherwise, members of multicultural groups may view this as a sign of incompetence and gross unfamiliarity with their respective cultures. Data should be gathered gradually across multiple sessions.

syndrome (young, attractive, verbal, intelligent, and successful). However, numerous reviews of existing research have concluded that there appears to be virtually no relationship between social class and outcome (Garfield, 1994). What has not been examined in great detail is whether patients and therapists should be matched according to social class or whether some forms of psychotherapy are more effective than others for patients from lower socioeconomic levels.

When there is a significant difference between the social class or the values of the patient and those of the therapist, some researchers have found that the patient's willingness to remain in therapy may suffer (Zane et al., 2004). Few would disagree that *cultural sensitivity* on the part of the therapist is very important. The field needs to develop culturally sensitive mental health services (Sue et al., 1994; Zane et al., 2004). Clinicians also need to develop a kind of cognitive empathy, or what Scott and Borodovsky (1990) have referred to as cultural role-taking, in their work with ethnic minorities. In the final analysis, it is imperative that clinical psychology develop culturally sensitive therapists who can work effectively with culturally diverse populations (Paniagua, 1998).

Therapists' Reactions to Patients. In the best of all worlds, it would make no difference whether or not the patient was an engaging person who elicited

7. *Definition of "Therapist."* It is important to understand the client's definition of the term *therapist*. The term may be equated with "physician," "medicine man/woman," or "folk healer." Therefore, it may be necessary to modify unwarranted expectations.

Jim West/PhotoEdit

Clinical Psychologists must be prepared to assess and treat individuals from a number of different cultural backgrounds.

positive responses from others. A therapist should be able to work with elegant effectiveness regardless of her or his positive or negative reactions to the patient. As we saw earlier, however, therapists are far from perfect creatures; they are indeed affected by the personal qualities of other persons. Fortunately, the understanding and self-control of therapists in their professional relations with patients exceed the understanding and self-control of many laypersons in their social and interpersonal relationships. Nevertheless, there is some evidence to suggest that patients who receive higher global ratings of attractiveness (e.g., Nash et al., 1965) or to whom the therapist can relate better (e.g., Isaacs & Haggard, 1966) tend to have better outcomes in therapy (Garfield, 1994). Also, in at least one study, therapists were less inclined to treat hypothetical patients whom they did not like as compared to those they liked (Lehman & Salovey, 1990).

The Therapist

It will hardly come as a shock to learn that certain therapist characteristics may affect the process of therapy. Having a specific theoretical or therapeutic orientation does not override the role of personality, warmth, or sensitivity. Even Freud recognized the potential effects of the psychoanalyst's personality on the process of psychoanalysis. To "prevent" such personal factors from affecting the process, he

PhotoDisc

The outcome of psychotherapy is influenced by a number of variables, including client characteristics, therapist qualities and skills, the problems for which relief is sought, and the therapeutic procedures that are used.

recommended that analysts undergo periodic analyses so that they could learn to recognize and control them. In a sense, Rogers turned to the other side of the same coin and made therapist qualities such as acceptance and warmth the cornerstones of therapy. Although Freud may have emphasized the negative and Rogers the positive, they both set the stage for an understanding of the role of therapist variables in the process of therapy. Unfortunately, although nearly everyone agrees that therapist variables are important, there is much less agreement on specifics. How therapist characteristics contribute to therapy outcome has become an important research area (Beutler, Machado, & Neufeldt, 1994; Beutler et al., 2004).

Age, Sex, and Ethnicity. In comprehensive reviews of therapist features that may influence psychotherapy outcome, Beutler et al. (1994, 2004) report the available research evidence suggests that therapist age is not related to outcome, that female versus male therapists do not appear to produce significantly better therapeutic effects, and that patient–therapist similarity with regard to ethnicity does not necessarily result in better outcomes. Beutler and colleagues (1994, 2004) acknowledge that these conclusions may run counter to prevailing sociopolitical opinions. At the same time, they assert that existing research in this area suffers from a number of methodological problems. These therapist variables may interact with client characteristics, setting for treatment, and modality of treatment. Again, the solution seems to be for therapists to become more sensitized to age, gender, and racial identity issues in relation to themselves as well as to the patient.

Personality. In discussing therapist variables, Strupp and Bergin (1969) made two points worth noting. First, even though the evidence shows that

the therapist's personality is a potent force, other factors in combination largely determine therapy outcomes. Second, research in this area has taken a back seat as behavioral therapies have gained in popularity. However, as behavior therapists attend increasingly to factors other than techniques or mechanics, it is likely that they will "rediscover" the importance of therapist characteristics and begin to integrate those characteristics into their research and practice.

Is there a set of personality traits that the "ideal" therapist should possess? Krasner (1963), with tongue in cheek, suggested that the research literature would depict the ideal therapist as

> mature, well-adjusted, sympathetic, tolerant, patient, kindly, tactful, nonjudgmental, accepting, permissive, non-critical, warm, likable, interested in human beings, respectful, cherishing and working for a democratic kind of interpersonal relationship with all people, free of racial and religious bigotry, having a worthwhile goal in life, friendly, encouraging, optimistic, strong, intelligent, wise, curious, creative, artistic, scientifically oriented, competent, trustworthy, a model for the patient to follow, resourceful, emotionally sensitive, self-aware, insightful of his own problems, spontaneous, having a sense of humor, feeling personally secure, mature about sex, growing and maturing with life's experiences, having a high frustration tolerance, self-confident, relaxed, objective, self-analytic, aware of his own prejudices, non-obsequious, humble, skeptical but not pessimistic or self-deprecatory … dependable, consistent, open, honest, frank, technically sophisticated, professionally dedicated, and charming. (pp. 16–17)

Certainly no human being, let alone a therapist, could possibly possess all of these traits (even allowing for overlap in terms). Therefore, as Goldstein, Heller, and Sechrest (1966) point out, it is doubtful whether the concept of the "ideal therapist" is very useful. Any study that is confined to a single trait or a small group of traits seems to make a great deal of sense. Taking all the traits together makes the message much less coherent.

Beutler et al. (1994, 2004) note that the influence of therapist personality traits on outcome has not received adequate research attention. Of those traits that have been studied, the greatest amount of attention has focused on dominance/dogmatism, locus of perceived control, and cognitive processing style. General conclusions are difficult to draw, however, because each of these variables appears to affect outcome differentially depending on client traits and type of therapy (Beutler et al., 1994, 2004). For example, Hall and Malony (1983) reported that high levels of dominance in a therapist resulted in better outcome in cases where the therapist and client were culturally similar, but low-dominance therapists were more effective with culturally dissimilar clients.

Empathy, Warmth, and Genuineness. Swenson (1971) has suggested that a major factor that differentiates successful from unsuccessful therapists is their interest in people and their commitment to the patient. In a similar vein, Brunink and Schroeder (1979) found that expert therapists of several different theoretical persuasions were similar in their communication of empathy.

The attention to empathy, along with the related notions of warmth and genuineness, grew out of Carl Rogers' (1951) system of client-centered therapy. He described these variables as necessary and sufficient conditions for therapeutic change (Rogers, 1957). Some research evidence has seemed to point to a relationship between these three qualities and successful outcomes in therapy (Truax & Carkhuff, 1967; Truax & Mitchell, 1971). However, in a careful review of research on therapeutic outcomes as they relate to therapist empathy, regard, and genuineness, Lambert, DeJulio, and Stein (1978) could find only modest support for the Rogerian hypothesis. Strupp and Bergin (1969) seem to regard empathy, warmth, and genuineness as necessary but not sufficient conditions for good therapy outcomes. In more recent years, these three qualities have been

regarded more as trainable and learnable skills. According to Bergin and Suinn (1975), "It is clearer now that these variables are not as prepotent as once believed; but their presence and influence are ubiquitous, even showing up strongly in behavior therapies" (p. 52). In the case of empathy, however, some have found that less effective therapists tend to score lower on empathy than do their more effective peers (Lafferty, Beutler, & Crago, 1989).

It has also been argued (Beutler et al., 1994) that these three features reflect not only qualities of the therapist but also qualities of the therapeutic relationship. Viewed this way, these features can be considered indicators of the quality of the therapeutic alliance. Studies have consistently demonstrated that the nature and strength of the working relationship between therapist and patient are significant, although modest, contributors to positive outcome (Beutler et al., 1994, 2004).

Emotional Well-Being. Although therapists need not be paragons of adjustment, it is unlikely that a therapist beset with emotional problems can be as effective as one would like. It is important that therapists recognize areas in their own lives that are tender. The tendency to become angry or anxious when certain topics arise or the inability to handle a client's questions without becoming defensive is a signal that something is amiss. In short, self-awareness is an important quality in the therapist (Weiner, 1975). Therapists must be able to look at their patients with objectivity and not become entangled in their personal dynamics. Nor is the therapy room a place for the gratification of one's own emotional needs (Bugental, 1964; Singer, 1965).

In some instances, the therapist may find it necessary to undergo personal therapy to resolve emotional problems. However, whether undergoing personal therapy makes the therapist more effective has long been argued. Unfortunately, the research evidence (Beutler et al., 1994, 2004) is less than definitive. This is not surprising when one considers the complexity of the therapy process. Nevertheless, it would not seem necessary for all therapists to undergo treatment as a qualification for conducting therapy.

Experience and Professional Identification. Conventional wisdom suggests that the more experienced a psychotherapist, the more effective she or he will be with patients. Although this is intuitively appealing, the bulk of research evidence has not supported this position (Beutler et al., 1994, 2004; Smith et al., 1980). Not only does there appear to be no consistent relationship between therapist experience and positive outcome but several studies suggest that *paraprofessionals* trained specifically to conduct psychotherapy produce outcomes equivalent to, or sometimes even exceeding, those produced by trained psychotherapists (Berman & Norton, 1985; Durlak, 1981; Hattie, Sharpley, & Rogers, 1984; Weisz, Weiss, Alicke, & Klotz, 1987). Lambert and Ogles (2004) argue that the jury is still out on this issue because many of the studies that have been conducted to date have major limitations. However, Lambert himself recently confirmed this lack of relationship between training level and client outcome in a sample of over 5,000 clients (Okiishi, Lambert, Egget, Nielsen, Dayton, & Vermeersch, 2006). Like all of us, Lambert and Ogles (2004) wonder why more studies supporting the superiority of experience and professional training have not appeared.

Does one profession turn out better therapists than others? Over the years, there have been many running feuds over which profession is best equipped to carry out proper therapy. For a long time, psychiatrists actively sought to prevent clinical psychologists from conducting therapy in the absence of psychiatric supervision. Their main argument was often reducible to one of medical omniscience and was never based on solid research, and clinical psychologists gradually freed themselves from this psychiatric domination. But old animosities and fights over territorial prerogatives fade slowly. Indeed, with the availability of federal funds to pay for health costs and with insurance coverage being broadened to include psychotherapy, economic competition has once again kindled these territorial fights between psychiatry and clinical psychology.

In fact, no real evidence supports the argument that one profession boasts superior therapists (be

TABLE 11-3 Common, but Unfounded, Assumptions Regarding the Relationship Between Patient/Client and Therapist Variables and Psychotherapy Outcome

Assumption	Evidence
1. Older patients have worse outcomes.	No strong support for this assumption (Clarkin & Levy, 2004; Garfield, 1994; M. L. Smith et al., 1980)
2. Only highly motivated patients achieve good outcome.	Mixed support (Garfield, 1994)
3. Women patients achieve better outcomes.	In general, biological sex appears unrelated to outcome (Sue et al., 1994; Zane et al., 2004)
4. Ethnic minority patients consistently achieve worse outcome.	No support for this assumption (Sue et al., 1994; Zane et al., 2004)
5. Patients of high socioeconomic status achieve better outcome.	No relationship between social class and outcome (Garfield, 1994)
6. Older therapists produce better outcomes.	No relationship between therapist age and outcome (Beutler et al., 1994, 2004)
7. Women therapists produce better outcomes.	Mixed support (Beutler et al., 1994, 2004)
8. Therapists matched with patients according to their ethnicity produce better outcomes.	Effect is equivocal (Beutler et al., 1994, 2004)
9. Therapists who have undergone their own personal therapy produce better outcomes.	Mixed results (Beutler et al., 1994, 2004)
10. More experienced therapists produce better outcomes.	Mixed results (Beutler et al., 1994, 2004; Lambert & Ogles, 2004; M. L. Smith et al., 1980)

they clinical psychologists, psychiatric social workers, psychiatrists, or psychoanalysts). In the *Consumer Reports* study ("Mental Health," 1995), people who saw a mental health professional rather than a family physician for their psychological problems reported greater progress and more satisfaction with their treatment. However, psychologists, psychiatrists, and social workers all received similarly high satisfaction ratings from consumers. Thus, at this time, data do not seem to support the superiority of one mental health profession over others in terms of effectiveness and client satisfaction.

To this point, we have surveyed a variety of patient and therapist variables that are commonly assumed to be related to outcome in psychotherapy. As noted in our discussion, many of these assumptions are unsupported by psychotherapy research findings. Table 11-3 lists some common assumptions about psychotherapy outcome that currently have little or no empirical support.

COURSE OF CLINICAL INTERVENTION

There are so many forms of intervention, along with so many different kinds of problems, that it is impossible to describe with precision a sequence of procedures that will apply equally well to every case. However, a general description of the typical sequence describes most forms of psychological treatment.

Initial Contact

When clients first contact the clinic or enter the clinician's office, they often do not know exactly what to expect. Some will be anxious; others, perhaps, suspicious. Some do not clearly understand the differences between medical treatment and psychotherapy. Others may be embarrassed or feel inadequate because they are seeking help. Parents who seek therapy for their child often do not know

whether the therapist will meet regularly with the child, with the parents, or with both. The first order of business, then, is for someone to explain generally what the clinic is all about and the kind of help that can be given. This important step can have a significant bearing on the client's attitude and willingness to cooperate. Whether this initial contact is made by a therapist, a social worker, a psychological technician, or someone else, it is important that the contact be handled with skill and sensitivity.

Once the client's reasons for coming have been discussed, the next step in the general sequence can be explained. It may be useful at this point to discuss several specific issues. Who are the professional staff, and what are their qualifications? What about the matter of fees? Are the contacts confidential, and if not, exactly who will have access to information? If there are medical complications, how will these problems be integrated with therapy contacts? Does it seem reasonable to proceed with the client, or does a referral to another agency or professional seem more appropriate? These and other questions must be dealt with up front.

Assessment

Once it has been mutually agreed that the client can likely profit from continued contact with the clinic, one or more appointments can be arranged for an assessment of the client's problems. As we have already seen in preceding chapters, a variety of assessment procedures may be followed depending on the exact nature of the client's problem, the orientation of the professional staff, and other factors. Often, there is an intake interview, which may consist largely of compiling a case history. Other information may be gathered by administering various psychological tests. Sometimes arrangements are made to interview a spouse, teacher, family members, or friends. In some instances, too, it may be considered desirable to have the client systematically record self-observations of behavior, thoughts, or feelings in different situations.

For some clients, consultations with other professionals may be desirable. A neurological workup may be necessary, or a medical examination may be scheduled to rule out non-psychological factors. For some clients whose problems are related to economics or unemployment, additional consultation with social workers or job counselors may be appropriate.

After all the information has been compiled and analyzed, a preliminary integration is attempted. What is desirable here is not a simple diagnostic label but a comprehensive construction of the client's problems in light of all the psychological, environmental, and medical data available. This initial conceptualization of the client will provide guidelines for the specific therapeutic interventions to be undertaken. As therapy proceeds, changes in the conceptualization of the client will likely occur, and therapeutic goals and techniques may change somewhat as a result. Assessment is an ongoing process that does not cease with the second or third interview. In fact, many now advocate weekly patient assessments during treatment in order to alert therapists to lack of progress or even deterioration in functioning (e.g., Lambert, 2007)

The Goals of Treatment

As soon as the assessment data are integrated, the therapist and client can begin to discuss more systematically the nature of the problems and what can be done about them. Some therapists describe this phase as a period of negotiation over the goals of treatment. Others suggest that client and therapist enter into a "contract" in which the therapist agrees to alleviate a specified set of the client's problems and to do it in the most effective way possible. Naturally, no one can absolutely promise a perfect cure or resolution of all problems. Clients in turn will state their desires and intentions. In effect, their contract usually covers such matters as the goals of therapy, length of therapy, frequency of meetings, cost, general format of therapy, and the client's responsibilities.

When a child's behavior is the focus of treatment, these discussions may include the child in a variety of ways. Importantly, many children may not understand what therapy is, why they are

attending, or may not agree that therapy is needed to address their behavior. Many children attend therapy as a result of their parents' wishes, but not their own. Compounding these complexities further, parents legally have a right to learn anything that occurred between the therapist and the child in therapy, although most therapists will discourage parents from intruding on the confidentiality of their work with a child. Consequently, the process of setting goals and determining a course of youth treatment involves several discussions to help engage the child in the process of therapy, establish trust with the child who may have been coerced to attend by their parents, and educate parents about their expectations and the importance of the therapist's neutral stance as an advocate for both the parent and child simultaneously.

Again, it is important to understand that various features of the contract may be modified as time goes on. One must deal with clients in terms of what they are prepared to accept now. An especially anxious or defensive client may be willing to accept only a limited set of goals or procedures. As therapy proceeds, that client may become more open and comfortable and thus better able to accept an expanded set of goals. Then, too, additional information about the client may surface during therapy, with the result that some modifications may be necessary. Some clients will want to expand their goals for treatment as they gain more confidence and trust in the therapist. Discussion of goals and methods must be handled with discretion, sensitivity, and skill.

Therapists must try to take clients only where they are psychologically prepared to go. Moving too fast or setting up grandiose treatment objectives can frighten or alienate certain clients. It is usually desirable to proceed with enough subtlety and skill so that clients feel they are the ones establishing or modifying the goals.

Implementing Treatment

After the initial goals are established, the therapist decides on the specific form of treatment. It may be client-centered, family-systems, cognitive, behavioral, or psychoanalytic, for instance. The treatment may be very circumscribed and deal only with a specific phobia, or it may involve a broader approach to the client's personality style. All of this must be carefully described to the client in terms of how it relates to the client's problems, the length of time involved, and perhaps even the difficulties and trying times that may lie ahead. Exactly what is expected of the client will be detailed as well—free association, "homework" assignments, or self-monitoring, for example. Inherent in all of this is the issue of informed consent. Just as participants in research have a right to know what will happen, therapy patients have the right to know what will happen in therapy. Children also have the right to know about therapy and what it will provide, although their capacity to truly understand the therapeutic agreement will naturally vary by age. Box 11-4 provides an outline of the information to which outpatients should have access.

Termination, Evaluation, and Follow-up

It is certainly to be hoped that a client will not be in psychotherapy her or his entire life. As the therapist begins to believe the client is able to handle his or her problems independently, discussions of termination are initiated. Sometimes termination is a gradual process in which meetings are reduced, for example, from once a week to once a month. As termination approaches, it is important that it be discussed in detail and that the client's feelings and attitudes are thoroughly aired and dealt with. Clients do sometimes terminate suddenly, in some cases before the therapist feels it is appropriate. Whenever possible, however, it is important to find the time to discuss at least briefly the client's feelings about leaving the support of therapy and the possibility of returning later for additional sessions if necessary. In other instances, the termination is forced because the therapist must leave the clinic, and a referral to a new therapist is offered. Many therapists find that "booster sessions" scheduled months after termination—perhaps 6 months and then 1 year later—can be quite helpful. These booster sessions are used to review the client's

BOX 11-4 Focus on Clinical Applications: Information Patients Have a Right to Know

Handelsman and Galvin (1988) have prepared a consent form for potential patients that sets forth the questions they are entitled to ask their therapists. Some research has shown that forms such as this can enhance patients' first impressions of their therapists (Handelsman, 1990).

When you come for therapy, you are buying a service. Therefore, you need information to make a good decision. Below are some questions you might want to ask. We've talked about some of them. You are entitled to ask me any of these questions, if you want to know. If you don't understand my answers, ask me again.

I. Therapy
   A. How does your kind of therapy work?
   B. What are the possible risks involved? (like divorce, depression)
   C. What percentage of clients improves? In what ways?
   D. What percentage of clients gets worse?
   E. What percentage of clients improve or gets worse without this therapy?
   F. About how long will it take?
   G. What should I do if I feel therapy isn't working?
   H. Will I have to take any tests? What kind?

II. Alternatives
   A. What other types of therapy or help are there? (like support groups)
   B. How often do they work?
   C. What are the risks of these other approaches?

III. Appointments
   A. How are appointments scheduled?
   B. How long are sessions? Do I have to pay more for longer ones?
   C. How can I reach you in an emergency?
   D. If you are not available, who is there I can talk to?
   E. What happens if the weather is bad, or I'm sick?

IV. Confidentiality
   A. What kind of records do you keep? Who has access to them? (insurance companies, supervisors)
   B. Under what conditions are you allowed to tell others about the things we discuss? (suicidal or homicidal threats, child abuse, court cases, insurance companies, supervisors)
   C. Do other members of my family, or of the group, have access to information?

V. Money
   A. What is your fee?
   B. How do I need to pay? At the session, monthly, etc.?
   C. Do I need to pay for missed sessions?
   D. Do I need to pay for telephone calls or letters?
   E. What are your policies about raising fees? (For example, how many times have you raised them in the past two years?)
   F. If I lose my source of income, can my fee be lowered?
   G. If I do not pay my fee, will you take me to small claims court? Do you use a collection agency or lawyer? Under what circumstances?

VI. General
   A. What is your training and experience? Are you licensed? Supervised? Board certified?
   B. Who do I talk to if I have a complaint about therapy that we can't work out? (e.g., Supervisor, State Board of Psychologist Examiners, APA ethics committee)

The contract [or brochure, or our conversation] dealt with most of these questions. I will be happy to explain them, and to answer other questions you have. This will help make your decision a good one. You can keep this information. Please read it carefully at home. We will also look this over from time to time. (p. 225)

Bill Aron/PhotoEdit

SOURCE: From "Facilitating Informed Consent for Outpatient Psychotherapy: A Suggested Written Format," by M. M. Handelsman and M. D. Galvin, *Professional Psychology: Research and Practice*, 1988, 19, 223–225. Copyright © 1988 by the American Psychological Association. Reprinted by permission.

progress, to address new problems or issues that have arisen in the interim, and to solidify the gains that have been made.

It is important to evaluate with clients the progress they have made (Lambert, 2007). Therapists should also compile data and make notes on progress in order to evaluate the quality of their own efforts or the agency's services and continue to improve services to clients. The most reliable data, of course, will come from formally designed research projects (described in the following section). However, clinicians and individual agencies owe it to themselves and their clients to evaluate the success of their own efforts.

STAGES OF CHANGE

Prochaska and colleagues (e.g., Prochaska & Norcross, 2002) have argued that it is also important to recognize the client's *stage of change* regardless of the treatment being administered. From this perspective, a client's behavior change is seen as a process that involves a progression through a set sequence of stages:

Precontemplation: At this stage, the client has no intention of changing his or her behavior in the near future. Clients at this stage of change have typically come in for treatment because of outside pressure to do so (e.g., court-ordered, pressure from family, etc.). Prochaska and Norcross estimate that 50 to 60% of clients or patients are in this stage.

Contemplation: At this stage, a client is aware that a problem exists but has not yet committed him- or herself to trying to make changes. It is estimated that 30 to 40% of clients or patients are in this stage.

Preparation: Here, a client intends to make a change in the near future.

Action: At this stage, clients are changing their maladaptive behaviors, emotions, and/or their environment. It is estimated that 10 to 20% are in this stage.

Maintenance: At this stage, the client works on preventing relapses and on furthering the gains that have been made during the action stage.

Termination: Here, the client has made the necessary changes, and relapse is no longer a threat.

The importance of this conceptualization of the change process is twofold. First, it highlights to clinicians that not all clients are at the point where they are ready to commit to make changes in their lives. In these situations, the goals in therapy involve "moving" the client through the precontemplation, contemplation, and preparation stages to the action stage. Once at the action stage, the "active ingredients" of the treatment can be administered and are more likely to have an effect. Thus, an assessment of each client's stage of change is important. Second, Prochaska and Norcross (2002) note that because certain "processes" characterize each stage, clinicians should attempt to use only those interventions that match or complement the processes of that stage. For example, a clinician with a client who is at the precontemplation stage should attempt to raise the client's awareness of his or her behavior and the problems it is causing, highlighting the advantages of making changes as well as the potential benefits of psychotherapy. If successful, the client can then be led from the precontemplation to the contemplation stage.

PSYCHOTHERAPY RESEARCH

In this last section, we briefly review the methods of psychotherapy research, the results of several major outcome studies, and the recent trends in psychotherapy research. More extensive reviews and books on methods of psychotherapy research are available for the interested reader (e.g., Lambert & Ogles, 2004).

In 1952, Eysenck produced a report suggesting that psychotherapy with "neurotics" was no more effective than no therapy at all (see Box 11-5). Investigators took this and related work (Eysenck,

BOX 11-5 Focus on Professional Issues: Eysenck's Bombshell

In arriving at his conclusions about the efficacy of psychotherapy, Eysenck considered statistical outcome data from over 7,000 patients. These patients included five psychoanalytic groups and fourteen groups who had undergone "eclectic" therapy. As control data, Eysenck employed the discharge rate among hospitalized patients from New York State hospitals and the amount of improvement that occurred in individuals who were seeking insurance settlements and were receiving medical treatment from general practitioners.

Basically, Eysenck claimed that 72% of the patients who had received only custodial or medical care had improved, whereas only 44% of the patients who had received psychoanalytic treatment and only 66% of the patients who had received eclectic therapy showed improvement. Clearly, a smaller percentage of psychotherapy patients than control patients showed improvement.

While some have argued for the validity of Eysenck's conclusions (e.g., Rachman, 1973; Truax & Carkhuff, 1967), others have vehemently disagreed (e.g., Bergin, 1971; deCharms, Levy, & Wertheimer, 1954). The criticisms have centered on Eysenck's failure to match participants in the treatment and control groups. In fact, there really was no control group in the classic sense, and there certainly was no matching for education, social class, personality structure, expectations about therapy, and so on. Also, there was little evidence that physicians and psychiatrists were using the same standards for improvement. Finally, there is a question about how Eysenck calculated his improvement rates. For example, Bergin (1971) argued that the improvement rate of custodial and medical care groups was really 30% rather than 72% as calculated by Eysenck.

ANNA WIDOFF Agence France Presse/Newscom

Hans Eysenck

1965, 1966) as a challenge. Consequently, the significance of Eysenck's work lies less in the validity of his conclusions (which many deemed flawed) than in the attack he made on the field's complacency.

As mentioned earlier in this chapter, the evidence concerning the efficacy of psychotherapy is now considerably more favorable. Still, an undercurrent of suspicion remains (Dawes, 1994). To better understand the nature of therapeutic change, we consider issues of research design and method, the results of outcome studies, and the process of change itself.

Issues in Psychotherapy Research

It is not enough to collect 25 patients undergoing psychoanalytic therapy, administer before-and-after measures of adjustment, determine that positive changes have occurred after 6 months, and then conclude that psychoanalytic treatment is effective. Would a comparable group of patients without therapy have shown improvement? Would a similar group undergoing systematic desensitization have improved as much? Was the improvement due to the psychoanalytic procedures employed, or was the crucial factor the mere presence of a warm, interested person who listened? The simple design suggested in our example does not permit answering any of these important questions.

As with many psychological experiments (see Chapter 4), studies that seek to investigate the efficacy of psychotherapy typically employ an experimental group and a control group of patients. The experimental group, or *treatment group*, receives the treatment being investigated, whereas the *control group* does not. Control groups can take many forms. In a *waiting list control group*, patients' treatment is delayed

until after the study is completed; in an *attention only control group*, patients meet regularly with a clinician, but no "active" treatment is administered. As much as possible, patients in the treatment and control groups are matched on variables that might be related to outcome, such as gender, age, diagnostic status, and severity of symptoms before the study began, prior to being randomly assigned to groups. Assessments of *patient functioning* (symptoms of psychopathology) are conducted in parallel fashion for both treatment and control participants. At the very least, assessments are obtained at the beginning of the study, at treatment completion, and possibly at some period of time after treatment is terminated (follow-up). This design allows a comparison of the two groups at treatment completion and follow-up as well as an evaluation of the amount of change (if any) within each group.

Following are some of the research considerations that help shape the meaning and generality of research findings on therapeutic outcomes.

1. What is the sample? Are the patients voluntary, or were they subtly or overtly coerced into therapy (e.g., prisoners vs. private practice patients). Were the therapists experienced, or were they neophytes? Were they psychoanalysts, or were they behaviorists? Were the patients "real" patients, or were they recruited by a newspaper ad requesting paid volunteers for an analog study on the "treatment of snake phobias"? Undoubtedly, the answer to each of these questions (and others like them) will determine how researchers can interpret their results. There are no absolute findings, only findings relative to the sample and to the conditions of the given study.
2. What relevant patient variables were controlled? Unfortunately, one cannot hope to provide a control group that is exactly the same as the treatment group. This being the case, how close did the study come to controlling relevant factors? If the waiting list or attention only control group was not identical with the patient group, in what ways did it differ? Were the presenting complaints of the patient group all basically alike, or was there diversity? Was the control group similar to the treatment group with respect to demographic factors, personality, knowledge about therapy, and expectations for help?
3. What were the *outcome measures*? Were the outcome measures identical for every patient and control, or were they "tailored" to meet the idiosyncratic situation (goals, hopes, and expectations) of each patient? Was a single outcome measure used, or were multiple measures employed? Were the measures nonreactive or unobtrusive, or were they measures that, by their very character, might reflect things other than what they were supposed to be measuring? Unfortunately, there is currently no consensus about which outcome measures should be used in psychotherapy research studies. This makes comparisons across studies more difficult.
4. What was the general nature of the study? The effects of therapy can be evaluated in a variety of ways. So far, we have concentrated on experimental studies. Other methods include case studies, clinical surveys, correlational studies, and analog studies. Each type has characteristic strengths and weaknesses. For example, a case study can offer a richness of detail and a fountain of hypotheses that may be far more valuable than an experimental study or an analog study. But a case study has an N (i.e., sample size) of 1, and how far can one generalize from one patient? Analog studies offer great potential for controlling relevant variables, avoiding ethical problems with no-treatment groups, and collecting a satisfactory number of participants. But how close to reality is an analog study? As we have had occasion to remark before, each method offers unique advantages and characteristic limitations. How researchers choose to proceed must be determined by what they seek to learn and what they can tolerate in the way of limitations. Perhaps the best hope is that numerous good investigators will decide to follow diverse research paths.

Comparative Studies

Therapy research has become increasingly sophisticated since Eysenck's critique. More and more studies do not just assess outcomes but also compare two or more techniques in terms of efficacy. However, several critics have questioned whether some designs are powerful enough (have enough study participants) to detect differences between alternative treatments (Kazdin & Bass, 1989).

The Temple University Study. A major comparative study was conducted by Sloane, Staples, Cristol, Yorkston, and Whipple (1975a, 1975b). More than 90 outpatient neurotics were assigned to (a) behavior therapy, (b) short-term psychoanalytically oriented therapy, or (c) a minimal treatment waiting list. The groups were matched in terms of sex and severity of symptoms; otherwise, assignment to the different therapeutic conditions was random. Treatment was carried out by three behavior therapists and three analysts, all of whom were highly trained and experienced. Before-and-after measurements included psychological tests, a target symptoms technique (a measure oriented toward individualized treatment criteria), a standard interview, informants' reports (people who had known the patients for an average of 12 years), and ratings by the therapist, the patient, and an independent rater. Note that these procedures correspond closely to several of the recommendations made earlier in the methodology section of this chapter.

All three groups had improved at a 4-month posttesting point. However, the psychoanalytic therapy (PT) and behavior therapy (BT) groups improved more than did the waiting list (W) group. The independent rater could find no differences with respect to improvement in target symptoms between the BT and PT groups. General estimates, such as improvement in work or social situations, also failed to discriminate between the PT and BT groups. The rater's global outcome assessment indicated that 80% of both the BT group and the PT group improved, whereas only 48% of the W group did. For general adjustment, 93% of the BT group and 77% of both the PT group and the W group showed improvement. Although the comparative change between the BT group and the PT group varied depending on the specific criterion, in general there was a slight trend in favor of the BT group. There was no evidence of deterioration effects, and all three groups maintained their improvement after 1 year. It should be noted, however, that there was a trend for the improvement to continue and for patients in the W group to approach or equal those in the BT and PT groups. This could suggest that what therapy does is accelerate change, rather than produce more change, as compared to no treatment. Psychoanalysts produced better outcomes with less disturbed patients, whereas the level of patient disturbance made no difference for behavior therapists. This suggests that behavior therapy may have greater versatility, perhaps because of the greater flexibility and eclecticism of the techniques employed by behavior therapists.

Meta-analyses. In 1977, Smith and Glass published a review of nearly 400 psychotherapy outcome studies. Their verdict was that the evidence is convincing in showing the effectiveness of psychotherapy. What is unique about their review is their use of a method called *meta-analysis*. Using this method, they analyzed all therapy studies that dealt with at least one therapy group and one control group, or with two therapy groups, and averaged the effects of therapy across all these studies. In their analysis, they defined *effect size* as the mean difference between treated and control participants' scores on relevant outcome measures divided by the standard deviation of the control group.

Earlier, we mentioned the meta-analysis of Smith et al. (1980). Their survey included 475 studies involving 25,000 patients treated by some 78 therapies for an average of 16 sessions. Outcome comparisons showed effect sizes that averaged a .85 standard deviation. As previously mentioned, this means "the average person who receives therapy is better off at the end of it than 80% of the persons who do not" (Smith et al., 1980, p. 87). Using a somewhat stricter definition of therapy and removing "placebo therapy" and "undifferentiated counseling" from the data, the

TABLE 11-4 Average Effect Size (ES) and Percentile Equivalent for Select Forms of Psychological Intervention

Type of Therapy	ES	Percentile Equivalent
Psychodynamic	0.69	75%
Client-centered	0.62	73%
Gestalt	0.64	74%
Rational-emotive therapy (RET)	0.68	75%
Non-RET cognitive therapies	2.38	99%
Systematic densensitization	1.05	85%
Behavior modification	0.73	77%
Cognitive-behavioral therapy	1.13	87%
Undifferentiated counseling	0.28	61%
All forms of psychological intervention	0.85	80%

NOTE: *Percentile equivalent* indicates the percentage of those not receiving treatment whose outcome is exceeded by those receiving the treatment in question.

SOURCE: Adapted with permission from *The Benefits of Psychotherapy*, by M. L. Smith, G. V. Glass, and T. I. Miller. Copyright © 1980 by Johns Hopkins University Press.

average effect size increased from .85 to .93 of a standard deviation unit. This figure would be analogous to reducing an illness or death rate from 66% to 34%! Table 11-4 presents a summary of Smith et al.'s findings for several major forms of psychotherapy.

Process Research

So far, we have focused on the outcomes of therapeutic intervention, along with many of the patient and therapist variables that may affect those outcomes. Other investigators, however, have addressed the specific events that occur *during* therapy in the course of the interaction between therapist and patient. This is called *process research*. The Rogerians were pioneers in this area and commonly conducted studies relating, for example, the amount of therapist talk in a given session to client spontaneity or the effects of therapist clarifications and restatements on the client's taking responsibility for the progress in a given session.

For a long time, therapy investigators were split into two camps (Beutler, 1990): those who did process research and those who did outcome research. Those who focused on outcomes criticized process research as failing to show that processes internal to therapy were correlated with outcome and, therefore, as not worthy of serious consideration. Indeed, it sometimes seemed as if the process was misleading in predicting outcomes.

But process-oriented researchers felt there should be relationships between outcome and the processes that occur during therapy (Strupp, 1971). One way of doing this kind of research is to film or tape actual therapy sessions (Hill & Lambert, 2004). This kind of research has increasingly begun to show substantive relationships between what happens during therapy and ultimate outcome (Orlinski, Ronnestad, & Willutzki, 2004). For example, across studies, one of the strongest associations found is between therapeutic bond (the degree to which client and therapist are invested in, communicate with, and affirm each other) and outcome (Orlinski et al., 2004). This highlights the importance of a strong, positive working relationship in psychotherapy.

Other consistent findings concerning the relationship between measures of therapeutic process and outcome include (Orlinsky et al., 2004):

- Therapist competence and adherence to treatment protocol are associated with positive outcome;

- The degree to which clients reflect on, think about, and emotionally process material within sessions is positively associated with outcome;
- Therapists' use of guidance and advice is generally not associated with outcome, and therapists' use of support and encouragement is inconsistently related to outcome;
- As might be expected, clients' degree of cooperativeness (vs. resistance) is positively related to outcome, as is the degree to which clients express positive affect in a session.

Findings such as these give us more clues as to what therapeutic ingredients are associated with positive outcome. What is especially intriguing is that these findings are generally consistent regardless of the "brand" of therapy or treatment used.

Recent Trends

Focus of Psychotherapy Research. As noted earlier, a great deal of research is conducted to examine the efficacy and effectiveness of specific therapeutic approaches for individual diagnoses. In addition, recent research has refined this question by asking whether there are specific factors (e.g., client motivation, socioeconomic status, etc.) that may be related to higher efficacy and effectiveness. In addition, research has begun to dismantle therapeutic approaches to determine whether specific components of cognitive-behavioral therapy, for instance, are the most important ingredients in therapy outcome. Last, research has begun to focus more specifically on the types of therapies that work for each specific diagnosis. In other words, the question of interest to contemporary researchers is no longer "whether psychotherapy works," but rather "which type of psychotherapy works for which diagnoses?" Part of this line of research includes asking whether psychotherapy, medication, or a combination of both may lead to better client outcome.

For example, Chorpita and colleagues (2011) offer an analysis of several different types of therapeutic approaches for several different types of disorders among youth. Their results led to a documentation of the evidence base for several different approaches to therapy. For instance, their results revealed that cognitive-behavioral therapy, particularly involving "exposure" as a therapeutic technique, has the best evidence base for the treatment of anxiety disorders; most studies suggest that this approach works better than no therapy at all. In contrast, there is very little evidence to suggest that psychodynamic or play therapy works any better in reducing anxiety disorder symptoms than no therapy at all (Chorpita et al., 2011).

Other recent studies have compared the effects of psychotherapy, medication, or a combined form of treatment. Many of these studies have involved large multisite national clinical trials, involving hundreds of clients across several U.S. geographic areas. For instance, one of these trials involved the study of treatment for ADHD in children (i.e., NIMH Collaborative Multisite Multimodal Treatment Study of Children With Attention-Deficit/Hyperactivity Disorder; MTA, 1999). Treatments included behavioral therapy, medication, combined treatment, and community-care controls. Results at the end of treatment indicated that youth in the combined and medication conditions evidenced greater improvement in ADHD symptoms and ODD symptoms than did children in the behavior-therapy-only condition and the community controls (MTA, 1999).

Practice Guidelines. Increasingly, clinical psychologists are being held accountable for the services they provide. Insurers and managed care companies no longer give clinicians free rein as to the interventions they employ and the pace at which treatment is administered. To maintain control over the psychotherapy enterprise, several professional organizations have become increasingly active in developing *practice guidelines* (Nathan, 1998). Practice guidelines recommend specific forms of intervention for specific psychological problems or disorders, and they have a common goal of "detailed specification of methods and procedures to ensure effective treatment for each disorder" (Nathan & Gorman, 1998, p. 12). The American Psychological Association began working on practice guidelines in 2011.

Manualized Treatment. A related, hotly debated issue is whether manual-based treatments should be used in clinical practice. Treatment manuals were originally developed by psychotherapy researchers to ensure that treatment protocols were standardized across patients. However, *manualized treatment* has also been used outside the research context in clinical practice. Some have criticized manual-based treatment for "undermining" the clinical judgment of clinicians, for not being tailored to patients with multiple problems (comorbid conditions), and for ignoring therapist effects on outcome (Davison & Lazarus, 1995; Garfield, 1996; Wilson, 1998).

In addressing these and other criticisms, Wilson (1998) points out that manual-based treatment has greater clinical utility than it is given credit for. The psychological testing and clinical judgment literature suggests that clinical judgment and clinical prediction are limited and are likely to be outperformed by an empirically supported manualized treatment that prescribes for the therapist the methods of intervention for a given problem. Second, there are no data to support the position that manual-based treatments are inferior to treatment-as-usual with regard to comorbid psychological problems (Wilson, 1998). In fact, manual-based treatments might be used to treat comorbid problems sequentially or concurrently. Third, Wilson (1998) argues that manual-based treatments actually encourage clinical innovation because they help identify patients who do not seem to respond to "first-choice" treatments. It then becomes possible and necessary to modify protocols to treat these individuals successfully. Finally, Wilson (1998) points out that manual-based treatments, like other forms of treatment, require clinical skill and a positive therapeutic alliance. He does acknowledge that treatment manuals need to become more "therapist friendly" and suggests providing more practical guidelines as well as more discussions of commonly encountered problems in implementing the treatment.

We would like to highlight a few additional advantages of manual-based treatment. This form of treatment is more focused, often more engaging from the patient's perspective, and easier to teach, supervise, and monitor (Wilson, 1998). Finally, the clinicians who master manual-based treatments will be much more attractive to managed care companies because these treatments are recognized as efficacious and efficient (Marques, 1998; Strosahl, 1998). Marques (1998) predicts that clinicians will be required to use manual-based treatment protocols to maintain their provider status for managed care organizations. For all of these reasons, it is important that clinical psychology trainees receive thorough training in manual-based, empirically supported treatments (Calhoun, Moras, Pilkonis, & Rehm, 1998). Table 11-5 presents a preliminary set of guidelines for training in empirically supported treatments.

TABLE 11-5 Guidelines for Training in Empirically Supported Treatments (ESTs)

- Include videotapes that illustrate the conduct of the central components of the EST in the training program.
- Rely mainly on audio- or videotapes of therapy sessions for supervision, rather than on trainees' self-reports.
- Use adherence measures developed for the EST to systematically and frequently evaluate each trainee's progress.
- Training material that illustrates common errors in the implementation of central components of an EST are efficient training aids.
- Group supervision using audiotapes of sessions might be more efficient than individual supervision in terms of rate of learning.
- Expect to provide supervision on a minimum of three to four prototypical cases for the EST and a minimum of four more nonprototypical cases to develop minimally adequate skill performing it.
- Include instruction in ongoing evaluation of a patient's response to the EST.

SOURCE: Adapted from Calhoun, K. S., Moras, K., Pilkonis, P. A., & Rehm, L. P. (1998). Empirically supported treatments. Implications for training. *Journal of Consulting and Clinical Psychology*, 66, 151–162.

SOME GENERAL CONCLUSIONS

Although most acknowledge that the efficacy of psychotherapy has been demonstrated, there is little evidence to suggest that one form of therapy is in any sense uniquely effective for all problems. J. D. Frank's (1979) conclusions about psychotherapy several decades ago also seem to characterize current thinking:

1. Several forms of psychotherapy are somewhat more efficacious than unplanned or informal help.
2. One form of therapy has typically not been shown to be more efficacious than another for all conditions.
3. Clients who show initial improvement tend to maintain it.

Careful research should be designed to help us predict which therapy will best work for a given problem. Lists of empirically supported treatments for common psychological problems should continue to be updated and expanded. At the same time, effort should also be devoted to investigating the factors common to all therapies and the manner in which they operate. Research might also focus on the effects of matching patients and therapists in terms of relevant characteristics. However, in the final analysis, therapist competence may be more critical than the simple matching of patients and therapists along lines of race, class, or sex.

Therapy is an intermittent process that occurs, for example, once a week. Thus, it is only a small part of a client's ongoing life. Other concurrent experiences may be as important or even more important in determining whether or not improvement occurs. Also, what happens in therapy may interact with other experiences in complex ways. Others may begin to react differently to the client, and these changed reactions may reinforce or counteract changes induced by therapy. Changes in the client may threaten family members, who then quietly conspire to sabotage treatment. The whole process is so complex and interactive that it is difficult for research to show what factors in therapy are related to client change or lack of it (Frank, 1982).

Perhaps the greatest reality limitation of all is suggested by Barlow's (1981) charge that many clinical psychologists simply do not pay attention to outcome research. They continue doing what they have always done without full realization of the difficulties in making valid inferences from their experiences with single cases (Kazdin, 1981). Persons (1995) discusses how deficits in training and the perceived inaccessibility of resources have caused clinicians to delay adopting empirically supported treatment techniques. However, Chambless et al. (1996) have said it best:

> Psychology is a science. Seeking to help those in need, clinical psychology draws its strength and uniqueness from the ethic of scientific validation. Whatever interventions that mysticism, authority, commercialism, politics, custom, convenience, or carelessness might dictate, clinical psychologists focus on what works. They bear a fundamental ethical responsibility to use where possible interventions that work and to subject any intervention they use to scientific scrutiny. (p. 10)

Clinical psychologists must learn more about the specifics of the efficacy and effectiveness of various forms of therapy and routinely implement this knowledge. They are under both ethical and scientific imperatives to do so.

CHAPTER SUMMARY

Clinical psychologists use psychological interventions to induce changes in a person's behavior, thoughts, or feelings. Psychotherapy is a form of intervention that occurs in a professional context whose aim is to solve psychological problems, improve coping and functioning, prevent future problems, or increase life satisfaction. Evidence suggests that psychotherapy is efficacious, especially for

certain types of psychological problems. However, no one form of psychotherapy or intervention is superior for all problems.

Certain features or characteristics are common to all forms of therapy, including the expert role of the therapist, the relationship or therapeutic alliance, the building of competence, the release of anxiety or tension, and the expectation of change. Although specific characteristics of the patient and of the therapist may influence outcome, such relationships appear to be multidimensional and complex. Interestingly, many commonly held beliefs regarding the relationships between patient and therapist factors and psychotherapy outcome are not supported by research.

Psychotherapy research is aimed at assessing whether or not certain interventions are effective with specific client populations, what factors seem related to change, and how such change can be brought about. More recent studies examine whether a specific therapy is useful with patients with specific psychological problems (e.g., specific *DSM-IV* diagnoses). In addition, clinical psychologists have begun to examine more thoroughly the relative benefits of psychotherapy versus medication for certain conditions and of combined therapy/medication treatments. Finally, research has helped shape practice guidelines that incorporate empirically supported treatments. In the future, clinical psychologists are likely to be using manual-based treatments with increasing frequency.

KEY TERMS

attention only control group A control group whose members meet regularly with a clinician but receive no "active" treatment.

catharsis The release of emotions.

common factors A set of features that characterize many therapy orientations and that may be the source of the positive changes effected by psychological treatment.

control group In psychotherapy research, the group that does not receive the treatment under investigation.

depth of a problem The changeability of a condition or behavior. (The "deeper" the condition, the less changeable it is perceived to be.)

effect size The size of the treatment effect (determined statistically).

effectiveness studies Studies that emphasize external validity and the representativeness of the treatment that is administered. A treatment is considered effective to the extent that clients report clinically significant benefit from the treatment.

efficacy studies Studies that place a premium on internal validity by controlling the types of clients in the study, by standardizing the treatments, and by randomly assigning patients to treatment or no-treatment groups. A treatment is considered efficacious to the extent that the average person receiving the treatment in clinical trials is demonstrated to be significantly less dysfunctional than the average person not receiving any treatment (e.g., those on a waiting list for treatment).

empirically supported treatments (ESTs) Treatments for various psychological conditions that have been shown through careful empirical study to be either "well established" or "probably efficacious." A list of ESTs is updated and published periodically by the APA's Division of Clinical Psychology.

evidence-based treatments (EBTs) Those interventions or techniques that have produced significant change in clients and patients in controlled trials.

evidence-based practice (EBP) Treatments informed by a number of sources, including scientific evidence about the intervention, clinical expertise, and patient needs and preferences.

expert role The therapist's demonstration of competence (i.e., knowledge and experience).

insight In the context of psychotherapy, the achievement of understanding the nature and origins of one's problems.

interpretation In the context of psychotherapy, the therapist's conceptualization of the meaning behind the patient's experiences or behaviors.

manualized treatment Psychotherapeutic treatment that is presented and described in a standardized, manual format (i.e., outlining the rationales, goals, and techniques that correspond to each phase of the treatment).

mastery The acquisition of a high level of knowledge or skill. One goal of psychotherapy may be for the patient to develop competence/mastery in a particular area.

meta-analysis A method of research in which one compiles all studies relevant to a topic or question and combines the results statistically.

nonspecific factors Factors that are not specific to any particular therapy orientation yet contribute to a positive treatment outcome (e.g., the expectation that one will improve).

outcome measures In psychotherapy research, indicators of patient functioning following treatment, used to gauge the treatment effectiveness.

paraprofessionals Individuals without advanced education in psychology who have been trained to assist professional mental health workers.

patient functioning How well a patient is getting along across a number of domains (e.g., psychological, social/interpersonal, occupational).

process research Research that investigates the specific events that occur in the course of the interaction between therapist and patient. Some therapy processes have been shown to relate to treatment outcome.

psychological intervention A method of inducing changes in a person's behavior, thoughts, or feelings.

stages of change A series of stages that represent a given client's readiness for change in psychotherapy. These include: precontemplation, contemplation, preparation, action, maintenance, and termination.

therapeutic alliance The relationship between therapist and patient. The forging of a strong therapeutic alliance is believed to be of primary importance for therapeutic change.

treatment group In psychotherapy research, the group that receives the treatment under investigation.

waiting list control group A control group whose members receive treatment only after the study is completed.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

11-1 Division 12 (Clinical Psychology) Web site on Research-Supported Treatments
http://www.psychology.sunysb.edu/eklonsky-/division12/index.html

11-2 Original Division 12 Web site on Empirically Supported Treatments
http://www.apa.org/divisions/div12/cppi.html

11-3 Division 29 (Psychotherapy) Web site
http://www.divisionofpsychotherapy.org/

11-4 Evidence-Based Psychology Practice (EBPP) updates
http://www.divisionofpsychotherapy.org/category/ebpp-treatment-updates/

11-5 SAMHSA's registry of evidence-based programs and practices
http://www.nrepp.samhsa.gov/

11-6 Evidence Based Behavioral Practice (EBBP)
http://www.ebbp.org

11-7 Evidence based mental health treatment for children and adolescents
http://www.effectivechildtherapy.com

12

Psychotherapy: The Psychodynamic Perspective

FOCUS QUESTIONS

1. What are the major assumptions of Freudian theory?
2. What techniques are used in psychoanalytic treatment, and why are these techniques used?
3. What are the major alternative forms of psychoanalytic therapy? Describe each.
4. What evidence suggests that psychodynamic treatment works?
5. What are the advantages and disadvantages of psychodynamic forms of treatment?

CHAPTER OUTLINE

Psychoanalysis: The Beginnings
- Anna O.
- BOX 12-1: *Focus on Professional Issues: A Brief Biography of Sigmund Freud*
- The Freudian View: A Brief Review
- From Theory to Practice
- The Role of Insight

Techniques of Psychodynamic Psychotherapy
- Free Association
- Analysis of Dreams
- Psychopathology of Everyday Life
- BOX 12-2: *Focus on Professional Issues: Freud's Self-Analysis*
- Resistance
- *A Case Illustration of Resistance*
- Transference
- Interpretation
- *A Case Illustration of Interpretation*

Psychoanalytic Alternatives
- Ego Analysis
- Other Developments
- Contemporary Psychodynamic Psychotherapy
- Interpersonal Psychotherapy: An Empirically Supported Treatment
- BOX 12-3: *Focus on Clinical Applications: Features of Interpersonal Psychotherapy (IPT)*

Summary Evaluation of Psychodynamic Psychotherapy
- Does Psychodynamic Psychotherapy Work?

BOX 12-4: *Clinical Psychologist Perspective: Kenneth N. Levy, Ph.D.*
Interpretation and Insight
Curative Factors
The Lack of Emphasis on Behavior
BOX 12-5: *Clinical Psychologist Perspective: Ali Khadivi, Ph.D.*
The Economics of Psychotherapy
BOX 12-6: *Graduate Student Perspective: Joseph E. Beeney*
CHAPTER SUMMARY
KEY TERMS
WEB SITES OF INTEREST

The psychodynamic approach to therapy focuses on unconscious motives and conflicts in the search for the roots of behavior (Shedler, 2010). It likewise depends heavily on the analysis of past experience. The roots of this perspective reside in the original psychoanalytic theory and therapy of Sigmund Freud (see Box 12-1).

Without question, psychoanalytic theory represents one of the most sweeping contributions to the field of personality. What began as a halting flow of controversial ideas based on a few neurotic Viennese patients was transformed into a torrent that changed the face of personality theory and clinical practice. Hardly an area of modern life remains untouched by Freudian thought. It influences art, literature, and culture as well (Luborsky & Barrett, 2006). Such words and phrases as *ego*, *unconscious*, *death wish*, *Oedipal*, and *Freudian slip* have become a part of our everyday language.

What is true in our culture at large is no less true for therapeutic interventions. Although psychoanalytic therapy is sometimes regarded as an anachronism, it is still practiced by some clinical psychologists (Norcross, Karpiak, & Santoro, 2005). In fact, almost every form of therapy that relies on verbal transactions between therapist and patient owes some debt to psychoanalysis—both as a theory and as a therapy. Whether it is existential therapy, cognitive-behavioral therapy, or family therapy, psychoanalytic influences are clearly evident, even though they are not always formally acknowledged.

PSYCHOANALYSIS: THE BEGINNINGS

In 1885, Freud was awarded a grant to study in Paris with the famous Jean Charcot. Charcot was noted for his work with hysterics. Hysteria then was viewed as a "female" disorder most often marked by paralysis, blindness, and deafness. These symptoms suggested a neurological basis, yet no organic cause could be found. Earlier, Charcot had discovered that, while under hypnosis, some patients with hysteria would relinquish their symptoms and sometimes recall the traumatic experiences that had caused them. It is likely that such recall under hypnosis helped stimulate Freud's thinking about the nature of the unconscious. In any event, Freud was greatly impressed by Charcot's work and, upon his return to Vienna, explained it to his physician friends. Many were quite skeptical about the benefits of hypnosis, but Freud nevertheless began to use it in his neurological practice.

Anna O.

A few years earlier, Freud had been fascinated by Josef Breuer's work with a young patient with "hysteria" called Anna O. She presented many classic hysterical symptoms, apparently precipitated by the death of her father. Breuer had been treating her using hypnosis, and during one trance, she told him about the first appearance of one of her symptoms. What was extraordinary, however, was that when she came out of the trance, the symptom had disappeared! Breuer quickly realized that he had stumbled onto something very important, so he repeated the same procedures over a period of

BOX 12-1 Focus on Professional Issues: A Brief Biography of Sigmund Freud

Sigmund Freud was born in Austria (in an area that later became part of Czechoslovakia) on May 6, 1856. Most of his childhood was spent in Vienna. He was the oldest of seven children. After a classical education, he began medical studies at the University of Vienna and received an M.D. degree in 1881. After a short period in research, he began a private practice, even though such work did not greatly interest him. At least three things helped him make this decision. First, he knew that as a Jew he stood little chance of advancement in a research-academic environment rife with anti-Semitic feelings. Second, his research efforts did not seem likely to produce much income. Third, he had fallen in love with Martha Bernays. Just as it does today, marriage required money, and Freud had very little. Consequently, he decided to open a practice as a neurologist. His marriage to Martha produced six children, one of whom, Anna, became a famous psychoanalyst herself.

Around this time, Freud began a brief but very productive collaboration with Josef Breuer, a renowned physician in Vienna. Together they sought an explanation for Breuer's discovery of the *talking cure*, a method by which a patient's neurotic problems are alleviated just by talking about them. In 1895, Breuer and Freud published *Studies on Hysteria*, a landmark psychiatric treatise. A bit later, the two men had a falling out for reasons not completely clear. Some suggest the problem was a disagreement over money, whereas others believed it had to do with Breuer's alarm over Freud's growing emphasis on sexual factors as a cause of hysteria.

Freud's most acclaimed work, *The Interpretation of Dreams*, appeared in 1900, capping a remarkably productive decade of work. As the 20th century dawned, his professional stature was growing, and his work had begun to attract a dedicated band of followers. Several of these converts later left the orthodox Freudian camp to develop their own psychoanalytic theories. Notable among these were Alfred Adler, Carl Jung, and Otto Rank. Freud became a truly international figure when, in 1909, he was invited to lecture at Clark University in the United States.

Many books and papers followed. But so did Nazi harassment in the 1930s. They burned his books and turned him into a choice anti-Semitic target. Finally, he was allowed to emigrate to England. In his declining years, he suffered from cancer of the jaw, experiencing great pain and undergoing about 32 operations. A heavy cigar smoker, he periodically gave up cigars, but never completely. He died in England in September 1939.

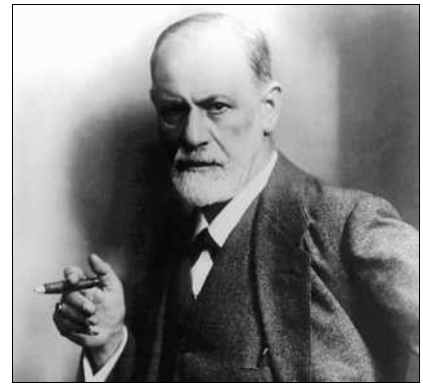

Photo Researchers Inc.

time. He was quite successful, but then a complication arose. Anna began to develop a strong emotional attachment to Breuer. The intensity of this reaction, coupled with a remarkable session in which Anna began showing hysterical labor pains, convinced Breuer that he should abandon the case. The jealousy of Breuer's wife may also have played a part in his decision.

These events, with which Freud was familiar, undoubtedly helped prompt his initial theories about the unconscious, the "talking cure," catharsis, transference, and moral anxiety. He treated many of his patients with hypnosis. However, not all patients were good candidates for hypnotic procedures. Others were easily hypnotized but showed a disconcerting tendency not to remember what had transpired during the trance, which destroyed most of the advantages of hypnosis. An example was Elisabeth, a patient Freud saw in 1892. He asked her, while she was fully awake, to concentrate on her ailment and to remember when it began. He asked her to lie on a couch as he pressed

his hand against her forehead. Subsequently, Freud found that placing his hand on patients' foreheads and asking them to remember events surrounding the origin of the symptom were just as effective as hypnosis. He soon gave up placing his hand on patients' foreheads and simply asked them to talk about whatever came to their minds. This was the beginning of what came to be known as the method of free association.

The Freudian View: A Brief Review

A major assumption of Freudian theory, *psychic determinism*, holds that everything we do has meaning and purpose and is goal directed. Such a view enables the psychoanalyst to utilize an exceptionally large amount of data in searching for the roots of the patient's behavior and problems. The mundane behavior, the bizarre behavior, the dream, and the slip of the tongue all have significance and meaning.

To account for many aspects of human behavior, Freud also assumed the existence of *unconscious motivation*. His use of this assumption was more extensive than that of any previous theorist, and it allowed him to explain much that had previously resisted explanation. The analyst first assumes that healthy behavior is behavior for which the person understands the motivation. The important causes of disturbed behavior are unconscious. Therefore, it follows that the goal of therapy is to make the unconscious conscious.

The Instincts. The energy that makes the human machine function is provided by two sets of instincts: the *life instincts (Eros)* and the *death instincts (Thanatos)*. The life instincts are the basis for all the positive and constructive aspects of behavior; they include bodily urges such as sex, hunger, and thirst as well as the creative components of culture such as art, music, and literature. But all these activities can serve destructive ends as well. When this happens, the death instincts are responsible. In practice, modern analysts pay scant attention to death instincts. However, Freud found them necessary to account for the dark side of human behavior (the compulsively self-destructive behavior of the neurotic, our inability to avoid wars, etc.). In any event, for Freud the ultimate explanation for all behavior was an instinctual one, even though the instincts he posited are unobservable, cannot be measured, and often seem better able to explain events after they occur than before.

Personality Structures. Psychoanalysis views personality as composed of three basic structures: the id, the ego, and the superego. The *id* represents the deep, inaccessible portion of the personality. We gain information about it through the analysis of dreams and various forms of neurotic behavior. The id has no commerce with the external world—it is the true psychic reality. Within the id reside the instinctual urges, with their desire for immediate gratification. The id is without values, ethics, or logic. Its essential purpose is to attain the unhampered gratification of urges whose origin resides in the somatic processes. Its goal, then, is to achieve a state free from all tension or, if that is unattainable, to keep the level as low as possible.

The id is said to obey the *pleasure principle*, trying to discharge tension as quickly as tension reaches it. To do this, it uses a *primary process* kind of thinking, expending energy immediately in motor activity (e.g., a swelling of the bladder that results in immediate urination). Later, the id replaces this aspect of the primary process by another form. It manufactures a mental image of whatever will reduce the tension (e.g., hunger results in a mental representation of food). Dreaming is regarded as an excellent example of this form of the primary process. Of course, this primary process cannot provide real gratifications, such as food. Because of this inability, a second process develops, bringing into play the second component of personality—the ego.

The *ego* is the executive of the personality. It is an organized, rational system that uses perception, learning, memory, and so on in the service of need satisfaction. It arises out of the inadequacies of the id in serving and preserving the organism. It

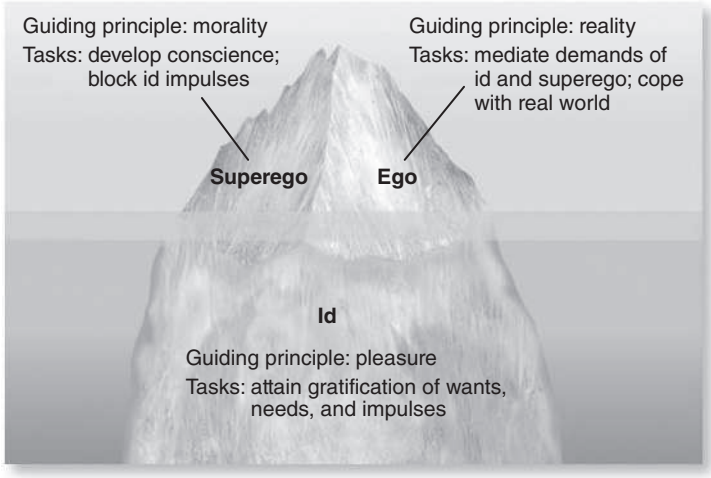

FIGURE 12-1 Freud's structure of the mind.

SOURCE: Adapted from Rathus, *Psychology: Concepts and Connections,* 9th ed., Fig 11.1, p. 402. Copyright © 2005 Wadsworth, a part of Cengage Learning. Reprinted by permission.

operates according to the *reality principle*, deferring the gratification of instinctual urges until a suitable object and mode are discovered. To do this, it employs the *secondary process*—a process that involves learning, memory, planning, judgment, and so on. In essence, the role of the ego is to mediate the demands of the id, the superego, and the real world in a way that will provide satisfaction to the organism and at the same time prevent it from being destroyed by the real world.

The third component of the personality is the *superego*. It develops from the ego during childhood, arising specifically out of the resolution of the *Oedipus complex* (the child's sexual attraction to the parent of the opposite sex). It represents the ideals and values of society as they are conveyed to the child through the words and deeds of the parents. These ideals and values are also conveyed via rewards and punishments. Punished behavior typically becomes incorporated into the individual's *conscience*, whereas rewarded behavior generally becomes a part of the *ego ideal*. Thus, within the superego, the conscience eventually serves the purpose of punishing individuals by making them feel guilty or worthless, whereas the rewards of the ego ideal are experienced as pride and a sense of worthiness. In general, the role of the superego is to block unacceptable id impulses, to pressure the ego to serve the ends of morality rather than expediency, and to generate strivings toward perfection.

The Psychosexual Stages. Like many other theorists, Freud considered childhood to be of paramount importance in shaping the character and personality of the individual. He believed that each person goes through a series of developmental stages. Termed *psychosexual stages*, each is marked by the involvement of a particular erogenous zone of the body (especially during the first 5 years). The *oral stage*, which lasts about a year, is a period in which the mouth is the chief means of reaching satisfaction. It is followed by the *anal stage*, in which attention becomes centered on defecation and urination; this stage may span the period from 6 months to 3 years of age. Next is the *phallic stage* (from 3 to 7 years of age), during which the sexual organs become the prime source of gratification. Following these so-called pregenital stages, the

child enters the *latency stage*, which is characterized by a lack of overt sexual activity and, indeed, by an almost negative orientation toward anything sexual. This stage may extend from about the age of 5 until 12 or so. Following the onset of adolescence, the *genital stage* begins. Ideally, this stage will culminate in a mature expression of sexuality, assuming that the sexual impulses have been handled successfully by the ego.

When the child experiences difficulties at any stage, these difficulties may be expressed in symptoms of maladjustment, especially when the troubles are severe. Either excessive frustration or overindulgence at any psychosexual stage will lead to problems. The particular stage at which excessive gratification or frustration is encountered will determine the specific nature of the symptoms. Thus, obsessive-compulsive symptoms signify that the individual failed to successfully negotiate the anal stage, whereas excessive dependence needs in an adult suggest the influence of the oral stage. Freud believed that all people manifest a particular character formation, which may not always be particularly neurotic but nonetheless does represent perpetuations of original childish impulses, either as sublimations of these impulses or as reaction formations against them. Examples would include an oral character's food fads or purist speech patterns, an anal character's prudishness or dislike of dirt, and a phallic character's excessive modesty.

Anxiety. The circumstances that give rise to the formation of the ego, and later the superego, produce the painful affective experience *anxiety*. Exaggerated responses of the heart, the lungs, and other internal organs are perceived and experienced as anxiety. There are three general classes of anxiety. The first is *reality anxiety*, which is based on a real danger from the outside world. *Neurotic anxiety* stems from a fear that one's id impulses will be expressed unchecked and thus lead to trouble from the environment. *Moral anxiety* arises from a fear that one will not conform to the standards of the conscience. What identifies and defines these anxieties is the source rather than the quality of the anxiety experience. The essential function of anxiety is to serve as a warning signal to the ego that certain steps must be initiated to quell the danger and thus protect the organism.

The Ego Defenses. We have already discussed that the ego uses the secondary process of memory, judgment, and learning to solve problems and stave off environmental threats. But such measures are less serviceable when threats arise from within the person. When one fears the wrath of the superego or the unleashed lusts of the id, where does one turn? The answer lies in the *ego defenses* or, as they are sometimes called, *defense mechanisms*. Nowhere was the insight of Freud more evident than in his ability to abstract the defense mechanisms from the often disconnected and illogical verbalizations of his patients. These mechanisms are generally regarded as pathological because they divert psychic energy from more constructive activities and at the same

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FIGURE 12-2 Freud's consulting room.

time distort reality. All the defense mechanisms operate actively and involuntarily, without the person's awareness.

The basic ego defense is *repression*. This can be described as the banishment from consciousness of highly threatening sexual or aggressive material. In some instances, the process operates by preventing the offending impulse from reaching consciousness in the first place. *Fixation* occurs when the frustration and anxiety of the next psychosexual stage are so great that the individual remains at his or her present level of psychosexual development. *Regression* involves a return to a stage that earlier provided a great deal of gratification; this may occur following extensive frustration. *Reaction formation* is said to occur when an unconscious impulse is consciously expressed by its behavioral opposite. Thus, "I hate you" is expressed as "I love you." *Projection* is revealed when one's unconscious feelings are attributed not to oneself but to another. Thus, the feeling "I hate you" is transformed into "You hate me."

From Theory to Practice

As mentioned earlier, Breuer's experiences with Anna O. led to the discovery of the "talking cure." This in turn became transformed into free association during Freud's work with Elisabeth. *Free association* meant simply that the patient was to say everything and anything that came to mind regardless of how irrelevant, silly, dull, or revolting it might seem. Freud also realized that Anna had transferred onto Breuer many of her feelings that really applied to significant males in her life. This notion of *transference* would eventually become a valuable diagnostic tool during therapy for understanding the nature of the patient's problems—especially the unconscious ones.

Through hypnosis, Freud learned that patients could relive traumatic events associated with the onset of the hysterical symptom. In some cases, this reliving served to release formerly bottled-up energy. This became known as *catharsis*—a release of energy that often had important therapeutic benefits. In his work with Elisabeth, Freud also witnessed *resistance*—a general reluctance to discuss, to remember, or to think about events that are particularly troubling or threatening. He viewed this as a kind of defense, but later he also analyzed it as repression—the involuntary banishing of a thought or impulse to the unconscious. The *unconscious*, of course, is the area of the mind inaccessible to conscious thought.

The Role of Insight

The ultimate goal of psychoanalytic intervention is the removal of debilitating neurotic problems. But the unswerving credo of the traditional psychoanalytic therapist is that, ultimately, the only final and effective way of doing this is to help the patient achieve *insight*. What does insight mean? It means total understanding of the unconscious determinants of those irrational feelings, thoughts, or behaviors that are producing one's personal misery. Once these unconscious reasons are fully confronted and understood, the need for neurotic defenses and symptoms will disappear. All of the specific techniques described later in this chapter have as their ultimate purpose the facilitation of insight.

An analysis culminating in insight is slow, tedious, and often very lengthy. An orthodox analysis is not measured in weeks or months but in years. This is because the patient is not simply informed, for example, that unconscious feelings of hostility and competitiveness toward a long-departed father are causing present outbursts against friends, a boss, or coworkers. At an intellectual level, the patient may readily concede this interpretation. But the unconscious is not likely to be much affected by such sterile information. The patient must actually experience the unconscious hostility. This may happen through the transference process; early experiences associated with the father may be relived as competition with the therapist begins to occur. The analyst begins to seem like that father of years gone by, and all the old reactions start flooding back. As the therapist comes to stand for someone else (the father), old emotions are re-experienced and then reevaluated. From this comes a deeper insight.

TABLE 12-1 Seven Key Features of Psychodynamic Psychotherapy (Shedler, 2010)

- Encourages patients to focus on affect and the expression of emotion.
- Helps people explore their attempts to avoid distressing thoughts and feelings.
- Identifies and focuses on recurring themes and patterns in patients' thoughts, feelings, and behaviors.
- Helps patients discuss how past experiences affect their current relationships, feelings, and behavior.
- Focuses on interpersonal relationships and interpersonal experience.
- Focuses on the current therapy relationship.
- Encourages patients to explore fantasy life (e.g., uncensored thoughts, feelings, dreams).

SOURCE: Adapted from "The efficacy of psychodynamic psychotherapy." *American Psychologist*, 65, pp. 98–109. Copyright © 2010 by the American Psychological Association. Reprinted by permission.

The true meaning of this insight is then brought into the patient's consciousness by the *working-through process*. This refers to a careful and repeated examination of how one's conflicts and defenses have operated in many different areas of life. Little may be accomplished by a simple interpretation that one's passivity and helplessness are really an unconscious form of aggression. Once the basis for the interpretation is firmly laid, it must be repeated time and time again. The patient must be confronted with the insight as it applies to relations with a spouse, a friend, or a supervisor, and yes, even as it affects reactions to the therapist. Patients must be helped to work through all aspects of their lives with this insight. This is not unlike learning a principle in a physics class. The principle only begins to take on real life and importance when one sees that it applies not just in a laboratory but everywhere—in automobile engines, house construction, baseball, and so on. So it is with insight. It comes alive when it becomes painfully clear in example after example how it has affected one's life and relationships. It is due in part to this extensive working-through period that traditional psychoanalysis takes so long—three to five therapy sessions per week for 3 to 5 years, and sometimes much longer.

TECHNIQUES OF PSYCHODYNAMIC PSYCHOTHERAPY

The analyst regards the symptoms of neurosis as signs of conflict among the id, ego, superego, and the demands of reality. A phobia, an undesirable character trait, and excessive reliance on defense mechanisms are all signs of a deeper problem. The symptom, then, indicates an unconscious problem that needs resolution. Obviously, if patients could resolve their problems alone, they would not need therapy. But the very nature of unconscious problems and defenses makes self-healing exceedingly difficult. To dissolve defenses and confront the unconscious in a therapeutic relationship are the purposes of psychoanalysis. Over the years, many variations in techniques have been developed. However, in nearly all these variations, the basic emphasis is on the dissolution of repressions through the reanalysis of previous experience. The fundamental goal remains freedom from the oppression of the unconscious through insight. Shedler (2010) identified seven features of psychodynamic therapy that seem to best characterize this approach (see Table 12-1), although many of these would characterize other forms of treatment as well. Below, we highlight some of the specific techniques used in psychodynamic psychotherapy.

Free Association

A cardinal rule in psychoanalysis is that the patient must say anything and everything that comes to mind. This is not as easy for the patient as it may appear at first glance. It requires the patient to stop censoring or screening thoughts that are ridiculous, aggressive, embarrassing, or sexual. All our lives we learn to exercise conscious control over such thoughts to protect both ourselves and others. According to Freud, however, if the therapist is to

release patients from the tyranny of their unconscious and thereby free them from their symptoms and other undesirable behavior, then such an uncensored train of free associations is essential. From it, the patient and the therapist can begin to discover the long-hidden bases of the patient's problems.

Traditionally, the psychoanalyst sits behind the patient, who reclines on a couch. In this position, the analyst is not in the patient's line of vision and will not be as likely to hinder the associative stream. Another reason for sitting behind the client is that having patients stare at you 6 or more hours a day can be rather fatiguing for the analyst. The purpose of the couch is to help the patient relax and make it easier to free-associate.

The psychoanalyst assumes that one association will lead to another. As the process continues, one gets closer and closer to unconscious thoughts and urges. Any single set of associations may not be terribly clear. But over many sessions, patterns of associations start to emerge, and the analyst can begin to make sense of them through their repetitive themes. In one sense, free associations are not really "free" at all. They are outgrowths of unconscious forces that determine the direction of one's associations. Often, but not always, these associations lead to early childhood memories and problems. Such memories of long-forgotten experiences give the analyst clues to the structure of personality and its development.

Analysis of Dreams

A related technique is the *analysis of dreams*. Dreams are thought to reveal the nature of the unconscious because they are regarded as heavily laden with unconscious wishes, albeit in symbolic form. Dreams are seen as symbolic wish fulfillments that often provide, like free associations, important clues to childhood wishes and feelings. During sleep, one's customary defenses are relaxed, and symbolic material may surface. Of course, censorship by the ego is not totally removed during sleep, or the material from the id would become so threatening that the person would quickly awaken. In a sense, dreams are a way for people to have their cake and eat it too. The material of the dream is important enough to provide some gratification to the id but not usually so threatening as to terrorize the ego. However, in some cases, this scenario is not applicable, and traumatizing dreams do occur.

The *manifest content* of a dream is what actually happens during the dream. For example, the manifest content of a dream may be that one is confronted with two large, delicious-looking ice cream cones. The *latent content* of a dream is its symbolic meaning. In the preceding example, perhaps there is a message about the need for oral gratification or a longing to return to the mother's breast.

To get at the latent content, the patient is often encouraged to free-associate to a dream with the hope of gaining insight into its meaning. Normally, the manifest content is an amalgam of displacement, condensation, substitution, symbolization, or lack of logic. It is not easy to cut through all this and find the latent meaning. Free association will help in this search, but the meaning of one dream alone is not always apparent. The real meaning of a dream in the life of an individual may only become apparent from the analysis of a whole series of dreams. Another problem is that patients often distort the manifest content of a dream as they retell it during the analytic session. Thus, not only does the analyst have to delve deeply to find the symbolic meaning, but there is the added burden of the patient's waking defenses that strive to thwart the goal of understanding. For many analysts, dreams do not provide inevitable, final clues to the patient's dynamics; rather, they are clues that help the analyst formulate hypotheses that can be validated or invalidated with further information. An example of how dreams and free associations go hand in hand is shown in a brief description of Freud's self-analysis (Box 12-2).

Psychopathology of Everyday Life

Another important method for gaining access to the unconscious is illustrated by Freud's how (1901/1960) sensitive analysis of the "psychopathology of everyday life." In the Freudian view, everything is

BOX 12-2 Focus on Professional Issues: Freud's Self-Analysis

To support his notion that people are motivated by sexual wishes that go all the way back to their childhood, Freud drew upon the results of his own self-analysis.

Freud's father died in 1896. This disturbed Freud a great deal, even though his father was old and ill. In fact, Freud became extremely anxious and depressed, so much so that his work was severely hampered. He became so disturbed at his own reactions that he decided to embark upon a detailed self-analysis, drawing on his dreams, associations, and behavior.

One childhood dream in particular seemed important. This was a dream Freud remembered having when he was 7 or 8 years old. Thirty years later, he interpreted it. In his dream, he saw his "beloved mother, with a peculiarly calm, sleeping countenance, carried into the room and laid on the bed by two (or three) persons with birds' beaks" (Freud, 1938, p. 522). His free associations led him to the idea of death and to an expression on his grandfather's face shortly before his death. This was a composite dream, then, combining elements of both his mother and grandfather. From here, his associations took him to the idea of a dying father. Freud then realized to his dismay that unconsciously he had harbored as a child hostile wishes toward his father. Additional associations (e.g., the German slang word for sexual intercourse was derived from the German word for bird) led him inevitably to the conclusion that his childhood sexual urges were directed toward his mother. So it was that the unconscious Oedipal strivings he had interpreted so often in his patients were equally true for him.

determined; there are no accidents. The slip of the tongue and the forgotten appointment are not simple mistakes. Rather, they represent the conscious expression of an unconscious wish. These little mistakes of everyday life are like dreams in the sense that sexual and aggressive urges receive partial gratification even though they interfere with our lives in minor ways. When the patient makes such mistakes in therapy or recounts during therapy mistakes made outside the therapy room, the therapist receives additional data by which to assess the patient's problems. In some instances, the meaning of the mistake is not readily apparent, and the patient may be asked to free-associate to the mistake. These associations, coupled with the therapist's interpretation, can help provide the patient with added insight.

Resistance

During the course of psychotherapy, the patient will attempt to ward off efforts to dissolve neurotic methods of resolving problems. This characteristic defense, mentioned earlier, is called resistance. Patients are typically loath to give up behaviors that have been working, even though these behaviors may cause great distress—the distress, in fact, that led the patients to seek help in the first place. In addition, patients find painful subjects difficult to contemplate or discuss. For example, a male patient who has always feared his father or has felt that he did not measure up to his father's standards may not wish to discuss or even recall matters related to his father. Although a certain amount of resistance is expected from most patients, when the resistance becomes sufficient to retard the progress of therapy, it must be recognized and dealt with by the therapist.

As previously mentioned, the term *resistance* is used to describe any client action or behavior that prevents insight or prevents bringing unconscious material into consciousness. Resistance takes many forms. Patients may begin to talk less, to pause longer, or to report that their minds are blank. Lengthy silences are also frequent. Sometimes a patient may repeatedly talk around a point or endlessly repeat the same material. Therapy may become an arena for discussing such problems as unemployment or taxes—weighty issues, but hardly the ones that brought the patient to therapy. Some patients may intellectualize about the relative merits of primal screaming versus nude marathons or even the effect of Freud's boyhood on the subsequent development of psychoanalysis. If the patient knows that

the therapist has a penchant for dreams, then the therapist may be deluged with dream material. In some instances, the patient's feelings or ideas about the therapist may begin to dominate the sessions. This can be very flattering until the therapist realizes that this interest is just a way of avoiding the real problems. Another form of resistance is the tendency to omit or censor certain information.

Resistance is also evidenced when a patient repeatedly comes late, cancels appointments without good reason, forgets meetings, and so on. The therapist may also begin to notice that a variety of "real" events in the patient's life seem to be conspiring against the sessions. For example, the patient may begin missing sessions because of a succession of physical illnesses or may constantly ask to change appointment times to meet one daily crisis after another.

Nearly anything can become a form of resistance. As the patient's defenses are addressed, there is sometimes an intensification of symptoms. But the opposite can also take place so that an actual "flight into health" occurs—the patient gets better. It is almost as if, in the first instance, the patient is saying, "Don't make me confront these things. I'm getting worse." In the second instance, the patient is saying, "See, I don't need to deal with these matters. I'm getting better." Another method is "acting out." Here the patient attempts to escape the anxiety generated in therapy by indulging in irrational acts or engaging in potentially dangerous behavior. For example, a patient suddenly takes up mountain climbing or begins to use cocaine or heroin. Still other patients flee into "intellectualization." Experiences or memories become stripped of their emotional content and are dissected calmly and rationally. Everything becomes cold and detached. Losing one's job becomes an occasion for an elaborate, intellectual discussion of economic conditions or the shift to high technology. Feelings are ignored, and the experience is handled by a flight into rationality.

In one form or another, resistance goes on throughout the course of therapy. In one sense, it is an impediment to the swift resolution of neurotic conflicts. But in another sense, it is the central task in therapy. The resistance that goes on in therapy probably mirrors what has happened in real life. If resistance during therapy can be analyzed and the patient made to understand its true function, then such defenses will not be as likely to operate outside the therapist's office. The following is an example of how one therapist met the problem of resistance.

A Case Illustration of Resistance

The wife of a minister has been in therapy for several months. In the previous session, a series of interpretations were made regarding her tendency to see her husband rather than herself as completely responsible for their unsatisfactory sexual adjustment.

Therapist: You don't seem very responsive today.

Patient: I don't have much on my mind.

Therapist: You seem almost impatient.

Patient: I was just thinking what a stupid little office this is. It's so oppressive.

Therapist: That's strange. You never commented on it till now.

Patient: I never thought about it until now.

There is a long silence during which the patient glances at her watch twice. Finally, the therapist breaks the silence.

Therapist: I wonder if all this has anything to do with what we discussed last time.

Patient: I just knew you were going to say that. Well, I don't think so because I can't recall what it was we talked about.

Therapist: Is that right? (Smiling)

Patient: Well … as a matter of fact … well, I think it is my husband's fault. He can be so aggressive. With other people he seems so patient and understanding, but …

The session continues, and there is further exploration into the patient's sexual attitudes.

Transference

A key phenomenon in psychoanalytic therapy, as we have seen, is transference. To some degree, transference is operative in most individual forms of verbal psychotherapy. It occurs when the patient reacts to the therapist as if the latter represented some important figure out of childhood. Both positive and negative feelings can be transferred. In short, conflicts and problems that originated in childhood are reinstated in the therapy room. This provides not only important clues as to the nature of the patient's problems but also an opportunity for the therapist to interpret the transference in an immediate and vital situation. Many characteristics of the psychoanalytic session—the patient is seated on a couch facing away from the analyst, the analyst does not give advice or reveal personal information—serve to encourage the establishment of transference.

Positive transference is often responsible for what appears to be rapid improvement at the beginning stages of therapy. Being in a safe, secure relationship with a knowledgeable authority can produce rapid but superficial improvement. Later, as the patient's defenses are challenged, this improvement is likely to fade, and marked negative transference may intrude.

Transference can take many forms. It may be reflected in comments about the therapist's clothing or office furnishings. It may take the form of direct comments of admiration, dislike, love, or anger. It may assume the guise of an attack on the efficacy of psychotherapy or a helpless, dependent posture. The important point is that these reactions do not reflect current realities but have their roots in childhood. It is all too easy to view every reaction of the patient as a manifestation of transference. However, the truly sensitive therapist is one who can separate reactions that have some support in reality from reactions that are neurotic in character.

Basically, both positive and negative transferences are forms of resistance. Through interpretation, the patient is helped to recognize the irrational nature and origins of transference feelings. With repeated interpretation and analysis, the patient can begin to gain control over these reactions in the therapy room and learn to generalize such control to the real world as well.

Interpretation

Interpretation is the cornerstone of nearly every form of dynamic psychotherapy. Although the content may vary significantly depending on the therapist's theoretical affiliation, the act of interpreting is perhaps the most common technique among all forms of psychotherapy. From the psychoanalyst's perspective, *interpretation* is the method by which the unconscious meaning of thoughts and behavior is revealed. In a broader sense, however, interpretation is a process by which the patient can be induced to view thoughts, behavior, feelings, or wishes in a different manner. It is a method calculated to free the patient from the shackles of old ways of seeing things—ways that have led to the patient's current problems in living. It is a prime method for bringing about insight. Of course, significant insight or behavioral change rarely comes from a single interpretation. Rather, it is a slow, repetitive process in which the essential meaning behind certain behaviors, thoughts, and feelings is pointed out to the patient in one context after another.

The following case study illustrates the interpretive process.

In this case study, the therapist used his final remarks to encourage understanding on the part of the patient. By calling attention to the possibility that the patient's behavior might have been a way of hurting her husband, the therapist was seeking to get the patient to reexamine her views of herself, her relationship with her husband, and her motives. His interpretation was directed to a central part of the patient's problems. It is important to emphasize that interpretations are not sprinkled about like confetti. Rather, they are limited to important life areas—those that relate directly to the problems that the therapist is trying to resolve.

It is best to offer an interpretation when it is already close to the patient's awareness. In addition, an interpretation should be offered when it will

A Case Illustration of Interpretation

This exchange occurred during the 15th session of psychotherapy with the 27-year-old wife of a college professor. In previous sessions, she had described how inadequate their sexual relationship was. In more recent sessions, she had also begun to discuss how much she and her husband shared the belief that theirs was a frank, open, and communicative relationship. Sometime before the present session, the patient had taken a 2-day trip to attend a convention in a neighboring city. On the first day of the convention, she met a man and promptly went to bed with him. Afterward, she was several days late with her period. This convinced her that she was pregnant. Suspecting that emotional factors might have delayed her period, her therapist suggested that she hold off telling her husband until she was sure. She disregarded this suggestion and proceeded to tell her husband everything. The very next day, her period began.

Patient: Well, I told Dick everything. God, was I upset.

Therapist: Then what happened?

Patient: He took it better than I thought he would. He was really understanding. Not so much forgiving, just calm and understanding. And now I'm not even pregnant. Can you beat that? But I think it really solidified our relationship and we can go on from here.

Therapist: Did you expect Dick to be so understanding?

Patient: I'm not sure I knew what to expect. I suppose I thought he would be upset as hell, but what else could I do? I know the episode at the convention was silly. But I just had to find out whether it was still possible to really enjoy sex.

Therapist: Was it?

Patient: Yes, it really was. Now I know it, and in a way I feel great.

Therapist: And now Dick knows it, and in a way he doesn't feel so great. That could well be the reason you were so eager to tell him everything.

arouse enough anxiety to engage the patient's serious contemplation but not so much anxiety that the patient will reject it. Although therapists have sometimes been known to make interpretations as shots in the dark, it is generally wise to be reasonably sure of one's target before firing the salvo. Being wrong, offering an interpretation too soon, or providing an interpretation that is beyond what the patient is ready to accept is likely to be counterproductive. As Colby (1951) put it, "Like pushing a playground swing at the height of its arc for optimum momentum, the best-timed interpretations are given when the patient, already close to it himself, requires only a nudge to help him see the hitherto unseen" (p. 91).

As a general rule, small dosages are best. Therefore, rather than prepare one grand interpretation that will subsume all the major aspects of the patient's conflicts, it is advisable to approach matters over a period of time. One can gradually move from questions to clarifications to interpretations. This will allow the patient to integrate each step. In making interpretations, it is important to build on what the patient has said previously, using the patient's own comments and descriptions to build the interpretive case.

It can be difficult to determine whether a specific interpretation has been effective. Sometimes the patient's response (e.g., a surprised exclamation, flushing, saying "My God, I never thought of it that way!") will suggest that the target has been hit. But at other times, patients may be entirely noncommittal, only to remark some sessions later how true the therapist's comment was. In any event, the real test of the utility of an interpretation is more likely to come from the subsequent course of the sessions. Even a patient's overt acceptance can sometimes be nothing more than a way of diverting the therapist or erecting a defense.

A classic psychoanalytic interpretation is designed to open up the patient to new ways of viewing things and, ultimately, to neutralize unconscious conflicts and defenses. In doing this, the therapist makes use of free associations, dream material, behavior that indicates resistance and transference, and so on. Interpretations can vary a

great deal in terms of their complexity and incisiveness. Sometimes they are designed to cut right to the heart of a patient's unconscious conflicts. But in other cases, they may be little more than comments or questions designed to move the patient ever so slightly in the direction of insight. Perhaps they should be labeled as verbal interventions rather than interpretations. But all have the potential for altering how a patient thinks or feels. These verbal interventions might be considered as a dimension in terms of how directly they seek to lead the patient to a fresh way of viewing things.

PSYCHOANALYTIC ALTERNATIVES

Psychoanalytic theory underwent considerable modification by the neo-Freudians, Alfred Adler, Carl Jung, Otto Rank, the ego analysts, and others. The seminal contributions of Freud remained, but the emphases often changed. Jung made much more of dreams and symbolic processes. Rank elevated the birth trauma to a preeminent position. Adler and the neo-Freudians stressed the importance of culture, learning, and social relationships instead of instinctual forces.

Such variations would be expected to influence the methods of therapy. However, these changes often did little to alter the critical roles of free association, dream analysis, interpretation, transference, and resistance. The supreme role of insight was little changed. Insight came about through traditional psychoanalytic methods, but now it was the insight of Horney or Fromm or Sullivan. The neurotic symptom was seen as rooted not only in repressed sexual or aggressive urges; it now became the outgrowth of a fear of being alone or of the insecurity that goes along with the adult role. In most of these early variants of psychoanalysis, interpretation remained the essential therapeutic ingredient. What distinguished these variants was often the content of the interpretation—the different ways in which unconscious material was construed by the analyst.

For many years, the therapy room was like an inner sanctum. The therapist talked with the patient and no one else. Now, family members or a spouse are often consulted, or sometimes therapy is conducted with the family as a unit. There tends to be much less emphasis on the past (childhood) and a more active confrontation with the present. Even the nature of the clientele has changed a bit. Clinics or institutes now provide some therapeutic services to aging clients, minority group clients, and others who have not traditionally received psychoanalytic treatment. They have tried to open up therapy to nontraditional populations. Again, none of this is meant to be a denial of Freudian principles; rather, it is a demonstration that traditional Freudian treatment procedures are not the only therapeutic techniques that can be deduced from Freudian psychoanalytic theory.

Ego Analysis

The *ego analysis* movement, originating from within the framework of traditional psychoanalysis rather than as a splinter group, held that classical psychoanalysis overemphasized unconscious and instinctual determinants at the expense of ego processes. This group of theorists accepted the role of the ego in mediating the conflict between the id and the real world but believed that the ego also performed other extremely important functions. They emphasized the adaptive, "conflict-free" functions of the ego, including memory, learning, and perception. These theorists include Hartmann (1939), Anna Freud (1946a), Kris (1950), Erikson (1956), and Rapaport (1953).

Ego-analytic psychotherapy has not departed from the usual therapy methods except in degree. In a sense, the ego analysts seem to prefer reeducative goals rather than the reconstructive goals of orthodox psychoanalysis. The exploration of infantile experience and the induction of a transference neurosis seem to be less common in ego-analytic therapy than in classical psychoanalysis. Ego-analytic therapy focuses more on contemporary problems in living than on a massive examination and reinstatement of the past. Also, the therapist must understand not only the neurotic aspects of the patient's personality but also the effective parts and how they interact with those neurotic trends.

The ego-analytic approach has also tended to emphasize the importance of building the patient's trust through "reparenting" in the therapy relationship. This approach sometimes even views transference as an impediment to therapy and works toward building adaptive defenses in the patient (Blanck & Blanck, 1974).

Other Developments

In particular, the work of Horney, Sullivan, and Adler was important in giving a new spin to psychoanalysis. Likewise, ego psychology and theories of object relations have encouraged an emphasis on the manner in which the patient relates to other people rather than on conflicts among instinctual forces. For example, object relations theorists see the need to form relationships with others as a primary influence on human behavior. Therefore, these theorists focus more on the role of love and hate, as well as autonomy and dependency, in the development of the self. In the self psychology of Kohut (1977), the central task of maturation is not the successful negotiation of the psychosexual stages but the development of an integrated self.

Discussions of changes in psychoanalytic therapies emphasize a shift in the therapeutic focus to the "here and now" and to the interpersonal exchanges that occur within it (W. P. Henry, Strupp, Schacht, & Gaston, 1994). Strupp and Binder (1984) have synthesized some of the more critical developmental changes in psychoanalytic practice. They emphasize a movement away from the recovery of childhood memories and their analysis toward a focus on the corrective emotional experiences that occur through the agency of the therapeutic relationship. The transference relationship as it occurs now helps provide the means for constructive changes in interpersonal relations outside the therapy room.

Contemporary Psychodynamic Psychotherapy

Over the years, enough changes have been made in traditional psychoanalysis that those who no longer practice the strict Freudian techniques are often said to be practicing "psychoanalytically oriented" therapy or *psychodynamic psychotherapy* (Shelder, 2010). It is important to note that there is great diversity in treatment techniques within this approach (Gibbons et al., 2008). For example, contemporary psychodynamic psychotherapy may involve only one or two sessions per week instead of five, and the entire treatment process can be either short-term or open-ended (Shedler, 2010). The therapist is no longer inevitably seated behind the patient's couch but now often sits at a desk, with the patient seated in a facing chair. Perhaps the easiest way to characterize these and other modifications is to say that greater flexibility has been introduced. Although many traditional Freudian tenets are still observed, the overall context is not so rigid. For example, free association is no longer absolutely required by these psychodynamic therapists. The importance of dreams may be downplayed somewhat. Medications and even hypnosis may be used.

We now turn to one particular form of psychodynamic psychotherapy that in many ways exemplifies the perhaps radical shift from traditional psychoanalytic therapy to a more focused, time-limited treatment.

Interpersonal Psychotherapy: An Empirically Supported Treatment

Interpersonal psychotherapy (IPT) (Klerman, Weissman, Rounsaville, & Chevron, 1984) is a brief, insight-oriented approach that has been applied primarily to depressive disorders, although it has been modified for use in the treatment of other disorders (e.g., substance dependence, bulimia) as well. When used to treat depression, IPT involves thorough assessment of depressive symptoms, targeting a major problem area (e.g., delayed grief, role transitions or disputes, or interpersonal deficits) and alleviating depressive symptoms by improving relationships with others (as by improving communication skills and social skills). IPT has been shown effective in treating acute depressive episodes and in preventing or delaying the recurrence of depressive episodes (Weissman & Markowitz, 1994). Box 12-3 outlines the major features and characteristics of IPT. As we

BOX 12-3 Focus on Clinical Applications: Features of Interpersonal Psychotherapy (IPT)

IPT is a brief form of psychodynamic psychotherapy that has been used in numerous research studies. It is one of the treatments cited as examples of empirically validated/supported treatments by the Division 12 Task Force of the American Psychological Association.

Weissman and Markowitz (1998) discuss the primary features of IPT.

Focus

IPT focuses on the connection between onset of clinical problems and current interpersonal problems (with friends, partners, relatives). Current social problems are addressed, not enduring personality traits or styles.

Length

Typically 12 to 16 weeks.

Role of the IPT Therapist

IPT therapists are active, non-neutral, and supportive. They use realism and optimism to counter patients' typically negative and pessimistic outlook. Therapists emphasize the possibility for change and highlight options that may effect positive change.

Phases of Treatment

1. *First phase* (up to three sessions): This includes a diagnostic evaluation and psychiatric history, an interpersonal functioning assessment, and patient education about the nature of the clinical condition (e.g., depression). The therapist provides a clinical formulation of the patient's difficulties by linking symptoms to current interpersonal problems, issues, and situations.
2. *Second phase:* Depending on which interpersonal problem area has been chosen (e.g., grief, role disputes, role transition, interpersonal deficits), specific strategies and goals are pursued. For example, treatment focusing on role disputes would aim to help the patient explore the problematic relationships, the nature of the problems, and the options for resolving them. If an impasse has been reached in a relationship, the therapist helps the patient find ways to circumvent whatever is hindering progress or to end the relationship.
3. *Third phase* (last two to three sessions): The patient's progress and mastery experiences are reinforced and consolidated. The IPT therapist reinforces the patient's sense of confidence and autonomy. Methods of dealing with a recurrence of clinical symptoms are discussed.

shall see, IPT is the most empirically supported of all psychodynamic therapies and appears to be a worthy alternative form of psychological treatment for major depressive disorder.

SUMMARY EVALUATION OF PSYCHODYNAMIC PSYCHOTHERAPY

In this section, we review the available empirical evaluations and offer some general observations about those psychotherapeutic practices that trace their origins to the psychoanalytic method. Our evaluation of psychodynamic psychotherapy is informed by the American Psychological Association's Society of Clinical Psychology (Division 12) Web site on Research Supported Psychological Treatments (http://www.div12.org/Psychological-Treatments/index.html), as well as several recent major reviews (e.g., Cuijpers et al., 2011; Gibbons et al., 2008; Shedler, 2010).

Does Psychodynamic Psychotherapy Work?

What evidence is there that the psychodynamic approach is efficacious or effective? The support for the efficacy and effectiveness of psychodynamic psychotherapy with children and adolescents is not promising. Few studies have been published that suggest any significant effects of psychodynamic approaches to therapy for most major diagnoses in youth (Chorpita et al., 2011).

More substantial research has been conducted for the study of therapy with adults, however. In the previous chapter, we mentioned the widely cited meta-analytic study by Smith, Glass, and Miller (1980) that examined the effectiveness of psychotherapy. In addition to examining the effects of psychotherapy in general, these authors also reported effects separately for different types of psychological intervention. They found that the average adult patient who had received psychodynamic psychotherapy was functioning better than 75% of those who had received no treatment. Two meta-analyses of studies examining the effectiveness of brief psychodynamic psychotherapy have produced conflicting results, with one supporting the efficacy of brief psychodynamic treatment (Crits-Christoph, 1992) but the other not (Svartberg & Stiles, 1991). Finally, in a selective review of major studies over 40 years, McWilliams and Weinberger (2003) argue that psychoanalytic and psychodynamic psychotherapy with adults have been shown to be efficacious and effective.

Most recently, Shedler (2010) presented a summary of major reviews of the efficacy of psychodynamic therapy in treating a range of adult psychological conditions. Shedler cited a number of reviews of the literature that produced effect sizes ranging from medium to large, and all supported the efficacy of psychodynamic treatment. Shedler was particularly struck by the larger effect sizes associated with long-term follow-up and longer periods of treatment. However, several have been critical of Shedler's evaluation and conclusion (Anestis, Anestis, & Lilienfeld, 2011; McKay, 2011; Thombs, Jewett, & Bassel; Tryon & Tryon, 2011). In particular, these authors were critical of the poor quality of many of the studies that were included in these reviews, the problematic meta-analytic methods and analyses used by some of the reviews, and the failure to specify the effects of psychodynamic therapy for specific disorders.

Concerning this latter point, Gibbons et al. (2008) reviewed evidence concerning the efficacy of psychodynamic treatments for a range of adult psychological disorders. Based on their review, which considered well-designed and implemented randomized controlled trials, Gibbons et al. concluded that there is at least tentative support for the efficacy of psychodynamic treatment for major depressive disorder, panic disorder, borderline personality disorder, and substance abuse and dependence.

BOX 12-4 Clinical Psychologist Perspective: Kenneth N. Levy, Ph.D.

Dr. Kenneth N. Levy is an Associate Professor of Psychology at The Pennsylvania State University in University Park, PA. His main research interests are in attachment theory, personality disorders, and psychotherapy process and outcome. He is a leading researcher and clinician in Transference Focused Psychotherapy (TFP). TFP is a modified psychodynamic treatment designed specifically for the treatment of patients with severe personality disorders such as borderline and narcissistic personality disorders. This therapeutic approach focuses on reducing symptomatology and self-destructive behavior through integration of disparate representations of self and others. TFP does not focus on early childhood experiences, rather in session, therapists focus on the patient's affective experience for identifying and explicating their dominant relational patterns as they are experienced and expressed in the here-and-now of the relationship with the therapist (conceptualized as the transference relationship).

Dr. Levy has authored more than 90 book chapters and articles and his research has been featured in *Newsweek* and *Scientific American* among other media outlets. His work has led to numerous honors and awards, including his selection as an Early Career Fellow and as an honorary member of the American Psychoanalytic Association, a Young Investigator Award from the National Alliance for Research in Schizophrenia and Depression, and early career awards from the Society for Psychotherapy Research and the American Psychoanalytic Association Division of Psychotherapy. Dr. Levy was also awarded the Raymond D. Fowler Award from the American Psychological Association for outstanding contributions to the professional development of psychology graduate students. Dr. Levy responded to several questions regarding his views of the field as well as his predictions for the future of clinical psychology and of psychodynamic psychotherapy and research.

(Continued)

BOX 12-4 Clinical Psychologist Perspective: Kenneth N. Levy, Ph.D *(Continued)*

What originally got you interested in the field of clinical psychology?

Psychology piqued my interest as an avenue to understand myself, others, and the surrounding social world. Clinical psychology provided the exciting promise of being able to relieve suffering and change maladaptive and unwanted behaviors. Like many people who study psychology, I was very curious about my own and other people's minds, behaviors and motivations. I grew up in a psychologically minded family and developed an interest in psychology through film, books, and household discussions with family and family friends. As I grew older, I read Judith Guest's (1976) *Ordinary People* and Freud's (1907) *Interpretation of Dreams*. I was intrigued by how thoughts and feelings outside one's awareness could influence a person's behavior. I was also fascinated by the idea of defensive processes. In high school, I took an introduction to psychology elective and became impressed with the cleverness of certain psychology experiments, such as Tolman's cognitive maps and Bandura's bobo doll studies, and their implications for understanding how mental processes influence behavior. In college, a number of courses and professors impacted my thinking but as I approached graduation, I was confused about how to "become a psychologist." Not so much in terms of the logistics of applying to graduate school, but I had not yet developed a clear theoretical orientation and I was concerned about figuring out the specifics of what I wanted to study, important factors in choosing a graduate program. Psychology is one of those disciplines where so much of it is interesting, yet I realized that although I saw myself as a generalist, I would need to become a specialist too. I had broad exposure to and interests in widely diverse theorists such as James, Lewin, Allport, Bandura, Mischel, Tolman, Rogers, and Freud, among others. I asked a professor about how one decides what to study in graduate school, and he responded that "It's easy … you study what your mentor studies." Although he meant to be comforting and soothing, his comment only served to intensify my uneasiness about applying to graduate school before I figured these things out. Upon graduation I was determined to figure out my theoretical orientation and to narrow my interests into a productive direction. I began an intensive course of self-study in which I read the great psychologists in their own words. I supplemented those readings with Raymond Corsini's *Current Psychotherapy* book and over many months began to have a better sense of what resonated with me regarding clinical theory. I also began work with seriously disturbed hospitalized patients where I was exposed to an array of problems, from hopelessness to chronic schizophrenia. While I enjoyed working with patients, I soon realized that I was equally interested in understanding both the developmental antecedents and the current forces that play vital roles in the development, expression, and maintenance of their psychopathology. Over time, I increasingly realized that I was most interested in how individuals think and feel about themselves, others, and the greater world and how this in turn affects self-regulation. During this time I was able to clarify my clinical orientation, and I came to recognize research as a way of answering critical questions and informing clinical theory.

Describe what activities you are involved in as a clinical psychologist

One of the aspects that I thoroughly enjoy about being a clinical psychologist is the breadth and depth of the activities in which I am involved. Broadly, my activities are geared towards contributing to the knowledge base and/or applying knowledge to relieve clinical problems. I contribute to the knowledge base at multiple levels: I teach graduate seminars in psychotherapy research, personality theory, and psychological assessment and supervise doctoral students as part of a clinical training practicum that emphasizes contemporary psychotherapy for personality disorders. At the undergraduate level, I teach personality theory, abnormal psychology, developmental psychopathology and psychotherapy research. I supervise and mentor graduate students in both their research and clinical training, and I mentor undergraduate students as they begin their journey in psychology. In addition to supervising, I maintain a part-time private practice where I work with child, adolescent, and adult patients across a wide range of psychopathology, but with a specific focus on personality disorders, in psychodynamically oriented individual psychotherapy. I also consult to colleagues from time to time. However, most of my 70-plus-hour week is spent conceptualizing, conducting, and disseminating research through presenting at conferences, workshops, colloquia, and grand rounds and through writing journal articles and chapters and editing books and special issues of journals. I spend a smaller but significant part of my time in citizenship by serving on committees for the department and university as well as serving on editorial boards and grant review panels for the profession. I have also served

professional societies by being on committees and recently as a conference program chair.

What are your particular areas of expertise or interest?
My main research interests are in attachment theory, borderline personality disorder (BPD), and psychotherapy process and outcome. My research is informed by psychoanalytic and developmental psychopathology frameworks, and I use methods from experimental psychopathology and intervention science. My goal is to understand the mechanisms involved in the development and perpetuation of BPD with the ultimate goal of developing and studying treatments that directly target these mechanisms.

What are the future trends you see for clinical psychology?
I am unsure of what it will look like because there are some competing trends that will need to be resolved. What I would like to see is a true evidence-based integration of science and practice and evidence-based integration of different approaches to psychotherapy. Only then will we be able to realize Gordon Paul's call to answer the question, "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances (Paul, 1967, p. 111)?" Despite increasing calls for dissemination of so-called evidence-based treatments and use of evidence-based principles, I feel we are very far from Paul's vision. Ironically, much of the evidence-based treatment movement has been narrowly construed and often suffers from "cherry-picking" in a manner that seems self-serving (what I call self-serving evidence-based as opposed to truly evidence-based). The integration of science and practice has always been important to our profession and may be more so now than ever before. Funding agencies all over the world are increasingly interested in the translation of science to practice and the dissemination of empirically tested ideas. Third parties such as private and government insurance companies are also requiring greater accountability. Finally, within the field, questions have been raised about the neglect of science by practitioners (see Baker, McFall, & Shoham, 2009)—a theme picked up widely by the popular media. Complicating matters, some clinicians have also been critical of researchers. They note that researchers have imposed interpretations of data that are experienced by clinicians as coercive and "out of touch" with key clinical realities. Clinicians have asked for more clinically relevant research. What I would like to see is the promotion of the integration of science and practice and creation of an authentic and lasting collaboration between these two overlapping communities.

What are some future trends you see for psychodynamic psychotherapy and research?
Psychodynamic psychotherapy is becoming increasingly research-based. Although there is still a small but significant portion of psychoanalysts who do not fully understand the need for research, this attitude, for the most part, has changed over the last 30 years. Psychoanalytic institutions are also actively investing resources to promote research. Additionally, we have been partnering with basic researchers such as neuroscientists and geneticists to test core dynamic hypotheses and treatment outcomes in fMRI environments. Independently, neuroscientists have become increasingly interested in basic psychoanalytic concepts and have been encountering evidence supporting these ideas. Additionally, there is now a critical mass of outcome studies indicating that psychodynamic treatments are efficacious in treating a range of disorders such as depression, panic disorder, marital discord, and borderline personality disorder, among other problems. The sum total of these studies, while not definitive by any means, strongly suggests that more research is warranted on psychodynamic psychotherapies. Ultimately, I hope that useful and tested psychoanalytic ideas will be openly embraced and integrated into non-psychoanalytic psychotherapies.

Kenneth N. Levy

Kenneth N. Levy

Of all the specific forms of psychodynamic therapy, interpersonal psychotherapy (IPT) has received the most research attention. Futhermore, the application of IPT to major depressive disorder has been studied extensively. Recently, Cuijpers et al. (2011) presented results from a large meta-analysis of controlled trials using IPT to treat depression. Their review evaluated results from 38 studies that included over 4,000 patients, both adults and adolescents. These studies compared IPT to no treatment, IPT to other forms of psychotherapy, and IPT to medication. Based on their results, the authors concluded that IPT showed moderate to large effects over no treatment for acute major depression, and IPT in combination with medication showed some advantage over treatment with medication alone. IPT did not show a consistent advantage over other forms of psychological treatment (typically cognitive-behavioral therapy), and IPT showed somewhat less efficacy than medication alone (i.e., selective serotonin reuptake inhibitors, SSRIs).

Based on these and other results, we offer the tentative conclusion that there appears to be at least modest support for the effectiveness of psychodynamic psychotherapy, particularly with adults. However, the strength of the efficacy evidence depends on the specific disorder, and a number of thorny methodological issues continue to plague research on psychodynamic therapy (e.g., appropriate outcome measures, length of treatment). Clearly, additional well-designed investigations are warranted.

Interpretation and Insight

A wide range of current psychotherapies depend to some extent on the patient's achieving insight through therapist interpretation. Psychoanalysis seems to retain its total commitment to insight as the supreme means for solving problems in living. When understanding is complete enough, it is believed that the patient's symptoms will be ameliorated or even disappear entirely.

This emphasis on the pursuit of understanding has great appeal to many people. For example, although many people who are sad may seek the therapeutic goal of happiness, most of them are not content just to become happy—they also want to know why they are sad. The commitment of psychoanalysis and its psychotherapeutic heirs to insight and understanding is their greatest asset, but it also contains the seeds of their failures. Especially in the case of psychoanalysis, reconstruction of the personality through insight and understanding can lead to a nearly interminable and sometimes exhausting examination of the past and analysis of motives. Although one can hardly fault psychoanalysis for teaching the importance of the past "shaping" the present, there can be too much of a good thing. At times, it almost seems that the patient can use the need for understanding and the pursuit of the past as reasons for not coming to grips with current problems. The endless analysis of conflicts and motives and of their childhood origins can easily replace the need to find solutions and behavioral alternatives to problems in living. Learning the reasons for one's problems may be important (and ultimately efficient if one is to attain generalized rather than piecemeal solutions), but the failure to emphasize alternative ways of behaving can be a major shortcoming of traditional psychoanalysis.

Psychoanalysis often appears to involve a tacit assumption that more adaptive behavior will occur automatically once insight is achieved by the working-through process—that behavioral change will surely follow insight. However, the evidence for this assumption is exceedingly sparse. In fact, it has been argued for some time that the true course of events follows a reverse pattern—that insight is brought about by behavioral change (Alexander & French, 1946).

One of the chief methods used by psychodynamic clinicians to facilitate patient insight is the interpretation of transference. A review of empirical studies that examined transference interpretation in psychodynamic psychotherapy (Henry et al., 1994) offers the following general conclusions:

1. The frequency of interpretations made is not related to better outcome. Indeed, some studies have found that a higher frequency of interpretation is related to poorer outcome.

2. Transference interpretations do not result in a greater degree of affective experience in the patient as compared with other types of interpretations or other types of interventions. When followed by affective responses, however, transference interpretations appear to be related to positive outcome.
3. Interpretations by the therapist are more likely to result in defensive responding on the part of the patient than are other types of interventions. Frequent transference interpretations may damage the therapeutic relationship.
4. Clinicians' accuracy of interpretations may be lower than was previously believed.

The authors conclude: "The available findings challenge some dearly held beliefs. In short, transference interpretations do not seem uniquely effective, may pose greater process risks, and may be counter-therapeutic under certain conditions" (W. P. Henry et al., 1994, p. 479).

This is not to say that transference interpretations are always harmful and should be avoided. Rather, the existing research suggests that the relationship between interpretation and outcome is a complex one that is likely to depend on factors such as patient characteristics, clinician interpersonal style, timing of interpretations, and accuracy of interpretations (W. P. Henry et al., 1994).

Curative Factors

What, then, seems to be responsible for positive outcomes that sometimes follow psychodynamic psychotherapy? The empirical evidence points to the quality and strength of the therapeutic alliance (Henry et al., 1994). Although the quality of the therapeutic alliance is related to outcome across a number of therapeutic modalities (e.g., client-centered, cognitive-behavioral), it is interesting to note that the importance of the clinician–patient relationship was recognized by Freud (1912/1966). Although various definitions of the *therapeutic alliance* have been proposed, this term is generally used to refer to the patient's affective bond to the therapist. A positive relationship or strong bond facilitates self-examination by the patient and permits interpretation. Presumably, a strong therapeutic alliance makes it less likely that a patient will react defensively to interpretations by the clinician. Research evidence suggests a direct link between alliance and outcome, whether short-term or long-term psychodynamic treatments are examined and regardless of the particular outcome measure used (Henry et al., 1994).

One study highlighted several influences on the therapeutic alliance and outcome. In a sample of 50 adults, Hilliard, Henry, and Strupp (2000) tested the hypothesis that both the patient's and the therapist's early parental relations (i.e., indicators of each participant's object relations) influence the quality of the therapeutic alliance (a therapy process variable) as well as treatment outcome. Results generally supported their hypotheses. The patients' and the therapists' reports of their early parental relations, respectively, were significantly related to their ratings of the therapeutic alliance. Further, patients' ratings of outcome were also significantly related to their early parental histories, and this effect held even after controlling the ratings of the therapeutic alliance. Therefore, this study highlights that importance of patient's early parental histories on both the process and outcome of psychodynamic psychotherapy.

The Lack of Emphasis on Behavior

The stereotypic practitioner of psychoanalytic psychotherapy plays a relatively passive role except for interpretation. The failure to deal with behavior, to make suggestions, or to adopt a generally more activist posture would seem to prolong psychotherapy unnecessarily. For example, it may be true that a male patient's unhappy heterosexual adjustment or lack of skills with women stems from unconscious generalizations from past unfavorable comparisons with a dominant brother. But simple insight into the childhood origins of the problem does not provide the skills that are lacking. The patient's expectations for success in establishing relationships with women will continue to be low and a source of anxiety until a heterosexual behavioral repertoire is established. An active therapist

BOX 12-5 Clinical Psychologist Perspective: Ali Khadivi, Ph.D.

Dr. Khadivi is a full-time, practicing clinical psychologist with a psychodynamic orientation. He was awarded his Ph.D. in 1990 from The New School of Social Research in New York City, following a clinical internship at New York Hospital–Cornell Medical Center in White Plains, New York. Dr. Khadivi has published articles in the area of psychological assessment, and has taught classes on personality assessment and diagnostic interviewing. He has also led workshops on bipolar disorder, assessment of suicide risk, differential diagnosis, and the treatment of difficult clients. Dr. Khadivi addressed a number of questions concerning his background, clinical interests, and practice.

Describe your background and your clinical interests

Currently I am Associate Chairman for Clinical Care, Evaluation and Research and the Chief Psychologist at Bronx-Lebanon Hospital Center, Department of Psychiatry. The hospital is a private institution in the South Bronx, New York. I have faculty appointments as Associate Professor of Clinical Psychiatry and Behavioral Sciences at Albert-Einstein College of Medicine. I am also adjunct professor of psychology at the New School for Social Research and John Jay College of Criminal Justice. I provide psychological consultation to the Department of Psychiatry. I also conduct and coordinate clinical research, teach psychiatric evaluation to psychiatric residents, and direct the externship program at the hospital. At the university and medical school level, I teach clinical and forensic assessment to psychiatric residents, fellows, and clinical psychology students. My interests are in the areas of personality assessment, forensic psychology, and severe psychopathology.

What types of services do you provide and to whom?

I am a consultant on an inpatient psychiatric service and provide psychotherapy and assessment. The population that I work with is primarily economically disadvantaged African American and Latino individuals. Most of the patients at the hospital have multiple psychiatric diagnoses including a high rate of poly-substance abuse. I also have a private practice in New York City where I see mostly higher-functioning patients. In addition to psychotherapy, I also conduct clinical and forensic assessments. My clinical and forensic work is informed by psychodynamic theory.

What are the things you enjoy most about your clinical work?

In psychotherapy, the kind of genuine and empathic connection that one makes with the patient is the most satisfactory aspect of my work. Similarly, in clinical assessment the empathic understanding that one can develop through the use of psychological tests is most enjoyable.

What are the biggest challenges you face as a practitioner?

Working in the inner city, the biggest challenge is the complexity of patients' problems. The patients have multiple psychiatric diagnoses, substance abuse, medical problems, and significant stressors in their environments. Both assessment and psychotherapy with such populations is challenging. Furthermore, empirical literature in clinical psychology on such populations is limited in guiding assessment and therapy.

Does research inform what you do? If so, how have you changed your practice to be more effective for your clients?

Research plays an important role in informing my clinical and forensic work. Although my orientation is psychodynamic, I have increasingly incorporated empirically supported cognitive and behavioral interventions in my hospital and private practices. Assessment research also has changed my practice. I have incorporated semistructured interviews in both clinical and forensic assessment. I have moved away from a traditional battery approach to a more focal assessment where multiscale self-report and performance-based measures are utilized and integrated. Furthermore, I have been using therapeutic assessment feedback interventions in most of my psychological evaluations.

Courtesy of Dr. Ali Khadivi, Ph.D.

Ali Khadivi, Ph.D.

who not only provides interpretations that will lead to insight but also guides the patient into new learning situations seems more likely to achieve lasting solutions to the patient's problems than does a therapist who relies solely on insight (or solely on behavior, for that matter).

It seems clear that a major reason for the rapid rise of the behavioral therapies was the failure of so many psychotherapists to deal directly with the specific problems of the patient. The approach inevitably seemed to be one of relegating the presenting problem to the status of a "symptom of something deeper." The therapist then began working with that "something deeper" while clinging to the abiding belief that once the patient understood it, the symptom or deficit would disappear. Unfortunately, things did not work out that way often enough. In any case, more and more therapists are trying to foster both insight and behavioral alternatives in their patients.

The Economics of Psychotherapy

By its very nature (reconstruction of the personality), psychoanalysis is a long and costly procedure. Its course over 3 to 5 years and the long and costly preparation of its practitioners ensure that it will be an expensive undertaking. Even more contemporary psychodynamic therapy approaches involve 1–2 sessions per week for one or more years. Consequently, it has become a therapy for the affluent—for those who have both the money and the time to pursue the resolution of their neuroses. Moreover, the procedures of psychoanalysis are such that only relatively intelligent, sophisticated, and educated groups are likely to be able to accept the therapeutic demands it makes. For all these reasons, only a small portion of those in need of psychotherapy are likely to be reached by traditional psychoanalysis. The poor, the undereducated, minority groups, older populations, the severely disturbed, and those beset by reality burdens of living for which they are woefully unprepared will in all likelihood not become psychoanalytic patients.

For these reasons alone, many regard psychoanalysis as a failure. It is inherently incapable of putting even a dent in the mental health problems of the nation. Yet, for persons who have the necessary personal qualities and financial resources, psychoanalysis has been sometimes helpful, particularly for those whose problems can best be met through the development of understanding.

Psychoanalytic techniques seem to have helped many patients, and as a theory of therapy, psychoanalysis undergirds many forms of psychotherapy. Yet many clinicians still question whether, after all these years, there is really much in the way of definitive research evidence for its effectiveness. These sentiments are echoed by Wolpe (1981). Although hardly unbiased, Wolpe is particularly critical of a method that can allow patients to remain so long in therapy, often with little evidence of improvement. Wolpe cites examples offered by Schmideberg (1970). In one case, a 54-year-old man had been in psychoanalysis for 30 years without noticeable improvement. A woman who began psychoanalysis with no specific symptoms later developed agoraphobia and after 12 years of therapy was worse than when she began. Admittedly, nearly every brand of therapy contains its share of horror stories. But lengthy therapy combined with little improvement does raise questions.

It is encouraging, however, that brief forms of psychodynamic psychotherapy have been developed. Recent meta-analyses indicate that brief psychodynamic treatments that incorporate the use of manuals show stronger treatment effects (versus psychodynamic treatments that do not use manuals) and in some cases may be equivalent to other forms of brief psychological treatment (Crits-Christoph, 1992). Furthermore, as we discussed earlier, recent reviews of the treatment literature do provide at least some tentative research support for the use of psychodynamic treatment with certain clinical populations (Cuijpers et al., 2011; Gibbons et al., 2008). In addition to providing encouragement to psychodynamically oriented clinicians, this finding should serve to impel them toward mastery and the use of manual-based, empirically supported brief psychodynamic treatments, such as interpersonal psychotherapy (IPT; Markowitz, 1998). This approach is both scientifically defensible and appealing to managed care companies.

BOX 12-6 Graduate Student Perspective: Joseph E. Beeney

Joseph E. Beeney is an advanced doctoral candidate in clinical psychology at The Pennsylvania State University. He completed a B.A. at University of California, Santa Cruz, and a second B.A. at Humboldt State University. He focuses on using neuroscience methods, predominantly fMRI, to understand aspects of borderline personality disorder (BPD), including interpersonal and identity disturbance, social cognition, and anger. He was awarded an NIMH R36 grant for his dissertation research, which utilizes EEG to examine aspects of interpersonal functioning with individuals with BPD.

What has graduate school in clinical psychology been for you?
Graduate school has been transformative for me. I am consistently thrilled with where I find myself in my research, in my clinical work, in my professional development, and even my personal development. This program has helped me get to places I never expected to be.

What things have you least expected about graduate school?
It has taken me in many surprising directions, particularly in my clinical work. My experience with psychodynamic psychotherapy pre-grad school was that it was often maligned by others and dismissed as an approach akin to quackery that had no empirical evidence. It was a tired relic of the past. When I began actually learning about psychodynamic theory in grad school, I was a bit surprised that it resonated with me greatly. Rather than quackery, I found an approach that was rich because of its history, supported by science, and that served as a clearly defined and effective framework for working with individuals with a variety of disorders and levels of functioning.

Has graduate school changed you? If yes, how so?
Out of necessity, my capacity to juggle multiple projects and areas of responsibility has improved dramatically. I've grown much more organized than I thought could be summoned from my former "chaotic-piles-all-over-the-desk" self. Also, because I love the work I do, I say "yes" frequently. But, I've also learned that sometimes it's very important to say "no" in order to keep myself from becoming an unresponsive sloth who has to habitually wipe the drool from my chin.

Are your professional or research interests similar or different now than they were when you started graduate school?
My research and clinical interests changed quite a bit. Before graduate school, I only had a vague inkling of what borderline personality disorder was. I began working with people with the diagnosis and became fascinated with better understanding the disorder and finding ways to be more helpful and effective with my clients. This led me to research on a psychotherapy process for BPD, and because of my interest in neuroscience, a desire to eventually evaluate functional brain activity as a marker of change in psychotherapy.

CHAPTER SUMMARY

The psychodynamic approach to therapy evolved from the work of Sigmund Freud. It focuses on the analysis of past experience and emphasizes unconscious motives and conflicts in the search for the roots of behavior. Even today, a significant percentage of clinicians identify their therapeutic orientation as psychodynamic. According to this viewpoint, psychological problems result from the conflicting demands of the id, ego, superego, and reality. Techniques of psychodynamic psychotherapy are aimed at uncovering unconscious conflicts and motivation. For example, dreams are analyzed, as are free associations and the nature of the transference.

Psychoanalytic theory and therapy have been modified considerably over the years by neo-Freudians, ego analysts, and others. Brief psychodynamic psychotherapy is also an important development. Here, the length of treatment is much shorter, and the focus is more on the here and now. Interpersonal psychotherapy is a form of brief psychodynamic therapy that has good empirical support for treating depression and other conditions.

Research evidence suggests that traditional forms of psychodynamic psychotherapy are moderately effective with adults and that brief, manual-based forms are more effective. The major curative factor appears to be the quality and strength of the

Looking back, what activities or experiences were the most important for you in your graduate school program.

Writing a grant was fundamental for me. I was thrilled that it was funded, but simply the process of writing it pushed me to greatly clarify my research ideas. After I wrote it, I felt confident designing other studies. I started to visualize more clearly what my own independent program of research would look like. Now, I see myself as a capable researcher, though I am continually learning more and more.

Any additional hints for those trying to make it through graduate school in clinical psychology?

Clinically, I think it's important to remain open and give respect to all of the great ideas present in our field. From my point of view, no orientation is wrong, and no orientation has it perfectly figured out for every client. Plus, writers from various orientations are often talking about the same thing, just with different names. I feel like my growth as a clinician has been entirely dependent on learning about psychotherapy from a variety of viewpoints and seeking to be thoughtful in how integration might be supportive in helping facilitate change for my clients.

In terms of research, the secret is to do as much as you possibly can and be continually vigilant for opportunities that can further your thinking and/or train you in new, useful modalities.

Joseph E. Beeney

Joseph E. Beeney

therapeutic alliance. Research evidence and the managed care environment should lead more and more psychodynamic clinicians to use brief, manual-based forms of psychodynamic psychotherapy.

KEY TERMS

anal stage The psychosexual stage that extends from about 6 months to 3 years of age, during which the child focuses on urination and defecation as means of satisfaction.

analysis of dreams A psychoanalytic technique that attempts to shed light on unconscious material. Because dreams are regarded as heavily laden with unconscious wishes in symbolic form, the analysis of dreams is believed to provide important clues to these wishes.

brief psychotherapy Psychotherapy of relatively brief duration that has grown in popularity due in large part to the cost-containment measures imposed by health care systems. Many brief therapies have retained a psychodynamic identity.

catharsis The release of psychic energy (achieved by reliving traumatic events) believed by psychoanalysts to have important therapeutic benefits.

death instincts (Thanatos) The innate drives that are responsible for all of the negative or destructive aspects of behavior.

defense mechanisms Strategies used by the ego to stave off threats originating internally, from one's id or superego. (Also referred to as *ego defenses*.)

ego The organized, rational component of the personality. The ego uses perception, learning, planning, and so forth to satisfy the needs of the organism while at the same time preserving its place in the world.

ego analysis An alternative to traditional psychoanalysis that is characterized by relative deemphases on the role of the unconscious and the exploration of childhood experience and relative emphases on the adaptive functions of the ego (e.g., perception, learning, memory) and the exploration of contemporary problems in living.

fixation The defense mechanism that occurs when the frustration and anxiety of the next psychosexual stage cause the individual to be arrested at his or her current level of psychosexual development.

free association A cardinal rule of psychoanalysis in which patients are required to say anything and everything that comes to mind. Over time, free association is believed to shed light on unconscious thoughts and urges.

genital stage The psychosexual stage that follows the onset of adolescence and ideally culminates in a mature expression of sexuality.

id The deep, inaccessible portion of the personality that contains the instinctual urges. The id is without order, logic, or morals and operates solely to gratify the instinctual urges.

insight In psychoanalytic psychotherapy, a complete understanding of the unconscious determinants of one's irrational and problematic thoughts, feelings, or behaviors.

interpersonal psychotherapy (IPT) A brief, insight-oriented therapy that is psychodynamic in tone. IPT has been applied primarily to the treatment of depression and is considered a "well-established" empirically supported treatment (EVT) for this disorder.

interpretation A method in which the psychoanalyst reveals the unconscious meanings of the patient's thoughts and behaviors, thus helping the patient to achieve insight. Interpretation is the cornerstone of nearly every form of dynamic psychotherapy.

latency stage The psychosexual stage that extends from about 5 to 12 years of age, during which the child is characterized by a lack of overt sexual activity (and perhaps even a negative orientation toward anything sexual).

latent content The symbolic meaning of a dream's events.

life instincts (Eros) The innate drives that are responsible for all of the positive or constructive aspects of behavior.

manifest content What actually happens during a dream.

moral anxiety Anxiety that arises from the concern that a person will act in a way that conflicts with the standards of his or her conscience.

neurotic anxiety Anxiety that stems from the fear that a person's id impulses will be expressed unchecked, thus resulting in trouble.

Oedipus complex The phase in which a child feels sexual attraction for the parent of the opposite sex and feelings of hostility toward the parent of the same sex. The superego emerges from the resolution of this complex.

oral stage The psychosexual stage spanning about the first year of life, during which the mouth is the chief source of pleasure and satisfaction.

phallic stage The psychosexual stage that extends from about 3 to 7 years of age, during which the sexual organs become the primary source of gratification.

pleasure principle The rule of conduct by which one seeks pleasure and avoids pain. The id operates according to the pleasure principle.

primary process The irrational and impulsive type of thinking that characterizes the id.

projection The defense mechanism that occurs when a person attributes his or her unconscious feelings to someone else.

psychic determinism A major assumption of Freudian theory that holds that everything one does has meaning and is goal directed.

psychosexual stages A series of developmental stages posited by Freud, each of which is marked by the involvement of a particular erogenous zone of the body.

reaction formation The defense mechanism that occurs when an unconscious impulse is consciously expressed by its behavioral opposite.

reality anxiety Anxiety that arises from the presence of a real danger in the outside world.

reality principle The rule of conduct by which one defers the gratification of instinctual urges until a suitable object and mode of satisfaction are discovered. The ego operates according to the reality principle.

regression The defense mechanism that occurs when extensive frustration causes a person to return to a stage that once provided a great deal of gratification.

repression The most basic defense mechanism. Repression serves to keep highly threatening sexual or aggressive material out of conscious awareness, often involuntarily.

resistance Any attempt by the patient to ward off the therapist's efforts to dissolve his or her neurotic methods for resolving problems. Any client action or behavior that prevents insight or prevents bringing unconscious material into consciousness.

secondary process The rational and self-preservative type of thinking that characterizes the ego.

superego The component of the personality that represents the ideals and values of society as they are conveyed to the child through the words and deeds of his or her parents. The role of the superego is to block unacceptable id impulses and to pressure the ego to serve the ends of morality rather than those of expediency.

talking cure Discovered by Breuer, the use of techniques that encourage patient talking as a way of addressing and alleviating neurotic symptoms.

therapeutic alliance The bond between patient and therapist. A strong therapeutic alliance is believed to contribute significantly to a positive therapeutic outcome.

transference A key phenomenon in psychoanalytic therapy in which the patient reacts to the therapist as if the therapist represented an important figure from the patient's past.

unconscious The portion of the mind that is not accessible to awareness.

unconscious motivation Motivation that resides outside conscious awareness. Freud posited the existence of unconscious motivation and asserted that it was responsible, in large part, for disturbed behavior.

working-through process A careful and repeated examination of how one's conflicts and defenses have operated in many areas of one's life. It is through this process that an insight achieves true, full meaning for the patient.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

12-1 American Psychoanalytic Association
http://www.apsa.org/

12-2 Online overview of the exhibition "Sigmund Freud: Conflict and Culture"
http://www.loc.gov/exhibits/freud/

12-3 Sigmund Freud on the Internet
http://people.brandeis.edu/~teuber/freud_links.html

12-4 Burying Freud: Online debate between Freud critics and supporters
http://human-nature.com/freud/

12-5 APA Division of Psychoanalysis (Division 39)
http://www.apadivisions.org/division-39/

13

Psychotherapy: Phenomenological and Humanistic-Existential Perspectives

FOCUS QUESTIONS

1. What are the major features that characterize client-centered therapists?
2. How do client-centered therapists view diagnosis and psychological assessment?
3. What are the advantages and disadvantages of client-centered therapy?
4. What techniques are used by existential therapists? What techniques are used by Gestalt therapists? What techniques are used in Emotion-Focused Therapy?
5. From the research evidence that is available, how would you evaluate the effectiveness of client-centered, Gestalt, and process-experiential therapy?

CHAPTER OUTLINE

Client-Centered Therapy
- Origins
- The Phenomenological World
- BOX 13-1: *Focus on Professional Issues: A Brief Biography of Carl Rogers*
- Theoretical Propositions
- Core Features
- The Therapeutic Process
- Diagnosis
- *A Case Illustration of Client-Centered Therapy*
- Other Applications
- Some Concluding Remarks

The Humanistic-Existential Movement
- Humanism
- BOX 13-2: *Clinical Psychologist Perspective: Leslie S. Greenberg, Ph.D.*
- Existential Therapy
- Logotherapy
- Gestalt Therapy

Emotion-Focused Therapy
- BOX 13-3: *Focus on Clinical Applications: Features of Emotion-Focused Therapy*

Summary Evaluation of Phenomenological and Humanistic-Existential Therapies
- Strengths
- Limitations
- BOX 13-4: *Graduate Student Perspective: Catalina Woldarsky Meneses, M. A.*

CHAPTER SUMMARY

KEY TERMS

WEB SITES OF INTEREST

Traditional psychotherapy traces its origins to a psychoanalytic point of view that regards both pathology and the inability to achieve one's potential as failures in understanding the past. These failures are seen as rooted in the unacknowledged role of inner forces or intrapsychic conflicts. Through therapy, one can learn to understand all this, and the ensuing insight will set one free—free from the misery of problems, symptoms, and the failure to live a productive, meaningful life.

For many years, these views dominated psychotherapy. In the early 1940s, however, a serious alternative to psychoanalytic psychotherapy began to appear. An approach known as *nondirective counseling*—later to become *client-centered therapy*—was taking shape under the guidance of Carl Rogers.

CLIENT-CENTERED THERAPY

The perspective of Carl Rogers is almost the diametric opposite of psychoanalysis; yet the two points of view do share a few characteristics. Both theories developed out of therapeutic encounters with people who had problems. As a result, neither perspective can be totally understood without an appreciation of the ways it relates to therapy.

Origins

The full extent of Rogers' contribution becomes apparent if one recalls the mental health world of the late 1930s. Psychoanalysis, both as theory and practice, was the dominant force. The theories of psychologists such as Gordon Allport and Kurt Lewin were attracting some attention, but the real spotlight was on theories that had a close association with treatment, which meant psychoanalysis or at least some close derivative of it. This attention seemed to increase as many prominent psychoanalysts fled Europe and settled in the United States.

At this time, Carl Rogers was an obscure clinical psychologist in Rochester, New York, struggling with the clinical problems of children. Like most therapists of the day, Rogers had been heavily exposed to psychoanalytic thinking. After completing his Ph.D. at Columbia University, he began work at a child guidance clinic in Rochester. There, he came in touch with the will therapy of Otto Rank and the relationship therapy of Jessie Taft. Rank believed that patients should be allowed free opportunity to exert their wills and to dominate the therapist. Taft, a social worker, brought Rank's notions to America, emphasizing the relationship between the therapist and the patient. Indeed, Taft regarded this relationship as more important than any intellectual explanations of the patient's problems. Consequently, the therapeutic situation was made a very permissive one.

Rogers found these views highly congenial. They were consonant both with his religious beliefs and with his democratic convictions regarding the nature of human relationships in society. A belief that no person has the right to run another person's life found subsequent expression in his therapeutic notions of permissiveness, acceptance, and the refusal to give advice.

The Phenomenological World

Rogers' theory of personality developed mainly out of therapeutic encounters with patients and from certain philosophic notions about the nature of people. Furthermore, client-centered therapy anchors itself in phenomenological theory (Greenberg, Elliott, & Lietaer, 2003; Rogers, 1951).

Phenomenology teaches that behavior is totally determined by the phenomenal field of the person. The phenomenal field is everything experienced by the person at any given point in time. Therefore, to understand people's behavior, one must know something about their phenomenal field—that is, what the world is like for them. A difficulty, however, is that one must make inferences regarding this field from the person's behavior. Those inferences in turn can be used to predict or understand the behavior in question. There is a real potential here for circularity if the therapist is not careful. For

BOX 13-1 Focus on Professional Issues: A Brief Biography of Carl Rogers

Born in Oak Park, Illinois, on January 8, 1902, Carl Rogers was the fourth of six children and grew up in a financially secure family. When Rogers was 12, his father, a civil engineer and contractor, moved the family to a farm outside Chicago. His parents maintained a devout, almost dogmatic set of religious beliefs, and the family became a tight little unit—perhaps in part because of those beliefs. Rogers had few friends and spent much of his time alone reading. He was an outstanding student in high school but was not really a part of the social scene.

He went to the University of Wisconsin in 1919 to major in agriculture. He was very active in campus religious affairs, especially during his first 2 years, even attending a religious conference in Peking, China, during this period. He was so impressed by the cultural and religious diversity he encountered on this trip that his traditionalist family and religious views were shaken. As a result, his fundamentalist orientation began to change noticeably. He graduated from the university with a degree in history in 1924.

He married Helen Elliott, with whom he had two children. Moving to New York City, he attended Union Theological Seminary for 2 years. However, a growing religious skepticism coupled with a desire to help others more directly led him to transfer to Columbia University and pursue training in clinical psychology. He was awarded the Ph.D. in 1931. He moved on to Rochester, New York, where he became a staff psychologist in a child guidance clinic.

The beginnings of Rogers' methods are clearly visible in his book *The Clinical Treatment of the Problem Child*, which was published in 1939. When he moved to Ohio State University in 1940, Rogers began to develop his approach to psychotherapy in earnest (Rogers, 1942). In 1945, he moved to the University of Chicago and began a period of intensive research as he developed a theoretical structure to buttress his therapeutic practices. During this period, the term "client-centered" began to supplant the older "nondirective" label (Rogers, 1951). Then, in 1957, Rogers accepted a position at the University of Wisconsin to extend his ideas about psychotherapy to more extreme populations, such as hospitalized schizophrenics (Rogers, Gendlin, Kiesler, & Truax, 1967). From 1968 until his death in February 1987, Rogers was a resident fellow at the Center for Studies of the Person in La Jolla, California.

Rogers published numerous books (several of which are cited in the References at the end of this book). His autobiography, written in 1967, is included in *A History of Psychology in Autobiography (Vol. 5).* An autobiographical paper, "In Retrospect: Forty-Six Years," appeared in *American Psychologist* in 1974. *A Way of Being*, published in 1980, provides some insight into the changes that occurred in his thinking over the years. A sensitive and revealing portrait of Rogers—both as a psychologist and as a person—has been offered by Gendlin (1988).

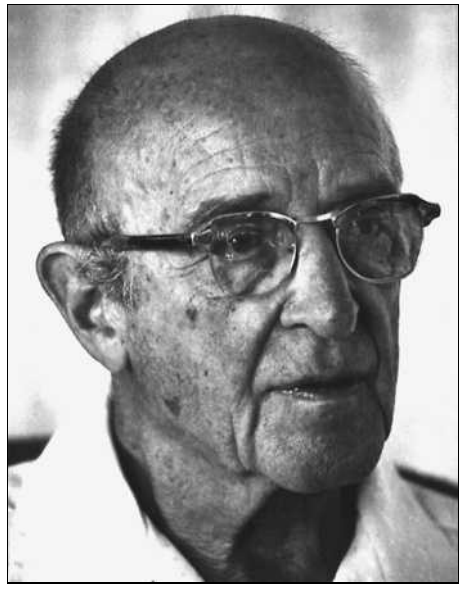


Photo Courtesy of Natalie Rogers

example, a therapist observes that Nico is behaving nervously prior to a test, infers that Nico must be experiencing threat from the test, and then proceeds to account for his nervousness by attributing it to the threat. Such an observation is both the basis for the inference and the object of the explanation.

A very important concept within phenomenological theory is the *phenomenal self*—that part of the phenomenal field that the person experiences as the "I." Obviously, this is not an objective experience. In addition, phenomenological theory states that the basic human urge is to preserve and enhance

the phenomenal self. In a sense, then, self-esteem becomes the fountainhead of behavior.

Problems in adjustment arise when the phenomenal self is threatened. However, what is a threat for one person is not necessarily a threat for another. In essence, a person will experience threat whenever he or she perceives that the phenomenal self is in danger. Thus, Ricardo, a man who perceives himself as being very attractive to women may become anxious if he is rejected by a woman because this represents a threat to his self-concept. Faced with such a threat, Ricardo may adopt a variety of defensive postures. For example, Ricardo may rationalize his failure, or he may narrow his perceptual field. The truly adjusted person is one who can integrate all experiences into the phenomenal field, not just the experiences that are immediately consistent with the self-concept. For example, a well-adjusted student who fails an exam will not claim unfairness or physical illness (assuming that these claims are unjustified). Rather, the student will integrate this experience by perhaps revising the self-concept. For example, "Maybe I am not as good in biochemistry as I thought. But then again, I do quite well in other areas, and I have good social skills. So clearly, this doesn't diminish me as a person." Or "I did fail, but with more effort I think I can do it. But if not, I will try other things that will bring a sense of fulfillment or contribution."

Theoretical Propositions

Early on, Rogers (1951) formulated a series of propositions that set the tone for a client-centered view of personality. He stated that individuals exist in a world of experience of which they are the center. This experience can only be known by the person. Therefore, the person is the best source of information about the self. These views have led members of the client-centered movement to rely heavily on verbal self-reports, rather than on inferences from test data or related observations, as the primary source of information. Because people react to the perceptual field as it is experienced and perceived, their perceptual field is reality. Therefore, objective knowledge about stimuli is not enough to predict behavior. The clinician must know something about the person's awareness of those stimuli. The psychology of objectivity is rejected in favor of the inner world of experience as reported by the person.

The basic human tendency is toward maintaining and enhancing the experiencing self, or *self-actualization*. This is what produces the forward movement of life—a force upon which the therapist will rely heavily in therapeutic contacts with the client. But this forward movement can occur only when the choices of life are clearly perceived and adequately symbolized.

Behavior is fundamentally a set of goal-directed attempts by the organism to satisfy experienced needs. All needs can ultimately be subsumed under the single urge of enhancement of the phenomenal self. All of this would seem to imply a kind of learning theory, but it is difficult to find any learning concepts in Rogers' theoretical expositions.

A crucial concept is the *self*, the awareness of one's being and functioning. The structure of the self is formed out of interactions with the environment and in particular out of evaluations of the person by others. The self is an organized, fluid, and yet consistent pattern of perceptions of the characteristics and relationships of the I or the Me, along with the values attached to them. During the life of the individual, a variety of experiences occur. Following an experience, three possibilities present themselves: (a) The experience can be symbolized or organized into some relationship with the self; (b) the experience can be ignored because its relevance to the self is not perceived; or (c) the experience can be denied symbolization or distorted because it is inconsistent with the structure of the self.

Under certain conditions, experiences that are inconsistent with the self may be examined and perceived, and the structure of the self revised to assimilate them. The principal condition is a complete absence of threat to the self. This in effect states the rationale for the warm, accepting, permissive, and nonjudgmental atmosphere that is the cardinal condition in client-centered therapy.

Core Features

As Rogers (1959) put it, psychotherapy is the "releasing of an already existing capacity in a potentially competent individual, not the expert manipulation of a more or less passive personality" (p. 221). This is the so-called *growth potential* on which the client-centered therapist relies so heavily. All people possess such a potential; the trick is to release it. In client-centered therapy, presumably the release is effected, thus permitting one's self-actualizing tendencies to gain ascendance over previously internalized factors that restricted one's acceptance of personal worth. The three therapist characteristics that precipitate all of this are (a) accurate, empathic understanding; (b) unconditional positive regard; and (c) genuineness or congruence.

Empathy. To convey *empathy* is to transmit to the client a sense of being understood. The empathic therapist conveys a kind of sensitivity to the needs, feelings, and circumstances of the client. Exceptionally empathic therapists can assume the attitudes of clients and, as it were, climb behind their eyeballs and see the world as they do. The client must come to know that the therapist is making every effort to understand correctly. When the client realizes this, the basis is laid for a therapeutic relationship. Empathy can never be total, of course—and it's a good thing that it can't. A measure of objective detachment must always be maintained; otherwise, the therapist would have the same problems as the client. Nevertheless, the empathic therapist can convey or communicate to clients a sense of understanding and appreciation of their needs or plight. And clients can find this attitude tremendously reassuring, more so than any words or any exclamations of interest. For the attitude of empathy is not stated; it is conveyed by its very existence.

Perhaps Rogers' (1946) own words will convey something of this attitude of understanding and empathy:

> We have come to recognize that if we can provide understanding of the way the client seems to himself at this moment, he can do the rest. The therapist must lay aside his preoccupation with diagnosis and his diagnostic shrewdness, must discard his tendency to make professional evaluations, must cease his endeavors to formulate an accurate prognosis, must give up the temptation subtly to guide the individual, and must concentrate on one purpose only; that of providing deep understanding and acceptance of the attitudes consciously held at this moment by the client as he explores step by step into the dangerous areas which he has been denying to consciousness.
>
> This type of relationship can exist only if the counselor is deeply and genuinely able to adopt these attitudes. Client-centered counseling, if it is to be effective, cannot be a trick or a tool. It is not a subtle way of guiding the client while pretending to let him guide himself. To be effective, it must be genuine. (pp. 420–421)

Unconditional Positive Regard. In most relationships with parents, friends, a spouse, or others, clients have learned that approval and acceptance are conditional upon meeting certain stipulations. Parents accept children if they are obedient. An employer is accepting if employees are prompt and efficient. Spouses require that their partners be interested and loving. But in therapy, there must be no conditions. Acceptance is given without hidden clauses or subtle disclaimers. *Unconditional positive regard* is nothing more and nothing less than a respect for the client as a human being. The therapist must lay aside all preconceived notions and be able to care about the client, be accepting, and above all, convey that here is someone who has faith and trust in the client's ability and strength to achieve that inner potential. These qualities, coupled with a complete lack of evaluative judgments on the part of the therapist, will go a long way toward creating an atmosphere in which the client is free to give up debilitating defenses and

can, in the absence of threat, begin to grow as a person.

Exhibiting these qualities with someone the therapist finds pleasing and in tune with his or her own background and values is relatively easy. The true test of the therapist's unconditional positive regard comes with clients whose behaviors and attitudes really challenge the therapist's beliefs. The bigot, the unmotivated or lazy, or the client who describes an incestuous experience with his niece can force a real test of the therapist's tolerance and acceptance. But just as every citizen is entitled to vote, so is every client worthy of unconditional positive regard, according to Rogers.

Congruence. At first glance, *congruence*—or *genuineness*, as it is sometimes called—would seem to contradict the qualities of empathy and positive regard. Congruent therapists are those who express the behaviors, feelings, or attitudes that the client stimulates in them. One does not smile if one is angry. If the client's remarks are upsetting, the therapist does not hide behind a mask of calm (Rogers, 1961). Rogers believed that in the long run clients would respond favorably to this honesty and congruence, knowing that here was a real person dedicated to their welfare. This can be most reassuring and can stimulate a sense of personal worth and a desire to come to grips with one's latent potential.

Attitude Versus Technique. In many ways, the core of client-centered therapy seems to reside more in stated values and attitudes toward people than in any specific methods. To that extent, client-centered therapy is a state of mind rather than a set of techniques. The client-centered therapist seeks to become nondirective by relinquishing any procedures that point to the therapist as an expert who will diagnose the client's ills and recommend the proper measures for their alleviation.

In fact, client-centered therapists will argue that such "prescriptions" are unnecessary because the release of clients' resources or potential will resolve the problems in question. Given therapist congruence, unconditional positive regard, and accurate empathic understanding, clients will discover their own capacity for growth and self-direction. In contrast to the psychoanalysts, Rogers saw people not as destructive but as possessed of a constructive force reaching toward health and self-fulfillment. In addition, the Rogerians forgo an emphasis on the past in favor of an awareness of current experience. For the interpretations of the activist psychoanalytic therapist they substitute the quiet, listening therapist whose caring facilitates the client's own discovery of inner strength and valid personal experience.

There are also distinct differences between client-centered therapy and the behavioral approaches (discussed in the following chapter). Rogerians declare that inner experiences are the paramount data and that to ignore those experiences is to ignore the basic data of the human being. Whereas behavioral approaches sometimes seem to focus on manipulating or controlling the environment to effect change, the client-centered therapist relies on change that emanates from within—a release of inner potential.

The Therapeutic Process

It almost seems easier to describe client-centered therapy in terms of what does *not* take place. A long series of "don'ts" includes giving information or advice, using reassurance or persuasion, asking questions, offering interpretations, and making criticisms. Perhaps the major activities of the therapist are the recognition and clarification of the feelings associated with the client's statements. For example, Greenberg et al. (1994) reports that approximately 75% of all client-centered therapists' responses were "reflections" of what the client had said. Comments are also made that convey to the client the therapist's total and unconditional acceptance. Occasionally, the therapist will find it necessary to explain the respective roles of the client and the therapist. Called *structuring*, this too includes the element of acceptance.

Typically, neither reassurance nor interpretation is used. It is assumed that the recognition of

feeling and the accompanying acceptance are themselves reassuring. Reassurance is also conveyed by the therapist's tone of voice, choice of words, facial expression, and general demeanor. Providing interpretation and giving advice or information are avoided because these imply that the therapist knows what is best for the client. In general, however, the idea is to place the responsibility for therapeutic progress on the client's shoulders rather than on those of the therapist. Similarly, to interpret is to tell clients why they behaved in a given fashion. Interpretation means that the therapist has preempted responsibility for progress rather than waiting for clients to arrive at their own explanations.

In the case of acceptance, this is less a technique than an all-pervasive attitude. The durable belief is that the client is capable of reaching a satisfactory solution to problems in living. Acceptance provides the atmosphere in which the client's potential for growth and self-actualization can be asserted. By responding to the client's feelings and then accepting them, the therapist provides warmth that leads to the feeling of being understood.

Client-centered therapy sessions are usually scheduled once a week. More frequent sessions, extra sessions, and phone calls are discouraged because these can lead to a dependence that will stifle any sense of growth. The general sequence or process of therapy has been described by Rogers as involving a series of seven stages that the client undergoes (Meador & Rogers, 1984). We present a highly condensed version here.

First stage: Unwillingness to reveal self; own feelings not recognized; rigid constructs; close relationships perceived as dangerous.

Second stage: Feelings sometimes described, but person is still remote from own personal experience; still externalizes heavily, but begins to show some recognition that problems and conflicts exist.

Third stage: Description of past feelings as unacceptable; freer flow of expressions of self; begins to question validity of own constructs; incipient recognition that problems are inside rather than outside the individual.

Fourth stage: Free description of personal feelings as owned by the self; dim recognition that long-denied feelings may break into the present; loosening of personal constructs; some expression of self-responsibility; begins to risk relating to others on a feeling basis.

Fifth stage: Free expression of feelings and acceptance of them; previously denied feelings, although fearsome, are clearly in awareness; recognition of conflicts between intellect and emotions; acceptance of personal responsibility for problems; a desire to be what one is.

Sixth stage: Acceptance of feelings without need for denial; a vivid, releasing sense of experience; willingness to risk being oneself in relationships with others; trusts others to be accepting.

Seventh stage: Individual now comfortable with experiencing self; experiences new feelings; little incongruence; ability to check validity of experience.

Diagnosis

In general, diagnosis or assessment is deemphasized or avoided in client-centered therapy. Most Rogerians believe that formal assessment is not only unnecessary but actually detrimental. According to these Rogerians, assessment places the psychologist in a superior, authoritative role that can impede the development of autonomy and self-actualization. The abandonment of assessment seems to imply that client-centered therapy is so potent and effective a method that it works on all clients, regardless of their problems or of the particular circumstances in which they find themselves. Needless to say, the utility of this assumption has not yet been adequately demonstrated (Greenberg et al., 1994).

What is important in client-centered therapy is the feelings, not whether they are wrong or

A Case Illustration of Client-Centered Therapy

The following case example illustrates some of the features of client-centered counseling that have been discussed. The client is a 20-year-old sophomore who was being seen in a university counseling center. His initial complaint involved a generalized feeling of unworthiness. As the sessions moved along, he began to focus specifically on his feelings of intellectual inadequacy. Even though his college grade point average in a demanding curriculum was 3.3, he was constantly absorbed by a sense of inferiority. He frequently compared himself (always unfavorably) to an older brother who had recently completed medical school and was the source of much parental pride. The following exchange took place during the 15th session.

Client: Well, it happened again yesterday. I got back that exam in American Lit.

Therapist: I see.

Client: Just like before. I got an "A" all right—me and eight others. But on the third question the instructor wrote a comment that I could have been a little clearer or else could have given more detail. The same old crap. I got an "A" all right, but it's pretty damn clear that I'm like a machine that can generate correct answers without ever understanding. That's it. I memorize, but there's no spark, no creativity. Boy!

Therapist: What else can you tell me about the exam?

Client: Well, it was like we talked about before. I'm doing OK, but I just don't feel like I really measure up. I remember my brother bringing home a paper in high school. It was a "C," but the instructor said John had real potential. I just don't think I've got it.

Therapist: Even though you got an "A" you are not satisfied.

Client: That's right. Never satisfied. I could get 42 "A^{+}s" and never feel good. I hate myself!

Therapist: M-hm.

Client: Sometimes I'm so ridiculous.

Therapist: You feel silly because of the way you react. Is that right?

Client: I should put it aside, think about other things. But I don't, and then I feel silly when I don't.

Therapist: You're silly because you feel dissatisfied and silly because you don't just forget it.

Client: I know I should be satisfied with an "A." Other guys would be. They'd be glad to get an "A."

Therapist: M-hm.

Client: But I can't. No wonder the folks are so proud of John. He got decent grades, and he was satisfied—not like me. It's a wonder they don't get fed up with my moping around.

Therapist: So even with good grades your unhappiness is enough to turn people off.

Client: Sure. But somehow I've got to get rid of this defeatist attitude. I've got to think about the good side.

Therapist: M-hm.

Client: A lot of times I've tried to forget my lack of potential. Just go on and plug along.

Therapist: Yeah. I guess you really felt people put you down because of this lack of potential?

Client: Boy, did they! Especially my folks. They never really said so, but I could tell from the way they acted.

Therapist: M-hm.

Client: They'd say that John really has a head on his shoulders, or (pause) … he can think his way out of anything.

Therapist: And this made you feel sort of worthless—not hearing things like that about yourself.

Client: That's right.

Therapist: M-hm.

Intense feelings were expressed in this session. The client felt worthless and inferior to his brother. Despite an outstanding college record, he continued to find ways to prove that he was intellectually unacceptable. The therapist did not attempt to contradict him or to prove him wrong; nor did he make reassuring comments. Rather, he accepted the client's statements and the feelings they conveyed.

whether they stem from an earlier unhealthy home situation. The therapist accepts the feelings in a manner that transmits neither approval nor disapproval—just understanding. It is the understanding and the occasional clarifications that permit the client to move ever closer to a careful examination of herself and of what she can do to change matters. Only in an atmosphere of acceptance can this potential for growth be cultivated and released. The foregoing case illustration also highlights the empathic statements made by the therapist, often summarizing, almost inferentially, what the client was feeling. The therapist, then, does more than just accept the client's feelings. By rephrasing and inferring, the therapist reminds the client of what he or she must be feeling.

Over the years, like any movement, client-centered therapy has evolved and changed. Both the method and the theory have been modified and extended. A brief summary of these developments can be found in Greenberg et al. (2003).

Other Applications

The client-centered approach was developed primarily in the counseling psychotherapy context, and this remains its chief application. However, the movement has found other applications as well. For example, the client-centered orientation is frequently used in human relations training. The emphasis on relationship, acceptance, and warmth is often an integral part of training programs for those who seek to work in crisis centers, for paraprofessionals who engage in counseling, and for volunteers in charitable organizations or agencies. Thus, whether one is dealing with professionals such as physicians and nurses, psychological technicians, or Peace Corps volunteers, their training in human relationships often contains a heavy dose of the client-centered philosophy. When the client-centered approach is applied to problems outside the therapy room, it is often called the *person-centered approach*.

As we shall see in Chapter 15, small groups, encounter groups, and personal growth groups make use of the client-centered framework. Often, these groups are established to reduce tension between factions in conflict, such as racial groups, labor and management, or students and faculty. In some instances, institutions such as churches, businesses, and school systems use the client-centered approach to foster improved human relations or changes in institutional functioning and goals.

Some Concluding Remarks

The Positive. The client-centered approach has produced many salutary effects. It provided a serious alternative to the traditional psychoanalytic forms of therapy. In so doing, it offered an alternative focus on self-determination and inner directedness rather than on the biological urges and instincts of the Freudian view. The becoming, evolving person replaced the victim of personal history. Freedom to choose was substituted for a mechanistically determined set of behaviors.

Rogers demonstrated that it is not necessary to dig up the past to conduct psychotherapy. Emphasis was placed on the relationship between the client and the therapist, and the application of "techniques" became secondary. Even the word *client* suggests something of importance. The role of the passive patient in the context of the physician's demand for authority was replaced by that of the client who actively seeks to experience choice, equality, and freedom.

The general ahistorical stance of the Rogerians also led to a form of therapy much shorter than psychoanalysis. The move away from lengthy resolutions of transference relationships, the detailed reconstruction of the past, and cathartic experiences considerably shortened the therapeutic process. In addition, the less active role played by the therapist required less training. Given the mental health needs of the nation, any therapeutic discipline that can provide personnel faster and more economically is to be seriously considered. However, it is possible that client-centered therapy has become a double-edged sword. Some feel that the client-centered, humanistic axis has produced a whole generation of therapists whose lack of training can

never be fully offset by their enthusiasm and "authenticity."

A contribution of major proportions was Rogers' emphasis on research. He was responsible for the first concerted efforts to carry out research on the therapeutic process. It was he who first employed recordings of therapy sessions to study the process and to investigate its effectiveness. The use of recordings is now a staple ingredient of training and research. Prior to Rogers, the sanctity of the therapy room was guarded with a vengeance. Rogers opened up therapy and made it an object of study rather than a subject of mystery. In making available recordings and transcripts of his own therapy sessions, he exhibited a degree of courage unusual for its time (though it may be commonplace today).

In addition to the pioneering efforts of Rogers and others in the recording and transcription of interviews, significant efforts were made to investigate the outcomes of therapy. For example, Rogers and his colleagues developed indices of therapeutic outcome based on client ratings of their present and their ideal self-concept, along with various indicators of improvement gleaned from counseling sessions, such as the ratio of client-to-therapist talk and the responsibility for talk (e.g., Cartwright, 1956; Rogers & Dymond, 1954; Rogers, Gendlin, Kiesler, & Truax, 1967; W. U. Snyder, 1961; Truax & Carkhuff, 1967; Truax & Mitchell, 1971).

As noted in Chapter 11, meta-analyses of studies including a client-centered treatment condition have indicated an effect size of .62, indicating that an adult client who received this form of therapy was functioning (on average) better than 73% of those who did not receive treatment. To investigate whether this finding characterized "newer" research on client-centered therapy, two additional meta-analyses have been conducted.

Greenberg et al. (1994) conducted a meta-analysis of studies published between 1978 and 1992. It is noteworthy that the authors could identify only eight studies conducted during this time period that investigated the efficacy of client-centered therapy and also included a control group. The average effect size across these studies was .88; on average, an adult client in these studies was functioning better than 81% of those not receiving treatment. Greenberg and colleagues were also able to evaluate the relative effectiveness of client-centered therapy compared to other forms of psychological treatment. Of the seven relevant comparisons, in only one instance did client-centered therapy outperform another treatment (in this case, short-term dynamic therapy; Meyer, 1981).

Elliott and colleagues (2004) presented results of a meta-analysis of studies published since 1992. They located 11 studies of the efficacy of client-centered therapy (in which a control group was also evaluated) and reported a mean effect size of .78. Compared to other forms of treatment, across 28 studies, client-centered therapy (on average) was no more effective than other treatments.

Most recently, Elliott and Freire (2010) reported on a meta-analysis of almost 200 studies of Person-Centered/Experiential therapies. Across studies, they found that the average adult client receiving this form of therapy reported significant positive change from pre- to posttreatment, and these treatment gains seemed to be maintained for at least one year, on average. Compared to clients that received no therapy, clients that received this form of treatment showed significant improvement (an average effect size of .78). Finally, across those studies that compared Person-Centered/Experiential therapies to other forms of psychological treatment ($n = 109$ studies), no significant differences in outcome were found, suggesting equivalent effects.

What aspects of person-centered/experiential therapies seem most helpful to clients? A recent series of meta-analyses sought to identify aspects of treatment often associated with this approach that are significantly related to outcome. It is important to note, however, that these meta-analyses did not restrict the selection of studies to only those that used Person-Centered/Experiential therapies. Rather, psychotherapy studies were selected for these meta-analyses based on their measurement of the constructs that were targeted. As mentioned earlier, the therapeutic alliance is believed to be an important correlate of outcome and is often considered a common factor that is responsible for the effects of

psychotherapy. Horvath, Del Re, Fluckiger, and Symonds (2011) analyzed data from over 200 studies and reported that quality of therapeutic alliance was correlated significantly ($r = .28$) with good outcome. Elliott, Bohart, Watson, and Greenberg (2011) reported that empathy scores were significantly correlated ($r = .31$) with therapy outcome across 59 studies, and Farber and Doolin (2011) reported a correlation of .27 between measures of positive regard and outcome across 18 studies. Finally, Kolden, Klein, Wang, & Austin (2011) reported a correlation of .24 between measures of congruence/genuineness and outcome across 16 studies.

In summary, research evidence suggests that client-centered therapy is moderately efficacious, but no more effective than any other psychological treatment. As for what components or features of Person-Centered/Experiential therapy seem most important for positive outcome, Norcross and Wampold (2011) suggest that these recent meta-analyses indicate the positive effect of a high-quality therapeutic alliance, empathy expressed and experienced in the relationship, and the expression and experience of positive regard.

The Negative. There is, however, another side of the coin. Client-centered therapists repeatedly argue that their efforts do not change clients. Instead, they say, the client's inner potential for growth is released. Whether this view is based on conviction or modesty, it seems to be incomplete. Therapy is a stimulus (the particular character of which is greatly affected by the therapist) that sets many reactions into motion. Whether those reactions are deemed positive, negative, or neutral, they seem in large measure to be attributable to the stimuli and the methods of the therapist.

Client-centered therapists claim that to understand clients, one must experience the same phenomenological world. But how does one do that? With intuition? How does one ever completely shed the idiosyncratic bias of a personal framework? Critics would argue that avoiding assessment and giving the past short shrift may actually impair the therapist's ability to understand and enter into the client's perceptual framework.

Client-centered therapy seems to involve only one technique, or rather one attitude set: empathy, acceptance, and unconditional positive regard. Thus, every client is treated in exactly the same way. The therapist need not assess the client to choose the most effective therapy or the specific technique to fit the unique characteristics of that client. Thus, a good case could be made for the contention that client-centered therapy is really technique centered! However, more recently, recognition of the problems with a one-size-fits-all approach to therapy has led some to develop specific techniques and methods for certain client problems (Greenberg et al., 2003).

There is also an abiding faith that the client knows best. The movement's emphasis on democracy, freedom of choice, and the indisputable supremacy of the client's inner potential leads to condemnation of therapist "interference" through interpretation, advice, or expressed values. In many cases, however, the severity of the client's problems would seem to dictate the use of a more active and directing set of procedures. For example, one might have reason to doubt the wisdom and resources of a psychopathic or schizophrenic client. Even if it were true (though this is probably not a testable proposition) that, given unlimited time or optimum circumstances, each client could make the right decisions or reach the proper conclusions, it seems a very inefficient way to operate. Client-centered therapists, at times, seem to be seeking to change the client (though claiming not to do so) without collecting enough diagnostic and/or historical data to do so efficiently. Their emphasis on verbal reports by the client places them at the mercy of information that is often defensive, distorted, and incomplete.

Much of the research on the effectiveness of client-centered therapy has relied on internal criteria. That is, clients are said to be improving when they take more responsibility for the conversation during the therapy session or talk proportionately more than the therapist. Others would argue, however, that the real criteria for improvement must come from outside the therapy room (through observation, reports by peers and spouse, etc.). Without validation from such external sources, it

is possible that any client changes observed within the therapy room represent adjustments to the demands of the situation rather than changes that will generalize beyond the confines of therapy.

Very often, descriptions of client-centered treatment philosophies and procedures are unique and involve a great deal of undefined terminology. Such words as *being*, *becoming*, *actualizing*, and *congruency* are not clearly defined or seem to carry a surplus of meaning that is difficult to communicate reliably. At other times, there is a grandiosity of language that seems out of keeping with the modesty that appears elsewhere. For example, Rogers (1951) says, "Therapy is the essence of life" (p. x).

Although some may simply chalk this up to jargon, there is nevertheless a marked tendency for Rogerians to use language that is emotionally tinged in such a way as to almost serve a propaganda function. Such words as *nondirective* and *client-centered* not only seem to convey something distinctly positive but by implication also seem to depict other approaches as directive or therapist-centered. A terminology that includes words such as *freedom*, *democratic*, *genuine*, *warm*, and *authentic* is likely to put advocates of other approaches at an immediate disadvantage. Before such advocates can explain what their approaches really are, they may have to answer implicit charges of being authoritarian, technique-centered, controlling, and without common humanistic values.

Finally, the client-centered approach grew and came of age on college campuses. The clients of the 1940s and 1950s were college students who were being seen at campus counseling centers. As often as not, the therapists trained in the Rogerian tradition in these centers became staff members at other college counseling centers. It is worth noting that, compared with people in the general population, college students as a group are brighter, better educated, and less severely maladjusted when they do develop problems, and they have a stronger arsenal of coping methods. The so-called nondirective, client-centered methods would probably be more effective with such a population than with, for example, those with psychosis, with poor verbal skills, or from a limited educational background.

THE HUMANISTIC-EXISTENTIAL MOVEMENT

The strands of phenomenology, humanism, and existentialism in psychology are inextricably woven together. In the preceding section, we have seen the importance that Rogers attached to immediate experience. This is basic phenomenology. At the same time, client-centered approaches stress the worth, uniqueness, and dignity of the client. This is basic humanism. Before we proceed to discuss existential therapies, logotherapy, and Gestalt therapy, let us pause to acknowledge the humanistic tradition that pervades those therapies.

Humanism

Although humanistic psychology is a fairly recent development, its origins extend far back into philosophy and the history of psychology. When one speaks of *humanism*, one thinks of psychologists such as Allport, Goldstein, James, Murray, and Rogers. The values that humanism contributes to psychology are not rooted in the determinism of either psychoanalysis or behaviorism. From a humanist perspective, people are not products of the past, the unconscious, or the environment. Rather, they exercise free choice in the pursuit of their inner potential and self-actualization. They are not fragmented patchworks of cognitions, feelings, and aspirations; rather, they are unified, whole, and unique beings. To understand is to appreciate those qualities, and this understanding can only be achieved by an awareness of the person's experience. So-called scientific constructs based on norms, experiments, or data must give way to intuition and empathy. The emphasis is not on sickness, deviations, or diagnostic labels but on positive striving, self-actualization, freedom, and naturalness. Bugental (1965), Buhler (1971), Buhler and Allen (1971), Jourard (1971), and Maslow (1962) have addressed various aspects of these values. In one form or another, humanism is expressed as a resistance to the positivistic determinism of science and as an active embrace of the essential humanity of people.

BOX 13-2 Clinical Psychologist Perspective: Leslie S. Greenberg, Ph.D.

Dr. Leslie S. Greenberg is a Distinguished Research Professor of Psychology at York University in Toronto, Canada. He specializes in psychotherapy research, and he has become a leader in conceptualizing and studying emotion-focused psychotherapy. This psychotherapeutic approach, which comes out of the humanistic-existential tradition, emphasizes both awareness and transformation of the client's emotional experience and the value of the therapeutic relationship. Therapist presence and empathy and acceptance and validation of clients' emotions are emphasized. Dr. Greenberg is the author of 15 books and more than 200 book chapters and articles. He has received numerous honors and awards for his work in the field, including the Distinguished Research Career award of the International Society of Psychotherapy Research, the Canadian Psychological Association Professional Award for distinguished contributions to psychology as a profession, and the Carl Rogers Award of the APA Society for Humanistic Psychology. Dr. Greenberg responded to several questions regarding his views of the field as well as his predictions for the future of clinical psychology and of experiential psychotherapy.

What originally got you interested in the field of clinical psychology?

I came from a master's degree in engineering in 1970 into psychology, as I was seeking greater social and personal relevance. I completed my bachelor's of engineering in South Africa, where I had gone into engineering rather than physics because I liked working with people and thought that engineering would lead more to managing and working with people. I was involved in antiapartheid student politics in South Africa, and when I came to Canada in the 1960s, I was not happy in engineering and was much more interested in people. I also saw psychology as a way of becoming more involved in the issues of the era—personal growth and changing society.

Describe what activities you are involved in as a clinical psychologist.

I teach counseling and psychotherapy and engage in research on the process of change and the role of emotion in this process. I supervise students' clinical practice in the research studies that I do. I have a private practice in which I see individuals and couples. I write.

What are your particular areas of expertise or interest?

I specialize in psychotherapy research, focusing most specifically on the process of change and on emotion-focused methods of intervention. I am particularly concerned with bringing emotion back into psychotherapy, as I see it as central in functioning and in

Existential Therapy

Existential psychology rejects the mechanistic views of the Freudians and instead sees people as engaged in a search for meaning. At a time when so many people are troubled by the massive problems of a technological society and seek to repair their alienated modes of living, existentialism has gained great popularity. It seems to promise the restoration of meaning to life, an increased spiritual awakening, and individual growth that will bring freedom from the conventional shackles created by a conformist society (Bugental, 1978).

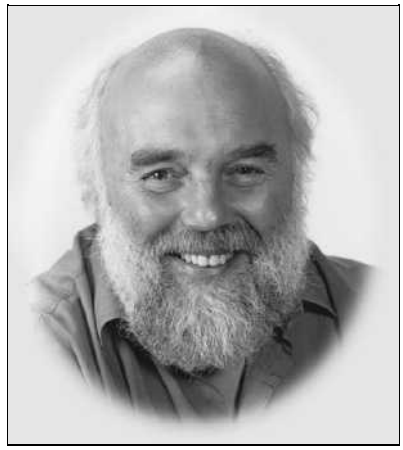
Hardly a unified movement that speaks with a single voice, the existential view actually turns out to be many views. Its roots lie deep in the philosophies of Kierkegaard, Heidegger, Tillich, Sartre, Jaspers, and others. When we discuss the psychological applications of existentialism, names such as Binswanger, Boss, Gendlin, Frankl, May, and Laing come to mind. Philosophically, existentialism springs from the same sources as does phenomenology (MacLeod, 1964; Van Kaam, 1966).

The existentialists make a number of assertions about human nature (Kobasa & Maddi, 1977; Maddi, 1989). Basic to all is a fundamental human characteristic: the search for meaning (Binswanger, 1963; Boss, 1963). That search is carried out through imagination, symbolization, and judgment. All of this occurs in a matrix of participation in society. From the standpoint of both their physical environment and their biological environment, people function in a social context.

change, and to this end, I have developed and written about an emotion-focused approach to individuals and couples.

What are the future trends you see for clinical psychology?
I believe that eventually there will be a single area of study, mental health or psychotherapy, integrating the various disciplines—clinical psychology, social work, psychiatry (maybe), and nursing—and the different levels of intervention—biological, psychological, social, and so on—plus an end to schools of therapy and the school wars.

What are some future trends you see for experiential/humanistic-existential therapy?
I see experiential therapy as overcoming its heritage of being seen as involving "just" listening, being based on the view of people as having an actualizing tendency that is an inner guide to health, and that simply getting in touch with one's feelings will lead to health. Although there is some truth in all these statements, I see these as becoming more differentiated and modified as our understanding of functioning increases. Experiential therapy will develop theoretically beyond its original statements into a more sophisticated view of human functioning, based on emotion and constructivist theory and research. It will offer a process view of functioning and therapy, offering more detail on in-session states that are amenable to particular types of intervention and how change in these states occurs. I also see experiential therapy as becoming more research based. Ultimately, it will become integrated into a non-school-based approach offering an understanding of in-session process.



Dr. Leslie S. Greenberg, Psychology Dept., York, Univ., Toronto, Canada.

Leslie S. Greenberg

A crucial facet of personality is decision making, which involves the world of both facts and possibilities. Thus, personality is not just what one is—a biological, social, and psychological being—but also what one might become. Many existentialists believe that decision making involves a set of inevitable choices. One can choose the present (the status quo), which represents lack of change and a commitment to the past. That choice will lead to guilt and remorse over missed opportunities. But one can also choose alliance with the future. That choice propels the person into the future with an anxiety that stems from one's inability to predict and control the unknown. Such experiences of guilt and anxiety are not learned but are part of the essence of living. It requires courage to choose the future and suffer the inevitable anxieties that this choice entails. A person can find that courage by having faith in self and by recognizing that choosing the past will inevitably lead to a guilt that is even more terrifying than anxiety.

The Goals of Therapy. The ultimate goal of existential psychotherapy is to help the individual reach a point at which awareness and decision making can be exercised responsibly. The exercise of cognitive abilities will allow for the achievement of higher states of love, intimacy, and constructive social behavior. Through therapy, one must learn to accept responsibility for one's own decisions and to tolerate the anxiety that accumulates as one moves toward change. This involves self-trust and

also a capacity to accept those things in life that are unchangeable or inevitable.

Techniques. Existential therapy does not emphasize techniques. Too often, techniques imply that the client is an object to which those techniques are applied. Instead, the emphasis is on understanding and on experiencing the client as a unique essence. Therapy is an encounter that should enable the client to come closer to experience. By experiencing self, the client can learn to attach meaning and value to life. Sometimes the therapist will confront the client with questions—questions that force the client to examine the reasons for failure to search for meaning in life. For example, a client who repeatedly complains that his job is not very fulfilling may be asked why he does not search for other employment or return to school for more training. Such questions may force the client to examine his or her orientation toward the past more closely, and this in turn creates feelings of guilt and a sense of emptiness. Gendlin (1969, 1981) discusses focusing as a means of reaching the preconceptual, felt sense. This is achieved by having clients focus on the concretely felt bodily sense of what is troubling them. Silences are encouraged to help accomplish this. However, very few research studies have been published that evaluate the use of focusing in treating clients; its efficacy, therefore, remains to be established (Elliott et al., 2004; Greenberg et al., 1994).

Logotherapy

One of the most widely known forms of existential therapy is *logotherapy*. This technique encourages the client to find meaning in what appears to be a callous, uncaring, and meaningless world. Viktor Frankl developed the technique. His early ideas were shaped by the Freudian influence. However, he moved on to an existential framework as he tried to find ways of dealing with experiences in Nazi concentration camps. He lost his mother, father, brother, and wife to the Nazi Holocaust and was himself driven to the brink of death (Frankl, 1963). It seemed to him that the persons who could not survive these camps were those who possessed only the conventional meanings of life to sustain them. But such conventional meanings could not come to grips with the realities of the Nazi atrocities. Therefore, what was required was a personal meaning for existence. From his wartime experiences and the existential insights that he felt permitted him to survive, Frankl developed logotherapy (the therapy of meaning). Many of his ideas are expressed in a series of books (Frankl, 1963, 1965, 1967). Frankl's views about personality and his ideas about the goals of therapy are generally quite consonant with our previous discussion of existentialism. However, it is not always clear that logotherapy techniques bear any close or rational relationship to the theory.

Logotherapy is designed to complement more traditional psychotherapy, not to replace it. However, when the essence of a particular emotional problem seems to involve agonizing over the meaning or the futility of life, Frankl regards logotherapy as the specific therapy of choice. Logotherapy then strives to inculcate a sense of the client's own responsibility and obligations to life (once the latter's meaning has been unfolded). Frankl makes much of responsibility, regarding it as more important than historical events in the client's life. What is crucial is the meaning of the present and the outlook for the future.

In particular, two techniques described by Frankl (1960) have gained considerable exposure. *Paradoxical intention* is a popular technique in which the client is told to consciously attempt to perform the very behavior or response that is the object of anxiety and concern. Fear is thus replaced by a paradoxical wish. For example, suppose a client complains that she is fearful of blushing when she speaks before a group. She would be instructed to try to blush on such occasions. According to Frankl, the paradoxical fact is that she will usually be unable to blush when she tries to do what she fears she will do. Typically, the therapist tries to handle all of this in a light tone. For example, in the case of a client fearful of trembling before his instructor, Frankl (1965) instructs the client to say to himself: "Oh, here is the instructor! Now I'll

show him what a good trembler I am—I'll really show him how nicely I can tremble" (p. 226). This procedure resembles those of implosion therapy, which is discussed in Chapter 14. The second technique, *de-reflection*, instructs the client to ignore a troublesome behavior or symptom. Many clients are exquisitely attuned to their own responses and bodily reactions. De-reflection attempts to divert the client's attention to more constructive activities and reflections.

Gestalt Therapy

In *Gestalt therapy*, the emphasis is on present experience and on the immediate awareness of emotion and action. "Being in touch" with one's feelings replaces the search for the origins of behavior. Existential problems expressed by a failure to find meaning in life have arisen in a technological society that separates people from themselves. The "unreality" of computers and plastic credit cards has overwhelmed the true meaning of life, which can only be found in the immediate experience of emotions. Gestalt therapy attempts to restore the proper balance.

A Movement of Heterogeneity. Frederick (Fritz) Perls is the figure most closely identified with the development of the Gestalt therapy movement. Perls's initial grounding was in medicine and psychoanalysis. He left Germany in 1934, after the Nazis came to power, and settled in South Africa, where he established a psychoanalytic institute. As time went on, however, he began to move away from the tenets of psychoanalysis and toward the development of what was to become Gestalt therapy. In 1946, Perls immigrated to the United States. He died in 1970.

Gestalt therapy is really a heterogeneous mix of techniques and ideas. Gestalt therapists do not agree among themselves and at times seem to revel in their lack of agreement. Their goal does not seem to be the construction of a monolithic theory of therapy but rather to express through their therapy their own sense of uniqueness and their interpretation of life. Even the contribution of Perls himself was hardly a model of consistency. Some of his major works—*Ego, Hunger, and Aggression* (Perls, 1947), *Gestalt Therapy* (Perls, Hefferline, & Goodman, 1951), *Gestalt Therapy Verbatim* (Perls, 1969a), and *In and Out the Garbage Pail* (Perls, 1969b)—express a variety of notions. Kempler (1973) provides an account of Gestalt therapy theory, as does Smith (1976). Adding to the confusion is the fact that Gestalt therapy does not really have very much to do with the Gestalt principles of Wertheimer, Koffka, Kohler, or Lewin. The connections are more superficial than substantive.

Basic Notions. Central to Gestalt therapy is the conceptualization of the person as an organized whole, not as a disjointed collection of emotions, cognitions, and behaviors. Also running through accounts of Gestalt therapy is the admonition that an individual must develop an awareness not only of themselves but also of the ways in which they defeat themselves. This awareness is reached through the expression of what one is feeling *now*, on a moment-to-moment basis. Whatever is impeding progress toward a higher plane of adjustment must be experienced so that it, too, becomes a part of awareness. Presumably, the person's inner potential is capable of overcoming problems in adjustment. But first there must be awareness both of the obstacles to improved adjustment and of that potential itself.

The therapist becomes a catalytic agent who facilitates the client's awareness of how inner potential is being deflected from expression. Thus, the therapist does not give the client reasons for the ineffective use of potential or tell the client how it all got started. Instead, the therapist shows the client where the responsibility for more effective experiences resides—in the client. The emphasis is on momentary awareness, not on the recovery of memories or repressed impulses. However, although Perls rejected many features of psychoanalysis, his approach is really an amalgam of existentialism and psychoanalysis. For example, he seems to readily accept the importance of traditional psychoanalytic insights regarding the nature of motivation and defense.

The Now. For Perls, reality is now, behavior is now, and experience is now. To seek answers in the past is to deal with what no longer exists. Therapy is now, and it must deal with and encourage the client's awareness of that now. One's capacity for growth can only be realized by attacking anything that threatens to divert awareness from the now. As Perls (1970) put it, "To me, nothing exists except the now. Now = experience = awareness = reality. The past is no more and the future not yet. Only the now exists" (p. 14).

For the Gestalt therapist, anxiety is the gap between now and later (a preoccupation with what the future may bring). Being preoccupied with the past also creates a host of negative emotions. A focus on either the past or the future leads to an immobilization of the individual in the present. During therapy, the patient is required to repeat, "Now I am aware…." Or the therapist will frequently ask, "What are you aware of now?" The role of the therapist is to constantly call the patient's attention to present feelings, thoughts, and experiencing. However, the therapist does not interpret because it is assumed that awareness of the now has its own curative powers. That awareness will enable the patient to integrate the formerly disavowed aspects of his or her personality.

Nonverbal Behavior. To probe the patient's defenses and expose the games being played, the therapist often pays close attention to nonverbal behavior. The patient may say one thing but suggest the opposite through various cues. Take the following example:

THERAPIST: How are you feeling?

PATIENT: I'm calm; I feel good.

THERAPIST: You are, really?

PATIENT: Oh yes.

THERAPIST: Why are you sitting so stiff, like a ramrod?

PATIENT: I'm not!

THERAPIST: Check yourself. See your legs, feel your back against the chair?

PATIENT: I see what you mean.

THERAPIST: Let the stiffness talk. What is it telling you?

PATIENT: I'm afraid to let go—I feel like I'm trying to control myself.

By paying attention to nonverbal cues, the therapist was able to cut right through to a significant experience. The therapist then used the posture cue to get to feelings that existed now and helped the patient get in touch with them.

Dreams. The psychoanalyst asks the patient to associate to various elements of dreams. The Gestalt therapist, in contrast, attempts to get the patient to relive the dream now, in the therapy room. This even means acting out the dream. According to the Gestalt therapist, interpretation leads only to an intellectualized insight. In Gestalt therapy, the patient discovers the inner self by confronting the dream experience directly. The dream conveys messages or even epitomizes the conflicting sides of the self. A dream is a kind of condensed reflection of the individual's own existence and the ways used to avoid facing oneself. By playing the part of various persons or objects in the dream, the individual can learn to recognize and identify the alienated parts of the self and then integrate them.

Topdog–Underdog. When conflicts involve opposing aspects of the personality, the patient may be asked to take each part in a dialogue. The opposing parts are usually analogous to Freud's superego and id. The topdog is the superego and contains the introjected "shoulds" of the personality (parental dictates and the like). The underdog is similar to the id. It is primitive, evasive, and constantly disrupts the efforts of the topdog. By playing both roles in a dialogue, the patient can integrate these two conflicting aspects of the self.

The Defenses. In Gestalt therapy, the aim is to expose the games clients play and the defenses behind which they hide. Perls explains neurotic behavior in terms of layers. In the first layer, the client plays games, avoids facing the self, and in

general is not an authentic person. Gestalt therapy forces one to experience and become aware of these shams. But this awareness is threatening because it leads to an experience of the very fears that the shams helped evade. Genuine behavior is threatening because such behavior could lead to terrible consequences (or so the client hypothesizes). Indeed, as environmental supports are also exposed, the client really becomes terrified, feeling that the inner capacity for growth is not equal to the relinquishing of neurotic defenses in favor of honest, independent behavior. Finally, however, the client becomes aware of the hollowness that the anxieties, phobias, or doubts are producing. Such awareness propels the person into an experience of aliveness, wholeness, and authenticity.

Responsibility. Of great importance in Gestalt therapy is getting clients to accept responsibility for their own actions and feelings. These belong to the client, and the client cannot deny them, escape them, or blame them on something or someone else. In summary, if one had to extract from Gestalt therapy expositions the four most descriptive words, they might be *awareness*, *experience*, *now*, and *responsibility*.

The Rules. The "rules" of Gestalt therapy (Levitsky & Perls, 1970) include the following:

1. Communication is in the present tense (looking backward or forward is discouraged).
2. Communication is between equals (one talks with, not at).
3. One uses "I" language rather than "it" language (to encourage the acceptance of responsibility).
4. The client continually focuses on immediate experience (e.g., the therapist will ask, "How does it feel to describe the hostility?" "Tell me what you are feeling at this moment").
5. There is no gossip (talking about someone else).
6. Questions are discouraged (because questions are often quiet ways of stating opinions rather than seeking information).

Gestalt Games. The Gestaltists have received much attention for the so-called games they have developed (Levitsky & Perls, 1970). For example, clients are taught to add the phrase "and I take responsibility for that" when describing something about themselves. Thus, "I am not a very happy person … and I take responsibility for that." Another game involves getting the client to repeat again and again (and louder and louder) some phrase or remark that the therapist deems important. Often, various aspects of role-playing are employed. To what extent any positive effects from these games are generalized beyond the therapy room has not yet been established empirically.

Moral Precepts. The "moral precepts" (or rules for patients to live by) of Gestalt therapy are described by Naranjo (1970):

1. Live now. (Be concerned not with the past or the future but with the present.)
2. Live here. (Be concerned with what is present, not with what is absent.)
3. Stop imagining. (Experience only the real.)
4. Stop unnecessary thinking. (Be oriented toward hearing, seeing, smelling, tasting, and touching.)
5. Express directly. (Do not explain, judge, or manipulate.)
6. Be aware of both the pleasant and the unpleasant.
7. Reject all "shoulds" and "oughts" that are not your own.
8. Take complete responsibility for your actions, thoughts, and feelings.
9. Surrender to being what you really are.

Concluding Comments. As indicated in Chapter 11, Smith et al. (1980) reported an effect size of .64 for Gestalt therapies, based on a large meta-analysis of relevant studies. The average client who received Gestalt therapy in these studies was functioning better than 74% of those not receiving treatment. Unfortunately, very little research on Gestalt therapy has been published since this review. Of those

studies that have appeared more recently, none suggests that Gestalt therapy is more effective than other forms of treatment (Elliott et al., 2004; Greenberg et al., 1994), and some suggest that it may be less effective. One reason we know relatively little about the effectiveness of Gestalt therapy is that most Gestalt therapists are vehemently opposed to the idea of research. For reasons that are not always clear, evaluation research is seen almost as an antihumanistic endeavor.

Gestalt therapy took root in America in an era of social turmoil and alienation. As a result, its most suitable clientele may turn out to be young, well-educated people whose problems center on personal estrangement and alienation. Therapists who have a Gestalt orientation sometimes seem to do especially well with overly intellectualized, college-educated people who have lost touch with their feelings and immediate experience. It certainly is not an antidote suitable for all patients—no therapy is. However, it remains to be seen whether Gestalt therapy will become more than a flashy solution and whether it will be able to address itself successfully to the problems in living that a wide range of patients bring to therapy. By dealing only with the present, Gestalt therapy runs the danger of becoming a short-lived solution that replaces the search for meaning with a hedonism that can be quite attractive to some whose brush with a powerful, technocratic society has left them inhibited and overcontrolled. At the same time, Gestalt therapy has already demonstrated a staying power greater than many expected.

EMOTION-FOCUSED THERAPY

Before concluding this chapter, it is important to introduce a contemporary form of humanistic-existential therapy that seems likely to be quite influential to the field, *Emotion-Focused Therapy* (EFT; Greenberg, 2010; Greenberg, Elliott, & Pos, 2007). Originally termed process-experiential therapy (PET), EFT integrates the client-centered and Gestalt psychotherapy traditions. At the heart of EFT is the theoretical proposition that emotions are fundamentally adaptive and that emotions give our life experience its value, meaning, and direction. Because emotions help us to integrate our life experiences, emotional self-regulation is necessary for personal growth. From this perspective, dysfunction is the result of some impairment in the ability to integrate experiences into a coherent self, in the ability to experience and identify emotional states, and in the ability to regulate emotions. Such dysfunction can in turn affect one's satisfaction with life and the quality of one's relationships with others.

In EFT, the therapist provides a safe and supportive environment such that the client can become more aware of different aspects of him- or herself, can access and explore emotional states, and can learn to better regulate and ultimately transform these emotional states (Greenberg, 2010). These goals are achieved through participation in a variety of therapeutic tasks, including focusing, two-chair dialogues, and empty-chair techniques (Greenberg et al., 2003).

Although relatively new, EFT has garnered some empirical support. Meta-analyses suggest that it is an efficacious treatment and that it compares favorably to other forms of treatment (Elliott, Greenberg, et al., 2004). Furthermore, it is listed as having at least modest research support for the treatment of depression (e.g., see Ellison, Greenberg, Goldman, & Angus, 2009). Therefore, it appears that this newer version of humanistic-existential therapy is an important development in treatment from this perspective. Box 13-3 presents some of the major features of EFT.

SUMMARY EVALUATION OF PHENOMENOLOGICAL AND HUMANISTIC-EXISTENTIAL THERAPIES

As we have mentioned throughout this chapter, relatively fewer empirically sound studies have been conducted to evaluate the efficacy and

BOX 13-3 Focus on Clinical Applications: Features of Emotion-Focused Therapy

Emotion-Focused Therapy (EFT) is a psychological treatment that focuses on the adaptive and self-organizing qualities of the emotional system in individuals (Greenberg, 2010). In treatment, therapists use EFT to help clients identify, experience, makes sense of, and transform emotions as well as to manage problematic emotional states. Underlying this treatment approach is the assumption that emotions are connected to basic human needs and serve as a way individuals make sense out of their own experience. Emotional change occurs by making sense of emotions through awareness, expression, regulation, reflection, and transformation (Greenberg, 2010). During EFT, emphasis is placed on the therapist's experience and expression of empathy, development of a good alliance with the client, and development of a collaborative relationship (Greenberg et al., 2007). There are three therapeutic tasks that are used in EFT: (a) helping the client to process experience; (b) helping the client focus on and complete the processing of emotions; and (c) fostering the client's self-growth, sense of responsibility, and sense of empowerment (Greenberg et al., 2007).

The following transcript demonstrates how an EFT therapist helps a depressed client explore her experience of the end of a romantic relationship:

Client: I keep wondering if he will call,

Therapist: The image I have is of you sitting there waiting for the phone to ring and even though there is only silence and emptiness it is just so hard to get up and walk away (evocative empathy) … somehow hoping he will call. (Exploratory)

Client: I keep hoping he will come back (weeping softly)

Therapist: So somehow hoping keeps the door open? (Exploratory)

Client: Yes I guess I have been reluctant to move on … It makes me feel so sad but I am beginning to realize there is no point in hanging around. (Greenberg et al., 2007, p. 28).

EFT has been shown to be an effective treatment for couples (Johnson, Hunsley, Greenberg, & Schindler, 1999), for individuals with depression (Greenberg & Watson, 2006), and for emotional trauma (Goldman, Greenberg, & Angus, 2006).

effectiveness of client-centered, Gestalt, EFT and other humanistic-existential therapies. This is somewhat ironic in light of Carl Rogers' pioneering role in psychotherapy research. Although some believe that this state of affairs is changing (Elliott, Greenberg, et al., 2004), the smaller number of well-controlled outcome studies makes an evaluation of the efficacy and effectiveness of these therapies difficult. Based on this limited database, it does appear that these therapies are modestly efficacious—but in general, no more so than any other form of treatment. More research is clearly needed, especially studies investigating the clinical conditions for which these approaches are most appropriate.

The general phenomenological and humanistic-existential therapies presented in this chapter, like all therapeutic approaches, offer a mixed bag of contributions and problems. The reader will recall that several of the following points were made earlier with regard specifically to Rogerian approaches.

Strengths

Let us begin with an enumeration of some of the chief contributions of the phenomenological and humanistic-existential perspectives.

Experience. By stressing the importance of inner experience and awareness, these therapies have helped reaffirm the view that clinicians must rely on something more than the sheer quantification or enumeration of stimulus/environment conditions. Human experiences run the gamut from knowing to joy to agony, and clinical psychologists can ill afford to ignore them in either their theories or

their therapies. The phenomenological-humanistic-existential axis has brought them in touch once more with the essential data of experience and awareness.

Choices. The phenomenological and humanistic-existential therapies also are reminders that humans are more than just concatenations of instincts, urges, and habits. We are not simply automatons that respond to stimuli. We make choices, we decide, we change, we examine ourselves, and yes, we even invent such words as *existential* and *humanistic.* Human beings are not only the objects of study; they are also the initiators of study. For perhaps too many years, psychology has tried to deny its essential human qualities by slavishly following the paths of the biologists and the physicists. Although the controversy over free will versus determinism is unlikely to be resolved soon, there does seem to be a growing recognition that a simple deterministic view of the individual can be sterile and unproductive.

The Present. By emphasizing the present, phenomenologists have helped the field to cast aside the view that positive change can only be achieved by insight into the past or by some enlightened awareness of the true nature of the unconscious. By exercising choice and responsibility, we can all mold the present and thereby escape the constrictions of the past.

The Relationship. Many of the therapies described in this chapter have attached great value to the therapeutic relationship. These therapies often represent a triumph of relationship over technique. Conventional therapies had long recommended a detached therapist who exercised benign interest and cool skill. Whether the newly prescribed role is one of passive yet unconditional positive regard, acceptance, or jumping in feet first to "have an encounter" with the patient, things have certainly changed. The nature of the therapeutic relationship is obviously of crucial importance and may indeed be a major contributor to the success or failure of any brand of therapy. With this recognition, the therapeutic relationship is no longer considered a given or an unobtrusive backdrop. It has become a major part of the foreground, thanks in part to phenomenologists and to humanistic-existential therapists.

Growth. For many years, the emphasis in therapy has been on psychopathology, sickness, or behavioral deficits. However, the humanists and the existentialists have brought an emphasis on positive growth. They look not so much for sickness as for self-actualizing tendencies or growth potential. They seek not to contain pathology but to liberate awareness, feeling, being, peak experiences, and freedom. This is heady language that may sometimes exhilarate to the point of confusion. But it does point out an essential emphasis on the positive rather than a sometimes depressing and stultifying emphasis on the negative. Thus, the goal has become not only the healing of psychopathology but also personal growth. Many institutes, growth centers, encounter groups, and weekend retreats have sprung up to serve those who feel the need for experiences that will expand their awareness and heighten their authenticity as human beings.

Limitations

Now we can turn to the problem side of the coin as we evaluate the phenomenological and humanistic-existential approaches.

Prejudicial Language. The general humanistic movement, like the more specific client-centered approach, can sometimes be accused of using language prejudicially. The constant use of words such as *humanistic*, *acceptance*, *freedom*, *self-fulfillment*, *growth*, and *authentic* seems to suggest by implication that all other approaches preach inhumanity, rejection, authoritarianism, emptiness, and phoniness. Yet nearly all psychoanalysts, psychiatrists, behaviorists, cognitive therapists, and eclectic psychotherapists are accepting persons who care a great deal; who are interested, involved, and permissive; and who try to do the best job possible to help their patients experience richer and more fulfilling lives. In short, not all the attributes that are said to be at the core of the humanistic movement are its private domain.

Emphasis on Feelings and Emotions. The reliance on subjective experience and feelings binds the clinician to a source of data that can be unreliable, biased, or self-serving, and devoid of the most human of all qualities—reason. The real issue is whether feelings or transcendental awareness, unleavened by sober analysis, reason, and insight, can lead the individual into a durable adjustment that will increase both personal satisfactions and social contributions. It seems evident now that most individuals cannot work their way out of problems and private terrors solely by the application of cold analysis and reason. But it does not seem likely that trips into what can be a quagmire of subjectivity will enable them to do so either. Perhaps the lesson here is that any single method or route is likely to be incomplete and therefore less than successful. Human beings think, act, feel, experience, look to the past for guidance, and are pulled into the future by their aspirations. Any approach that focuses on behavior alone, or experience alone, or insight alone ignores much that is a central part of the human being. When such single-edged approaches work (at least for a while), it is probably because they confront individuals with an aspect of themselves that they had long ignored. For example, an inhibited, overintellectual, repressed patient may find great joy and happiness as she works herself through an "emotional now," guided by a sensitive therapist. However, any long-term abandonment of intellect and reason is likely to lead to other problems.

Phenomenal Field. Another problem is whether one person can ever completely know the nature of another person's subjective experience. Phenomenology instructs that a person's behavior is determined by his or her phenomenal field as it exists at any moment in time. This places the therapist in the position of having to know the patient's inner world of experience in order to understand or predict. Yet how do clinicians climb into that world? How do they escape from the past experiences that have shaped their own perceptions? How do clinicians gain an unbiased appreciation of the patient's phenomenal awareness? It almost seems that the phenomenological viewpoint demands something of clinicians that, given all humans' very imperfect and biased nature, it is impossible for them to achieve.

The problem is not with an empathic attempt to get close to the patient's experience or to "try to put oneself in the patient's shoes." It is always useful to search one's own experience to better relate to the patient's feelings or predicaments (while recognizing the ever-present danger of bias). The problem lies in the exclusive reliance on the clinician's exact knowledge of the patient's inner experience in order to operate as a clinician.

Assessment. In many of the humanistic-existential approaches, there is a total disregard for assessment and diagnosis. This disregard is reinforced by the belief that assessment interferes with or destroys the empathic relationship. Assessment is seen as impinging on the freedom and dignity of the individual. It is believed to thwart the self-actualizing potential of the client by imposing a conceptualization from the therapist.

Many will agree that diagnosis is not always necessary in its more full-blown manifestations. Indeed, the humanistic-existential movement has rendered a real service by pointing out some of clinical psychology's diagnostic excesses and by suggesting that too often diagnostic emphasis is on pathology rather than the growth potential or strengths of patients. It is all too true that diagnosis has often become a search for weaknesses rather than strengths and assets.

But if clinical psychologists were to totally reject assessment, where would this leave them? With the patient's verbal report perhaps—with all its potential for distortion and incompleteness. Faith in patients' abilities to solve their problems through getting in touch with their own feelings may work well with intelligent, introspective, sophisticated young persons who are not terribly disturbed. But what about the patient who is psychotic or the patient who is burdened with psychosomatic problems? And how does one deal with the nonverbal person who has only a minimal education and has never learned to look inward? Does the clinician ignore assessment in the case of the person

BOX 13-4 Graduate Student Perspective: Catalina Woldarsky Meneses, M. A.

Catalina Woldarsky Meneses is completing the final year of her doctorate degree in clinical psychology at York University in Toronto, Canada. As a scientist-practitioner, Catalina is most engaged conducting clinically relevant research that serves to shed light on the process of change in psychotherapy. The primary focus of her academic research has been on exploring the process of forgiveness within emotion-focused couples therapy and understanding the adaptive role of shame in this context. Catalina is also a certified yoga instructor, who hopes to eventually find a way of integrating yogic philosophy and practice with psychotherapy. Catalina shared the following insights regarding her graduate school experience.

What has graduate school in clinical psychology been like for you?
Graduate school has been a lengthy, transformative experience. The nature of the work we do as clinicians-in-training is an invitation to personal development and growth. Unlike other professional trainings, the work that is required of a clinical psychology student is very confronting since it's not simply learning about theories of personality and understanding when functioning is "abnormal," it's also hopefully about integrating this knowledge and learning about oneself in relation to others. I feel fortunate to have trained at a setting with a humanistic tradition alongside faculty members who encouraged me to reflect on my own experiences as a therapist, and in doing this, I reflected upon my own growth. I also developed deep friendships, with wonderful people in my program and department, including my supervisor.

What things have you least expected about graduate school?
I did not realize that this training would impact me so profoundly on an individual level. I cannot "unlearn" how to see the world through the eyes of a therapist or a psychotherapy researcher. For example, I feel like I developed another set of ears for emotional processes and I find myself acutely aware of people's gestures and vocal qualities.

Has graduate school changed you? If yes, how so?
There was a major shift in the anxiety I felt about fitting in within the competitive world of academia. I recall starting graduate school with a sense of pride about going forward and expanding my knowledge and experience. I think that at the time I felt that the worst answer to a question was "I don't know." And so I went through my early years feeling like I had to read everything and ultimately know everything if I was to understand something as complex as human behavior. Needless to say, I was drowning in my own stress and I struggled with feeling like an imposter (especially as a researcher). Then something beautiful happened: It took many years and lots of therapy but I eventually realized that I will never know everything and that's okay! It's paradoxical that in graduate school I learned how to let go of my perfectionist tendencies and accept myself for having my idiosyncratic way of being a student. I now take great pride in answering a question by saying, "I don't know."

Are your professional or research interests similar or different now than they were when you started graduate school?
I came to graduate school asking the question "How does change happen in therapy?" After seven years of exploring this question I still cannot answer it fully. Instead, I can break it down into more precise questions in order to test hypotheses. While I feel a sense of accomplishment in dissecting therapeutic interactions and articulating the subtleties of the process, I accept that I will never fully know how healing happens and what allows change to unfold. I enjoy conducting psychotherapy research because it keeps me stimulated and humbled.

I have also developed new research interests through my experiences in graduate school. I had one clinical supervisor whose first language was not English

who is having adjustment problems and may also suffer from mental retardation? No one condones diagnoses that are nothing more than mindless labeling. But the prohibition against all assessment seems to assure that therapists will remain more ignorant than they need be.

Technique-Centered. Perhaps many humanistic-existential clinicians disregard assessment in part because they treat every patient alike. Many of these clinicians seem to have an abiding faith that every troubled soul can be rescued by acceptance, positive regard, and the assertion of responsibility for self. If

and as a multilingual speaker myself, we had many conversations about the impact of language in psychotherapy. This resulted in a cross-cultural research study where I interviewed multilingual therapists about their experiences.

Looking back, what activities or experiences were the most important for you in your graduate school program?

I am very grateful that I have the opportunity to work with Les Greenberg, who has been both my research and clinical supervisor. I have been deeply impacted by the genuine curiosity with which he approaches the world, his zeal for scientifically analyzing psychotherapeutic processes, and his determination to have the scientific community recognize the importance of working with emotions. I have been involved in numerous research projects in our lab and have observed countless hours of therapy sessions even before I was personally doing clinical work. I learned to conduct micro-level analyses involving the measurement of fascinating processes like depth of *experiencing*, degree of emotional arousal, vocal quality, and emotional productivity. Conducting research in this field has had an immense impact on my clinical skills, as it has heightened my sensitivity to being attuned to areas that I otherwise would not have noted.

Moreover, I have received intensive clinical supervision from Les both as a practicum student in the program and in working as a therapist on the Couples Emotional Injury Project. The supervision I received from Les has been essential to my development as a clinician.

I also grew immensely from my experience as both a practicum student and research analyst in a Borderline Personality Disorder Clinic, under the supervision of Dr. Shelley McMain. Working with this population is challenging but at the same time very rewarding. The experiences at the BPD Clinic led me to appreciate how central emotional regulation is to a person's functioning and also how individuals change and grow in both dramatic and subtle ways.

Any additional hints for those trying to make it through graduate school in clinical psychology?

1. There is an end to it! Graduate school is like running a marathon: you can't see the finish line for a long, long time but I assure you that it is there and you will reach it before you know it.
2. I've come to see learning as a true privilege and while graduate school is a very rich experience on so many levels (the good, bad, and the ugly moments—including those required courses in statistics), my hope is that it does not become your life. Get your head out of the ivory tower from time to time, go for a walk, and get some fresh air by doing non-academic things that shake you up and help you get some "real" perspective.

Photo of Catalina Woldarsky Meneses, M. A.

Catalina Woldarsky Meneses

that is so, then diagnosis does indeed become superfluous. But if this is the case, then the charge of many humanistic existentialists that psychoanalysis or behavior therapies are technique-centered can be turned against them as well. To the extent that everyone who enters the therapy room is seen as having the same basic problem, with the "cure" always the same, such approaches are, in a sense, themselves technique-centered. Increasingly, however, clinicians seem to be recognizing the need to develop data that will allow them to select from among several treatment possibilities the one most suitable for a given

patient. Such recognition should enhance the role of diagnosis in the future.

Lack of Research. As we mentioned previously, relatively less empirical research is conducted on client-centered or phenomenological/existential psychotherapy compared to other major modes of treatment. This is likely to be problematic for several reasons. First, in this age of managed care and the sophisticated consumer, modes of treatment that are not supported empirically will likely be shunned or ignored. For example, it is hard to imagine that a managed behavioral health care company would be willing to reimburse a provider who cannot provide an empirically supported rationale for the choice of client-centered treatment or who refuses to set objective goals for treatment. Second, it is likely that training programs will emphasize these forms of treatment less to focus more on empirically supported treatments that are frequently evaluated in the empirical literature and that are preferred by managed care organizations. Finally, the relative dearth of research may give the impression that these treatments are primarily of historical interest and not relevant to contemporary clinical practice. As noted by Norcross, Karpiak, and Santoro (2005), the humanistic, existential, Gestalt, and Rogerian orientations are among the least frequently endorsed by contemporary clinical psychologists (all less than 2% of clinicians surveyed). Proponents of these orientations should take these trends seriously and consider how the deemphasis of empirical research may be affecting professional and public perception.

Obscure Language. A final problem for many who seek to understand what it is that the humanistic-existential movement offers has to do with the language used. Part of this difficulty lies in the lack of cohesiveness within the movement. There are so many thematic variations that the language readily becomes vague and ill-defined. But beyond this, there is often a wild, undisciplined quality to the writing that almost assures that variable meanings will be applied. The terminology is so vague that almost any interpretation is possible. It is almost as if the language has taken on a life of its own. In fact, it is possible to string together words in such a way that they sound exactly like a profound discourse in humanistic-existential psychology even though the writer does not have the foggiest notion of what they mean. It resembles the comedian who can imitate speaking in a foreign language without ever using real words—only some characteristic sounds and emphases are necessary.

From Maslow, Perls, Bugental, Boss, Binswanger, Rogers, and others, we find such phrases and terms as "internal silence," "from here-to-there rhythmic awareness exercises," "meta-needs," "peak experiences," "Dasein," "authenticity," "I-process," "being," "encounter," and "sick point." Granted that every theory seems to contain its share of neologisms and jargon, but the humanistic-existentialist movement seems to be especially well endowed with such terms. The language does serve to underline the movement's conscious divorce from any alliance with science. But in "humanizing" its language, the movement may also have erected barriers against the more widespread acceptance of the really important elements of its contributions.

CHAPTER SUMMARY

The best example of a phenomenological and humanistic-existential approach to psychotherapy is perhaps Carl Rogers' client-centered therapy. This mode of treatment developed from Rogers' reaction to traditional psychoanalytic perspectives on psychopathology and on psychological health. Instead of adopting such a deterministic and, to some degree, pessimistic perspective, Rogers' views emphasized the client's own phenomenological world and experience and the client's inherent tendency toward self-actualization. Client-centered therapists seek to facilitate the client's growth potential by providing empathic understanding, unconditional positive regard, and genuineness. Diagnosis, formal

assessment, and therapeutic "techniques" are generally eschewed. Humanistic-existential approaches are similar to client-centered therapy in that they emphasize the client's free will, inner potential, and ability to get in touch with her or his emotions. Finally, the emergence of process-experiential therapy, which integrates the client-centered and Gestalt therapy traditions, represents an important new development in this field. Emotion-Focused Therapy, in particular, has emerged as a viable evidence-based treatment for couples and for individuals with depression.

These forms of treatment have made several noteworthy contributions to the field of psychotherapy. Clients' internal experience, feelings, free will, and growth potential have been brought to the forefront. Demonstrating the importance of the therapeutic relationship and of rapport is another major contribution. However, these forms of therapy also present some problems. The sometimes prejudicial language used implies that other approaches are insensitive and harmful. Feelings seem to be overemphasized, and behavior underemphasized. Obscure and jargony language is often used, and there is a strong bias against empirical research and formal assessment. How these forms of treatment will be modified, or if they will even survive in their present form, remains to be seen. A number of trends (e.g., managed behavioral health care) pose threats to the popularity and utility of these forms of psychotherapy.

KEY TERMS

client-centered therapy A psychotherapy developed by Carl Rogers that emphasizes the importance of the client's perceptions of his or her experience and recognizes an inherent human tendency toward developing one's capacities. This therapy orientation seeks to facilitate the client's growth potential.

congruence One of the three therapist characteristics considered essential for client-centered work (also referred to as *genuineness*). Congruence refers to the honest expression by the therapist of the behaviors, feelings, and attitudes that have been stimulated by the client.

de-reflection A technique described by Frankl in which the client is instructed to ignore a troublesome behavior or symptom in order to divert his or her attention to more constructive thoughts or activities.

Emotion-Focused Therapy A psychotherapy that integrates the client-centered and Gestalt psychotherapy traditions. At the heart of EFT is the theoretical proposition that emotions are fundamentally adaptive and that emotions give our life experience its value, meaning, and direction.

empathy One of the three therapist characteristics considered essential for client-centered work. Empathy refers to sensitivity to the needs, feelings, and circumstances of clients so that they feel understood.

existential psychology An orientation to psychology that views people as engaged in a search for meaning.

Gestalt games "Games" developed by the Gestaltists to emphasize the "rules" of Gestalt therapy. Often, these games may involve making prescribed verbalizations or engaging in various role-plays.

growth potential A capacity for competence that all individuals possess. The goal of client-centered therapy is to release this capacity.

humanism An approach to psychology that views individuals as unified, whole, and unique beings who exercise free choice and strive to develop their inner potentials.

logotherapy (Literally, "the therapy of meaning.") A widely known form of existential therapy developed by Victor Frankl that encourages the client (a) to find meaning in what appears to be a

callous, uncaring, and meaningless world and (b) to develop a sense of responsibility for his or her life.

moral precepts In Gestalt therapy, rules for patients to live by (e.g., live now, express directly, reject all "shoulds" and "oughts" that are not your own, take complete responsibility for your actions).

paradoxical intention A technique described by Frankl in which the client is told to consciously attempt to perform the very behavior or response that is the object of anxiety or concern. The paradox is that the person will usually be unable to do what he or she fears doing when he or she tries to do it intentionally.

person-centered approach The client-centered approach when it is applied to problems or situations outside of the therapy room (e.g., volunteer training, the training of medical professionals).

phenomenal self The part of the phenomenal field that the person experiences as "me." According to phenomenological theory, humans have a basic urge to preserve and enhance the phenomenal self.

phenomenology A philosophical/theoretical approach that asserts that an individual's behavior is completely determined by his or her phenomenal field, or everything that is experienced by the person at any given point in time.

process-experiential therapy A relatively new treatment approach that integrates the client-centered and Gestalt therapy traditions.

self The awareness of one's being and functioning as separate and distinct from all else.

self-actualization The basic human tendency toward maintaining and enhancing the self.

unconditional positive regard One of the three therapist characteristics considered essential for client-centered work. Unconditional positive regard refers to complete acceptance of and respect for the client as a human being, without conditions or requirements.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

13-1 Center for the Studies of the Person
http://www.centerfortheperson.org/

13-2 Carl Rogers Biography
http://www.nrogers.com/carlrogersbio.html

13-3 Gestalt Therapy Page
http://www.gestalt.org/

13-4 Gestalt Organizations
http://www.sonoma.edu/users/d/daniels/gestaltorg.html

13-5 Experiential Psychotherapy Research
www.experiential-researchers.org

13-6 Emotion-Focused Therapy Web site
http://www.emotionfocusedtherapy.org/

14

Psychotherapy: Behavioral and Cognitive-Behavioral Perspectives

FOCUS QUESTIONS

1. What features best characterize a behavioral approach to clinical problems?
2. What are the major features of the following forms of behavior therapy: systematic desensitization, exposure therapy, behavioral rehearsal, contingency management, aversion therapy?
3. How have behavioral and cognitive perspectives been integrated into a cognitive-behavioral viewpoint?
4. What are the major features of the following forms of cognitive-behavioral therapy: modeling, rational restructuring, cognitive therapy?
5. What are the strengths and limitations of behavior therapy?

CHAPTER OUTLINE

Origins of the Behavioral Approach
- Definition
- A Brief History

Traditional Techniques of Behavior Therapy
- The Relationship
- Broad Spectrum of Treatment
- Systematic Desensitization
- BOX 14-1: *Psychologist Perspective: Judith S. Beck, Ph.D.*
- Exposure Therapy
- BOX 14-2: *Focus on Clinical Applications: Rationale for Exposure Therapy Presented to a Client with Panic Disorder*
- BOX 14-3: *Focus on Clinical Applications: Behavior Therapy for Obsessive-Compulsive Disorder: Exposure Plus Response Prevention*
- Behavior Rehearsal
- Contingency Management
- Aversion Therapy

Cognitive-Behavioral Therapy
- Background
- BOX 14-4: *Graduate Student Perspective: John Guerry, M. A.*
- Modeling
- Rational Restructuring

Stress Inoculation Training
BOX 14-5: *Focus on Clinical Applications: Common "Irrational" Ideas*
Beck's Cognitive Therapy
BOX 14-6: *Focus on Clinical Applications: Features of Cognitive Therapy for Depression*
Dialectical Behavior Therapy
An Evaluation of Behavior Therapy
Strengths
BOX 14-7: *Focus on Clinical Applications: Excerpts from Sessions of Dialectical Behavior Therapy (DBT)*
BOX 14-8: *Psychologist Perspective: Rhonda Oswalt Reitz, Ph.D.*
Limitations
The Future
CHAPTER SUMMARY
KEY TERMS
WEB SITES OF INTEREST

Behavioral and cognitive-behavioral therapies, often together referred to as *CBT*, have become a major force in clinical psychology. A constant flow of books provides wide-ranging discussions of the theory, technique, and application of an extensive variety of these methods. Lists of evidence-based treatments (see Chapter 11) include many treatments that fall under the broad rubric of CBT. CBT has truly come of age and is now a force with which to be reckoned.

ORIGINS OF THE BEHAVIORAL APPROACH

We begin our discussion of behavior therapy with the question of definitions and then move into a brief presentation of this treatment's historical roots. We then discuss CBT more specifically.

Definition

The diversity of behavioral approaches to therapy makes a satisfactory definition almost impossible. Some definitions are couched largely in the terminology of operant conditioning (Skinner, 1971). Others rely on concepts of classical conditioning (Wolpe, 1958). For still others, the emphasis is on general principles of learning (Ullman & Krasner, 1969) or may even have strikingly cognitive overtones (Meichenbaum, 1977). In light of this diversity, Goldfried and Davison (1994) were moved to comment:

> We believe that behavior therapy is more appropriately construed as reflecting a general orientation to clinical work that aligns itself philosophically with an experimental approach to the study of human behavior. The assumption basic to this particular orientation is that the problematic behaviors seen within the clinical setting can best be understood in light of those principles derived from a wide variety of psychological experimentation, and that these principles have implications for behavior change within the clinical setting. (pp. 3–4)

Traditionally, the behavioral approach allies itself with (a) a scientific emphasis and (b) a de-emphasis of the role of inferred variables. The behaviorists are likely to trace their origins to the "science" of Skinner or Pavlov rather than the "mentalism" of Freud. The focus is on stimuli and responses rather than variables that are presumed to mediate them. However, as we shall see later in this chapter, CBT over the years has broadened its scope to include techniques that address cognitive and other mediational processes (Goldfried & Davison, 1994). Nevertheless, it is instructive to review behavior therapy's historical roots.

A Brief History

We begin by presenting the groundbreaking work of Watson and Rayner (1920), who conducted the widely cited laboratory study of Albert and a

laboratory rat. This study was, in effect, a demonstration of how a "neurosis" can develop in a child. In the tradition of Pavlovian conditioning, Albert was given a laboratory rat to play with. But each time the rat was introduced, a loud noise was introduced simultaneously. After a few such trials, the rat (previously a neutral stimulus) elicited a fearful response in Albert that also generalized to similar furry objects.

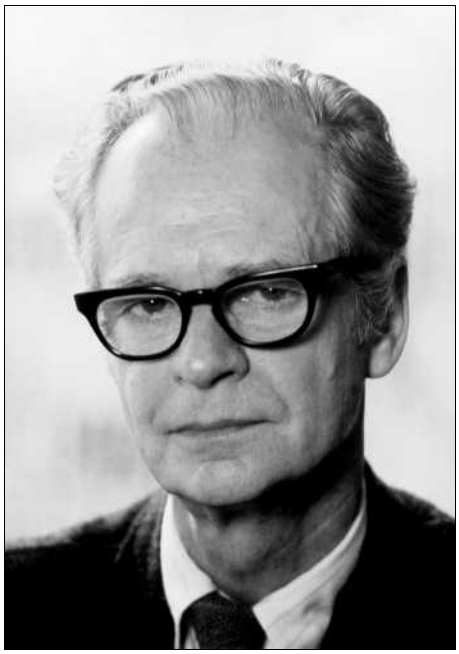
Mary Cover Jones (1924) demonstrated how such learned fears can be removed. A 3-year-old boy, Peter, was afraid of rabbits, rats, and other such objects. To eradicate the fear, Jones brought a caged rabbit closer and closer as the boy was eating. The feared object thus became associated with food, and after a few months, Peter's fear of the rabbit disappeared entirely. It is important, however, to recall Jones's admonition that the fear of the rabbit must not be so intense that the child will develop an aversion to food. Watson's conditioning of fears and Jones's "reconditioning" of them were direct antecedents of the development of Wolpe's (1958) therapy by reciprocal inhibition, which arrived on the scene some 30 years later.

As the foregoing experiences of Albert and Peter suggest, the major theoretical underpinnings of the behavior therapy movement were Pavlovian conditioning and Hullian learning theory. In the 1950s, Joseph Wolpe and Arnold Lazarus in South Africa and Hans Eysenck at Maudsley Hospital in London began to apply the results of animal research to the acquisition and elimination of anxiety in humans. Wolpe began to experiment with the reduction of fears in humans by having patients, while in a state of heightened relaxation, imagine the situations in which their fears occurred. Wolpe's technique of *systematic desensitization*, like Jones's reconditioning work, provided a practical demonstration of how principles of learning could be applied in the clinical setting. In his work on conditioned reflex therapy, Salter (1949) also attempted to develop a method of therapy that was derived from the Pavlovian tradition.

It is important to note that these investigators did not merely introduce new techniques. They also argued vigorously that their techniques were derived from the framework of a systematic experimental science. In addition, they took pains to point out that their demonstrations of the origins and treatment of neurotic fears proved that it was unnecessary to subscribe to the "mentalistic demonology" of Freudianism or to the "psychiatric pigeon-holing" practiced by Kraepelinians.

At about the same time that Wolpe, Lazarus, and Eysenck were developing their conditioning procedures, the operant tradition was beginning to have an impact. Skinner and his colleagues (Lindsley & Skinner, 1954; Skinner, 1953) were demonstrating that the behavior of hospitalized psychotic patients could be modified by operant procedures. By establishing controlled environments to ensure that certain responses of the patient would be followed by specific consequences, significant behavioral changes were produced.

At first, there was a radical quality to behavior therapy. The inner world of the patient was largely ignored in the rush to focus on behavior. Whether in reaction to the mentalism of psychoanalysis or out of an overly provincial view of what should be the subject matter of science, the early behavior therapists studiously avoided anything of a cognitive nature. However, in 1954, Julian Rotter published his book *Social Learning and Clinical Psychology*. In it, he demonstrated convincingly that a motivation-reinforcement approach to psychology could be coupled with a cognitive-expectancy approach. Thus, behavior was regarded as determined both by the value of reinforcements and by the expectancy that such reinforcements would occur following the behavior in question. What is more, Rotter's novel views were supported by a series of laboratory studies that left no doubt that one could be clinical, oriented toward both learning theory and cognitive theory, and scientifically respectable, all at the same time. Also significant in this context was the application of Albert Bandura's (1969) social learning contributions to the modification of behavior. It was theorists such as Rotter and Bandura who led the way to the current cognitive emphasis, giving CBT a more wide-ranging and



Omikron/Getty Images

B.F. Skinner pioneered the field of operant conditioning

serviceable character (Goldfried & Davison, 1994; Meichenbaum, 1977; Thorpe & Olson, 1997).

TRADITIONAL TECHNIQUES OF BEHAVIOR THERAPY

Before we discuss specific behavior therapy techniques, let us note both the importance of the therapeutic relationship and the tendency of modern behavior therapists to use multiple techniques with the same patient.

The Relationship

In their explanation of the success of their therapeutic methods, many behavior therapists seem to ignore the relationship as a contributing factor. Yet in Wolpe's (1958) accounts of systematic desensitization, we find that the therapist is exhorted to adopt an attitude of acceptance toward patients, to explain their difficulties to them, and to make clear the behavioral rationale for treatment. In fact, there are data that indicate clients perceive relationship factors to be very important to successful behavior therapy and CBT outcome, similar to clients' perceptions concerning other forms of psychotherapy (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975a). There are several reasons behavior therapy clients might view the therapeutic relationship as positive and at least partially responsible for changes made. Behavior therapists may be experienced as more open and accepting of the client's problems (rather than viewing problems as indicative of unconscious processes); treatment is collaborative and more "educational" in style; and interventions are clearly linked to the problematic behaviors that have been targeted for change by the client and therapist (Spiegler & Guevremont, 2010).

None of this is meant to suggest that behavior therapy can be reduced to "nothing more" than subtle relationship factors. What is suggested, however, is that one can never afford to ignore aspects of the relationship as contributors to successful therapeutic intervention. After all, it is through the therapy relationship that the patient's expectations of help can be nurtured so that behavioral therapy will be accepted as a viable alternative (Goldfried & Davison, 1994; Spiegler & Guevremont, 2010). Stated differently, behavior therapy is not going to be successful if the patient expects it to fail or is otherwise antagonistic toward it. Behavior therapists have sometimes been said to be cold and mechanistic in their approach to patients. This is probably more myth or stereotype than fact. Indeed, Sloane et al. (1975a) found that behavior therapists were generally warmer and more empathic than other psychotherapists!

Broad Spectrum of Treatment

Behavior therapists use a variety of specific techniques—not only for different patients but for the same patient at different points in the overall treatment process. Lazarus (1971a) refers to this as

broad spectrum behavior therapy. As specific techniques are described in the following pages, the reader should realize that each can serve a specific purpose but that, in reality, they are complementary. For example, a woman who has trouble coping with a domineering husband may undergo assertiveness training to learn specific behaviors. But when she uses these behaviors, other sets of fears about their relationship may begin to worry her. Therefore, she may also require therapeutic sessions that will help her restructure her beliefs about the marriage that are illogical and tend to perpetuate her submissive behavior. She might also participate in modeling or observational learning to help her cope.

In addition, it is important to recall from Chapter 9 that a comprehensive behavioral assessment is conducted before behavioral treatments or techniques are selected and implemented. For example, a functional analysis of the presenting problem helps to identify (a) the stimulus or antecedent conditions that bring on the problematic behavior; (b) the organismic variables (e.g., cognitive biases) that are related to the problematic behavior; (c) the exact description of the problem; and (d) the consequences of the problematic behavior. By completing such a detailed analysis, behavior and cognitive-behavioral therapists can prescribe appropriate treatments.

Systematic Desensitization

This technique is typically applied when a patient has the capacity to respond adequately to a particular situation (or class of situations), yet reacts with anxiety, fear, or avoidance. Basically, systematic desensitization is a technique to reduce anxiety. Developed by Salter (1949) and Wolpe (1958), it is based on *reciprocal inhibition*—the apparently simple principle that one cannot be relaxed and anxious simultaneously. The idea is to teach patients to relax and then, while they are in the relaxed state, to introduce a gradually increasing series of anxiety-producing stimuli. Eventually, the patient becomes desensitized to the feared stimuli by virtue of having experienced them in a relaxed state. Systematic desensitization has been shown efficacious for animal phobias, public speaking anxiety, and social anxiety (Chambless et al., 1998; Chambless & Ollendick, 2001; Spiegler & Guevremont, 2010).

Technique and Procedures. Systematic desensitization begins with the collection of a history of the patient's problem. This includes information both about specific precipitating conditions and about developmental factors. Collecting a history may require several interviews, and it often includes the administration of questionnaires. The principal reason for all of this is to pinpoint the locus of the patient's anxiety. It is also part of assessment to determine whether systematic desensitization is the proper treatment. In a patient with adequate coping potential who nevertheless reacts to certain situations with severe anxiety, desensitization is often appropriate. On the other hand, if a patient lacks certain skills and then becomes anxious in situations that require those skills, desensitization could be inappropriate and counterproductive. For example, if a man becomes seriously anxious in social situations that involve dancing, it would seem more efficient to see that he learns to dance rather than desensitize him to what is, in fact, a behavioral deficit.

Next, the problem is explained to the patient. This explanation is normally elaborated to include examples from the patient's life and to cover the manner in which the patient acquired and maintains the anxieties. Following this, the rationale for systematic desensitization is also explained. The explanations and the illustrations should be in language that the patient can understand—free from scientific jargon. In a sense, the clinician uses this phase to "sell" the patient on the efficacy of systematic desensitization. It should be added that the entire process of interviewing, assessment, and explanation is conducted with warmth, acceptance, and understanding.

The next two phases involve training in *relaxation* and the establishment of an *anxiety hierarchy*. While work is begun on the anxiety hierarchy, training in relaxation is also started.

BOX 14-1 Psychologist Perspective: Judith S. Beck, Ph.D.

Dr. Judith S. Beck is the director of the Beck Institute for Cognitive Therapy and Research and a clinical associate professor at the University of Pennsylvania School of Medicine. Dr. Beck is an expert in cognitive therapy, and she travels around the country and the world training practitioners in the theory and practice of this approach for psychological problems. In addition to her teaching and administrative roles, Dr. Beck conducts and publishes research in the areas of cognitive assessment and cognitive treatment. She has also authored or coauthored a number of publications for the general public concerning cognitive therapy and depression. Dr. Beck gave us some background information about herself as well as her impressions regarding the future of clinical psychology and cognitive therapy.

What originally got you interested in the field of psychology?

I had always been interested in working with children and decided early on I wanted to be a teacher. In fact, my degrees are in education and educational psychology. Initially, I taught students with learning disabilities, then supervised special education teachers. I then became interested in the work of Aaron T. Beck, M.D., who is my father and the "father" of cognitive therapy. Midway through my doctoral program, I decided I should learn more about his field of expertise. I was skeptical at first that I could ever be a good psychologist, because I did not realize that counseling skills could be learned; they did not have to be inborn or intuitive, the way my teaching skills had been. Taking psychology courses and doing practica demonstrated to me that many of the skills I had learned and refined as a teacher (and later as a supervisor) served me in good stead. Coming full circle, one of my favorite professional activities today is teaching students and professionals in mental health fields, and occasionally in education as well.

Describe what activities you are involved in as a psychologist.

As the director of a nonprofit psychotherapy center whose missions include clinical care, education, and research, my activities are quite varied. I spend a great deal of time in administration. I supervise our clinical staff, psychologists, and other mental health professionals in our extramural and visitor training programs. I do a significant amount of teaching of cognitive therapy, nationally and internationally, in courses, conferences, and workshops.

In addition, I treat a small caseload of patients with a variety of outpatient psychiatric disorders. I am involved in several research grants as a consultant or principal investigator. I publish articles and chapters and am currently working on a second book, which teaches clinicians how to conceptualize, plan treatment, and work with patients who have challenging disorders. I am on the board of several community and professional organizations. I am president-elect of the Academy of Cognitive Therapy, a nonprofit organization that certifies mental health professionals in cognitive therapy. As a clinical associate professor of psychology in psychiatry at the University of Pennsylvania, I develop and teach courses in cognitive therapy, supervise third- and fourth-year psychiatric residents, and teach graduate-level psychology students and psychiatric nurses.

What are your particular areas of expertise or interest?

My major expertise is cognitive therapy. One area I have concentrated on is the cognitive conceptualization of patients, especially those with personality disorders. I have developed a structured format to help clinicians make data-based hypotheses about how patients, as a result of adverse childhood experiences (and genetic predisposition), develop rigid, global, negative beliefs about themselves, other people, and their worlds, and how these beliefs have affected their information processing, perceptions, emotional reactions, and behavior throughout their lives.

Connected with this interest is teaching clinicians to use cognitive conceptualization as a guide in forming and maintaining a sound therapeutic alliance, in developing treatment plans, and in varying the structure, interventions, and expectations for patients with complex problems and disorders who do not respond to standard cognitive therapy.

I also continue to develop more effective strategies to teach and supervise students and professionals.

Relaxation. Behavior therapists frequently use the progressive relaxation methods of Jacobson (1938). The patient is first taught to tense and relax particular muscle groups and then to distinguish between sensations of relaxation and tensing. The instructions for relaxation can easily be taped and played at home for practice. Generally, about six sessions are devoted to relaxation

For example, I structure teaching and supervision sessions in the same way that I structure therapy. Also, I have developed instruments for patients to evaluate therapists and for supervisors to evaluate therapists (and for therapists to evaluate supervisors).

I have coauthored a scale measuring personality-related beliefs and am involved in developing self-administered scales for children that assess symptoms of depression, anxiety, anger, disordered conduct, and low self-esteem.

What are the future trends you see for clinical psychology?

One trend will be in devising and refining instruments to diagnose patients and assess their symptoms more accurately. Future scales will likely include more cognitive items in addition to the traditional emotional, behavioral, and biological symptoms. More scales will be developed to identify and measure relevant beliefs that underlie specific problems and diagnoses. Clinical psychologists will increasingly focus on measuring outcomes to assess efficacy of treatment.

I believe that master's-level clinicians, social workers, and primary care physicians will provide treatment for straightforward cases of depression and anxiety. Clinical psychologists, who are more highly trained and have specific expertise, will be asked primarily to care for patients with more complex problems, and they will increasingly utilize empirically based treatments. Behavioral health care organizations will ultimately ration care that psychologists provide on a more rational basis that recognizes the severity and comorbidity of various diagnoses.

What are some future trends you see in cognitive therapy?

One trend is the application of cognitive therapy to a wider variety of psychiatric disorders. Recent outcome studies, for example, have demonstrated the efficacy of cognitive therapy for substance abuse, eating disorders, personality disorders, and as an adjunctive treatment for bipolar disorder and schizophrenia, to name a few. Cognitive therapy will also continue to be refined for the treatment of a variety of medical illnesses: post-heart attack patients who are depressed, diabetics who do not follow their treatment regimen, patients with stress-induced or stress-exacerbated conditions.

Clinicians will also continue to expand the delivery of cognitive therapy to patients (and their families) in a variety of settings: in inpatient and partial hospitalization programs, outpatient clinics, in the offices of primary care providers and specialists, rehab centers, nursing homes, and schools. Cognitive therapists who are clinical psychologists will do more widespread teaching of psychiatrists, psychiatric nurses, social workers, counselors, primary care physicians, and other adjunctive therapists whose efficacy can be enhanced by incorporating cognitive techniques into their practice.

Finally, cognitive therapy teachers and supervisors will refine methods to take advantage of evolving technology for distance learning programs, dissemination of information, forums for discussion via the Internet, and interactive multimedia computer programs.

Dr. Judith Beck, director of the Beck Institute for Cognitive Therapy & Research and clinical associate professor at University of PA. Medical School

Judith S. Beck

training. In some instances, hypnosis may be used to induce relaxation. More commonly, the patient may be asked to imagine relaxing scenes and/or breathing exercises are used to enhance relaxation.

The Anxiety Hierarchy. In discussions about specific problems, the situations in which they occur, and their development, the patient and the therapist work together to construct a hierarchy.

Courtesy of Joseph Wolpe

FIGURE 14-1 Joseph Wolpe has been primarily identified with the development of systematic desensitization as a method of reducing anxiety.

The recurrent themes in the patient's difficulties and anxieties are isolated and then ordered in terms of their power to induce anxiety (from situations that provoke very low levels of anxiety through situations that precipitate extreme anxiety reactions). A typical anxiety hierarchy consists of 20 to 25 items in approximately equal intervals from low through moderate to extreme. The following anxiety hierarchy was that of a 24-year-old female student who experienced severe examination anxiety (Wolpe, 1973):

1. Four days before an examination.
2. Three days before an examination.
3. Two days before an examination.
4. One day before an examination.
5. The night before an examination.
6. The examination paper lies face down before her.
7. Awaiting the distribution of examination papers.
8. Before the unopened doors of the examination room.
9. In the process of answering an examination paper.
10. On the way to the university on the day of the examination. (p. 116)

This hierarchy illustrates two points. First, it is organized largely along spatial-temporal lines. Second, the items are not exactly organized in a logical fashion. One might expect item 10 (the most anxiety-provoking item) to be placed near the middle of the hierarchy. This suggests how idiosyncratic hierarchies can be—after all, it is the patient's anxiety, not the clinician's!

In the desensitization procedure, the patient is asked to imagine the weakest item in the hierarchy (the item that provokes the least anxiety) while being completely relaxed. The therapist describes the scene, and the patient imagines (for about 10 seconds) being in the scene. The therapist moves the patient up the hierarchy gradually (between two and five items per session). However, if at any time the level of anxiety begins to increase, the patient is instructed to signal, whereupon the therapist requests that the patient stop visualizing that scene. The therapist then helps the patient to relax once more. After a few minutes, the procedure can be started again. Ideally, over a period of several sessions, the patient will be able to imagine the highest item in the hierarchy without discomfort. A typical example of the instructions given to a male patient during desensitization is provided by Goldfried and Davison (1994):

> (*The client has been relaxing on his own in the reclining chair.*) OK, now just keep relaxing like that, nice and calm and comfortable. You may find it helpful to imagine a scene that is personally calm and relaxing, something we'll refer to as your pleasant scene.... Fine. Now, you recall that 0 to 100 scale we've been using in your relaxation practice, where 0 indicates complete

relaxation and 100 maximum tension. Tell me approximately where you'd place yourself on that scale…. (*Therapist is advised to look for a rating that reflects considerable calm and relaxation, often in the range of 15 to 25.*)

Fine. Soon I shall ask you to imagine a scene. After you hear the description of the situation, please imagine it as vividly as you can, through your own eyes, as if you were actually there. Try to include all the details in the scene. While you're visualizing the situation, you may continue feeling as relaxed as you are now. If so, that's good. After 5, 10, or 15 seconds, I'll ask you to stop imagining the scene and return to your pleasant image and to just relax. But if you begin to feel even the slightest increase in anxiety or tension, please signal this to me by raising your left forefinger. When you do this, I'll step in and ask you to stop imagining the situation and then will help you get relaxed once more. It's important that you indicate tension to me in this way, as we want to maximize your being exposed to fearful situations without feeling anxious. OK? Do you have any questions? … Fine, we'll have ample opportunity afterwards to discuss things in full. (pp. 124–125)[1]

Rationale. Many explanations have been offered for why systematic desensitization works (Spiegler & Guevremont, 2010). Although Wolpe's explanation for the success of systematic desensitization is based on the principle of *counterconditioning* (the substitution of relaxation for anxiety), others are not so sure (Davison & Wilson, 1973). Some have argued that the operative process is really *extinction*. That is, when the patient repeatedly visualizes anxiety-generating situations but without ensuing bad experiences, the anxiety responses are eventually extinguished (Wilson & Davison, 1971). Alternatively, Mathews (1971) argues on behalf of a *habituation* hypothesis. Finally, some suggest that cognitive factors may be responsible for the beneficial effects of systematic desensitization (e.g., creating expectations that one will be less anxious in a given situation).

The standard method of desensitization is to present scenes in a graduated ascending fashion to avoid premature arousal of anxiety that would disrupt the procedure. Systematic desensitization involves a number of components. The instructions to the procedure suggest that a positive outcome is likely. Consequently, the patient's expectations for improvement may affect the process. Another crucial element may be positive reinforcement from the therapist following the patient's reports of reduced anxiety, improvement outside the consulting room, or the successful completion of anxiety hierarchies. For example, Leitenberg, Agras, Barlow, and Oliveau (1969) observed that, with snake phobias, the effects of systematic desensitization are best when the therapist uses reinforcing comments, such as "Good," "Excellent," and "You're doing fine," when participants (a) visualize a scene without reporting anxiety, (b) complete a hierarchy item, and (c) report progress in approaching a snake during practice. Goldfried (1971) argues that systematic desensitization is far from a passive process that is applied to patients to reduce their fears. Rather, it represents the acquisition of a skill that the patients can use to reduce their own fear. In that sense, Goldfried regards systematic desensitization as training in self-control.

All of the foregoing suggests that systematic desensitization is hardly the simple mechanical or conditioning process that it was once thought to be. A number of relationship variables seem implicated as well as beliefs or expectations on the part of the patient. In general, systematic desensitization has proven to be a moderately useful form of psychological intervention for a variety of

1. From *Clinical Behavior Therapy* (Expanded Edition) by M. P. Goldfried & G. C. Davison. Copyright © (1994) John Wiley and Son, Inc. Reprinted by permission.

clinical conditions. As might be expected, research suggests that it is most effective when used to treat anxiety disorders, particularly specific phobias, social anxiety, public speaking anxiety, and generalized anxiety disorder (Chambless et al., 1998; Chambless & Ollendick, 2001; Emmelkamp, 1994, 2004).

Exposure Therapy

The term *exposure therapy* describes a behavior therapy technique that is a refinement of a set of procedures originally known as flooding or implosion. The roots of exposure therapy can be traced to Masserman (1943), who studied anxiety reactions and avoidance behaviors in cats. Masserman's studies involved inducing "neurotic behaviors" in cats by administering shock under certain environmental conditions. He subsequently discovered that the avoidance behavior could be extinguished if the cats were forced to remain in the situation in which they had previously been shocked (i.e., no escape or avoidance was possible). These findings were the basis for developing anxiety treatments for humans. There is empirical support for the efficacy of exposure treatments for specific phobias, panic disorder, agoraphobia, social phobia, posttraumatic stress disorder, and obsessive-compulsive disorder (Chambless et al., 1998; Chambless & Ollendick, 2001; Emmelkamp, 1994, 2004; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa, & Marin-Martinez, 2008; Sanchez-Meca, Rosa-Alcazar, Marin-Martinez, & Gomez-Conesa, 2010; Wolitzky-Taylor, Hororwitz, Powers, & Telch, 2008).

In exposure therapy, patients expose themselves to stimuli or situations that were previously feared and avoided. The "exposure" can be in real life (in vivo) or in fantasy (in imagino). In the latter version, patients are asked to imagine themselves in the presence of the feared stimulus (e.g., a spider) or in the anxiety-provoking situation (e.g., speaking in front of an audience). Several researchers suggest that certain features must be present in exposure treatments for the patient to achieve maximum benefit (Barlow & Cerny, 1988):

1. Exposure should be of long rather than short duration.
2. Exposure should be repeated until all fear/anxiety is eliminated.
3. Exposure should be graduated, starting with low-anxiety stimuli/situations and progressing to high-anxiety stimuli/situations.
4. Patients must attend to the feared stimulus and interact with it as much as possible.
5. Exposure must provoke anxiety.

Like other behavioral therapies we describe in this chapter, exposure treatment can be used as a self-contained treatment or as one component of a multimodal treatment. For example, Barlow and Cerny (1988) describe a psychological treatment for panic disorder that includes relaxation, cognitive restructuring, and exposure components. What is especially ingenious about their version of exposure treatment is that they have patients expose themselves to *interoceptive cues*—internal physiological stimuli such as rapid breathing and dizziness. This modification was necessary because individuals suffering from panic disorder typically report that their panic attacks are unpredictable and "come out of the blue." In such cases, no external anxiety-provoking stimulus or situation is apparent. In contrast, individuals with other non-panic anxiety disorders report acute anxiety primarily in the face of certain external stimuli or situations.

How do clinicians convince patients that completing tasks that increase levels of anxiety will ultimately be helpful? To illustrate the rationale that is presented for exposure treatment, Box 14-2 provides the introduction that is used in Barlow and Cerny's (1988) psychological treatment for panic disorder.

Craske, Rowe, Lewin, and Noriega-Dimitri (1997) compared the effectiveness of two forms of treatment for panic disorder with agoraphobia—one that included interoceptive exposure and one that

BOX 14-2 Focus on Clinical Applications: Rationale for Exposure Therapy Presented to a Client with Panic Disorder

For many behavioral techniques, it is important that the clinician provide a rationale to the client. This is especially true for exposure-based therapies in which the client is asked to engage in behaviors that will, initially, increase levels of anxiety or fear. Barlow and Cerny's (1988) rationale for exposure treatment appears below.

As you may recall from our earlier meetings, we feel that panic attacks are essentially "false alarms" issued by the body in response to a cue or signal that you have learned to associate with danger or threat. The problem, of course, is that these panic alarms are, in fact, false. Nevertheless, the fear associated with the panic attacks is quite real. Just as false alarms are learned phenomena, the treatment for them also involves planned relearning experiences. The term we use to describe these corrective learning experiences is *exposure therapy*.

The basic logic of exposure therapy is quite simple. Exposing yourself to those situations and cues that have been associated with anxiety and panic attacks provides you with the opportunity to learn at least three things: (1) You will learn that anxiety and panic symptoms can be controlled using the relaxation and cognitive coping techniques that you have been learning. In fact, you will learn that you are able not only to reduce those troublesome symptoms, but also actually to bring them on at will. (2) You will learn that there is no basis for the fear associated with your panic attacks. (3) And, finally, you will learn to break the association between the cues that signal your fears and panic attacks and teach yourself new ways of responding during graduated exposure to those panic-associated cues.

At the present time, we do not fully understand the exact mechanisms that explain how this new learning takes place, but we do know that exposure therapy is highly effective in treating anxiety disorders. Let me emphasize that it is the new learning that takes place during exposure trials that is the critical element in therapy. The exposure to panic-associated cues merely provides the opportunity for that learning to occur. Therefore, passive exposure to these same cues—that is, unplanned exposures during which no corrective learning takes place—is not sufficient to bring about therapeutic changes in your behavior. During the exposure trials we encourage you to deal directly with your anxiety and fear and to take an active part in the new learning process.

Because you will be exposing yourself to these anxiety-provoking cues, you should anticipate that initially you may become more anxious and perhaps notice an increase in panic attacks. However, as you know, in most cases, anxiety and panic attacks are self-limiting—that is, in most situations the anxiety and/or panic symptoms will subside. The anxiety and fear itself, of course, may be quite unpleasant.

In order to minimize the amount of unpleasantness you will have to experience, we will develop together a graduated hierarchy of anxiety-provoking cues and work through that hierarchy from the least to the most anxiety-provoking situations. Nevertheless, it will be necessary for you to tolerate some anxiety, at least initially. As you learn to deal more effectively with anxiety and panic symptoms and to eliminate "false alarms," you should notice substantial reductions in the number and perhaps the intensity of your panic attacks.

There are three ways that you can expose yourself to panic-provoking cues. First, you can imagine yourself experiencing the panic-provoking situation or cues. Imaginal exposure provides not only an exposure trial under controlled and low-arousal conditions, but it also allows you rather easily to plan and practice your management skills in imagination so that you will be prepared to take advantage of in vivo exposures. Second, you can expose yourself to certain panic-provoking cues here in the office. We will explore ways to induce those bodily sensations that have come to signal the possibility of a false alarm. And, finally, you will be exposing yourself to actual situations in your daily life. Today, we will begin with imagery training and hierarchy development.

SOURCE: From Barlow, D. H., & Cerny, J. A., *Psychological Treatment of Panic* (p. 155–156). Copyright © 1988 Guilford Publications, Inc. Reprinted with permisison.

incorporated breathing retraining instead of interoceptive exposure. Although both forms of treatment were effective, results indicated that panic disorder patients who received the interoceptive exposure component reported less impairment and fewer panic attacks at posttreatment and at follow-up. Thus, the addition of the interoceptive exposure component had some beneficial effects.

BOX 14-3 Focus on Clinical Applications
Behavior Therapy for Obsessive-Compulsive Disorder: Exposure Plus Response Prevention

Obsessive-compulsive disorder (OCD) is an Axis I disorder characterized by recurrent intrusive thoughts, impulses, or images (obsessions) that generate great anxiety and distress. Repetitive behavior or ritualistic mental acts aimed at counteracting obsessions or otherwise preventing or reducing anxiety often are present as well (American Psychiatric Association, 2000). Once thought to be largely intractable, research results over the past few decades indicate that a particular form of behavior therapy, exposure plus response prevention, can be particularly effective in treating OCD symptoms (Emmelkamp, 2004).

As noted by Foa (1996), this treatment is based on the assumption that obsessions produce marked anxiety and distress, while compulsions serve to reduce this anxiety. Further, even though compulsions temporarily reduce anxiety, obsessional anxiety is maintained because no habituation develops. Compulsive behavior continues because it is reinforced by the reduction in anxiety. Exposure plus response prevention aims to disrupt this pattern by (a) exposing the patient to situations that lead to obsessional distress and (b) preventing the patient from engaging in compulsive behaviors that are typically emitted in the face of this distress. Ideally, in this way, (a) habituation to the obsessional thoughts, images, or impulses will develop (and thus, the level of anxiety produced by these will be reduced) and (b) compulsive behaviors will no longer be reinforced because they will be prevented.

Foa (1996) provides an overview of a typical exposure plus response prevention treatment for OCD:

1. Fifteen 2-hour exposure sessions are conducted over the course of three weeks.
2. During these sessions, patients are "exposed" to the situations or objects that seem to trigger the obsessions. For example, a patient who obsesses about dirt and germs might be asked to rub newspaper print all over his arms and face.
3. In addition, patients are asked to imagine that the tragic consequences they anticipate occurring if they do not engage in compulsive behavior did occur. In this way, patients can begin thinking about these "catastrophes" without being markedly fearful.
4. Homework is assigned and involves repeating these exposure experiences.
5. At the same time that exposure is introduced, the therapist ensures that ritualistic compulsions that typically occur in the face of the obsessional fear do not occur. For example, the patient who obsesses about dirt and germs and engages in excessive hand washing or showering would not be allowed to engage in these behaviors. At a later point in time, "normal" hand washing and showering will be introduced.
6. Finally, a maintenance phase of treatment involves about ten office visits or phone calls aimed at encouraging the patient and reinforcing the therapeutic gains.

To provide another example of an exposure-based empirically supported treatment, Box 14-3 presents an overview of the treatment *exposure plus response prevention* for obsessive-compulsive disorder. Exposure plus response prevention is the most successful psychological treatment for obsessive-compulsive disorder (Emmelkamp, 2004; Rosa-Alcazar et al., 2008).

Behavior Rehearsal

Included under this broad heading are a variety of techniques whose aim is to enlarge the patient's repertoire of coping behaviors. Clearly, *behavior rehearsal* is not a new concept; it has been around in one form or another for many years. For example, Moreno (1947) developed psychodrama, a form of role-playing, to help solve patients' problems, and Kelly (1955) used fixed-role therapy. However, it is important to note that such forms of role-playing or behavior rehearsal have purposes that depart from behavioral goals. For Moreno, role-playing provided a therapeutic release of emotions that was also diagnostic in identifying the causes of the patient's problems. For Kelly, role-playing was a method of altering the patient's cognitive structure. Again, we are reminded that specific therapeutic techniques are not the exclusive province of one theoretical frame

of reference. Different theorists may use similar techniques for vastly different reasons.

The Technique. According to Goldfried and Davison (1994), the use of behavior rehearsal involves four stages. The first stage is to prepare the patient by explaining the necessity for acquiring new behaviors, getting the patient to accept behavior rehearsal as a useful device, and reducing any initial anxiety over the prospect of role-playing. The second stage involves the selection of target situations. At this point, many therapists will draw up a hierarchy of role-playing or rehearsal situations. This hierarchy should relate directly to situations in which the patient has been having difficulty. A sample hierarchy of target situations (ranked in order of the increasingly complex behavioral skills required) might be as follows:

1. You ask a secretary for information about a class.
2. You ask a student in class about last week's assignment.
3. After class, you approach the instructor with a question about the lecture.
4. You go to the instructor's office and engage her in conversation about a certain point.
5. You purposely engage another student, who you know disagrees with you, in a minor debate about some issue.

The third stage is the actual behavior rehearsal. Moving up the hierarchy, the patient plays the appropriate roles, with the therapist providing both coaching and feedback regarding the adequacy of the patient's performance. Sometimes videotaped replays are used as an aid. In other instances, the therapist (or a therapeutic aide) exchanges roles with the patient to provide an appropriate model. When patients develop proficiency in one target situation, they move up the hierarchy.

The final stage is the patient's actual utilization of newly acquired skills in real-life situations. After such in vivo experiences, the patient and the therapist discuss the patient's performance and feelings about the experiences. Sometimes patients are asked to keep written records describing the situations they were in, their behavior, and its consequences.

Assertiveness Training. One application of behavioral rehearsal is *assertiveness training*. Wolpe regarded assertive responses as an example of how reciprocal inhibition works. That is, it is impossible to behave assertively and to be passive simultaneously. Situations that once evoked anxiety will no longer do so because the assertive behavior inhibits the anxiety.

Originally, assertiveness training was designed as a treatment for persons whose anxiety seemed to stem from their timid mode of coping with situations (Wolpe, 1958; Wolpe & Lazarus, 1966). A variety of assertiveness training programs have been developed specifically for individuals seeking to overcome destructive passivity. But assertiveness training has also been used in treating sexual problems, depression, and marital conflicts. It is important to note that cognitive self-statements (e.g., "I was thinking that I am perfectly free to say no") may enhance the effects of assertiveness training. In fact, many procedures can be used to increase assertiveness. Behavior rehearsal is perhaps the most obvious one.

Lack of assertiveness may stem from a variety of sources. In some cases, the cause may be a simple lack of information, in which case the treatment might center largely on providing information. In other instances, a kind of anticipatory anxiety may prevent persons from behaving assertively. In such cases, the treatment may involve desensitization. Yet other individuals may have unrealistic (negative) expectations about what will ensue if they become assertive. Some clinicians would deal with such expectations through interpretation or rational-emotive techniques. Similar techniques might be applied to patients who feel that assertiveness is wrong. Finally, there are patients whose lack of assertiveness involves a behavioral deficit—they do not know how to behave assertively. For such patients, behavior rehearsal, modeling, and related procedures would be used.

Assertiveness training is not the same as trying to teach people to be aggressive. It is really a method of training people to express how they feel without trampling on the rights of others in the process

(Wolpe & Lazarus, 1966). Take the spectator at a basketball game who cannot see because the person in front constantly jumps up. To react by saying "If you don't sit down, I'm going to knock you down" is aggressive. But saying "Please, I wish you would sit down; I just can't see anything" is an assertive response. Indeed, assertiveness training has been useful in teaching overly aggressive persons gentler and more effective ways of meeting their needs.

Contingency Management

A variety of Skinnerian or operant techniques are all referred to as *contingency management* procedures. They share the common goal of controlling behavior by manipulating its consequences. Because many children are brought by their parents to receive psychological treatment, particularly for "acting-out" or rule-breaking behavior, contingency management techniques are used very commonly with child and adolescent patients.

Techniques. Contingency management can take many forms, of which the following are just a few examples.

1. *Shaping*: A desired behavior is developed by first rewarding any behavior that approximates it. Gradually, through selective reinforcement of behavior more and more closely resembling the desired behavior, the final behavior is shaped. This technique is sometimes called *successive approximation*.
2. *Time-out*: Undesirable behavior is extinguished by removing the person temporarily from a situation in which that behavior is reinforced. A child who disrupts the class is removed so that the disruptive behavior cannot be reinforced by the attention of others.
3. *Contingency contracting*: A formal agreement or contract is struck between therapist and patient, specifying the consequences of certain behaviors on the part of both.
4. *"Grandma's rule"*: The basic idea is akin to Grandma's exhortation, "First you work, then you play!" It means that a desired activity is reinforced by allowing the individual the privilege of engaging in a more attractive behavior. For example, the child is allowed to play ball after homework is completed. This method is sometimes referred to as the *Premack principle* (Premack, 1959).

Token Economies. The operant approach is most commonly used by parents who wish to teach their children to engage in appropriate behavior. However, these techniques also can be used among adults and youth who are in residential care (e.g., individuals with mental retardation or chronic mental illness) (Kazdin, 1977; Liberman, 1972; Spiegler & Guevremont, 2010). Such programs can make an institution a more livable place that ultimately is more conducive to therapeutic gains.

In establishing a token economy, there are three major considerations (Krasner, 1971). First, there must be a clear and careful specification of the desirable behaviors that will be reinforced. Second, a clearly defined reinforcer (or medium of exchange—e.g., colored poker chips, cards, or coins) must be decided upon. Third, backup reinforcers are established. These may be special privileges or other things desired by the patient. Thus, two tokens, each worth 10 points, might be exchanged for permission to watch TV an extra hour, or one token worth 5 points might be exchanged for a piece of candy. It goes without saying that a token economy also requires a fairly elaborate system of recordkeeping and a supervising adult that is very observant and committed to the importance of the program.

Token economies are used to promote desired behavior through the control of reinforcements. Whether the desired behavior is increased neatness, greater social participation, or improved job performance, the probability of its occurrence can be enhanced by the award of tokens of varying value. But why use tokens at all? Why not reinforce proper bed-making directly? The reason is essentially that the effect of reinforcement is greater if the reinforcement occurs immediately after the behavior occurs. If the reward of attending a movie occurs 10 hours after a patient sweeps out

his or her room, it is not likely to be nearly so effective as a token given immediately. That token will come to signify reward and will assume much of the effectiveness of the backup reward for which it may be exchanged. Of course, for youth it is important to have rewards that are developmentally meaningful and these rewards cannot be offered so far in the future that it is difficult for a young child to understand the relationship between their behavior and what that behavior has earned.

Aversion Therapy

One of the most controversial of all treatments is *aversion therapy*. Actually, this is not a single therapy but a series of different procedures applied to behaviors regarded as undesirable. These applications are based on the apparently simple principle that when a response is followed by an unpleasant consequence (e.g., punishment or pain), its strength will diminish. As Wolpe (1973) put it, "Aversion therapy consists, operationally, of administering an aversive stimulus to inhibit an unwanted emotional response, thereby diminishing its habit strength" (p. 216). An unpleasant stimulus is placed in temporal contiguity with the undesirable behavior. The idea is that a permanent association between the undesirable behavior and the unpleasant stimulus will be forged, and conditioning will take place.

Such techniques may appear to be recent additions to scientific and clinical repertoires. However, a little reflection will remind us that they have been around for eons, often in the form of such unsophisticated practices as spanking, "Go to your room," and "No TV tonight for you." Modern aversive therapy techniques differ from these examples in at least two important ways. First, the presentation of the aversive agent is done systematically. The temporal contiguity is very carefully monitored. Second, the punishment is consistently applied. The punishment applied by parents is often highly inconsistent. Sometimes the undesirable behavior of the child is immediately punished. But very often, the parent forgets or is distracted, too tired, or whatever to respond. As a result, the child learns that sometimes the behavior is ignored, and thus extinction fails to occur. As formal clinical procedures, these techniques have been applied most often to help patients develop increased self-control. They have been used to cope with problems of obesity, smoking, alcoholism, and sexual deviations.

Aversive Agents. Among the aversive agents that have been used most frequently are electrical stimulation and drugs. For example, strong emetic drugs have been used aversively for many years (see, e.g., Voegtlin & Lemere, 1942), especially in the treatment of alcoholism. The patient is given a drug that produces nausea or vomiting and then takes a drink (or the drug may be mixed with the drink). The patient soon becomes ill. This combination of alcohol and emetic is given for a week to 10 days. Eventually, just the sight of a drink is sufficient to induce nausea and discomfort.

Wolpe (1973) has described a variety of other aversive agents, including holding one's breath, stale cigarette smoke, vile-smelling solutions of asafetida, intense illumination, white noise, and shame. Clearly, the range of potential aversive agents is limited only by the imagination of resourceful therapists.

Covert Sensitization. Cautela (1967) developed a set of procedures, known as *covert sensitization*, that rely on imagery rather than the actual use of punishment, drugs, or stimulation. Patients are asked to imagine themselves engaging in the behaviors they wish to eliminate. Once they have the undesired behaviors clearly in mind, they are instructed to imagine extremely aversive events. Some of the instructions are vivid to say the least. A rather mild example from the treatment of a case of overeating should suffice: "As you touch the fork, you can feel food particles inching up your throat. You're just about to vomit" (Cautela, 1967, p. 462). The ensuing descriptions become more graphic.

Other Techniques. Other behavior therapy techniques, while technically considered forms of aversion therapy or punishment, are less extreme

than the administration of aversive agents or covert sensitization. For example, *response cost* is a technique in which positive reinforcers (e.g., tokens in a token economy system) are removed following an undesired response (e.g., a temper tantrum) made by a patient (Spiegler & Guevremont, 2010). Another example is a technique called *overcorrection*. Here, the idea is that having the patient or client "overcorrect" the consequences of an act will make the behavior less likely to recur (Spiegler & Guevremont, 2010). For example, an adolescent who has used a marker to write "Screw you, Dad" on a bedroom wall might be required to apply a fresh coat of paint to all the walls of the bedroom.

Second Thoughts. Prominent behaviorists (e.g., Skinner) have questioned the effectiveness of punishment in influencing and controlling behavior, and many clinicians have de-emphasized aversion methods in their behavioral therapy approaches. Lazarus (1971a), for example, stated that the building of better response repertoires and the reduction of anxiety produce longer-lasting results than do aversion techniques. Thus, it may turn out that, in the long run, it is more efficient to deal with a sexual fetish by reducing the patient's fear of heterosexual behaviors through behavior rehearsal than by punishing him each time he visualizes a pair of women's shoes.

Many critics, both within and without the behavior therapy movement, have been highly critical of aversion therapy. The concentration on punishment and the use of what are sometimes terrifying stimuli often seem totally incompatible with human dignity. Whether or not patients present themselves voluntarily for treatment is beside the point. Such techniques as inducing vomiting, using a curare-like drug so that the patient will experience the sensation of suffocating, or injecting stale smoke into the nostrils seem better relegated to the status of torture than dignified as treatment.

Others, however, maintain that aversive techniques, used in a sensitive fashion by reputable professionals, have real merit. Most often, aversive techniques are used after everything else has failed. Furthermore, patients are not dragged kicking and screaming into the situation. Usually, the procedures are applied to people who have seriously debilitating problems (alcoholism, excessive smoking, sexual deviations) and who are in despair because nothing else has worked. Spiegler and Guevremont (2010) remind us to keep several additional points in mind as we are evaluating the ethics of aversion therapy: (a) The aversive stimulus is of relatively brief duration and does not have long-lasting effect; and (b) clients are not required to engage in this treatment but do so by choice. Such people voluntarily undertake aversion therapy as the lesser evil—in the same spirit, perhaps, that one submits yearly to that terrifying "torture" at the hands of a friendly dentist.

COGNITIVE-BEHAVIORAL THERAPY

Background

A cognitive perspective on clinical problems emphasizes the role of thinking in the etiology and maintenance of problems. *Cognitive therapy* seeks to modify or change patterns of thinking that are believed to contribute to a patient's problems. These techniques have a great deal of empirical support (Hollon & Beck, 1994, 2004; Smith, Glass, & Miller, 1980; Tolin, 2010) and in combination with behavioral approaches (i.e., CBT) are seen as among the most efficacious of all psychological interventions. For example, cognitive-behavioral treatments dominate the most recent list of examples of empirically supported treatment (Chambless et al., 1998; Chambless & Ollendick, 2001; Chorpita et al., 2011), and they have been shown to be equal or superior to alternative psychological or psychopharmacological treatments for adults (DeRubeis & Crits-Christoph, 1998; Tolin, 2010) and for children and adolescents (Chorpita et al., 2011; Kazdin & Weisz, 1998). Most large-scale clinical trials examining the effects of psychotherapy and/or pharmacotherapy have revealed that the combination of both approaches offers more significant symptom reduction than either alone (e.g., Rhode et al., 2008).

The Move Toward Cognitive-Behavioral Therapy. In reflecting upon these cognitive trends, apparent even almost four decades ago, Mahoney (1977a) observed:

> Despite their long history of often bitter rivalry, behaviorists and cognitive psychologists appear to be cautiously easing into the same theoretical bed. This rather startling flirtation is not, of course, without its detractors. A few behaviorists seem to be viewing it as a softheaded fling with mentalism that they hope will pass. Likewise, some cognitive psychologists have viewed the merger with suspicion. (p. 5)

Although several effective treatments based on traditional behavioral learning principles had been developed, by the early 1970s it was clear that a number of frequently encountered clinical conditions (e.g., depression) were not so easily addressed by treatments based on classical or operant conditioning. In a sense, the present blending of behavioral and cognitive methods was stimulated by the limitations of both psychodynamics and radical behaviorism. This blending was also facilitated by the presence of several theoretical models that incorporated cognitive variables along with the scientific and experimental rigor so precious to behaviorists.

The Role of Social Learning Theory. In particular, Rotter's social learning theory (Rotter, 1954; Rotter, Chance, & Phares, 1972) helped bridge the chasm between traditional psychodynamic clinical practice and learning theory. It was a theory that explained behavior as a joint product of both reinforcement and expectancies. People choose to behave in the way they do because the behavior chosen is expected to lead to a goal or outcome of some value.

The presence of such a social learning theory had at least two effects on the development of behavior therapy. First, it produced a number of clinicians (and influenced others) who were ready to accept newer behavioral techniques and were equipped with a theoretical point of view that could facilitate the modification of those techniques along more cognitive lines. Second, the theory, being both cognitive and motivational, was capable of blending the older psychodynamically derived therapeutic procedures with the newer behavioral and cognitive approaches. By its very presence, then, social learning theory facilitated a fusion of approaches that is still in progress. In evaluating the relevance of this social learning theory for the practice of both traditional psychotherapy and behavior therapy, consider the following implications discussed by Rotter (1970):

1. Psychotherapy is regarded as a learning situation, and the role of the therapist is to enable the patient to achieve planned changes in observable behavior and thinking.
2. A problem-solving framework is a useful way in which to view most patients' difficulties.
3. Most often, the role of the therapist is to guide the teaming process so that not only are inadequate behaviors and attitudes weakened but more satisfying and constructive behaviors are learned.
4. It is often necessary to change unrealistic expectancies; in so doing, one must realize how it was that certain behaviors and expectancies arose and how prior experience was misapplied or overgeneralized by the patient.
5. In therapy, the patient must learn to be concerned with the feelings, expectations, motives, and needs of others.
6. New experiences or different ones in real life can often be much more effective than those that occur only during the therapy situation.
7. In general, therapy is a kind of social interaction.

Another highly significant contribution that has facilitated the cognitive swing in behavior therapy has been the work of Bandura (1969). Bandura demonstrated the importance of vicarious learning and the role of cognitive mediators in both affect and performance. Bandura's (1977a) emphasis on the ways in which various treatment procedures increase the patient's sense of self-efficacy is a

BOX 14-4 Graduate Student Perspective: John Guerry, M. A.

John D. Guerry is currently completing a predoctoral internship in clinical psychology at Montefiore Medical Center in the Bronx, N.Y. He received his B.A. from Wesleyan University, his M.A. from the University of North Carolina at Chapel Hill, and is currently a doctoral candidate at UNC. His research interests include adolescent suicidal and nonsuicidal self-injurious behaviors, depression, and the transactional roles that cognitions and psychophysiology play within these difficulties. After earning his degree, John hopes to continue to combine research, clinical work, and teaching at an academic medical center.

John shared the following insights regarding his graduate school experience.

What got you interested in clinical psychology?
Broadly speaking, we are all life-long students of psychology. In this sense, it's difficult for me to trace the origin of my interests to any singular moment or experience. Throughout my formal undergraduate coursework, volunteer experiences with clinical populations, postgraduate research assistantships, etc., I have always been captivated by the individual and her social context. I believe that by far our most pressing challenges call for psychological science to be directed towards the service of alleviating human distress and dysfunction—whether through evidence-based clinical work or clinically focused research.

What did you do as an undergraduate to prepare for graduate school in clinical psychology?
Easily the most important and rewarding experience of my undergraduate career was my work as a volunteer in a research laboratory. The opportunity to become directly involved in various aspects of ongoing psychological research was an essential complement to an intensive "classroom" curriculum. By my senior year I was eager to learn how to better operationalize my own empirical questions; I completed an honors thesis with my undergraduate advisor. Through this project I felt the extraordinary satisfaction of "owning" meaningful research. Aided unobtrusively by a superb mentor, I directed all levels of research, including study design, implementation and data collection, statistical analyses of results, and manuscript preparation. These opportunities proved invaluable both in terms of my developing the necessary skills to conduct original research as well as directly informing my decision to pursue graduate study.

What was the application process like for you?
Laborious, oftentimes overwhelming, but exhilarating nonetheless. Looking back, I realize that in many ways the application process was a thorough, pre-graduate school "hazing" ritual. Whether you are an applicant or grad student, a high premium is placed on many parallel skills, including meticulous organization, careful short- and long-term time management, constant prioritizing, multitasking, and people skills. For me, however, the most important part of the process was more personal; I did a great deal of soul-searching in order to focus my research interests and decide what I was looking for in a graduate program.

What was the interviewing process like for you?
I thought interviews were the best part of the application process. As intimidating as it was to share the attention of each world-class faculty with rooms of unbelievably qualified applicants, it was still a relief to cease being just one application file among hundreds. It was both humanizing and hugely informative to finally have the opportunity to interact—both on a personal and professional level—with prospective mentors.

Looking back, what activities or experiences were most important in preparing you for your graduate school program?
In general, throughout my undergraduate and postgraduate years, the most valuable experiences were those that gave me a firm clinical research background. After college, I was careful to accept research assistantships according to my interests and whether the position would expose me to a broad variety of responsibilities (e.g., data entry and analysis, manuscript preparation, lab management, IRB correspondence, etc.). In addition, the opportunity to continually

further step toward unifying the behavioral and cognitive realms. In his proposed model, Bandura argues that expectations of personal efficacy arise from the patient's actual accomplishments, verbal persuasion, vicarious experience, and physiological states. Various forms of therapy are seen as particularly productive in leading patients to an increased belief in their personal efficacy.

Social learning theorists such as Rotter, Bandura, and others highlighted the idea that

work with clinical populations both in the context of research and treatment settings was both personally rewarding and necessary from a professional development standpoint.

Any additional hints for applying to graduate school in clinical psychology?

Both on paper and in person, present yourself as genuinely as possible. Because applicants are selected on the basis of overall match (i.e., for a certain research advisor, for the particular year, for that particular program, etc.), you won't be doing anyone any favors by trying to conform to some notion of a prototypically ideal applicant.

What do you see as the advantages of a CBT approach to working with adolescents?

Although my graduate training has been far more influenced by CBT than any other orientation, I've had the privilege of receiving supervision to work with adolescent clients using complementary frameworks, including those that are psychodynamically informed. As a firm believer in "meeting the client where he/she is," I've made continuous efforts to receive broad, integrationist training to better honor client preferences and expectations.

That said, to the best of my ability, my starting point in therapy must be in accord with the evidence base for a given problem. More often than not, the evidence base for child and adolescent psychological problems points to CBT. I have to admit that I'm certainly biased because I find that I'm usually relieved that it does, particularly when working with adolescents. Given that many adolescents lack agency (e.g., "My parents *made* me come!") and are highly skeptical of/anxious about the therapeutic process, I often find that a CBT approach is uniquely suited to address and alleviate these concerns. For example, by providing early, authoritative psychoeducation about an adolescent's particular problem and the empirically based likelihood of improvement with treatment, the essential question "Can you help? is often answered in the affirmative. This goes a long way to reducing anxiety and fostering trust and alliance. At the same time, CBT's emphasis on transparency of process (e.g., agenda setting, rationale provided for principle-based techniques, etc.) not only arms the therapist and adolescent client with a roadmap for treatment but paves the way for ongoing, reciprocal collaboration between adolescent and his/her therapist. At its core, CBT assume that both the therapist and client are experts—the therapist with respect to the treatment and the adolescent with respect to his/her life challenges and strengths. I can't imagine a better way to approach an adolescent client than from a perspective that assumes equal standing.

John Guerry

learning is an active, not a passive, process. That is, a host of personal characteristics and cognitive processes influence behavior, sometimes independently of stimuli, situations, or reinforcers. Therefore, attempts were made to better investigate these "new" influences on behavior, and treatments that focused on these mediating, cognitive, and personal factors were developed. In this section, we describe a number of different cognitive-behavioral treatment approaches.

Modeling

Bandura (1969, 1971) advocated the use of *modeling*, or observational learning, as a means of altering behavior patterns, particularly in children. Imitation, modeling, or observation is a much more efficient technique for learning than is a simple reliance on punishment for incorrect responses and reward for correct ones. A new skill or a new set of behaviors can be learned more efficiently by observing another person. Seeing others perform a behavior can also help eliminate or reduce associated fears and anxieties. Finally, through observation one can learn to use behaviors that are already part of the behavioral repertoire.

Perhaps the most widespread use of modeling has been to eliminate unrealistic fears (Bandura, Adams, & Beyer, 1977; Bandura, Jeffrey, & Wright, 1974). Phobias (especially snake phobias) have been the principal means both of demonstrating and of investigating modeling techniques. In participant modeling, for example, the patient observes the therapist or model holding a snake, allowing the snake to crawl over the body, and so on. Next, in guided participation, the patient is exhorted to try out a series of similar activities, graded according to their potential for producing anxiety. Illustrative of this general approach is a study of nonorgasmic women treated by a self-administered masturbation training program over a 6-week period. The general techniques, used in two different treatment conditions, were described by McMullen and Rosen (1979) as follows:

> *Videotape modeling procedure*. A series of six 20-minute videotape sequences were prepared specifically for the study. The tapes featured a coping model, an actress portraying a non-orgasmic woman who learns over the course of the six sessions to stimulate herself to orgasm and then to transfer her ability to sexual intercourse with her partner. Content of the tapes included self-exploration, self-stimulation, and finally, an explicit representation of reaching orgasm through intercourse with a partner.
>
> *Written instructions*. The videotaped scripts were excerpted in the form of written booklets, which pretesting indicated were of equivalent content to the videotapes. The same procedure was followed for these subjects, in that they were required to come in once a week to read the appropriate booklet over the six weeks of the training program. Booklets were also read in private, and approximately the same amount of time was spent by these subjects in the clinic. (p. 914)

As noted by Thorpe and Olson (1997), observational learning is best and most efficient when the following four conditions are met:

1. Patients attend to the model. Incentives may be helpful to facilitate attention.
2. Patients retain the information provided by the model. It may be helpful to use imagery techniques or verbal coding strategies to help patients organize and retain the information provided.
3. Patients must perform the modeled behavior. It is important that the behavior be mimicked and practiced to facilitate learning and behavior change.
4. Finally, patients must be motivated to use the behavior that is modeled. It is suggested that reinforcing consequences be used to increase the likelihood that the modeled behavior will be used.

Rational Restructuring

Drawing on the work of Albert Ellis (1962), Goldfried and Davison (1994) accept the notion that much maladaptive behavior is determined by the ways in which people construe their world or by the assumptions they make about it. If this is true, it follows that the behavior therapist must help patients learn to label situations more realistically so that they can ultimately attain greater satisfactions. To facilitate this *rational restructuring* of events, the therapist may sometimes use argument

or discussion in an attempt to get patients to see the irrationality of their beliefs. In addition to providing patients with a rational analysis of their problems, the therapist may attempt to teach them to "modify their internal sentences." That is, patients may be taught that when they begin to feel upset in real situations, they should pause and ask themselves what they are telling themselves about those situations. In other instances, the therapist may have patients in the therapy room imagine particular problem situations. All of this may be combined with behavior rehearsal, in vivo assignments, modeling, and so on. Thus, rational restructuring is not a self-contained, theoretically derived procedure but an eclectic series of techniques that can be tailored to suit the particular demands of the patient's situation.

A good example of rational restructuring is Ellis's (1962) *rational-emotive therapy* (RET). Ellis was clearly a pioneer in what has become cognitive-behavior therapy. RET aims to change behavior by altering the way the patient thinks about things. Conventional wisdom often suggests that events cause (lead directly to) emotional and behavioral problems. According to Ellis, however, all behavior, whether maladjusted or otherwise, is determined not by events but by the person's interpretation of those events. In the ABCs of RET, Ellis argued that it is *beliefs* (B) about *activating* events or situations (A) that determine the problematic emotional or behavioral *consequences* (C). He saw psychoanalytic therapy, with its extreme reliance on insight, as inefficient; the origins of irrational thinking are not nearly as important as the messages that people give to themselves.

In a sense, the basic goal of RET is to make people confront their own illogical thinking. Ellis tried to get the client to use common sense. The therapist becomes an active and directive teacher. Box 14-5 presents some of the more common irrational ideas believed by Ellis to influence many people. Reviews of the empirical literature suggest that RET is an effective psychological intervention (Smith et al., 1980). However, more detailed investigation of the components of RET that lead to change in clinical status has been called for (Haaga & Davison, 1993). As noted by Hollon and Beck (2004), RET is among the least adequately tested of the cognitive-behavioral treatments. Although certain principles and strategies of RET are incorporated into other forms of cognitive-behavioral treatments, it seems that "pure" RET is now much less frequently used than in the past.

Stress Inoculation Training

Based on his own research, which indicated that patients could use self-talk or self-instruction to modify their behavior and that therapists could in effect train patients to change their self-talk, Meichenbaum (1977) developed *stress inoculation training* (*SIT*). SIT aims to prevent problems from developing by "inoculating" individuals to ongoing and future stressors (Meichenbaum, 1996). It is designed to help individuals develop new coping skills and make full use of the coping strategies that are already in place (Meichenbaum, 1996). SIT for coping with stressors appears on the most recent list of examples of empirically supported treatments (Chambless et al., 1998; Chambless & Ollendick, 2001). It proceeds in three overlapping phases (Meichenbaum, 1996):

1. *Conceptualization phase*: First, the client is educated with regard to how certain thinking or appraisal patterns lead to stress, other negative emotions, and dysfunctional behavior. The client is taught how to identify potential threats or stressors and how to cope with them.
2. *Skill acquisition and rehearsal phase*: The client practices coping skills (e.g., emotional self-regulation, cognitive restructuring, using support systems) in the clinic and then gradually out in the "real world" as he or she is confronted with the stressors.
3. *Application phase*: Additional opportunities arise for the client to apply a wide variety of coping skills across a range of stressful conditions. To consolidate these skills, the client may be asked to help others who are experiencing similar problems. Further "inoculation" procedures, including relapse prevention and booster sessions, are incorporated during the follow-up period.

BOX 14-5 Focus on Clinical Applications: Common "Irrational" Ideas

The 12 irrational ideas that Ellis (1977) believes are very common in the thinking of many people are listed below. Although most of us share this kind of thinking, extreme reliance on such beliefs can be problematic.

1. The idea that you must, yes, must have sincere love and approval almost all the time from all the people you find significant.
2. The idea that you must prove yourself thoroughly competent, adequate, and achieving; or that you must at least have real competence or talent at something important.
3. The idea that people who harm you or commit misdeeds rate as generally bad, wicked, or villainous individuals, and that you should severely blame, damn, and punish them for their sins.
4. The idea that life proves awful, terrible, horrible, or catastrophic when things do not go the way you would like them to go.
5. The idea that emotional misery comes from external pressures and that you have little ability to control your feelings or rid yourself of depression and hostility.
6. The idea that if something seems dangerous or fearsome, you must become terribly occupied with and upset about it.
7. The idea that you will find it easier to avoid facing many of life's difficulties and self-responsibilities than to undertake some rewarding forms of self-discipline.
8. The idea that your past remains all-important and that, because something once strongly influenced your life, it has to keep determining your feelings and behavior today.
9. The idea that people and things should turn out better than they do; and that you have to view it as awful and horrible if you do not quickly find good solutions to life's hassles.
10. The idea that you can achieve happiness by inertia and inaction or by passively and uncommittedly "enjoying yourself."
11. The idea that you must have a high degree of order or certainty to feel comfortable; or that you need some supernatural power on which to rely.
12. The idea that you give yourself a global rating as a human and that your general worth and self-acceptance depend upon the goodness of your performance and the degree that people approve of you.

SOURCE: From "A Basic Clinical Theory of Rational-Emotive Therapy," by A. Ellis, p. 10. In A. Ellis and R. Grieger (Eds.), *Handbook of Rational-Emotive Therapy*. Copyright © 1977 by Springer Publishing Company, Inc., New York 10012. Used by permission.

SIT has been used for the treatment of several clinical problems, including rape and assault trauma, posttraumatic stress disorder, and anger dyscontrol. For example, Novaco (1977) describes the application of stress inoculation procedures to deal with the anger problems of adult depressed patients on acute psychiatric wards. In essence, the procedures involve the cognitive preparation of such patients, the acquisition and rehearsal of the necessary skills, and practice in the application of the skills. To cognitively prepare patients, they are given instructional manuals describing the nature and functions of anxiety, including a discussion of situations in which anger is a problem, what causes anger, and how anger can be regulated. The components of this cognitive preparation include identifying persons and situations that precipitate anger, learning to differentiate between anger and aggression, discriminating between justified and unnecessary anger, and recognizing early signs of tension and arousal in a provocation sequence.

Beck's Cognitive Therapy

Aaron Beck has been a pioneer in the development of modern cognitive-behavioral treatments that have been applied to a variety of clinical problems (Beck, 1991). This model of intervention entails the use of both cognitive and behavioral techniques to modify dysfunctional thinking patterns that characterize the problem or disorder in question (Beck, 1993). For example, depressed individuals are believed to harbor negative/pessimistic beliefs about themselves, their world, and their future.

Thus, a depressed 45-year-old man might be prone to be highly self-critical (and often feel guilty, even when it is not appropriate), to view the world as generally unsupportive and unfair, and not to hold much hope that things will improve in the future. The following *cognitive therapy* (*CT*) techniques might be used in the treatment of his depression (Beck, Rush, Shaw, & Emery, 1979):

1. Scheduling activities to counteract his relative inactivity and tendency to focus on his depressive feelings.
2. Increasing the rates of pleasurable activities as well as of those in which some degree of mastery is experienced.
3. Cognitive rehearsal: Have the patient imagine each successive step leading to the completion of an important task (e.g., attending an exercise class) so that potential impediments can be identified, anticipated, and addressed.
4. Assertiveness training and role-playing.
5. Identifying automatic thoughts that occur before or during dysphoric episodes (e.g., "I can't do anything right").
6. Examining the reality or accuracy of these thoughts by gently challenging their validity ("So you don't think there is *anything* you can do right?").
7. Teaching the patient to reattribute the "blame" for negative consequences to the appropriate source. Depressed patients have a tendency to blame themselves for negative outcomes, even when they are not to blame.
8. Helping the patient search for alternative solutions to his problems instead of resigning himself to their insolubility.

This is an abbreviated, illustrative sample of the techniques used in Beck's cognitive therapy of depression. Box 14-6 presents the major features of cognitive therapy for depression. It is worth repeating that cognitive therapy has proven to be one of the most effective techniques available for treating depression (Chambless et al., 1998; Chambless & Ollendick, 2001; Hollon & Beck, 1994, 2004). In addition, cognitive therapy has been adapted for use with patients suffering from anxiety disorders (Beck & Emery, 1985), eating

BOX 14-6 Focus on Clinical Applications: Features of Cognitive Therapy for Depression

Aaron Beck's cognitive therapy for depression is an empirically supported treatment (Chambless et al., 1998; Chambless & Ollendick, 2001) that is active, structured, and time limited. It is characterized by the following features (Butler & Beck, 1996).

Focus
CT focuses on the connection between thinking patterns/styles, emotions, and behavior.

Length
Typically 14 to 16 sessions. Many patients show a remission of symptoms in 8 to 12 sessions.

Role of the CT Therapist
The CT therapist is an active, supportive collaborator. Through psychoeducation, guided discovery, Socratic questioning, role-playing, and behavioral experiments, patients are helped to address and change maladaptive ways of thinking that lead to or maintain depression and other negative affects.

Structure of a Typical Session
Mood symptoms are checked, an agenda for the session is set, the previous session is summarized, homework assignments are reviewed, issues on the agenda are discussed, new homework is assigned, and the current session is summarized and evaluated by both therapist and patient.

Phases of Treatment
In the first phase (about 8 sessions), the cognitive model is introduced, skills are acquired, and some mastery is achieved. Reduction in depressive symptoms occurs. In the remaining sessions, dysfunctional beliefs that may lead to relapse (e.g., "This good feeling won't last") are evaluated and modified, relapse prevention skills are taught, and termination issues are discussed.

disorders (Fairburn et al., 1991), and personality disorders (Beck, Freeman, & Associates, 1990), to cite but a few examples. Empirical studies suggest that it may be an especially effective form of intervention for a broad range of clinical problems (Hollon & Beck, 1994, 2004; Smith et al., 1980).

Dialectical Behavior Therapy

Dialectical behavior therapy (*DBT*; Linehan, 1993) is a relatively new cognitive-behavioral treatment for borderline personality disorder (BPD) and related conditions involving emotional dysregulation and impulsivity. Linehan developed DBT based on her clinical experience with women diagnosed with BPD who engaged in self-injurious behavior. The theory behind DBT posits that individuals are born with emotionally vulnerable temperamental styles that, in interaction with an "invalidating" family environment, lead to emotional dysregulation and self-harming behaviors. Invalidating environments are those in which a person's wants and feelings are discounted or disrespected and efforts to communicate are disregarded or punished.

DBT involves skills training in problem-solving techniques, emotional regulation, and interpersonal skills. The skills training takes place in a validating therapeutic environment, usually involving both an individual DBT therapist as well as group DBT skills training. Clients in DBT cycle twice through four skills training modules: (a) *mindfulness* (the ability to be aware of the moment, not to be distracted, and to be nonjudgmental); (b) *emotional regulation* (identifying emotions, appreciating the effects of emotions on oneself and others, learning to counteract negative emotional states and to engage in behavior that will increase positive emotions); (c) *distress tolerance* (learning to cope with stressful situations and to self-soothe); and (d) *interpersonal effectiveness* (learning to deal effectively with interpersonal conflict, to appropriately get one's desires and needs met, and to appropriately say no to unwanted demands from others). Individuals are asked to commit to 12 months of DBT treatment. DBT has been shown more effective than "treatment as usual" in reducing self-harm behaviors, number of days of hospitalization, and substance use (Koerner & Linehan, 2000). Box 14-7 presents an excerpt from a DBT therapy session, and Box 14-8 presents the work of DBT therapist Dr. Ronda Reitz.

AN EVALUATION OF BEHAVIOR THERAPY

Proponents of CBT see their progress as tangible evidence of what can be accomplished when the mentalistic, subjective, and nonscientific "mumbo jumbo" of psychodynamics or phenomenology is cast aside. Critics, on the other hand, see CBT as superficial, pretentiously scientific, and even dehumanizing in its mechanistic attempts to change human behavior. Indeed, these criticisms reflect many of the "myths" about CBT (Goldfried & Davison, 1994). In any case, more clinical psychologists describe their orientation as cognitive or behavioral than any other orientation (Norcross, Karpiak, & Santoro, 2005).

We now examine some of the strengths and limitations of the behavioral and cognitive behavioral approaches and then close with a summary of some of the challenges ahead.

Strengths

In many ways, CBT has changed the fields of psychotherapy and clinical psychology (Wilson, 1997). What follows is a discussion of several major ways that CBT has had an impact.

Efficacy. As mentioned throughout this chapter, there is ample evidence that a wide variety of behavioral and cognitive-behavioral therapies are efficacious (Chambless et al., 1998; DeRubeis & Crits-Christoph, 1998; Emmelkamp, 1994; Hollon & Beck, 1994, 2004; Kazdin & Weisz, 1998; Smith et al., 1980; Tolin, 2010). In fact, behavior therapy and CBT appear to be the treatment of choice for many disorders (Tolin, 2010). The reader may recall the results of the Smith et al. (1980)

meta-analysis presented in Chapter 11 (see Table 11-4). The separate effect sizes calculated for RET, non-RET cognitive therapies, systematic desensitization, behavior modification, and cognitive-behavioral therapy indicated that, on average, a client who received any of these forms of behavior therapy was functioning better than at least 75% of those who did not receive any treatment. More recent meta-analyses have reached similar conclusions across a range of disorders. Further, the majority of meta-analytic studies that have compared the effectiveness of behavioral or cognitive-behavioral techniques with that of other forms of psychotherapy (e.g., psychodynamic or client-centered) have found a small but consistent superiority for behavioral and cognitive-behavioral methods (Hollon & Beck, 2004; Svartberg & Stiles, 1991; Tolin, 2010). Clearly, these are important treatment techniques for a clinician to master.

Efficiency. The CBT movement also brought with it a series of techniques that were shorter and more efficient. The interminable number of 50-minute psychotherapy hours was replaced by a much shorter series of consultations that focused on the patient's specific complaints. A series of equally specific procedures was applied, and the entire process terminated when the patient's complaints no longer existed. Gone was the everlasting "rooting out" of underlying pathology, the exhaustive sorting out of the patient's history, and the lengthy quest for insight. In their place came an emphasis on the present and a pragmatism that was signaled by the use of specific techniques for specific problems. Because of its efficiency, CBT may be especially well suited for the managed care environment.

In fact, some CBT techniques can be implemented by technicians who are trained to work under the supervision of a doctoral-level clinician. Thus, not every component of CBT needs to be executed by Ph.D. personnel. Behavior therapy programs (e.g., token economies) should be set up by trained professionals, but their day-to-day execution can be put in the hands of technicians, paraprofessionals, nurses, and others. This constitutes a considerable savings in mental health personnel and enables a larger patient population to be reached than can be treated by the in-depth, one-on-one procedures of an exclusively psychodynamic approach.

An Array of Evidence-Based Techniques. Behavior therapy has evolved to the point that it includes a broad array of techniques, from systematic desensitization to cognitive restructuring (Spiegler & Guevremont, 2010). Unless a CBT therapist is unalterably committed to a single set of procedures, this broad spectrum demands that choices be made. To increase the probability of making the correct choice, the therapist is likely to gather information that will best match technique with patient (Peterson & Sobell, 1994). If assessment eventually recaptures its position of prominence in the list of the clinician's preferred activities, it will be due in no small measure to the behavior therapist's desire for information to guide the therapeutic decision-making process.

CBT is a very active collection of procedures. It involves assessment, planning, decisions, and techniques. In some ways, it may be construed as a complex technology. A technology cannot be passively allowed to happen to a patient. It is something that must be guided with care and foresight and with great attention to detail. It is not a process that permits the therapist to wait until the patient shows up on Thursday before thinking about the case. The therapist cannot play everything by ear. If a therapist is using aversion procedures, the time relationship between the onset of the stimulus and the onset of punishment may need strict supervision. Token economies are not haphazard regimens that can be left to creative, on-the-spot decision making. Everything must be worked out carefully in advance. It is important to decide whether the patient has a behavioral deficit rather than a "pure" anxiety problem because the therapeutic implications are vastly different in the two cases.

None of this is meant to imply that every psychodynamically oriented psychotherapist fails to think about cases between therapy sessions or always makes up strategy spontaneously along the

BOX 14-7 Focus on Clinical Applications: Excerpts from Sessions of Dialectical Behavior Therapy (DBT)

The client was a 30 year-old woman with borderline personality disorder who had been hospitalized at least 10 times in the previous 2 years for treatment of suicidal ideation and who had engaged in numerous instances of self-harm behaviors including drinking Clorox bleach, cutting and burning herself, and one suicide attempt (Linehan & Kehrer, 1993).

In this segment (Linehan & Kehrer, 1993, pp. 428–429), the DBT *therapist* (T) explains the DBT program and goals to the *client* (C):

T: Now, the most important things to understand is that we are not a suicide-prevention program, that's not our job. But we are a life enhancement program. The way we look at it, living a miserable life is no achievement. If we decide to work together I'm going to help you try to improve your life so that it's so good that you don't want to die or hurt yourself. You should also know that I look at suicidal behavior, including drinking Clorox, as problem-solving behavior. I think of alcoholism the same way. The only difference is that cutting, burning, unfortunately, it works. If it didn't work, nobody would do it more than once. But it only works in the short term, not the long term. So quitting cutting, trying to hurt yourself, is going to be exactly like quitting alcohol. Do you think this is going to be hard?

C: Stopping drinking wasn't all that hard.

T: Well, in my experience, giving up self-harm behavior is usually very hard. It will require both of us working, but you will have to work harder. And like I told you when we talked briefly, if you commit to this it's for 1 year. Individual therapy with me once a week, and group skills training once a week. So the question is, are you willing to commit for 1 year?

C: I said I'm sick of this stuff. That's why I'm here.

T: So you've agreed to not drop out of therapy for a year, right?

C: Right.

T: And you do realize that if you don't drop out for a year, that really does, if you think about it, rule out suicide for a year?

C: Logically, yeah.

T: So, we need to be absolutely clear about this, because this therapy won't work if you knock yourself off. The most fundamental mood-related goal we have to work on is that, no matter what your mood is, you won't kill yourself, or try to.

C: Alright.

T: So that's what I see as our number one priority, not our only one but our number one, that we will

way. Yet the nature of traditional psychotherapy renders it vulnerable to such problems of passivity. It is even possible that the active, vigorous quality of cognitive-behavioral methods and the analogous attitude that this forces upon the therapist may be responsible for a measure of patient improvement beyond that caused by the specific procedures employed. An active therapist may be reassuring, exciting, or encouraging to some patients (in contrast to a passive, contemplative, noncommittal psychotherapist who often has little to say or suggest).

It is also worth repeating that behavior therapy is the undisputed leader in "manualizing" its treatments so that empirically supported techniques can be administered in a standardized fashion. Not only does this facilitate conducting research and providing effective treatment but it also facilitates the training of future clinical psychologists to administer these effective treatments.

Symptom Substitution. As much as anything, CBT will have a secure and valued position in the history of psychology because it helped lay to rest the hallowed notion of *symptom substitution*. It not only demonstrated that there are alternatives to the psychodynamic view of pathology but also effectively attacked the medical model of pathology and its cherished notions of illnesses and symptoms. After years of research and clinical experience, it is now clear that not every patient's complaint can be labeled as a symptom of some underlying psychic illness—an illness that will surely return in the form

work on that. And getting you to agree, meaningfully of course, and actually following through on staying alive and not harming yourself and not attempting suicide no matter what your mood is. Now the question is, whether you agree to that.

C: Yes, I agree to that.

In this segment (Linehan & Kehrer, 1993, p. 433), the therapist reinforces the client for using distress tolerance skills when her request for pain medication was refused by her physician.

T: That's good thinking. That's when you're thinking about the advantages and disadvantages of doing it. OK, so at that point the advantages of making it worse were outweighed by the disadvantages. OK. So you keep up the good fight here. Now what else did you try?

C: I tried talking about it with other patients.

T: And what did they have to say?

C: They said I should get pain medication.

T: Right. But did they say you should cut yourself or hurt yourself if you didn't get it?

C: No. And I tried to get my mind off my pain by playing music and using mindfulness. I tried to read and do crossword puzzles.

T: Um hmm. Did you ever try radical acceptance?

C: What's that?

T: It's where you sort of let go and accept the fact that you're not going to get the pain medication. And you just give yourself up to that situation. You just accept that it isn't going to happen, that you're going to have to cope in some other way.

C: Which I did yesterday. I needed a little Aptiva (lorazepam) to get me there but I got there.

T: Yesterday?

C: Yeah. I took a nap. When I woke up I basically said, "Hey, they're not going to change, so you've just got to deal with this the best that you can."

T: And did that acceptance help some?

C: I'm still quite angry about what I believe is discrimination against borderline personalities. I'm still very angry about that.

T: OK. That's fine. Did it help though, to accept?

C: Um hmm.

T: That's good. That's great. That's a great skill, a great thing to practice. When push comes to shove, when you're really at the limit, when it's the worst it can be, radical acceptance is the skill to practice.

of another symptom if the present one is removed without attending to the underlying pathology. Attacking a patient's anxieties directly will not necessarily force the anxieties to return in another guise. This demonstration not only lent credibility to the behavioral movement; it also chipped away at the credibility of those psychiatric and psychodynamic orientations that had so stoutly defended the symptom substitution notion. As a result, the avenue was opened for the development of specific techniques for dealing with specific patient complaints. However, these remarks should be tempered by recognition that direct onslaughts on the patient's stated problem may not always be the most efficient route. As noted earlier in this chapter, it may turn out that a specific anxiety is being sustained by something not immediately obvious (Lazarus, 1971a).

Breadth of Application. A contribution of major proportions has been the extension of the range of applicability of therapy. Traditional psychotherapy had been reserved for the middle and upper classes who had the time and money to devote to their psychological woes and for articulate, relatively sophisticated college students with well-developed repertoires of coping behaviors who were attending colleges or universities that made counseling services available to them at little if any cost. Behavior therapy has changed all that.

Now, even financially strapped individuals with mental retardation or a chronic mental illness

BOX 14-8 Psychologist Perspective: Rhonda Oswalt Reitz, Ph.D.

Dr. Reitz is a cognitive-behavioral therapist with a specialty in dialectical behavior therapy. She is a psychologist for the Missouri Department of Mental Health, providing treatment, training, and consultation in the state hospital and community mental health centers statewide. Finally, Dr. Reitz is a trainer and consultant for BTech, a company that provides training and consultation in DBT to mental health professionals in the United States.

We asked Dr. Reitz a number of questions about her background, interests, and activities.

Describe your background and your clinical interests.
I began to focus on a career in psychology when I was 12 years old. I had a friend whose psychiatrist father modeled effective compassion and respect in the treatment of his clients and I was inspired to do the same. Paired with this ideal of a mental health professional was my interest in the process and structure of learning. I learned behavioral methods by training dogs in high school, took as many courses in learning theory as were available as an undergraduate, participated in brain autopsies on internship, and did neuropsychological assessment of clients with HIV/AIDS, traumatic brain injury, and other impairments as a master's-level clinician and intern. While my graduate training largely emphasized cognitive-behavioral therapy, I found myself drawn to more pure forms of behavior therapy in work with the organically impaired, children and adolescents, and then with an increasingly broad range of presenting concerns. This has been made easier in more recent years as more empirically supported protocols have been made available.

Dialectical behavior therapy was a natural synthesis of my interests in behaviorally based methods and empirically supported treatments. This became a dominant mode of treatment for me when I attended one of Marsha Linehan's workshops and for almost 15 years now I have worked primarily with clients who meet criteria for borderline personality disorder.

What types of services do you provide and to whom?
I am the DBT Program Coordinator for the State of Missouri. In this role, I train mental health providers to do DBT, develop teams of providers across communities, consult on difficult cases across the state, and carry a caseload of clients at a local mental health center. In addition, I developed and manage a certification process for DBT teams in the state of Missouri.

What are the things you enjoy most about your clinical work?
The most rewarding part of my job is getting to know each of the clients with whom I work. The DBT model prescribes a "radically genuine" interpersonal approach with clients and encourages staff to minimize professional distance. While the therapy requires a high level of attentiveness and cognitive flexibility, it also allows for a more relaxed and personal relationship, in which client impact on the therapist is overtly considered important. It is a satisfying experience to engage in behaviorally honest interactions with another individual and to watch difficult behavior patterns change as a result.

can be helped by therapy. Such persons may not be raised to the level of independent functioning, but with the advent of operant procedures and token economies, their institutional adjustment can often be significantly improved.

Not only the institutionalized have benefited from behavioral techniques. Patients at lower socioeconomic levels with limited sophistication and verbal skills can also experience anxieties and phobias or lack necessary problem-solving skills. In cases where lengthy verbal psychotherapies that were highly dependent on insight, symbolism, or the release of some inner potential were likely to fail, a broad band of behavior therapies seems to offer real hope.

Scientist-Practitioner and Clinical Scientist. For those who support the scientist-practitioner or clinical scientist model of clinical psychology, CBT is an approach that seems to encourage a blending of the two roles. The CBT tradition springs from a heritage that is experimental and oriented toward research. Many of the specific techniques of behavior therapy have developed directly from the

What are the biggest challenges you face as a practitioner?

Delivery of quality treatments within limited financial and staff resources is difficult in any setting. However, there is often additional bias against the public funding of aggressive new treatments for what are seen as chronically mentally ill individuals or for forensic, or "offender," populations. Empirical support of treatments for these populations is limited, so it can be difficult to defend implementing these treatments during times of deep budget cuts.

Demonstrating the benefit of treatments for these populations and helping legislators and other influential bodies to understand, value, and provide funding for effective treatments is critical. It can also be difficult to maintain focus on clinical services in a public mental health setting, as paperwork, team meetings, behavioral crises, and administrative responsibilities abound.

Does research inform what you do? If so, how have you changed your practice to be more effective for your clients?

I feel strongly that psychologists (like any other service or product provider) must bear the burden of proof that the treatment they provide is appropriate to the presenting concern, has some objective record of benefit for similar problems, and is being delivered according to protocol. Given this point of view, I have worked to educate the administration and staff in the organizations where I have been employed about the importance of implementing *all elements* of a protocol, rather than adopting only the most cost-efficient portions of a treatment. It has taken longer to implement "full protocol" in some settings due to resistance to the initial cost involved, but has been worth the effort when the clinical benefit is seen. Additionally, it has been necessary on many occasions to pursue funding for patient treatment beyond the usual channels. For example, it is important to ask insurance companies to provide sessions beyond the typical frequency or overall number limits for a year when the client is diagnosed with a condition that requires more intensive or longer-term treatment (refractory agoraphobia, borderline personality disorder, etc.).

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Rhonda Oswalt Reitz

experimental laboratory. Sometimes even the language of behavior therapy is straight out of the experimental research journals. In behavior therapy, there is an easy communication between the researcher and the clinician, and very often, the same person alternates comfortably between the two roles. Such rapport increases the likelihood that advances in the laboratory will be reflected in new therapeutic techniques and, conversely, that clinical experience will serve a vital role in determining the kind of research and evaluation that are carried out.

Limitations

Linking Practice to Science. For some years, the CBT movement rode the crest of a wave of scientific respectability. Many behaviorists, especially the radical variety, seemed to be clamoring for preferred status by claiming that behavior therapy rested on the sturdy, established scientific principles of learning theory. Psychodynamic approaches, by contrast, were said to be crude extrapolations from a mentalism only slightly removed from witchcraft. But research rarely has been conducted to "dismantle"

CBT techniques to determine the most effective components of this approach that seem to be most strongly associated with symptom reduction. Consequently, it cannot be ruled out that other, nonbehavioral aspects of therapy are actually as responsible for symptom relief as the techniques that are the focus of CBT treatment (Goldfried & Davison, 1994). For instance, is systematic desensitization the technique that *causes* anxiety symptom reduction, or is it perhaps the therapeutic alliance between the therapist and patient that occurs during systematic desensitization that is more efficacious?

Dehumanizing? Among the more durable characterizations of the behavioral movement are "sterile," "mechanistic," and "dehumanizing." To demonstrate that there is real labeling bias operating here, Woolfolk, Woolfolk, and Wilson (1977) asked two groups of undergraduates to view identical videotapes of a teacher using reinforcement methods. The first group was told that the tape illustrated behavior modification; for the second group, the tape was labeled as an illustration of humanistic education. A subsequent questionnaire revealed that when the tape was described in humanistic terms, the teacher on the tape received significantly better ratings and the teaching method depicted was seen as significantly more likely to promote learning and emotional growth.

The use of mechanistic-sounding terms such as *response, stimulus, reinforcement*, and *operant* need not imply that either the therapist or the method is detached, sterile, or dehumanizing. The systematic use of learning principles and the examination of animal analogues for simple illustrations to highlight the nature of human learning should not lead to a facile inference that behavior therapists are cold, manipulating robots whose interests lie more in their learning principles than in their clients. Ideally, with the increasing cognitive orientation, such erroneous images will begin to fade.

Although nothing inherent in behavior therapy should lead one to conclude that it is necessarily dehumanizing, its early history provided a few unfortunate episodes and a considerable stridency of rhetoric. We have already commented on the use of aversion techniques that many regarded as more akin to sadism than therapy, for example. In the final analysis, no technology or set of principles is going to permit clinicians the luxury of giving up their clinical sensitivity.

Inner Growth. CBT has also been criticized as ameliorative but not productive of any inner growth. It has been said to relieve symptoms or provide a few skills while failing to offer fulfilling creative experiences. Although it may alter behavior, it falls short of promoting understanding. It leaves out the inner person, values, responsibility, and motives. Again, though not completely off the mark, such criticisms are less appropriate for the cognitive aspects of CBT, an emphasis that does deal with mediating variables such as expectancies and self-concepts—as long as these are objectively describable and are inferred from specific stimuli and responses.

Manipulation and Control. One of the most volatile, emotion-laden criticisms of CBT centers on the issue of manipulation and control. The argument seems to be that cognitive-behavior therapies represent insidious and often direct assaults on the patient's capacity to make decisions, assume responsibility, and maintain dignity and integrity. But patients typically seek professional assistance voluntarily, thereby acknowledging their need for help and guidance in altering their lives. Thus, the patient does have the opportunity to accept or reject the procedures offered (though this defense may not apply as well in institutional settings). Further, many CBT techniques are aimed at helping patients establish skills that will lead to greater self-direction and self-control (Goldfried & Davison, 1994).

Generalization. A particularly damaging criticism of several forms of CBT concerns their effectiveness in settings other than those in which they are conducted. In other words, do the effects of CBT programs generalize beyond the situations in which they are practiced? Again, in the interests of evenhandedness, it should be pointed out that most forms of psychotherapy are subject to the same question. For example, some patients show a marked

improvement or adjustment in the psychotherapy situation even though this adjustment fails to generalize to nontherapy settings.

Lack of a Unifying Theory. A final problem with behavior therapy may be its potential for theoretical chaos. At present, it is an amalgam of techniques—some from the operant tradition, others from a classical conditioning base, and still others that are heavily cognitive in nature. Without an integrating theoretical framework, individual clinicians may find themselves flailing about in a morass of competing techniques, each claiming to be forms of CBT. What is needed is a systematic theoretical position that will incorporate the techniques, classify them, and help the clinician decide when and under what conditions to use one technique rather than another. Such a theoretical framework would be infinitely more efficient than multiple rules of thumb.

The Future

Over a decade ago, Wilson (1997) reflected on CBT's past and highlighted some of the challenges for the future. His reflections and concerns are still relevant to CBT as it is practiced today. Wilson noted the need for wider dissemination and adoption of CBT; given its strong empirical support, it is somewhat surprising that these techniques are not more widely used. Additionally, Wilson (1997) is concerned that CBT remain firmly linked to advances in psychological science:

> To fulfill its original promise of linking clinical practice to advances in scientific research, behavior therapy must be responsive to developments both in experimental psychology and biology. Dramatic breakthroughs in genetics and neuroscience have already revolutionized the biological sciences, and progress will likely continue to unlock the secrets of the brain. A better understanding of the role of brain mechanisms in the development and maintenance of clinical disorders, and in the modification of these disorders via both pharmacological and behavioral methods, will arguably improve our theories of behavior change. (p. 454)

CHAPTER SUMMARY

Behavior therapy is based on the assumption that clinical problems should be addressed using assessment and treatment techniques that have empirical support and are based on established principles from experimental psychology. Although procedures derived from classical and operant conditioning initially dominated this approach, behavior therapy has been broadened to include procedures that draw from learning theories based on observational learning and cognitive processes.

Traditional behavioral treatments include systematic desensitization, exposure therapy, behavior rehearsal, contingency management, and aversion therapy. These treatments have documented efficacy, and several are the treatments of choice for certain clinical problems (e.g., systematic desensitization for phobias, exposure plus response prevention for obsessive-compulsive disorder). Cognitive-behavioral treatments emphasize the roles of thinking, expectations, and beliefs in the etiology and maintenance of clinical problems. Examples of cognitive-behavioral techniques include modeling, rational restructuring, stress inoculation training, cognitive therapy, and dialectical behavior therapy. The most recent list of examples of evidence-based treatments is dominated by cognitive-behavioral and traditional behavioral techniques.

CBT has had a positive impact on the field because of its wide range of effective and efficient treatments. It has been the leader in manualizing treatments, facilitating research, training, and practice. In many ways, it is the ideal therapeutic

orientation choice for scientist-practitioners and clinical scientists. There are, however, several limitations and challenges that lie ahead. At times, the link between behavior therapy techniques and scientific, experimental evidence has not been as strong as has been claimed. Further, many myths still plague the field, including that behavior therapy is dehumanizing and overly controlling. For the future, there is a need for more attention to the incorporation of advances in psychological science.

KEY TERMS

anxiety hierarchy In systematic desensitization, a list of situations that precipitate anxiety reactions, ordered from lowest to highest severity. Often, items may be organized according to their spatial or temporal distance from the feared stimulus.

assertiveness training Using behavioral rehearsal and other techniques to train people to express their needs effectively without infringing on the rights of others.

aversion therapy A controversial type of treatment in which an undesired behavior is followed consistently by an unpleasant consequence, thus decreasing the strength of the behavior over time.

behavioral rehearsal A general technique for expanding the patient's repertoire of coping behaviors. Successful behavioral rehearsal involves explaining to the patient the necessity of acquiring the new behaviors, selecting the target situations, conducting the rehearsal and providing feedback, and having the patient apply the newly acquired skills in real-life situations.

behavior therapy A framework for treating disorders that is based on the principles of conditioning or learning. The behavioral approach is scientific in nature and deemphasizes the role of inferred (i.e., unobservable) variables on behavior.

cognitive-behavioral therapy A therapy framework that emphasizes the role of thinking in the etiology and maintenance of problems. Cognitive-behavioral techniques attempt to modify the patterns of thinking that are believed to contribute to a patient's problems and may also employ the principles of conditioning and learning to modify problematic behaviors.

cognitive therapy A mode of therapy pioneered by Aaron Beck that focuses on the connection between thinking patterns, emotions, and behavior and uses both cognitive and behavioral techniques to modify the dysfunctional thinking patterns that characterize a disorder. Cognitive therapy is active, structured, and time limited and has been adapted for the treatment of several disorders.

contingency contracting A contingency management technique in which the therapist and patient draw up a contract that specifies the behaviors that are desired and undesired as well as the consequences of engaging or failing to engage in these behaviors.

contingency management Any one of a variety of operant conditioning techniques that attempts to control a behavior by manipulating its consequences.

counterconditioning The principle of substituting relaxation for an anxiety response.

covert sensitization A form of aversion therapy in which patients are directed to imagine themselves engaging in an undesired behavior and then are instructed to imagine extremely aversive events occurring once they have the undesired behavior clearly in mind.

dialectical behavior therapy A cognitive-behavioral therapy developed by Marsha Linehan for borderline personality disorder and related conditions that teaches skills in mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.

exposure plus response prevention A behavioral technique often used for the treatment of OCD. In this technique, the patient is exposed to the

situation that spurs his or her obsession (e.g., touching a doorknob) and is prevented from engaging in the compulsive behavior that relieves the obsession (e.g., repeated hand washing). Ultimately, the patient will habituate to his or her obsession, and the compulsive behavior will be extinguished.

exposure therapy A behavioral technique for reducing anxiety in which patients expose themselves (in real life or in fantasy) to stimuli or situations that are feared or avoided. To be effective, the exposure must provoke anxiety, must be of sufficient duration, and must be repeated until all anxiety is eliminated.

extinction The elimination of an undesired response (e.g., behavioral, emotional).

habituation The elimination of a response that comes about from the repeated and/or prolonged presentation of the provoking stimulus.

interoceptive cues Internal physiological stimuli (e.g., dizziness or nausea).

modeling Also known as observational learning, the learning of a new skill or set of behaviors by observing another person perform these skills/behaviors.

overcorrection A form of aversion therapy in which the client is made to "overcorrect" for the consequences of his or her undesired behavior.

Premack principle Also known as "Grandma's rule," the contingency management technique in which a behavior is reinforced by allowing the individual to engage in a more attractive activity once the target behavior is completed.

rational-emotive therapy (RET) A therapy pioneered by Albert Ellis in which patients are forced to confront and correct their own illogical thinking. In Ellis's system, a person's beliefs about events, rather than the events themselves, determine the problematic emotional or behavioral consequences.

rational restructuring An eclectic set of techniques that teaches individuals to examine their assumptions about situations or the world in general and alter their ideas to be more realistic or rational.

relaxation A state of lowered anxiety, stress, and physiological arousal. Relaxation may be induced by tensing and then relaxing various muscle groups or via breathing exercises, imagery exercises, or hypnosis.

response cost A form of aversion therapy in which positive reinforcers are removed following an undesired behavior.

shaping A contingency management technique in which a behavior is developed by first rewarding any behavior that approximates it and then by selectively reinforcing behaviors that more and more resemble the target behavior.

stress-inoculation training (SIT) A technique developed by Donald Meichenbaum that attempts to prevent problems by "inoculating" patients to ongoing and future stressors. SIT involves educating patients about how certain appraisal patterns lead to stress, teaching them to identify and cope with potential stressors, rehearsing these coping skills in the therapy setting, and consolidating these skills by applying them across a range of real-life, stressful situations.

successive approximation Another term for shaping.

symptom substitution The notion that if a symptom is removed without attending to the underlying pathology of an illness, another symptom will emerge to take its place.

systematic desensitization A behavioral technique for reducing anxiety in which patients practice relaxation while visualizing anxiety-provoking situations of increasing intensity. In this way, the patient becomes "desensitized" to the feared stimulus.

time-out A contingency management technique in which a person is removed temporarily from the situation that is reinforcing the undesired behavior.

token economy A system in which desired behaviors are promoted through the strict control of reinforcements. Establishing such a system requires specifying the immediate reinforcers for each behavior as well as the backup reinforcers for which patients can exchange their immediate reinforcers.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

14-1 Link to research-supported psychological treatments
http://www.psychology.sunysb.edu/eklonsky-/division12/index.html

14-2 Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

14-3 The Beck Institute for Cognitive Therapy and Research
http://www.beckinstitute.org/

14-4 International Association for Cognitive Psychotherapy
http://www.the-iacp.com/

14-5 Albert Ellis Institute
http://www.rebt.org/public/about-us.html

14-6 Dialectical Behavior Therapy information and training
http://behavioraltech.org/index.cfm

15

Group Therapy, Family Therapy, and Couples Therapy

FOCUS QUESTIONS

1. What are the basic assumptions, arrangements/features, and purported curative factors that characterize group psychotherapy?
2. Compare and contrast time-limited group therapy with other forms of group therapy.
3. What are the major goals and features of family therapy?
4. What are the major features of marital therapy?
5. Overall, how efficacious are family and couples therapies?

CHAPTER OUTLINE

Group Therapy
- A Historical Perspective
- Approaches to Group Therapy
- *A Case Illustration of Psychoanalytic Group Therapy*
- The Arrangements
- BOX 15-1: *Focus on Clinical Applications: Time-Effective Group Psychotherapy for Patients with Personality Disorders*
- The Curative Factors
- Does Group Therapy Work?
- The Future of Group Therapy

Family Therapy
- The Development of Family Therapy
- The Concept of Communication
- Forms and Methods
- BOX 15-2: *Clinical Psychologist Perspective: Greta Francis, Ph.D., ABPP*
- Conjoint Family Therapy
- *A Case Illustration of Conjoint Family Therapy*
- Other Varieties of Family Therapy
- BOX 15-3: *Graduate Student Perspective: David Wagner, M.A.*
- When to Conduct Family Therapy?

Couples Therapy
- BOX 15-4: *Focus on Clinical Applications: The Nine Steps of Emotionally Focused Couples Therapy (EFT)*
- Do Family Therapy and Couples Therapy Work?

CHAPTER SUMMARY
KEY TERMS
WEB SITES OF INTEREST

One could argue that most of the problems that bring patients to therapy are acquired and maintained in a social context. It is very likely that current emotional and behavioral problems have been influenced, to some degree, by past interpersonal dysfunction. A marital conflict, by definition, involves two people. An unassertive salesperson manifests his or her problem in interactions with customers. Children's disruptive behavior often occurs in the context of family relationships. Therefore, inasmuch as the strands of human misery are woven so tightly into the fabric of social relationships, should we not consider forms of therapy that take place in a group or dyadic setting?

In addition, proponents maintain, group and family therapies are more economical. Seeing patients individually for therapy is, they argue, simply not a rational response to the mental health needs of society (Kazdin & Blase, 2011). The economics of health care has led many insurers to demand more efficient and less costly forms of mental health treatment. Whatever the reasons, a variety of methods for treating a number of patients at one time, including group therapy, family therapy, and couples therapy, have become increasingly popular. In this chapter, we discuss group therapy, family therapy, and couples therapy in some detail.

GROUP THERAPY

A Historical Perspective

For many years, group therapy was practiced as a method of choice by only a handful of dedicated therapists. Others used it primarily because their caseload was so heavy that group therapy was the only means by which they could deal with the overload. Still other therapists used group therapy as a supplementary technique. During individual therapy, for example, a therapist might work toward getting a patient to achieve insight into his pathological need to derogate women; then, during a group session, other members of the group might reinforce the therapist's interpretation through their reactions to the patient. Instead of being seen as a second choice or supplementary form of treatment, however, group methods have now achieved considerably more visibility and respectability.

One of the earliest formal uses of group methods was Joseph H. Pratt's work with tubercular patients in 1905. This was an inspirational approach that used lectures and group discussion to help lift the spirits of depressed patients and promote their cooperation with the medical regimen. A major figure in the group movement was J. L. Moreno, who began to develop some group methods in Vienna in the early 1900s and, in 1925, introduced his psychodrama to the United States. Moreno also used the term *group therapy*. Trigant Burrow was a psychoanalyst who used the related term *group analysis* to describe his procedures (Rosenbaum, 1965). In the 1930s, Slavson encouraged adolescent patients to work through their problems with controlled play. His procedures were based on psychoanalytic concepts. These and other figures have been identified as pioneers of the group movement (American Group Psychotherapy Association, 1971; Lubin, 1976).

As was true for clinical psychology generally, it was the aftermath of World War II that really brought group methods to center stage. As we have observed before, the large number of war veterans sharply increased the demand for counseling and therapy. The limitations of the existing agency and hospital facilities made it necessary to use group methods to cope with the immediate demand. Once these methods had gained a foothold in the terrain of pragmatism, respectability

was but a short distance away. As a result, nearly every school or approach to individual psychotherapy now has its group counterpart. There are group therapies based on psychoanalytic principles, Gestalt therapy principles, behavior therapy principles, and many other types as well.

Approaches to Group Therapy

Different approaches to group therapy have emanated from different theoretical origins, and the descriptions of group therapy are couched in a variety of theoretical languages. However, as we saw with individual psychotherapy, experienced group therapists of the same theoretical persuasion often use quite different methods. Because of this poor fit between what therapists do and where they come from theoretically, it is difficult to evaluate the similarities and differences among approaches and, indeed, to describe in any coherent way the methods used in a particular approach. Nevertheless, the following approaches seem fairly typical of the general group therapy movement.

Psychoanalytic Group Therapy. As with individual approaches to treatment, much of the work in group therapy began from a psychoanalytic tradition, Most forms of psychoanalytic group therapy are basically psychoanalytic therapy carried out in a group setting. Although there are obvious differences from individual psychotherapy (e.g., multiple transference effects, modified therapist–patient transference, and influences from one member to another), the focus is still on phenomena such as free association, transference, interpretation of resistance, and working through. Although one can hardly argue that group processes do not exist, their role is viewed as secondary to that of individual processes. The group becomes a vehicle through which the individual can express and eventually understand the operation of unconscious forces and defenses and thereby reach a higher level of adjustment. In general, this approach to group therapy is considered "nondirective," and group processes may transpire with only subtle input from the therapist. As will be seen below, this approach deviates from more contemporary group therapy strategies.

Wolf (1975) has emphasized that psychoanalysis can occur in groups as well as on the individual couch. Wolf believes that the dynamics of the group are secondary to the individual analysis and that the role of the therapist is key. In contrast to individual psychotherapy, group therapy can permit a deeper analytic experience because individuals can "lean" on the group and thus increase their anxiety tolerance. In addition, group members react to one another, to the therapist, and to relationships of authority and intimacy. By observing how others in the group communicate with one another, by participating in a situation in which the individual is not the sole object of the therapist's attention, and by both receiving help from others and giving help to them, the individual can achieve an analysis that is more effective than it might be in the individual therapy setting.

Typically, these groups consist of eight to ten members (equal numbers of men and women) who meet for 90 minutes three times a week. Sometimes the group meets once or twice a week without the therapist to facilitate the working through of transference relationships. Patients often free-associate to their feelings about other members, report dreams, and analyze resistance and transference feelings toward both the therapist and other group members. The following excerpts illustrate *psychoanalytic group psychotherapy*.

Psychodrama. Another historic approach to group therapy involved "psychodrama." This is a form of role-playing that was developed by Moreno (1946, 1959). The patients act out roles much as if they were in a play. This acting is said to bring about a degree of emotional relief (catharsis) and spontaneity that heightens insight and self-understanding. Patients may be asked to play themselves or another role. At times, they may be asked to switch roles in the midst of a dramatization. The drama may involve an event from the patient's past or an upcoming event toward which the patient looks with trepidation.

A Case Illustration of Psychoanalytic Group Therapy

This particular group consists of three men (A, B, C), three women (X, Y, Z), and the therapist. The therapist is a psychoanalytically oriented psychiatrist. The meeting place is the therapist's office. He arranges chairs in a circle, seating himself behind his desk. He knows each of the members, having had them in individual treatment for several to several hundred sessions. The group meets twice weekly, for an hour at a time, and is "closed"; that is, no new members will be permitted during the life of the group. Here, we present excerpts from the first and the tenth group sessions. The members do not know one another when the first session begins.

Session 1

Therapist: This is our first session in an experience that I hope will be helpful to each of you. None of you know each other, and I would like to introduce you. To my right is Mr. A....

Now that we are through with introductions, I would like to explain how I think we should operate, and make some remarks that I hope will help us in getting the greatest value out of group psychotherapy.

Each of you has been in individual therapy with me. But we are starting here afresh. I will not reveal in the group any information that I may have about you that I have obtained prior to today. In general, the same rules will hold as in individual therapy—that is to say, you will speak about whatever may be in your mind, and I will try to tell you whatever I see in your statements. You may try to analyze one another if you wish. I expect that each of you will respect each other's confidences. While I cannot give you any guarantees about the other members, I know each of you rather well, and I have every confidence in the integrity of each of you. But at the same time you will do well to use your good judgment on what to talk about.

I don't expect to talk in the future as much as I will today in the first session, but let me continue a bit more with some further information. First, psychotherapy is psychotherapy, no matter in which mode it is found. Essentially, it is a problem of self-understanding, learning what unconscious motives excite us to behavior. We want to attain insight, so that we will understand what is behind our behavior and our reactions. The goal of psychotherapy is increased satisfaction with ourselves and greater improvement in social behavior. Second, you may be somewhat suspicious about this method, and you think, as I know from talks with each of you, that it may be difficult for you to reveal yourself to others. I think you all share this feeling. However, if you will be able to defer judgment and share in the discussions, you may find that the group method will be valuable and more useful than you believe now. Third, the experience of being in the group per se may not be of value, unless you participate. As trite as this may seem, you will probably get no more out of the situation than you put in. And finally, we may experience all sorts of positive and negative attitudes about one another. These transferences are an essential part of psychotherapy, and you should not be upset if you go through these experiences.

I think that I have said enough, but let me conclude by saying that I am very optimistic about the potentialities of what we are doing, and that I have great hopes we shall all benefit. And so, let us now start.

Session 10

Therapist: Well, I guess we are all here and ought to begin. I wonder how things have been going with Miss Z? She seemed to be right in the midst of a problem when we stopped last session.

A: I was wondering about that too. I hoped that she was able to make out.

Z: Well, I thought quite a lot about what we discussed, and I am glad to say that I think I made progress. I realized that I was fighting with my mother because of resentment I had to her, and that I really did not love her as much as I thought. Then, it came to me, I was really too dependent on her and it would be much healthier if I were able to deal more realistically with her. After all, it wasn't good for her, either.

Y: Then you think you really don't love your mother?

Z: I wouldn't say that. What I think is true is that I am overly dependent on her, and that my resentment of her was really a resentment of myself because, because ... no one really loves me. [Begins to cry]

X: I feel that Z is wrong. People can love her, just anybody can be loved, but in order to be loved, you have to love others.

A: Even in this group, Z seems to keep aloof and won't let others get too close to her.

Z: It is as though my mother and I formed a combination against the whole world. My father left her, and so she depended on me, and I was frightened of the world by her, and so the two of us were alone together, and I had little to do with anyone else. It is a pretty bad situation.

Therapist: Let us try to understand this. I think you are touching something of great value. Both you and your mother formed a cabal against the world. I think you resent her complete possession of you. But now you are aware that it isn't only love you have for your mother, but also hatred. However, you begin to understand how you came to depend on your mother, and also how she came to depend on you. Finally, you are able to see how you have been emotionally enslaved by her. But it must be difficult to experience such emotions, and you must feel alone.[1]

1. From *Methods of Group Psychotherapy*, by R. J. Corsini, pp. 160–161, 163–164. Copyright © 1957 by McGraw-Hill, Inc. Reprinted by permission of the author.

In general, *psychodrama* involves a patient, a stage on which the drama is played, a director or therapist, "auxiliary egos" (other patients, therapeutic aides, and others), and an audience. The director assigns the patient a role, and the supporting cast is made up of the auxiliary egos. The audience can provide acceptance and understanding and may even participate contemporaneously.

Moreno contended that acting out a situation, listening to the responses of the auxiliary egos, and sensing the reactions of the audience lead to a deeper kind of catharsis and self-understanding. He believed that this is much more effective than simply "talking" to a therapist. Particularly for patients who are inhibited or lack social skills, psychodrama can lead to improved levels of self-expression and to the development of heightened social skills. A recent meta-analysis suggests that psychodrama is an efficacious treatment, although this was based on a relatively small number of studies (Kipper & Ritchie, 2003).

Transactional Analysis. Eric Berne (1961) was the developer of and the dynamic force behind *transactional analysis* (*TA*). TA is essentially a process in which the interactions among the various aspects of the people in the group are analyzed. Analyses often focus on three chief "ego states" within each person: the Child ego state, the Parent ego state, and the Adult ego state. Each state is composed of positive and negative features. The positive Child is spontaneous, uninhibited, and creative. The negative Child is fearful, overly emotional, or full of guilt. On the positive side, the Parent state may be characterized as supportive, loving, or understanding. The negative Parent is punishing and quick to condemn. The Adult ego state is less oriented toward feelings and emotions and is more involved with logic, planning, or information gathering. But the Adult can be reasonable (positive) or nonspontaneous (negative).

Depending on how a person was raised, he or she will manifest various aspects of these positive and negative characteristics. A child who was oversupervised or overregulated by the parents might develop an inhibited or guilt-ridden ego state. As a result, if a person in the TA group setting discusses sex in a pompous, authoritative way, and the inhibited person is then asked to respond, she or he may be unable to do so or may respond under great tension. The therapist might then point out how each person is playing negative roles (either Child, Adult, or Parent). One person is playing a negative Parent role by being pompous and authoritative. The other person is responding in a negative Child fashion by being inhibited and tense. Repeated analyses of the interactions among group members reveal the ego states that they typically employ. These analyses lead the patients toward more rational, appropriate ways of thinking that are closer to the Adult ego state (positive).

The units that are analyzed are *transactions*—the stimuli and responses that are active between ego states in two or more people at any given moment.

A transactional analysis involves the determination of which ego states are operative in a given transaction between people.

Another aspect of TA is the emphasis on *games* (Berne, 1964). Games are behaviors that people frequently use to avoid getting too close to other people. Such games are orderly transactions that contain ulterior motives. In TA group therapy, much effort is devoted to discovering and analyzing how the members play games with one another. Berne tends to believe that pseudointimacy rather than authentic intimacy characterizes TA groups. The games members play tend to cover their real feelings and beliefs. He sees one function of the therapist as that of a teacher who, through questions, interpretation, and even confrontation, tries to bring patients to the point where they can choose between games and more satisfying behavior.

TA tends to be a swift-moving, action-oriented approach. There is an emphasis on the present and a sense of grappling with immediate problems that makes it attractive to many patients and therapists. TA has an aura of responsibility, of learning how to choose between options, and this can be a desirable alternative to more traditional forms of group therapy that often appear to lumber along at an agonizingly slow pace. There is also a conceptual simplicity to the whole technique that seems to make it understandable and perhaps more acceptable to patient and professional alike.

Yet this very simplicity, coupled with the zeal and entrepreneurship of some TA practitioners, has led to a popularization that can be dangerous. Critics argue that human problems are complex events that cannot easily be translated into games and that any gains from such procedures are therefore likely to be short-lived. Certainly, there is little in the research literature to calm such fears because TA therapists rarely produce research.

Gestalt Groups. *Gestalt group therapy* is difficult to categorize. Like psychoanalytic group therapy, it is oriented toward the experience of the individual patient. At the same time, its emphasis on resident seminars, weekend retreats, brief workshops, and general popularization gives it a distinct flavor of the encounter movement (e.g., Rogers, 1970). These features may have stemmed in part from the strong and at times flamboyant nature of Fritz Perls (the leader of the Gestalt movement), coupled with the considerable publicity that was given the Esalen Institute in Big Sur, California.

As we saw in Chapter 13, Gestalt therapy focuses on leading the patient to an awareness of the "now" and an appreciation of one's being in the world. In group therapy, this is achieved by concentrating on one member at a time. The therapist focuses on the patient, while the other group members serve as observers. This has been dubbed the "hot seat" approach. Patients are asked to experience their feelings and behavior—to lose their minds and find their senses. Other members of the group are not just passive observers; they may be called on to say how they regard the person in the hot seat. At times, there are bits of role-playing, the reporting of dreams, and dialogues between patients (Perls, 1973). But regardless of whether a member is an observer or in the hot seat, there tends to be intense involvement in the proceedings. As with TA methods, the popularization of the procedures, the lack of research on the results, and the emotionality involved all make it difficult to assess the effectiveness of Gestalt group therapy and to determine whether its effects generalize beyond the specific situation or weekend.

Behavior Therapy Groups. *Group behavior therapy*, a fairly popular mode of group therapy in contemporary clinical psychology, seems to have grown out of considerations of efficiency rather than a primary decision to focus on the dynamics of group interactions (Lazarus, 1975; Rose, 1991). It is entirely feasible to conduct desensitization sessions, model interpersonal skills, or use cognitive restructuring interventions in a group setting (Rose, 1991). For example, it is possible to teach patients in a group setting how to relax, and it is equally possible to establish common anxiety hierarchies simultaneously with several patients. Where such procedures are feasible, it is certainly efficient to use them. In contrast to other group therapy

approaches, the therapist in group behavioral therapy often plays a very active, almost didactic role, providing lessons, skills training, and homework assignments.

Behavioral and cognitive-behavioral groups are usually time limited (e.g., 12 sessions) and are comprised of patients with similar problems. As in most behavior therapy treatments, these group members complete a number of assessment instruments before, during, and after treatment to monitor progress. Rose (1991) provides a number of examples of how reinforcement, modeling, problem solving, and cognitive interventions are implemented in behavior therapy groups. Research has supported the efficacy of behavioral and cognitive-behavioral group interventions for the treatment of depression, social skills deficits, pain, agoraphobia, and other conditions (Rose, 1991).

For example, a group approach is usually the treatment of choice for assertiveness training. Groups provide nonassertive individuals with an excellent environment in which to confront their problems, reduce their fear of being assertive, and learn acceptable methods of self-expression. Such groups typically involve direct teaching, with the therapist describing the group's goals and the problems that nonassertiveness can generate for people. Assertiveness training groups are usually also characterized by such features as cooperative problem solving, honesty, and acceptance among group members. Group members are provided with opportunities to comment and to criticize the manner in which they present themselves. New assertiveness skills are demonstrated and practiced, and homework assignments are often given, followed by group discussion of their success.

Another example is cognitive-behavioral group therapy for social phobia. Heimberg and Becker (2002) present a detailed description of this treatment. Briefly, group members are first introduced to a cognitive-behavioral model of social phobia that incorporates cognitive, behavioral, and physiological components. After the basics of cognitive-behavioral therapy are introduced, the group sessions focus on exercises concerning in vivo or simulated exposure to feared situations, cognitive restructuring, and the development of skills that involve identifying and modifying cognitive biases that serve to produce and maintain symptoms of social phobia. This treatment approach to social phobia has proven efficacious (Burlingame, MacKenzie, & Strauss, 2004) and, due to the nature of social phobia, is arguably the treatment of choice.

Group therapy also is popular in working with young children and adolescents. Because youth are often comfortable with a classroom-type setting, the use of a group approach can be a nice fit for work on reducing aggressive behavior, anxiety, or the development of social skills, for instance. In some cases (e.g., groups of youth with pervasive developmental disorders, such as high-functioning autism), the group setting allows for immediate practice of skills that may be otherwise hard to obtain.

Group behavioral therapy meetings, like other time-limited approaches, typically take place on a weekly basis for a predetermined number of sessions (e.g., eight sessions for a group consisting of members dealing with a life crisis). Often, the group has been comprised following a careful pregroup preparation and screening to ensure that potential group members have similar issues and the requisite skills to contribute to the group.

Box 15-1 describes the application of this approach to patients with personality disorders.

The Arrangements

Because of the wide variety of group approaches used by clinicians, it may be somewhat misleading to give a general description of the arrangements for group therapy. Despite the diversity of techniques, however, there are some general similarities. For example, most groups consist of five to ten patients who meet with the therapist at least once a week for 90-minute to 2-hour sessions. The members are often seated in a circle so that they can all see each other. Sometimes they are seated around a table, sometimes not.

The composition of the group may vary depending both on the therapist's convictions and

BOX 15-1 Focus on Clinical Applications: Time-Effective Group Psychotherapy for Patients with Personality Disorders

Budman et al. (1996) discussed how group psychotherapy can be particularly effective and useful for a group of patients that are often seen as among the most difficult to treat—those with Axis II personality disorders. With these patients, group therapy offers special advantages:

- The patients' social/interpersonal behavior can be directly observed (e.g., being hostile and critical of others);
- Group members can provide on-the-spot feedback regarding the adaptive and maladaptive aspects of a patient's interpersonal behavior (e.g., "When you said that I don't know what I am talking about, I felt hurt and angry at you.")
- Patients have a chance to modify their interpersonal behavior in a group setting;
- Peer pressure may encourage the individual group member to decrease problematic behaviors (e.g., verbally lashing out at others) and to increase more adaptive responses (e.g., telling another member that she or he felt hurt by a particular comment); and
- The group essentially serves as "a social microcosm of the 'real-world'." (Budman et al., 1996, p. 331)

A number of other features are noteworthy. Budman et al.'s (1996) time-effective group psychotherapy (a) has an interpersonal focus; (b) requires the therapist/leader to actively facilitate the group process (e.g., "jump-starting" the group, setting limits on actions that are destructive to the group); (c) is time limited to encourage change; (d) encourages patient responsibility, goal-setting, and monitoring of progress toward the goals; (e) uses homework assignments to encourage change; and (f) utilizes session summaries to tie together group process, recurring themes, and individual progress.

Group members are evaluated for appropriateness based on an extensive screening (via an individual session with the group leader) and a pregroup workshop in which all prospective members meet to introduce themselves, to complete small-group tasks (e.g., role-play problematic interpersonal behaviors and then alternative behaviors), and to complete a whole-group exercise (e.g., planning a party). In this way, the group leader can assess each prospective member's appropriateness for the group—does he respond well to limit-setting? Does she use feedback appropriately? Is he able to engage with other group members?

Budman et al. (1996) report that such a treatment is likely to lead to better affective control, the development of better coping skills, and improved interpersonal behavior in patients with personality disorders.

on practical considerations. Some therapists feel strongly that a heterogeneous group is best—one that includes women and men with a variety of problems, backgrounds, and personalities. Other therapists feel that homogeneous groups are best—groups composed, for example, exclusively of alcoholics or patients with phobias. They believe that homogeneity makes for greater efficiency, quicker understanding, and mutual acceptance (e.g., Budman & Gurman, 1988). In institutional settings with large numbers of patients, it is relatively easy to establish homogeneous groups. In private practice, however, the therapist may have no alternative except to use heterogeneous groups. Most therapists agree that certain kinds of patients must generally be excluded. These include those with severe cognitive limitations, the grossly psychotic, and persons who are especially prone to disrupt the group process (e.g., those who monopolize group discussions or are extremely antagonistic).

In some instances, the therapist sees all group members concurrently on an individual basis. In others, the therapist sees the patients only at group therapy meetings. At times, some therapists like to use a cotherapist (often a therapist of the opposite sex who will add another dimension to such processes as transference). Some groups meet occasionally without a therapist. Whatever the exact format, the role of the group leader is critical. In some groups, there are prohibitions against extracurricular fraternizing; other therapists feel that such prohibitions are unrealistic. Open groups admit a new member whenever someone leaves the

group; closed groups admit no new members once the group has begun to function. Issues of confidentiality in group therapy can be important. In explaining group arrangements and "rules" to group members, the therapist may find it necessary to state that, although all members should maintain the confidentiality of the sessions, no final guarantees can be offered (see the case illustration earlier in the chapter).

The Curative Factors

The diversity of group approaches is apparent. Yet underlying all of them are common threads that speak to the utility of group therapy. Yalom (1975) has specified a set of *curative factors* that seems to define the essence of what these group methods offer:

1. *Imparting information*. Group members can receive advice and guidance not just from the therapist but also from other group members.
2. *Instilling hope*. Observing others who have successfully grappled with problems helps to instill hope—a necessary ingredient for any successful therapy experience.
3. *Universality*. Listening to others, one discovers that he or she has the same problems, fears, and concerns. Knowing that one is not alone can be highly rewarding.
4. *Altruism*. In the beginning, a group member often feels useless and demoralized. As it becomes apparent that one can help others in the group, a feeling of greater self-value and competence emerges.
5. *Interpersonal learning*. Interacting with others in the group can teach one about interpersonal relationships, social skills, sensitivity to others, resolution of conflicts, and so on.
6. *Imitative behavior*. Watching and listening to others can lead to the modeling of more useful behaviors. Group members learn from one another.
7. *Corrective recapitulation of the primary family*. The group context can help clients understand and resolve problems related to family members. The effects of past family experiences can be dissolved by learning that maladaptive coping methods will not work in the present group situation.
8. *Catharsis*. Learning how to express feelings about others in the group in an honest, open way builds a capacity for mutual trust and understanding.
9. *Group cohesiveness*. Group members become a tightly knit little group that enhances self-esteem through group acceptance.

Does Group Therapy Work?

Reviews of the research literature assessing the efficacy of group psychotherapy consistently conclude that group treatment is more effective than no treatment (e.g., Burlingame et al., 2004). This is particularly true for adults and youth with diagnoses of panic disorder, social phobia, or eating disorders and for those treated with cognitive-behavioral group therapy. However, group treatments do not appear to be any *more* effective than other forms of psychotherapy (Burlingame et al., 2004). The major advantage of group therapy is that it is more efficient and more economical, especially the time-limited group treatments.

In general, research on group therapy has not advanced much beyond answering the general question of overall effectiveness (Bednar & Kaul, 1994; Riva & Smith, 1997). However, some believe that evidence is mounting to show the differential effectiveness of certain group models of treatment in different psychological disorders (Burlingame et al., 2004). Although theorists such as Yalom have proposed a variety of "curative factors" or other variables that may influence outcome in group treatment (e.g., group leadership style, the necessity of pregroup training), relatively few studies have been conducted that critically examine the effect of these factors. The studies that have been completed are plagued with a number of conceptual and methodological problems. Clearly, more research investigating the process of group psychotherapy and the proposed curative

factors is needed to better understand why and how group therapy works (Bednar & Kaul, 1994; Burlingame et al., 2004; Rose, 1991).

The Future of Group Therapy

Despite the economy and efficiency of group treatments, they appear to be underutilized. One major reason is that clients and therapists alike tend to view group therapy as a second-choice form of treatment. Fewer clients are referred for group therapy as compared with other forms of treatment, and even those who are referred may not follow through and join a group. However, there is evidence that the demand for group therapy may be increasing (Burlingame et al., 2004).

Managed behavioral health care is likely to make group therapy a more viable option in the future (Steenbarger & Budman, 1996). Group therapy is attractive to therapists and managed care organizations because it can save staff time (and ultimately money) in the care of less severely disturbed patients (MacKenzie, 1994), and it offers an alternative to inpatient treatment in some cases (Steenbarger & Budman, 1996). However, to take advantage of these opportunities, group therapists need to better educate the public and health care professionals about this mode of treatment, aggressively lobby governments and managed behavioral health care companies to financially support group therapy as a service, and better educate themselves about managed care and the health care needs that remain unfulfilled (Steenbarger & Budman, 1996).

FAMILY THERAPY

Generally, when a member of a family develops a problem, everyone in the family is affected. Increasingly, families are going into therapy as units in an attempt to fathom the nature of their difficulties and the means by which to deal with them. Family therapy is a burgeoning field, as indicated by the numerous handbooks and overviews of the field that appear every year. Further evidence of this interest is the special sections on the treatment of families that appear frequently in clinical journals such as the *Journal of Consulting and Clinical Psychology*.

However, it is important to note that family therapy differs somewhat from simply involving family members in treatment. Indeed, it is quite common to involve parents in the treatment of youth, or sporadically to involve spouses, siblings, or additional support members in the treatment of patients more generally. In fact, most therapeutic approaches with children involve substantial interaction with parents to help change the context in which children are raised. Some therapists may even refer to these instances as "family therapy sessions." Yet, true "family therapy" often is characterized by a unique approach to treatment involving the conceptualization of psychological symptoms as arising from the family system.

The Development of Family Therapy

Fruzzetti and Jacobson (1991) trace the origins of family therapy to the 19th-century social work movement. However, family therapy did not immediately gain prominence. It was not until the mid-20th century that family therapy became a popular form of treatment. Some of the delay had to do with the long-standing dominance of psychoanalysis. The perspectives of behaviorism and humanism paved the way for an alternative treatment like family therapy to become a viable option for clinicians. The problems of individuals were conceptualized in systemic terms, as a manifestation of some type of family dysfunction. This new perspective on clinical problems was most evident in some of the conceptualizations of severe mental disorders such as schizophrenia.

In trying to understand schizophrenia, a Palo Alto research group (Bateson, Jackson, Haley, Satir, and others) approached the problem from a communication point of view. To influence a family member, one must deal with the entire family system (Jackson & Weakland, 1961). Related to the idea of the family as a unit is the concept of the *double-bind* (Bateson, Jackson, Haley, & Weakland, 1956). For example, a child might be told by a father, "Always stand up for your rights, no matter who, no matter what!" But the same father tells the

same child, "Never question my authority. I am your father, and what I say goes!" The contradiction inherent in the two messages ensures that no matter what the child does in relation to the father, it will be wrong. According to the Bateson group, the contradiction, the father's failure to admit that there is a contradiction, and the lack of support from other family members can provide fertile soil for the development of schizophrenia. Actually, there is very little empirical support for the double-bind theory of schizophrenia. Indeed, there has been a failure even to establish such communications as reliable phenomena. But the hypothesis was a remarkably fertile one because it nourished much of the Palo Alto family therapy work. This illustrates the point that the value of concepts and research does not reside exclusively in their rightness or wrongness. Their heuristic value—that is, the extent to which they stimulate new work, new ideas, or new procedures—is also important.

Theodore Lidz and his research team also emphasized the family in the etiology of schizophrenia (Lidz, Cornelison, Fleck, & Terry, 1957a, 1957b). When marriage partners fail to meet each other's psychological and emotional needs, one partner may form a pathological alliance with the child, ultimately precipitating the child's schizophrenia. Bowen's (1960) observation of schizophrenic patients who lived together with their parents in a hospital ward for sustained periods led to the conclusion that the entire family unit was pathogenic, not just the patient. Ackerman (1958, 1966) reached similar conclusions. This work is important not because it explained the etiology of schizophrenia (it did not) but because such work and that of Satir (1967a), Haley (1971), Jackson (1957), and Bell (1961) gave impetus and direction to the family therapy movement—a movement rich in technique, theory, and history.

The Concept of Communication

From the time of its origins in the work on schizophrenia, family therapy has emphasized *communication*. Pathology has typically been seen as a failure of communication among family members. This communication focus can be seen in what many regard as the central concept in family therapy—*general systems theory*. Family therapy deals with the relationship between the individual family member and the family system. The family is conceived of as a system, which family therapy seeks to alter in some important way. Many conceptualize the family as constantly striving to maintain a homeostasis. One person's behaviors (e.g., a child's developmental delays) may shift attention away from a conflictual marital relationship. Sometimes the family successfully adapts to their particular pattern of interaction within this system. However, when the system changes (e.g., the child gets older and is no longer experiencing significant delays), then the system is unable to adjust to a new homeostasis. General systems theory would suggest that this "unbalanced" state is the focus for family therapy. The therapist achieves positive change by using feedback that alters the way the system functions and reestablishing a new, healthy homeostasis.

Forms and Methods

There is no clear, consensual definition of what constitutes family therapy. Indeed, there is not even a consensus on who should conduct it. The general procedures of family therapy are carried on by psychologists, psychiatrists, social workers, counselors, and others. Family therapists and counselors are trained in several different programs, including clinical psychology, counseling psychology, psychiatry, social work, family and child development, and education. All of this, of course, makes for considerable confusion and some squabbling over professional credentials. Some therapists use family therapy as only one of several techniques; others are exclusively family therapists. With so little agreement as to who is qualified to conduct family therapy, is it any wonder that the specific techniques employed (which actually seem to have much in common) are given such distinctive titles? Thus, we have *family therapy, behavioral family therapy, conjoint family therapy, concurrent family therapy, collaborative family therapy, network family therapy, structural family therapy, multiple family*

therapy, and on and on. Theoretical approaches range from the systemic, to the psychodynamic, to the behavioral, and on to those that purport to integrate various theoretical practices.

The Goals. Most family therapists share the primary goal of improving communication within the family and deemphasize the problems of the individual in favor of treating the problems of the family as a whole. However, once we get beyond such general statements, there seems to be some disarray of purposes and goals. For example, many therapists who talk about the family system still seem to view family therapy as a kind of context in which to solve an individual's problems. Seeing the family together becomes a technique (perhaps a more efficient one) for inducing changes in the individual patient. Other family therapists are devoted to the philosophy that regarding the family as a unit and working with it as such will enhance that unit. Although this may benefit the individual members, the real focus is on the family. As in most enterprises, the largest number of family therapists falls somewhere between the two extremes.

BOX 15-2 Clinical Psychologist Perspective: Greta Francis, Ph.D., ABPP

Dr. Greta Francis received her B.S. in psychology from the University of Pittsburgh in 1982 and completed her M.S. and Ph.D. in clinical psychology at Virginia Tech in 1987. She returned to the University of Pittsburgh School of Medicine for her predoctoral internship at Western Psychiatric Institute and Clinic and then stayed on to do a National Research Service Award postdoctoral fellowship. Upon completion of her fellowship in 1988, Dr. Francis moved to Rhode Island for a faculty position at Brown in the department of psychiatry and human behavior and a job as a staff psychologist on the adolescent inpatient unit at Bradley Hospital. She assumed the role of coordinator for training in clinical child psychology for the internship program shortly after arriving at Brown. In 1989, Dr. Francis was promoted to assistant chief of services for the adolescent unit. After four years on the inpatient unit, she accepted a position in a school-funded day treatment program on the Bradley campus and moved into the role of clinical director of that program. Dr. Francis was promoted to associate professor in 1997, and, in 2003, became an associate director for the clinical psychology training consortium. In 2008, Dr. Francis was board certified in clinical child and adolescent psychology.

We asked Dr. Francis a few questions about her background, her interests and expertise, and her predictions for the future of clinical psychology and family therapy.

What originally got you interested in the field of clinical psychology?

As the daughter of a nurse and a psychiatrist, I had an interest in some sort of helping profession since childhood. While an undergraduate at Pitt, I became fascinated (briefly) with biological psychology after taking classes from an amazing teacher, Dr. Frank Colavita. His ability to engage students in the subject matter was remarkable, but I eventually realized that I was more interested in clinical work than laboratory work. I had the opportunity to be a research assistant in two different clinical labs at Pitt. One was an adult social skills lab in the department of psychology and the other was a child psychopathology lab in the medical school. I learned a lot from both but definitely was drawn more to working with kids. When I went to graduate school, I was incredibly fortunate to end up in the lab of my mentor, Dr. Thomas Ollendick. Dr. Ollendick is a child clinical psychologist, so that is where I first learned what it meant to be a child clinical psychologist. My training incorporated developmental psychopathology within a cognitive-behavioral framework. At that time, I was absolutely certain that I wanted to return to a graduate program in clinical psychology to start my career when my training was done. Certain, yes, until I went to a medical school for my internship. I then became absolutely certain that I wanted to work in a medical school. Right now, I'm seeming kind of flighty, huh? Some might say flighty, while others might say that I was relying on experiential learning to guide my decision making.

Describe what activities you are involved in as a clinical psychologist.

When I left graduate school, I knew I wanted to stay involved with "faculty stuff" but it never occurred to me that I would end up on the faculty at Brown

running a school for students with psychiatric and developmental disorders. My job now is multifaceted and always busy. I can say honestly that I've never been bored at work. Exasperated at times? Yes. Delighted? Frequently. Amazed at the resiliency of students when given structure and support? Always.

I believe that the key to feeling satisfied at work is the ability to continue to grow and learn. What I do now has been informed and shaped by what I've learned over time. For example, I remain committed to CBT as an evidence-based treatment for many childhood disorders, but the way I practice CBT has changed having worked in a setting where students stay for lengthy periods of time and have very complicated symptom presentations. Now I spend more time establishing rapport and providing education about the child's mental illness and how CBT works. I set smaller goals that can be practiced with support very frequently, rely on other professionals to help carry out treatment tasks, fade support over longer periods of time, and am able to assess when booster sessions might be necessary because of my continued access to the student.

One of my greatest pleasures is the opportunity to teach. I am fortunate to be able to teach advanced trainees in clinical child psychology and child psychiatry. My job also affords me the luxury of teaching introductory psychology to small groups of high school students at my school. These students are eager to learn about psychology, and working with them keeps me motivated to make the subject matter as interesting and entertaining for them as it was for me when I first got interested in psychology. In addition to teaching students, I run educational workshops for educational and mental health professionals in the community and provide in-service training workshops for staff at my school. Recently I was part of a workshop series designed to provide training in CBT for anxiety disorders for mental health professionals in the community. A recent in-service training topic for my school staff was the impact of chronic trauma on the emotional and academic functioning of students in school.

In addition to providing clinical services to students and families at my school, I supervise assessment, treatment, and consultation conducted by clinical psychology residents and postdoctoral fellows. I have a strong interest in the relationship between supervision and the developmental course of trainees and supervisors. Each year, one of my child psychiatry colleagues and I run a seminar for our psychology residents on the topic of supervision and development. Working with trainees who are steps away from being able to fly independently is tremendously rewarding. Our residents and fellows are extremely well trained coming to Brown, so that is a great motivator to me to keep current so I can facilitate their development as soon-to-be independent clinical psychologists.

Two of my other training roles are coordinator of training in clinical child psychology for our internship program and associate director of our training consortium. As internship coordinator, I oversee training in clinical child and pediatric psychology for 5–6 residents across two hospital settings that include 15+ clinical rotations and 6+ research placements. I have the pleasure of working with faculty who are committed to training and who excel as teachers and supervisors of clinical and research work. As an associate director of the training consortium, I work closely with our training director and fellow associate directors on big-picture issues affecting our training program (e.g., preparing for site visits, facilitating faculty development).

Lastly, I am involved in clinical administration in a variety of ways. As clinical director of the Bradley School, I am responsible for all aspects of the clinical and educational services provided to students. I am very fortunate to work with an extremely talented staff who make the job of running the school a daily pleasure. We are one of five Bradley School sites in RI, so I also work closely with the clinical directors of our sister sites on tasks as diverse as coordinating staff training, facilitating admissions to the schools, and developing a music education program for the students.

What are your particular areas of expertise or interest?

I identify myself as a cognitive-behavioral therapist who has developed expertise in treating students with a variety of psychiatric disorders within a school setting. I have the most interest in youth with anxiety, mood, and psychotic disorders. Given the nature of referrals to my school, I get to work with a large number of adolescents newly diagnosed with psychotic disorders. The empirical literature on treating psychosis in adolescents is very limited, so I have looked to adult literature on psychotic disorders to learn how to help these kids and families understand and manage their symptoms (using both medication and CBT strategies) to maximize their functioning inside and outside of school. I have extensive experience with classroom-based behavior management. I've learned how to set up and implement a school-wide classroom behavior management system that is structured, predictable, reinforcing, and flexible enough to meet the needs of students across the age range and with varying

(Continued)

BOX 15-2 Clinical Psychologist Perspective: Greta Francis, Ph.D., ABPP (*Continued*)

psychiatric disorders. Finally, I have expertise in the systems issues inherent in running a school for students with psychiatric disorders. I know how to work with professionals from a variety of disciplines to facilitate their ability to do their best work and make progress toward shared goals for our students.

What are the future trends you see for clinical psychology?
I see a need to continue to disseminate evidence-based treatments for childhood disorders to mental health practitioners in the community so that more youth have access to the most effective treatments available. By virtue of working in an internship training program, I also see the necessity of resolving the now chronic issue of the mismatch between the smaller number of internship slots available and the larger number of applicants coming out of graduate programs.

What are the special challenges involved in working with adolescents in a family or group context?
The developmental differences between a 13-year-old and a 19-year-old are enormous as teenagers tackle many transitions from middle school to high school and beyond. When working with adolescents, it is important to acknowledge the increasing importance of peer relationships and the need to facilitate the development of independence and autonomy.

In the context of family therapy, learning to negotiate and problem-solve within the family is a necessary skill for teenagers and their parents. It is particularly important to support parents as they negotiate a different relationship with their adolescent than they had with their child. Parents have to manage the often scary process of letting their teenager try new things even though they know their teen isn't always going to succeed. The family therapist has to juggle the roles of coach for the teenager and the parents in order to model effective problem-solving skills.

In group therapy, it is important for therapists to be thoughtful when determining the membership of therapy groups. For example, groups consisting only of teenagers with conduct problems run the risk of facilitating more maladaptive behaviors among group members. Group therapists also must be mindful of setting clear rules about confidentiality among group members, particularly in this time of easy access to social media.

Greta Francis

Greta Francis

Some General Characteristics. Certain aspects of family therapy differentiate it from the customary individual therapy. For example, family members have a shared frame of reference, a common history, and a shared language of connotations that may be foreign to the therapist. The therapist has to learn the family roles and something about the family's idiosyncratic subculture. This information is used to enhance communication or to confront family members. At the same time, the therapist must remain detached and not become overly identified with one faction of the family at the expense of another. This can be a difficult and delicate task because family members will often attempt to use

the therapist in their power struggles or in their defenses against open communication.

A history and assessment process is a typical part of family therapy. The presenting problem must be stated and understood. It may be that a son is a delinquent or a daughter is sexually promiscuous. It is often interesting and diagnostically important to see how different family members construe the same problem in quite divergent ways. Usually, a family history will be taken. This, too, can have ramifications. When the family problem is placed in the larger context of information about the parents' origins and their early life and marriage, children can often attain improved communication and understanding. Laying out the entire panorama of family history—its extended members and their goals, aspirations, fears, and frailties—can lead to deeper understanding, empathy, and tolerance. This larger context can promote a shared frame of reference that was not possible earlier. A child can begin to learn what it meant for the mother to relinquish her own aspirations in favor of the family or what it meant for the father to experience abuse from his own father. In the controlled setting of the family therapy room, the parents may, at the same time, remember (via the current experience of their children) what it was like to encounter peer pressure.

Conjoint Family Therapy

In *conjoint family therapy*, the entire family is seen at the same time by one therapist. In some varieties of this approach, the therapist plays a rather passive, nondirective role. In other varieties, the therapist is an active force, directing the conversation, assigning tasks to various family members, imparting direct instruction regarding human relations, and so on.

Satir (1967a, 1967b) regarded the family therapist as a resource person who observes the family process in action and then becomes a model of communication to the family through clear, crisp communication. Thus, Satir viewed the therapist as a teacher, a resource person, and a communicator. Such a therapist illustrates to family members how they can communicate better and thereby bring about more satisfying relationships. The following excerpts from Satir (1967a) clarify the interaction process for a family.

A Case Illustration of Conjoint Family Therapy

Therapist: (to husband) I notice your brow is wrinkled, Ralph. Does that mean you are angry at this moment?

Husband: I did not know that my brow was wrinkled.

Therapist: Sometimes a person looks or sounds in a way of which he is not aware. As far as you can tell, what were you thinking and feeling just now?

Husband: I was thinking over what she [his wife] said.

Therapist: What thing that she said were you thinking about?

Husband: When she said that when she was talking so loud, she wished I would tell her.

Therapist: What were you thinking about that?

Husband: I never thought about telling her. I thought she would get mad.

Therapist: Ah, then maybe that wrinkle meant you were puzzled because your wife was hoping you would do something and you did not know she had this hope? Do you suppose that by your wrinkled brow you were signaling that you were puzzled?

Husband: Yeah, I guess so.

Therapist: As far as you know, have you ever been in that same spot before, that is, where you were puzzled by something Alice said or did?

Husband: Hell, yes, lots of times.

Therapist: Have you ever told Alice you were puzzled when you were?

Wife: He never says anything.

Therapist: (smiling, to Alice) Just a minute, Alice, let me hear what Ralph's idea is of what he does. Ralph, how do you think you have let Alice know when you are puzzled?

Husband: I think she knows.

(Continued)

A Case Illustration of Conjoint Family Therapy *(Continued)*

Therapist: Well, let's see. Suppose you ask Alice if she knows.

Husband: This is silly.

Therapist: (smiling) I suppose it might seem so in this situation, because Alice is right here and certainly has heard what your question is. She knows what it is. I have the suspicion, though, that neither you nor Alice are very sure about what the other expects, and I think you have not developed ways to find out. Alice, let's go back to when I commented on Ralph's wrinkled brow. Did you happen to notice it, too?

Wife: (complaining) Yes, he always looks like that.

Therapist: What kind of message did you get from that wrinkled brow?

Wife: He don't want to be here. He don't care. He never talks. Just looks at television or he isn't home.

Therapist: I'm curious. Do you mean that when Ralph has a wrinkled brow that you take this as Ralph's way of saying, "I don't love you, Alice. I don't care about you, Alice"?

Wife: (exasperated and tearfully) I don't know.

Therapist: Well, maybe the two of you have not yet worked out crystal-clear ways of giving your love and value messages to each other. Everyone needs crystal-clear ways of giving their value messages. (to son) What do you know, Jim, about how you give your value messages to your parents?

Son: I don't know what you mean.

Therapist: Well, how do you let your mother, for instance, know that you like her, when you are feeling that way. Everyone feels different ways at different times. When you are feeling glad your mother is around, how do you let her know?

Son: I do what she tells me to do. Work and stuff.

Therapist: I see, so when you do your work at home, you mean this for a message to your mother that you're glad she is around.

Son: Not exactly.

Therapist: You mean you are giving a different message then. Well, Alice, did you take this message from Jim to be a love message? (to Jim) What do you do to give your father a message that you like him?

Son: (after a pause) I can't think of nothing.

Therapist: Let me put it another way. What do you know crystal-clear that you could do that would bring a smile on your father's face?

Son: I could get better grades in school.

Therapist: Let's check this out and see if you are perceiving clearly. Do you, Alice, get a love message from Jim when he works around the house?

Wife: I s'pose—he doesn't do very much.

Therapist: So from where you sit, Alice, you don't get many love messages from Jim. Tell me, Alice, does Jim have any other ways that he might not now be thinking about that he has that say to you that he is glad you are around?

Wife: (softly) The other day he told me I looked nice.

Therapist: What about you, Ralph, does Jim perceive correctly that if he got better grades you would smile?

Husband: I don't imagine I will be smiling for some time.

Therapist: I hear that you don't think he is getting good grades, but would you smile if he did?

Husband: Sure, hell, I would be glad.

Therapist: As you think about it, how do you suppose you would show it?

Wife: You never know if you ever please him.

Therapist: We have already discovered that you and Ralph have not yet developed crystal-clear ways of showing value feelings toward one another. Maybe you, Alice, are now observing this between Jim and Ralph. What do you think, Ralph? Do you suppose it would be hard for Jim to find out when he has pleased you?[2]

1. From Virginia Satir, *Conjoint Family Therapy,* 2nd ed., p. 97–100. Copyright © 1967 Science and Behavior Books, Inc. Palo Alto, CA. USA. Reprinted with permission.

In conjoint and other forms of family therapy, there are five basic modes of communication (Satir, 1975): placating (always agreeing, no matter what is going on); blaming (a person's way of showing how much he or she can criticize another and thus throw his or her weight around); super-reasonable (especially characteristic of teachers, whose words may come out "super-reasonable" but may bear no relationship to how they feel); irrelevant (the words are completely unrelated to what is going on); congruent (the words

relate to what is real). These modes of communication provide, in a sense, the essence of communication and feeling. They do not negate the role of cognitions, but they do place the emphasis where Satir believed it belongs.

Other Varieties of Family Therapy

There are many other types of family therapy. The following are a sample of the more commonly encountered versions.

Concurrent Family Therapy. In *concurrent family therapy*, one therapist sees all family members, but in individual sessions. The overall goals are the same as those in conjoint therapy. In some instances, the therapist may conduct traditional psychotherapy with the principal patient but also occasionally see other members of the family. As a matter of fact, it is perhaps unfortunate that the last variation is not used more often as a part of traditional psychotherapy. Because it is often the case that an individual patient's problems can be understood better and dealt with better in collaboration with significant others in the patient's life, the use of such arrangements should facilitate the therapeutic process.

Collaborative Family Therapy. In *collaborative family therapy*, each family member sees a different therapist. The therapists then get together to discuss their patients and the family as a whole. As we saw earlier, the use of this approach with child patients was one of the factors that stimulated the early growth of family therapy. In a variation of this general approach, cotherapists are sometimes assigned to work with the same family. That is, two or more therapists meet with the family unit.

Behavioral Approaches to Family Therapy. Some clinicians (e.g., Liberman, 1970; Patterson, 1971) have viewed family relations in terms of reinforcement contingencies and skills training. The role of the therapist is to generate a behavioral analysis of family problems. This analysis helps identify the behaviors whose frequency should be increased or decreased as well as the rewards that are maintaining undesirable behaviors or that will enhance desired behaviors. *Behavioral family therapy* then becomes a process of inducing family members to dispense the appropriate social reinforcements to one another for the desired behaviors.

Given the recent developments in cognitive-behavioral therapy, it is not surprising that this approach has found its way into the family therapy enterprise. Similar to cognitive-behavioral therapy for the individual, the family version involves teaching individual family members to self-monitor problematic behaviors and patterns of thinking, to develop new skills (communication, problem resolution, negotiation, conflict management), and to challenge interpretations of family events and reframe these interpretations if necessary (Carlson, Sperry, & Lewis, 1997; N. Epstein, Schlesinger, & Dryden, 1988).

Multisystemic Therapy. A more recent mode of family therapy, *multisystemic therapy* (MST) (Henggeler, 2011; Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), was developed as an intervention for juvenile offenders and their families. The model behind MST assumes that clinical problems are determined by multiple factors, including the individual, the family, the school environment, and the neighborhood. These influences are viewed as "systems" of influence within which each person operates. MST sees the family as the most important link in changing problematic behavior, and this approach is characterized by several key components: (a) treatment is delivered in the person's home, school, or other community locations; (b) MST therapists are available for consultation 24 hours a day, 7 days a week; (c) the caseloads of MST therapists are kept intentionally low (4 to 6 families) in order to provide intensive services to each family; (d) MST therapists serve on a team in order to provide continuity of services and to be available for back-up should the need arise (Henggeler, 2011). MST uses several evidence-based techniques (e.g., cognitive-behavioral), and both individual and family outcomes are tracked. MST has been shown to be both efficacious (compared to no treatment) as well as effective

BOX 15-3 Graduate Student Perspective: David Wagner, M.A.

David V. Wagner is a sixth-year doctoral candidate in clinical psychology at the University of Missouri. He received his B.A. in child psychology from the University of Minnesota and M.A. from the University of Missouri. David studies the effect of multisystemic therapy (MST) on nonreferred family members (e.g., siblings, parents). David has also been involved with adapting MST for use with adolescents with autism spectrum disorder and is currently conducting a randomized clinical trial to assess the efficacy of this adapted treatment. After graduation, he hopes to find a university-affiliated position where he can continue to modify and evaluate this new adapted treatment for autism spectrum disorder as well as continue his research on the effects of treatment on multiple family members.

We asked David to share his thoughts about graduate school, as well as his interests and expertise.

What has graduate school in clinical psychology been for you?

For me, graduate school has been the ideal blend of research, teaching, and clinical practice. My program provided me with coursework to supplement my knowledge base in psychology. It also supplied me with clinical training and practice experiences that have helped me to better understand what we know about whether and how treatment works as well as, and perhaps more importantly, what we still don't know about treatment outcomes and processes. I've also had the experience of instructing undergraduate courses, from 30 juniors and seniors in an upper-level course to 500 students in an introductory course. Graduate school has offered me the opportunity to collaborate with experts in other fields and settings and to conduct my own basic and applied research. In sum, graduate school has, for me, been the foundation upon which my career in this field will be built, whether that be in research, supervision, dissemination, or teaching.

What things have you least expected about graduate school?

Most of what I encountered in graduate school fit my preconceptions. As I had hoped, I found graduate school in clinical psychology to be a setting populated with bright and inquisitive individuals who share many of the same interests. In addition, our graduate program has expectedly tested the limits of my abilities and challenged me to be a more efficient and diligent worker. Despite this, I was surprised by a number of characteristics of my program. I hadn't expected the faculty to be as approachable and down-to-earth as they were. I also hadn't expected the level of specialization that I encountered. That is, a number of individuals will receive the same degree but have very little overlap in their areas of research and clinical experience. Finally, no matter how many times I was previously informed of my program's research emphasis, I was still surprised at the seemingly much larger value placed on academic publications when compared to clinical work.

Has graduate school changed you? If yes, how so?

Graduate school has been linked to changes for me in numerous ways. Some of these changes have been small, such as an expanded vocabulary, and some large, such as an increased consideration of multiple alternative explanations for the behavior of others. Perhaps the biggest change has been the increased emphasis that I now place on empirical results, not only in my study and understanding of psychology but when considering and making life decisions. For example, whether I'm choosing a workout routine, shopping for a used car, or watching a baseball game, I now find myself more frequently questioning the claims of others, considering alternative explanations, and searching for research data that will better help me understand the information presented to me. That is, what empirical evidence supports this new workout? Is there unbiased research on the claim that this car model will last another 5 years? How meaningful is a player's home run total? Although I've always considered myself to be a critical thinker, whether for good or bad, I now find myself applying the lessons I've learned in my studies not only to psychology but also to my daily life.

Are your professional or research interests similar or different now than they were when you started graduate school?

My professional interests and research interests are surprisingly similar to what they were before starting graduate school. In high school, I worked as a provider for a child with autism, and, as a college undergraduate, I worked in a lab conducting research related to autism. In addition, during and after my undergraduate education, I worked as a group leader and case manager for children with mental health disorders and their families. As such, I came to graduate school hoping to find ways to better help these populations. Indeed, I now find myself researching whether family-based therapies (e.g., multisystemic therapy, MST) have positive effects on nonreferred family members and am in the process of adapting and evaluating MST for autism spectrum disorders. In sum, I've found that, over time, my program has

allowed me to pursue research in the very areas that brought me to graduate school in the first place.

Tell us about the work you have conducted in using MST while in graduate school.

During my time in graduate school, I've had extensive experience practicing, adapting, and researching MST. I spent 2 years working with the local juvenile office as a MST provider for juvenile delinquents and their families. I conducted research on whether MST leads to long-term improvements (e.g., less severe criminal outcomes) for nonreferred family members (e.g., siblings, parents) when compared to usual services. I've also received over 4 years of supervision in MST from a cofounder of MST, Dr. Charles Borduin.

Given my separate experience with MST and children with autism, I was fortunate enough to be provided with an opportunity to collaborate with Dr. Borduin and experts in autism research, assessment, and practice to adapt MST for youths with autism spectrum disorders and their families. As part of this project, I spent an additional year providing MST to youths with autism spectrum disorder, learning about how they and their families may differ from those individuals and families typically seen in MST and beginning to determine whether this model would be feasible to adapt and helpful for these youths and families. I was provided with the opportunity to work with this team to consider adaptations to the model and secure grant funding for future studies. I was then allowed to train and help supervise MST therapists responsible for providing this new treatment and oversaw the collection of outcome data used to assess the feasibility of using MST with this population. As a whole, this project has provided me with the experiences I had hoped to some day gain *after* graduate school.

Looking back, what activities or experiences were the most important for you in your graduate school program?

Experiences, such as providing MST or adapting a treatment model, were perhaps the most interesting and rewarding for me. However, looking back, I now see that many of the most important experiences for me in my graduate program were also those that were the most stressful and that I was most likely to want to avoid. These experiences included defending a thesis, orally presenting research in front of faculty and peers, and taking comprehensive exams. Upon reflection, I learned the most about conducting research, disseminating results, and both consuming and summarizing clinical research literature from those experiences.

Any additional hints for those trying to make it through graduate school in clinical psychology?

I believe that everyone responds a little differently to the unique stressors and opportunities associated with graduate school in clinical psychology and therefore have few blanket recommendations. There are, however, three things that I do mention to our incoming students that I found to be helpful for me. First, it is completely normal to feel as though you are not competent enough or don't belong in graduate school. Many of us feel that way at times, especially during our first year, regardless of our ability levels. Second, explore recreational or social outlets outside of your program. We spend an inordinate amount of time in classes, labs, and clinics with our peers, and I feel having at least a few "non-psychology" outlets helps me when I don't want to talk shop and/or be reminded of work. Lastly, don't spend too much time fretting and planning for all of the work that you have to do. Just do it. Looking back, I realized that I spent endless hours trying to think about or plan for my work during my early years and am now amazed by how much more can be accomplished when I just sit down and work.

David Wagner

David Wagner

(Henggeler, 2011). Finally, MST has been modified to address other clinical problems as well, including youth emotional disturbance, youth substance use disorder, family abuse and neglect, and child/youth health problems (Henggeler, 2011).

When to Conduct Family Therapy?

There are no hard-and-fast rules as to when family therapy is appropriate and when it is not. Most often, family therapy is begun with an adolescent as the principal patient. Perhaps the patient's problems are so tied up with the family that family therapy is really the only sensible course. Perhaps the family has impeded therapeutic progress in the past or has resisted the therapist's advice. Alternatively, some therapists may conceptualize the adolescents' symptoms as a signal that there is trouble somewhere else in the family unit (e.g., a teen's acting out keeps attention away from a conflictual marriage; until the marital relationship is addressed, it will be hard to get the adolescent to reduce disruptive behavior).

Sometimes, family crises, such as the death of a family member, propel the entire family unit into pathology almost as one. In some families, there are conflicts over values. For example, an adolescent who begins to take drugs or becomes totally absorbed in a cult or a different religion may disrupt the entire family by seeming to undermine its values. In such instances, family therapy may be a logical recourse.

Finally, significant marital or sexual problems may be resolved best by a form of family therapy. It can, of course, be difficult to determine whether individual, family, or couples therapy should be undertaken as a way of working out such problems. However, family therapy or couples counseling would seem appropriate when the problems do not seem to stem from deep-seated emotional conflicts but from matters that can be dealt with educationally, including misguided attitudes, poor knowledge about sexuality, or lack of communication.

However, family therapy is not a cure-all, and it is not always appropriate. Sometimes a family is so disrupted that such intervention would clearly be doomed to fail. It is also possible that one or more family members will refuse to cooperate. In some instances, it quickly becomes clear that a given family member is so disturbed, so uncooperative, or so disruptive that the entire process of family therapy would be poisoned by his or her presence.

Since family therapy involves several people, one must sometimes consider its possible use in cost–benefit terms. Although family therapy might benefit the identified patient of the group, the process could have malignant consequences for some of the other members. Like individual patients, some families do not possess the psychological strength or resources to cope with the threatening material that may come out in family therapy sessions. Deciding when to use family therapy is often a difficult matter that requires careful assessment and a great deal of clinical sensitivity.

Couples Therapy

Although we use the term *couples therapy*, this approach is not limited to married couples and can be provided to unmarried couples, same-sex couples, and others. There are many issues that bring couples in to consult with a clinician. In one sense, couples therapy can be construed as a form of family therapy. For example, when a husband and wife are seen together and the focus of treatment is on the marital relationship rather than on the problems of the individuals, a form of family therapy seems to be involved.

Although the couples therapy movement, like the family therapy movement, owes much to interpersonal theorists such as Sullivan, Horney, and Fromm, the development of couples therapy as a discipline can be attributed to pragmatic concerns (Fruzzetti & Jacobson, 1991). Essentially, a wide variety of professionals (including doctors and lawyers), in the course of carrying out their normal professional duties, became increasingly involved in attempting to resolve marital conflicts. Fruzzetti and Jacobson (1991) note the remarkable growth of couples therapy since the 1960s. Today, the most popular forms of couples therapy are behavioral marital therapy, cognitive couples therapy, emotionally focused couples therapy, sex therapy, and insight-oriented (psychodynamic) couples therapy. To give the reader a flavor of what techniques are used in couples therapy, we briefly describe

behavioral marital therapy (Jacobson & Margolin, 1979; Stuart, 1980; Weiss, Hops, & Patterson, 1973) and emotionally focused couples therapy (Johnson, Hunsley, Greenberg, & Schindler, 1999).

Behavioral Marital Therapy. The beginnings of *behavioral marital therapy* (*BMT*) are often traced to the work of Richard Stuart (1969). (Again, despite the use of the term *marital*, BMT does not require that the partners be married.) Stuart's treatment of marital dysfunction involved the application of reinforcement principles to couple's interactions. A major component of his treatment was a technique called *contingency contracting*; spouses were trained to modify their own behavior to effect a specific desired change in their mate's behavior.

Over the years, BMT has broadened to include a number of additional techniques. *Support-understanding techniques* aim to increase positive behaviors emitted by partners, increase collaboration within the couple, and increase positive feelings in each partner. For example, each partner generates a list of behaviors that, if produced by his or her mate, will bring pleasure. Next, each partner agrees to perform three of the behaviors from her or his partner's list before the next session. *Problem-solving techniques* involve training couples in positive communication skills so that effective decision making and negotiating are possible. For example, couples are given a list of basic rules of positive communication skills and then "practice" these skills within the session. The clinician intervenes if she or he thinks it will be helpful (e.g., clarifying the appropriate communication skills, modeling alternative ways to communicate that are more positive). These and other BMT strategies are described in more detail in a number of sources (e.g., Gottman, Notarius, Gonso, & Markman, 1976; Jacobson & Margolin, 1979; Stuart, 1980).

Emotionally Focused Couples Therapy. *Emotionally focused couples therapy* (*EFT*) is a brief treatment that seeks to change partners' problematic interactional styles and emotional responses so that a stronger and more secure emotional bond can be established (Johnson et al., 1999). This treatment approach assumes that negative affect and associated destructive interactional styles create marital distress. Further, it is believed that a more secure attachment to one's partner is necessary to stabilize a dyadic relationship.

Johnson et al. (1999) have outlined the nine treatment steps in EFT (see Box 15-4). The first

BOX 15-4 Focus on Clinical Applications: The Nine Steps of Emotionally Focused Couples Therapy (EFT)

Cycle De-escalation.

Step 1. Assessment—creating an alliance and explicating the core issues in the couple's conflict using an attachment perspective.

Step 2. Identifying the problem interactional cycle that maintains attachment insecurity and relationship distress.

Step 3. Accessing the unacknowledged emotions underlying interactional positions.

Step 4. Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

Changing Interactional Positions.

Step 5. Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions.

Step 6. Promoting acceptance of the partner's new construction of experience in the relationship and new responses.

Step 7. Facilitating the expression of specific needs and wants and creating emotional engagement.

Consolidation/Integration.

Step 8. Facilitating the emergence of new solutions to old problematic relationship issues.

Step 9. Consolidating new positions and new cycles of attachment behavior. (p. 70)

From Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D., "Emotionally focused couples therapy: Status and challenges," *Clinical Psychology: Science and Practice*, 6, pp. 67–79. Copyright © 1999 American Psychological Association. Reprinted with permission.

four steps involve assessment of the couple and attempts to interrupt the cycle of negative interactions. The next three steps involve helping create new, more adaptive interactional styles that meet partners' needs. Finally, the last two steps of EFT involve the consolidation of changes made.

Through these steps, partners are better able to recognize their own emotional and bonding needs and to modify their interactions with each other. In this way, they can ensure that these needs are more likely to be met and that destructive interactional patterns are minimized.

Do Family Therapy and Couples Therapy Work?

As with other forms of psychotherapy, it is important to evaluate the empirical evidence that speaks to the efficacy of different forms of family and couples therapy. Before presenting these data, however, it is important to note that the measurement of outcome in family and couples therapy is complex because of the multiple perspectives that must be considered (different family members, both spouses). As in individual psychotherapy research, self-report measures, ratings by others (e.g., the therapist), and observational ratings are used extensively in family and couples therapy research.

Family Therapy. Despite the popularity of family therapy in clinical practice, relatively few well-controlled empirical studies have been conducted to evaluate its effectiveness. One meta-analysis of this literature (Shadish et al., 1993) computed 44 effect sizes from published articles and unpublished dissertations (years 1963–1988) that evaluated the efficacy of family therapy. The average effect size for any form of family therapy was .47, indicating that the average treated client was functioning better than 68% of those individuals not receiving treatment. Shadish and colleagues also reported average effect sizes separately for various types of family therapy. Eclectic (combinations of orientations) and behavioral/psychoeducational treatments were most effective, whereas humanistic and systemic approaches were least effective. These data are shown in Table 15-1.

Although the Shadish et al. (1993) meta-analysis gives us a sense of the overall efficacy of family therapy across modalities and target populations, another meta-analytic study provides data on the efficacy of family therapy for specific disorders

TABLE 15-1 Average Effect Size (ES) and Percentile Equivalent for Selected Forms of Family Therapy and Couples Therapy

Type of Therapy	*Mean ES*	*Percentile Equivalent*
Any Type of Family Therapy	0.47	68%
Behavioral/Psychoeducational	0.44	67%
Systemic	0.25	60%
Humanistic	0.29	61%
Eclectic	0.55	71%
Any Type of Couples Therapy	0.60	73%
Behavioral/Psychoeducational	0.74	77%
Systemic	0.62	73%
Humanistic	0.12	55%
Eclectic	0.63	74%

NOTE: *Percentile equivalent* indicates the percentage of those *not* receiving treatment whose outcome is *exceeded* by those receiving the treatment in question.

SOURCE: "Effects of Family and Marital Therapies: A Meta-Analysis," by W. R. Shadish, L. M. Montgomery, P. Wilson, I. Bright, and T. Okwumabua, *Journal of Consulting and Clinical Psychology,* 61, pp. 992–1002. Copyright © 1993 American Psychological Association. Reprinted with permission.

in a particular family member. Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) report that family treatment appears to be helpful in treating two particular psychological disorders. Specifically, family-assisted exposure plus response prevention treatment for obsessive-compulsive disorder (see Chapter 14) was superior to the traditional form of treatment without a family member assisting (Mehta, 1990). Family therapy has also been shown efficacious for a second psychological disorder, schizophrenia. Baucom et al. (1998) report that behavioral, supportive, and family systems forms of family therapy provided for at least 9 months to the families of patients with schizophrenia appear efficacious in reducing relapse rates for the disorder. Relapse rates for patients with schizophrenia typically range between 50% and 75%, but the relapse rates for patients whose families received treatment were typically 35% or less.

Finally, Shadish and Baldwin (2003) summarized 20 previous meta-analyses that evaluated the efficacy of different forms of family therapy. Results indicated that the average effect size of family therapy across all studies was .58, slightly higher than their previous estimate (Shadish et al., 1993). No form of family therapy was consistently superior to the others.

As for the "ingredients" of successful family therapy, Sexton, Alexander, and Mease (2004) point to evidence suggesting that redefinition of the problem into a "family problem," the ability to resolve impasses, strong therapeutic alliances, a reduction in within-session negative family interactions, and fostering improved family communication were all linked to positive family therapy outcome.

Couples Therapy. In addition to the data on family therapy, Table 15-1 presents Shadish et al.'s (1993) meta-analytic results for couples therapy. First, it should be noted that even fewer studies and effect sizes were available to evaluate couples therapy than family therapy. As can be seen in Table 15-1, the average effect size for any form of couples therapy was .60, somewhat higher than for family therapy. Shadish et al. found great variability in the efficacy of different forms of couples therapy; humanistic couples therapy appeared to be much less efficacious than other forms.

Baucom et al. (1998) provide additional information on the efficacy of different forms of couples therapy. They concur that behavioral marital therapy (BMT) is efficacious, noting that data suggest that between one-third and two-thirds of the couples who receive BMT are likely to be similar to nondistressed couples (based on their scores on outcome measures of relationship functioning) by the end of treatment. In addition, Baucom et al. (1998) report that the available evidence suggests that emotionally focused couples therapy (EFT) is an effective form of treatment, especially with mildly to moderately distressed couples, and that EFT was superior to BMT in at least one study (Johnson & Greenberg, 1985). Finally, Baucom et al. note that cognitive, cognitive-behavioral, and insight-oriented forms of couples therapy appear promising in their effects to date and should be investigated further.

More recent studies offer stronger evidence for the efficacy of couples therapy. For instance, Powers, Vedel, and Emmelkamp's (2008) meta-analyses reveal superior long-term effects for behavioral couples therapy as compared to individual CBT in the treatment of substance use disorders. Snyder, Castellani, and Whisman (2006) report several examples of couples therapy as an efficacious approach to treat depressive symptoms, anxiety disorders, as well as the reduction of several health-related behaviors (e.g., smoking, overeating, etc). As noted by Snyder and colleagues, couples therapy appears to be efficacious not only in reducing the psychological symptoms of an individual but also simultaneously addressing related marital-satisfaction partner issues (e.g., partner aggression, sexual dysfunctions, extramarital affairs) that are comorbid with these symptoms.

In summary, reviews of the empirical literature suggest that, in general, these treatments appear to be efficacious in reducing relationship distress. Further, both couples and family therapy may be useful in the treatment of specific psychological disorders in individual partners or family members (Baucom et al., 1998; Carr, 2009a, 2009b; Shadish & Baldwin, 2003).

CHAPTER SUMMARY

Over the years, group, family, and couples therapies have become more viable treatment options. Group therapy developed primarily out of the necessity of managing heavy caseloads. However, some clinicians came to view group therapy as a treatment of choice. Unlike its predecessors, contemporary group therapy is typically time limited (meeting for a predetermined number of sessions) and focused in the present. These groups are efficient and economical for clinicians, managed behavioral health care organizations, and clients. Unfortunately, from a research perspective, we know relatively little about group therapy other than it is more effective than no treatment but no more effective than other forms of psychotherapy. Again, its main attractions are economy and efficiency.

The origins of family therapy can be traced back to the 19th-century social work movement. Problems of individuals came to be conceptualized in systemic terms, as a manifestation of some type of family dysfunction. As with group therapy, many forms of family therapy exist. They are distinguished by their methods and techniques as well as by their underlying theoretical orientation (e.g., behavioral). Marital therapy, the traditional name for couples therapy, is a misnomer because there is no requirement that participants be married or of different sexes. The two most frequently studied forms of couples therapy are behavioral marital therapy (BMT) and emotionally focused couples therapy (EFT).

There is evidence to suggest that several forms of family and couples therapies are efficacious. Among family therapies, eclectic and behavioral/psychoeducational treatments for obsessive-compulsive disorder and schizophrenia in a family member appear useful. Among the varieties of couples therapy, research most strongly supports the use of BMT and EFT.

KEY TERMS

behavior therapy groups An approach in which patients with similar problems (e.g., depression, agoraphobia, pain) are treated as a group using standard behavioral or cognitive-behavioral methods. In behavior therapy groups, little attention is generally given to group dynamics.

behavioral family therapy An approach to family therapy that views family relations in terms of reinforcement contingencies. Here, the therapist's role is to generate a behavioral analysis of family problems and induce family members to reinforce each other so as to increase the frequency of desired behaviors. A more cognitively focused therapist might teach individual family members to self-monitor problematic behaviors and patterns of thinking and challenge their interpretations of family events.

behavioral marital therapy (BMT) A form of couples therapy that applies principles of reinforcement to a couple's interactions. Major components of BMT include contingency contracting, support-understanding techniques, and problem-solving techniques.

collaborative family therapy A form of family therapy where each family member sees a different therapist, and the therapists meet periodically to discuss their patients and the family as a whole. A variation of this approach involves having cotherapists work with the same family.

communication The verbal or nonverbal exchange of information about facts, thoughts, or feelings.

concurrent family therapy A form of family therapy in which one therapist sees all family members in individual sessions. In some cases, the therapist may conduct traditional psychotherapy with the principal patient but also occasionally see other members of the family.

conjoint family therapy A form of family therapy in which one therapist meets with the entire family at the same time.

contingency contracting In BMT, a technique in which spouses are trained to modify their own behavior to bring about a specific desired change in the behavior of their mate.

couples therapy A form of psychotherapy in which a couple (married, unmarried, or same-sex) meets with one or more therapists to work on any number of issues.

curative factors in group therapy The commonalities among diverse group therapy approaches proposed by Yalom to be the source of the positive treatment effect. These factors include imparting information, instilling hope, universality, altruism, interpersonal learning, imitative behavior, corrective recapitulation of the primary family, catharsis, and group cohesiveness.

double-bind A case in which an individual is told two contradictory messages by an important figure in his or her life such that every response he or she makes with regard to that figure is wrong. At one time, double-bind situations were believed to contribute to the development of schizophrenia.

emotionally focused couples therapy (EFT) A form of couples therapy that is based on the assumption that marital distress results from negative affect and destructive interactional styles. The interventions of EFT attempt to change partners' problematic interactional styles and emotional responses so that a stronger and more secure emotional bond can be established.

family therapy A form of psychotherapy in which several members of a family are seen by the therapist in addition to the identified patient. This therapy modality is based on the idea that everyone in a family is affected when one member develops a problem and that the home environment may have contributed to the development of the problem in the first place. Although there are a variety of theoretical family approaches, most share the primary goal of improving communication within the family.

general systems theory An important concept in family therapy that conceives of the family as a system and believes that "pathology" is best reduced by altering the way that the system functions.

Gestalt groups A group approach in which the therapist focuses on one patient at a time and asks that person to experience his or her feelings and behaviors while the other group members are asked to observe or provide feedback to the person in the "hot seat."

group therapy A form of psychotherapy in which one or more therapists treat a number of patients at the same time. Generally speaking, most groups consist of five to ten patients who meet with the therapist at least once a week for 90-minute to 2-hour sessions. However, groups may differ greatly in their theoretical orientations, their rules and exclusions, and whether they are viewed as primary or supplemental modes of treatment.

multisystemic therapy A form of family therapy originally developed to treat antisocial behaviors in youth. It is unique in that it is administered in the home, school, or neighborhood and focuses on the family's role in the problems.

problem-solving techniques In BMT, training couples in positive communication skills to enhance the effectiveness of decision making and negotiation.

psychoanalytic group psychotherapy Generally speaking, psychoanalytic therapy carried out in a group setting. Here, group dynamics are considered secondary to individual processes, and the group acts as a vehicle through which the individual may obtain insight into his or her unconscious forces and defenses.

psychodrama A form of role-playing developed by Moreno in which one patient in a group acts out a role assigned by the therapist, other patients serve as the supporting cast of "auxiliary egos," and yet other patients serve as the audience. The idea is that by listening to the responses of the auxiliary egos and the reactions of the audience, the patient in the primary role will experience catharsis and self-understanding.

support-understanding techniques In BMT, techniques that aim to increase partners' positive feelings, positive behaviors, and the degree of collaboration between them.

time-limited group therapy A group approach to brief therapy forwarded by Budman and Gurman in which patients meet weekly for a predetermined number of sessions. Four central characteristics include pregroup screening and preparation, the establishment and maintenance of a working focus, group cohesion, and member reactions to the time limits of the group.

transactional analysis A group method developed by Berne that focuses upon the "ego states"—Child, Parent, or Adult—that are evident based on patients' transactions with other group members, as well as the valence (positive or negative) of these ego states, and helps patients adopt ways of thinking that are more characteristic of the positive Adult ego state. Another emphasis in TA is on identifying the games that patients employ to avoid getting too close to others and helping them to adopt more satisfying behaviors.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

15-1 American Association for Marriage and Family Therapy
http://www.aamft.org/iMIS15/AAMFT/

15-2 Association for Specialists in Group Work
http://www.asgw.org/

15-3 International Association of Group Psychotherapy
http://www.iagp.com/

15-4 Association for Behavioral and Cognitive Therapies (ABCT) Couples Special Interest Group
http://www.abctcouples.org/

15-5 Multisystemic Therapy
http://mstservices.com/

PART IV

Specialties in Clinical Psychology

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17 Health Psychology and Behavioral Medicine

18 Neuropsychology

19 Forensic Psychology

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16

Community Psychology

FOCUS QUESTIONS

1. What is unique about a community psychology perspective?
2. What historical factors contributed to the community psychology movement?
3. Discuss the various types of prevention. How is prevention research conducted?
4. What are the major forms of intervention used by community psychologists?
5. What issues are likely to confront the field of community psychology in the future?

CHAPTER OUTLINE

Perspectives and History
- The Community Psychology Perspective
- Chronology and Catalyzing Events

Key Concepts
- Ecological Levels of Analysis
- The Concept of Community Mental Health
- The Concept of Prevention
- BOX 16-1: *Clinical Psychologist Perspective: Kristin Hawley, Ph.D.*
- BOX 16-2: *Focus on Clinical Applications: The High/Scope Perry Preschool Program*
- BOX 16-3: *Focus on Clinical Applications: The JOBS Program*
- BOX 16-4: *Focus on Clinical Applications: Primary Prevention Mental Health Programs for Children and Adolescents*
- Empowerment
- Diversity
- BOX 16-5: *Graduate Student Perspective: Shawn C.T. Jones, M.H.S*
- Social Intervention Concepts

Methods of Intervention and Change
- Consultation
- Community Alternatives to Hospitalization
- Intervention in Early Childhood
- Self-Help
- Paraprofessionals

Concluding Comments
- Questions of Effectiveness
- Values, Power, and Civil Rights
- The Training of Community Psychologists
- The Future of Prevention

CHAPTER SUMMARY

KEY TERMS

WEB SITES OF INTEREST

For well over 100 years, the helping professions have sought to alleviate psychological problems by one form of therapy or another. Some approaches have emphasized insight; others have sought to change behavior more directly. Whatever the differences in approaches, their basic common focus has been on the individual who has already developed psychological problems. By and large, clinical psychology has been a psychology of the individual.

At the theoretical level, therapists have long accepted the idea that all behavior (pathological or otherwise) is a joint product of situational and personal factors. Yet in their day-to-day therapeutic efforts, the emphasis of clinicians was generally on one-to-one therapy of some sort. The troubled individual engaged the help of an expert, and by this act, he or she submitted to the role of patient. The clinician treated; the patient responded. However, given the rate of mental health problems in the world today, some have questioned whether this general approach is a reasonable one. For them, a relatively newer approach, *community psychology*, shows great promise for addressing mental health problems.

PERSPECTIVES AND HISTORY

Let us begin by trying to identify exactly what community psychology is. Then we can move to the events that gave rise to the movement. Table 16-1 presents a set of principles that characterize community psychology, including assumptions regarding the causes of problems, the variety of levels of analysis that can be used to define a problem, where community psychology is practiced, how services are planned, the emphasis on prevention, and the willingness to "give psychology away" by consulting with self-help programs and nonpsychologists. We discuss each of these basic principles at various points throughout this chapter.

The Community Psychology Perspective

Community psychology has been described as an approach to mental health that emphasizes the role of environmental forces in creating and alleviating

TABLE 16-1 Principles of Community Psychology

What "causes" problems?
Problems develop due to an interaction over time between the individual, social setting, and systems (e.g., organizations); these exert a mutual influence on each other.

How are problems defined?
Problems can be defined at many levels, but particular emphasis is placed on analysis at the level of the organization and the community or neighborhood.

Where is community psychology practiced?
Community psychology is typically not practiced in clinics, but rather out in the field or in the social context of interest.

How are services planned?
Rather than providing services only for those who seek help, community psychologists proactively assess the needs and risks in a community.

What is the emphasis in community psychology interventions?
An emphasis is placed on prevention of problems rather than treatment of existing problems.

Who is qualified to intervene?
Attempts are made to share psychology with others via consultation; actual interventions are often carried out through self-help programs or through trained nonpsychologists/nonprofessionals.

SOURCE: Adapted from Orford (1992), p. 4.

problems (Zax & Specter, 1974). Rappaport (1977) characterized community psychology in terms of a perspective rather than to attempt a formal definition. The major aspects of this perspective are cultural relativity, diversity, and ecology (the fit between persons and the environment) (Orford, 2008; Seidman, 2011; Trickett, 2009).

This perspective has several implications. First, community psychologists do not focus exclusively on inadequate environments *or* persons. Rather, they direct their attention to the fit between environments and persons—a fit that may or may not promote adaptation. Second, community psychologists emphasize the creation of alternatives through identifying and developing the resources and strengths of people and communities. Thus, the focus is on action directed toward the competencies of persons and environments rather than their deficits. Third, the community psychologist believes that differences among people and communities are desirable. Societal resources, therefore, should not be allocated according to one standard of competence. The community psychologist does not become identified with a single social norm or value but instead looks to the promotion of diversity.

In Rappaport's (1977) view, three sets of concerns define the community psychology perspective: human resource development, political activity, and science. In many ways, these elements are antagonistic. Political activists are often impatient and deride more traditional clinicians as bringing society too little too late. Clinicians in turn often criticize activists as unprofessional and overly concerned with hawking their own visions of the world. Both groups often regard scientists as too far removed from real problems to know what is going on in the world (the "ivory tower" syndrome). The scientists in turn are appalled by activists and clinicians alike; both are seen as shockingly willing to act on the basis of invalidated hunches and lack of data or, worst of all, without a viable theory to guide them. However, true societal changes vis-à-vis mental health will require the cooperation of each of these "camps." For example, scientists must provide data to support and direct the efforts of clinicians and political activists, and political activists must assist with funding for scientists so that they can conduct the research that is needed. After all, each camp has the common goal of improved well-being and mental health for individuals, communities, and the larger society.

Whatever else community psychology may be, it is not a field that emphasizes an individual disease or individual treatment model (Iscoe, 1982; Orford, 2008; Seidman, 2011; Trickett, 2009). The focus is preventive rather than curative. Further, individuals and community organizations are encouraged to take control of and master their own problems (via empowerment) so that traditional professional intervention will not be necessary (Orford, 1992).

Chronology and Catalyzing Events

In 1955, the U.S. Congress passed legislation creating the Joint Commission on Mental Health and Illness. Its report encouraged the development of a community mental health concept and urged a reduction in the population of mental hospitals. Based on the premise that psychological distress and the development of mental disorders were influenced by adverse environmental conditions, President Kennedy called for a "bold new approach" to *prevent* mental disorder. The so-called Kennedy Bill of 1963 funded the construction of mental health centers. Their aims were to promote the early detection of mental health problems, treat acute disorders, and establish comprehensive delivery systems of services that would prevent the "warehousing" of chronic patients in mental hospitals (Bloom, 1973). The American Psychological Association endorsed the desirability of community residents' participating in all these decisions (Smith & Hobbs, 1966) and helped focus attention on the concept of community approaches and participation.

A conference held in 1965 is regarded by many as the "official" birth of community psychology (Zax & Specter, 1974). At Swampscott, Massachusetts, a group of psychologists set out to review the status of the field and to plot a future course of development for the place of psychology in the community mental health movement.

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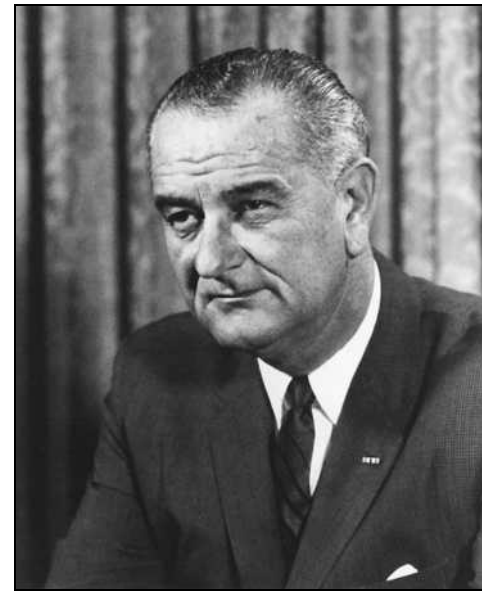
Library of Congress

FIGURE 16-1 President John F. Kennedy and President Lyndon B. Johnson were instrumental in providing the political leadership to get the community psychology movement underway.

Shortly after this conference, the Division of Community Psychology (also called the Society for Community Research and Action) was organized within the American Psychological Association. Soon *The Community Mental Health Journal* and the *American Journal of Community Psychology* began publication. By 1977, President Jimmy Carter had commissioned a panel on mental health issues with specific directives to promote community mental health centers and their facilities. Textbooks began to appear, including Zax and Specter (1974); Heller and Monahan (1977); Rappaport (1977); Heller, Price, Reinharz, Riger, and Wandersman (1984); Orford (1992); and more recently, Dalton, Elias, and Wandersman (2001) and Orford (2008). Reviews began to appear regularly in the *Annual Review of Psychology* (e.g., Trickett, 2009), and handbooks have been published (e.g., Rappaport & Seidman, 2006).

Then, things changed. President Ronald Reagan's election led to changes in funding for community health centers that gradually fragmented the mental health services available and reduced the emphasis on focused, centralized mental health centers. Funding dissipated, and the community mental health system began to fall apart. Several individual states have developed programs based on the original community mental health center model; however, this approach to mental health services has been fading. Recently, President Obama's health care reform offered some promise for a revival of the community approach, with an emphasis on prevention, evidence-based community approaches, and the integration of multiple systems of influence (e.g., schools, homes, justice systems, health care systems) to promote mental health. The next several decades will be critical for determining the role of community-based approaches in clinical psychology.

To flesh out the foregoing chronology, it is helpful to pinpoint several issues or concerns that have catalyzed the emergence of community psychology.

Treatment Facilities. Although the mental hospital population in the United States peaked at about 500,000 in the mid-1950s, socially oriented clinicians continued to press for alternatives to the costly, inefficient, and often largely custodial hospitalization of patients. Two factors combined at

about this time to markedly reduce the population of mental hospitals: the advent of psychotropic medications and a more liberal discharge philosophy in mental hospitals. But as more patients were being discharged, often under heavy medication, and as patients who formerly would have been hospitalized were no longer admitted, the need for better community treatment and supportive services became evident. In some ways a cause but in other ways an effect of these events, the community philosophy was beginning to gain a foothold.

A problem with many mental hospitals was their lack of trained therapists. Regarded by laypersons as a realistic means for solving difficult emotional problems, hospitalization itself often created nearly as many problems as it alleviated. Over the years, mental hospitals (particularly those run by the states) too often became warehouses or custodial bins. Care was often marginal and sometimes downright inhumane. Professional staff was severely lacking in numbers and sometimes in quality. Indeed, many still argue (and have demonstrated empirically) that hospitalization is not an especially effective treatment strategy.

Personnel Shortage. Even as more clinical psychologists and psychiatrists were trained, demands for their services outstripped their increase in numbers. Many of the newcomers were entering private practice, and others were diverted into teaching or research. In any event, the supply of trained professionals for service in hospitals and clinics was hardly keeping pace with the demand. A number of trends (Albee, 1959, 1968; Arnhoff, 1968) all seemed to coalesce to produce critical shortages of hospital and clinic personnel. To grapple with these shortages, it became imperative that new sources of personnel be sought, that more effective use be made of professional time, and that new models of coping with human problems be developed. Albee (1959, 1968) predicted that it would be literally impossible to train enough mental health professionals to meet existing and future needs and recommended that prevention be pursued as a strategy.

Questions About Psychotherapy. In the 1950s, people began to question not only the efficiency of psychotherapy but also its efficacy. Some began to wonder if it was not just intrapsychic factors that created problems, but the interaction between person and society. At the same time, because psychotherapy was expensive and more and more clinicians and psychiatrists were going into private practice, economic factors were pushing therapy beyond the reach of the poor and disadvantaged. The relationship between mental illness and social class had been documented by Hollingshead and Redlich (1958). Now, it seemed, there was also a relationship between social class and the availability of psychotherapy.

Medical Models and Roles. Throughout this book, we have commented on the widespread role of the medical or disease model and some of the discontent with it. The 1960s ushered in a climate in which institutional prerogatives and traditionalist beliefs came under attack. That climate produced listeners who were more willing to accept attacks on traditional views about mental illness. All of this contributed to an increased tendency to look for the social-community antecedents of problems in living rather than internal biological or psychological etiological agents.

The general activism of the 1960s also catalyzed the long-standing discontent of many clinicians with a role that relegated them to waiting passively for society's casualties to walk in the door. Would not an activist role that took mental health services to the people be more consonant with a social-community model? If so, such a role would also provide a measure of autonomy from the dominance of the medical profession. We must not overstate these developments, however. After all, a major trend in clinical psychology over the last few decades has been a headlong rush into private practice. Such behavior is hardly a rejection of the medical model or an acceptance of the social-community approach.

The Environment. Another force that helped shape the community psychology movement was a greater awareness of the importance of social and environmental factors in determining people's behavior and problems. Poverty, discrimination, pollution, and crowding were being recognized as potent factors. Providing people with choices and enhancing their well-being required that psychologists pay attention to these factors—that they go beyond a reflexive consideration

of the early childhood determinants of people's personalities. The emotional problems of large numbers of people may be influenced by poverty, unemployment, job discrimination, racism, diminished educational opportunities, sexism, and other social factors. Such influences are hardly the ones proposed by psychoanalytic and other theories that seek answers in the internal dynamics of the individual.

The Tenor of the Times. Perhaps as much as anything, the sociopolitical events that saturated the 1960s gave sustenance to the community approach. The school desegregation ordered by the Supreme Court in 1954 and the rise of the civil rights movement pointed to discrimination in all its malignant forms and raised the consciousness of the entire country. For the first time, many began to understand what social repression does to the minds and emotions of its victims. At the same time, civil rights activists proved that protests, rallies, pressure, and occasionally even logic could have an effect. The lessons of this era were not lost on some of the persons who later became advocates of a community approach to mental health.

KEY CONCEPTS

To this point, we have tried to sketch an overall perspective and chronology of community psychology. In the process, we have alluded to several important concepts. Now, we take a closer look at some of these concepts that are at the heart of community psychology.

Ecological Levels of Analysis

One underlying principle of community psychology is that individuals and society are interdependent. To understand and to enhance the lives of others, it is essential that we consider a variety of systems or levels of analysis (Bronfenbrenner, 1979; Dalton et al., 2001; Trickett, 2009). Figure 16-2 presents these levels of analysis that are the subject of research in community psychology.

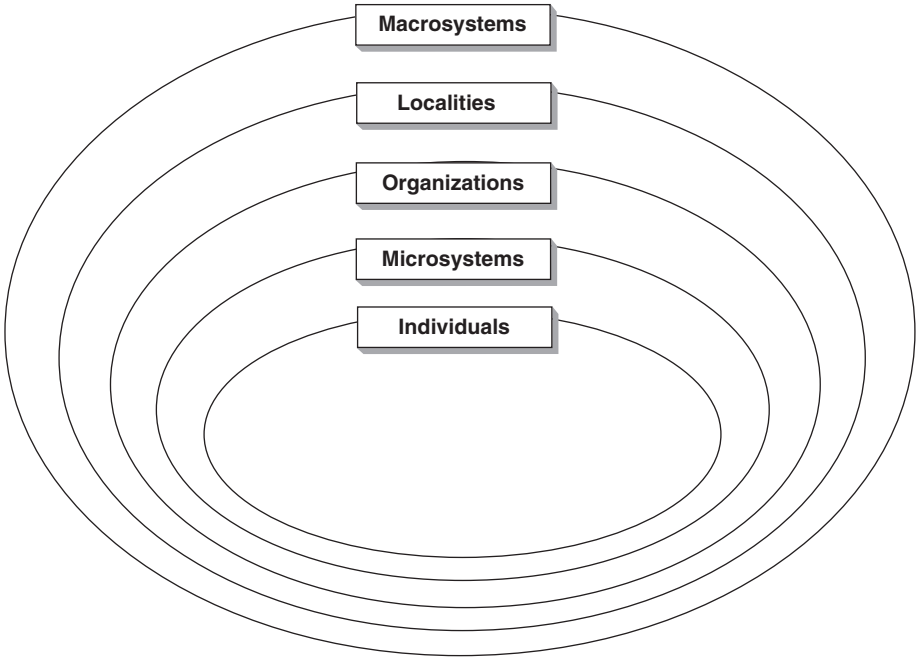

FIGURE 16-2 Levels of analysis for community psychology

SOURCE: Dalton, Elias, and Wandersman (2001). *Community psychology*. Belmont, CA: Wadsworth/Thomson Learning.

First, at the level of the *individual*, community psychologists study the relationships between individuals and their environments. Individuals are influenced by their environments (e.g., the loss of a job), and individuals also influence their environments. Second, the next level of analysis focuses on the connection between individuals and *microsystems*—environments in which the individual is directly engaged with others, whether they are family members, fellow students, friends, or business associates. *Organizations* involve sets of larger microsystems (e.g., schools, religious organizations). Individuals may be involved in an organization, but their participation is usually through a microsystem of the organization. The level of *localities* (typically that of geographic localities) is comprised of multiple sets of organizations of microsystems. For example, community coalitions exist to address problems concerning drug abuse or local health care access. Finally, *macrosystems* include societies, cultures, and governmental or economic institutions that reach beyond the local community.

In addition to these structural features of ecology, Kelly, Trickett, and associates (e.g., Trickett, 2009; Trickett, Kelly, & Todd, 1972) emphasize several ecological principles that can provide a framework for community psychology. First, every ecosystem, whether in biology or psychology, consists of *multiple parts that are interdependent*. Change in one part of the system will affect other parts of the system. For example, a change in school leadership will affect teachers, students, parents, and the community at large. Second, ecosystems can be understood by examining the *resources* that are used and required for their well-being. Many times, it is only when there is a stress in or problems with the ecosystem that it becomes more apparent what the important resources are. Thus, certain resources may need to be created, preserved, or strengthened. Third, individuals (and other levels of an ecosystem) *adapt* to the environment by coping with restraints or demands and using available resources. Fourth, ecosystems are *dynamic,* not static. Thus, over time, they are likely to change due to patterns of interdependence, the resources that are available, and the ensuing adaptive changes.

In summary, any individual or societal problem, because of the interdependence of different levels of the ecosystem, can be examined at a number of levels; social environments change and are changeable.

The Concept of Community Mental Health

The 1955 Joint Commission on Mental Health and Illness made several basic recommendations that set the tone for the subsequent development of community psychology. These recommendations were (a) more and better research into mental health phenomena; (b) a broadened definition of who may provide mental health services; (c) mental health services should be made available in the community; (d) an awareness should be fostered that mental illness can stem from social factors (e.g., ostracism and isolation); and (e) the federal government should support these recommendations financially.

In 1963, federal funds were provided to help in the construction and staffing of comprehensive mental health centers across the United States. To qualify for these funds, a *community mental health center* had to provide five essential services: (a) inpatient care; (b) outpatient care; (c) partial hospitalization (e.g., the patient works during the day but returns to the hospital at night); (d) round-the-clock emergency service; and (e) consultation services to a variety of professional, educational, and service personnel in the community. Beyond these required services, it was hoped that the mental health centers would also provide (a) diagnostic services, (b) rehabilitation services, (c) research, (d) training, and (e) evaluation. But despite Hobbs's (1964) description of a "third revolution" in mental health, the medical model still prevailed (perhaps because psychiatrists remained at the top of the administrative hierarchy), and there seemed to be a continuing neglect of minority patients, poverty-stricken individuals, and even children.

In a highly influential paper, Smith and Hobbs (1966) argued that community control of mental health care and services was essential. They saw

the role of prevention as paramount. This implied early detection and work with schools, police departments, social service agencies, businesses, and other organizations. The idea of personal deficit was replaced by the view that the social system had failed to provide an appropriate environment. A community mental health center, then, must not merely set about remedying individual deficits but must do everything it could to enable the system to function better. Consultation was given prominence, as was the development of new community resources. Going beyond Smith and Hobbs, some even argued that the center should be the central coordinator of all social systems in the community. The goal was to reach those who needed services and in particular those who were so often excluded from services (the poor, the indigent, minorities). New methods to meet mental health needs were encouraged (e.g., crisis intervention and group treatment). Advocacy of social action programs to improve housing, employment, and opportunity took precedence over the one-to-one therapy session. The role of the therapist was replaced by that of the social change agent.

Many of the foregoing antecedents had an idealistic tone. Nevertheless, in the 1960s, many community centers became operational. Some approximated the hopes of Smith and Hobbs. Others were more in the mold of older clinical approaches even though they used a community language. Some have been smooth-running enterprises, but others have created community tensions and controversy. For many reasons (including cutbacks in federal funding beginning in 1968), the goal of establishing 2,000 centers by 1975 was not realized. In fact, by 1974, only 540 centers had been established with funds from the Community Mental Health Centers Act. Despite the recommendations of President Carter's Commission on Mental Health in 1977 that more emphasis should be placed on "serving the underserved" (children, elderly, ethnic minorities, and rural inhabitants), fewer funds were appropriated specifically for community mental health centers over the subsequent years. State and local governments failed to fill the financial gaps. Today, there is a declining number of community mental health centers, and it is unclear whether this trend will reverse.

The Concept of Prevention

The idea of *prevention* is the guiding principle that has long been at the heart of public health programs in the United States (Boglan & Hinds, 2009; Institute of Medicine [IOM], 1994; National Research Council and Institute of Medicine [NRC-IOM], 2009). Basically, the principle asserts that, in the long run, preventive activities will be more efficient and effective than individual treatment administered after the onset of diseases or problems (Felner, Jason, Moritsugu, & Farber, 1983). That such approaches can work is graphically illustrated by Price, Cowen, Lorion, and Ramos-McKay (1988). Their classic book, *Fourteen Ounces of Prevention*, describes 14 model prevention programs for children, adolescents, or adults. Box 16-2 presents an overview of one of these programs that targets preschool children from low-income families.

Prevention programs for adults have been developed and implemented as well. Box 16-3 presents an overview of the JOBS program, which was designed to assist adults who have recently lost their employment.

Primary Prevention. This type of prevention represents the most radical departure from the traditional ways of coping with mental health problems. The essence of the notion of *primary prevention* can be seen in Caplan's (1964) emphasis on "counteracting harmful circumstances before they have had a chance to produce illness" (p. 26). Albee (1986) points out, however, that the complexity of human problems often requires preventive strategies that depend on social change and the redistribution of power. For many in society, this is not a highly palatable prospect. Some examples of primary prevention include programs to reduce job discrimination, enhance school curricula, improve housing, teach parenting skills, and provide help to children from single-parent homes. Also grouped under this heading are genetic counseling, Head Start, prenatal care for disadvantaged women, Meals on Wheels, and school

lunch programs. Box 16-4 presents the results of a recent meta-analysis evaluating the efficacy of primary prevention mental health programs for children and adolescents (Durlak & Wells, 1997).

Secondary Prevention. This involves programs that promote the early identification of mental health problems and prompt treatment of problems at an early stage so that mental disorders do not develop. The basic idea of *secondary prevention* is to attack problems while they are still manageable, before they become resistant to intervention (Caplan, 1961; Sanford, 1965). Often, this approach suggests the screening of large numbers of people. These people are not seeking help, and they may not even appear to be at risk. Such screening may be carried out by a variety of community service personnel, including physicians, teachers, clergy, police, court officials, social workers, and others. Early assessment is followed, of course, by appropriate referrals.

An example of secondary prevention is the early detection and treatment of individuals with potentially damaging drinking problems (Alden, 1988). A further example is the Rochester Primary Mental Health Project pioneered by Emory Cowen, which began in 1957. The project systematically screens primary-grade children for risk of school maladjustment. The development of early detection and prevention programs in several states has been described by Cowen, Hightower, Johnson, Sarno, and Weissberg (1989).

Tertiary Prevention. The goal of *tertiary prevention* is to reduce the duration and the negative effects of mental disorders after their occurrence. Thus, tertiary prevention differs from primary and secondary prevention in that its aim is not to reduce the rate of new cases of mental disorder but to reduce the effects of mental disorder once diagnosed.

A major focus of many tertiary programs is rehabilitation. This can range from increasing vocational competence to enhancing the client's self-concept. The methods used may be counseling, job training, and the like. Whether the purpose of a program is to teach better independent-living skills to those with mental retardation or to restore the social skills of a recently discharged patient with a diagnosis of schizophrenia, the goal is the prevention of additional problems. Although their language is a bit different, tertiary preventive programs are not very different from person-oriented programs based on a deficit philosophy. However, it is important to remember that all forms of prevention are distinguished by their attempts to reduce the rates of, or problems associated with, mental disorder on a community-wide (or population-wide) basis.

Alternative Models of Prevention. Although the traditional primary-secondary-tertiary prevention model (Caplan, 1964) is the one most commonly cited, alternative classification frameworks have been proposed (Orford, 1992). As one example, we will briefly discuss a framework for preventing mental disorder proposed in the 1994 Institute of Medicine (IOM) report, *Reducing Risks for Mental Disorders*. This model, adopting terms proposed by R. Gordon (1983, 1987), classifies prevention intervention into one of three types. *Universal preventive interventions* target the entire population; these interventions may be costly because they are given to everyone. *Selective preventive interventions* target individuals or subgroups of the population that have a higher-than-average likelihood of developing the disorder in question (either in the near or distant future). These targeted individuals are identified on the basis of biological, psychological, or social risk factors that have been shown to be associated with disorder development. Finally, *indicated preventive interventions* target "high-risk" individuals, identified by their manifestation of subthreshold symptoms of the disorder or by biological markers indicating a predisposition to develop the disorder.

The value of this model is that it places prevention, treatment of mental disorder, and maintenance on a continuum representing the full range of interventions for mental disorders. Prevention occurs before a disorder develops; treatment is administered to those who meet (or are close to meeting) diagnostic criteria for a disorder; and maintenance involves interventions for individuals with a diagnosis of mental disorder whose illness continues to warrant attention (Institute of Medicine, 1994). Figure 16-3 depicts the

BOX 16-1 Clinical Psychologist Perspective: Kristin Hawley, Ph.D.

Dr. Hawley is Assistant Professor of Psychological Sciences at the University of Missouri, Columbia. Before joining the faculty at MU, she received her Ph.D. in clinical psychology from the University of California, Los Angeles, completed clinical training at several community mental health agencies in the Los Angeles area, and received postdoctoral research training in child mental health services research at the Child and Adolescent Services Research Center in San Diego. In addition to her current faculty position at MU, she is also co-director of the Missouri Therapy Network, a collaborative network of community mental health providers and services researchers who are committed to practice-based research, and she is a co-investigator with the Center for Mental Health Services Research at Washington University in St. Louis. Dr. Hawley's primary research interests include community-based mental health services for children and families, including service use, engagement, and outcomes as well as clinician training and implementation of research-supported treatments. Her research has been funded by both nonprofit and governmental organizations, and she is actively involved in disseminating information about research-supported treatment options to the public and professional communities.

Dr. Hawley provided responses to several questions we posed concerning her background and assessment of the field of community mental health:

What originally got you interested in community mental health services for children and youth?

I had long-standing interests in child development and psychopathology and knew as an undergraduate that I wanted to pursue some sort of career in that area. However, I did not have a clear idea what form that career would take and college seemed like a good time to figure that out. I took a volunteer position (and later a paid position) at a mental health hospital, where I worked on the child, adolescent, and adult inpatient psychiatric units. This experience had a powerful impact on me and on my career. I saw clearly the toll that a lifetime of poorly treated mental illness can take on an individual while also seeing some fairly dramatic improvements in several of the patients. Particularly for some of the younger children, these changes took place within days of arriving and being integrated into the behaviorally oriented treatment program provided on the inpatient unit. As I continued working, though, I began to notice children being discharged only to come back weeks or months later—right back where they had started and sometimes far worse. I also began to notice that parent and family involvement in the hospital-based treatment was rare. Some families were overwhelmed, a few seemed indifferent, and many simply lived hours from the hospital with a work schedule or financial situation that made it impossible to attend regular therapy appointments during their child's stay. With no changes being made to parenting behaviors or family environment, the same children who had made such strides with the application of basic social learning principles were sent home to a situation that had not improved and may well have contributed to their difficulties in the first place.

For other patients, particularly those with more long-standing problems, the treatments that my clinical supervisors had at their disposal were not very helpful. These individuals struggled with long stays and minimal improvement. This experience left me confident that I wanted to pursue a career where I could both work to discover the treatments that would be most helpful to those struggling with emotional and behavioral problems and work to ensure that those treatments were available to the children and families who needed them and in the communities in which they lived. A Ph.D. in clinical psychology provided me with the training in psychopathology, clinical interventions, and research methods to allow me to pursue just such a career.

Describe what activities you are involved in as a clinical psychologist.

I am a faculty member at a large research university. This position allows me to be actively involved in conducting research on community mental health services, teaching courses in developmental psychopathology and clinical interventions for children and families, providing clinical

IOM's conceptualization of the intervention spectrum for mental disorders.

Prevention Research. Planning, developing, and evaluating prevention programs are a multistage process requiring years of community psychologists' time. To guide prevention researchers, the Institute of Medicine (1994) recommends a series of steps focusing on the conceptualization, design, implementation, and evaluation of prevention intervention research programs. Figure 16-4 depicts these steps. First, the problem or disorder to be addressed

supervision to graduate students in research-supported treatments, working with community clinicians on the implementation and evaluation of research-supported treatments, and consulting about mental health policy. Like other academic psychologists, a big part of my work is disseminating my research findings through journal articles and conference presentations. However, since my research is so focused on the application of science within practice settings, I also spend a good deal of my time disseminating research findings, my own as well as those of the larger research community, to a wide variety of public and professional audiences (e.g., groups of private clinicians, school counselors, community mental health centers, state agencies).

What are your particular areas of expertise or interest?
My research broadly falls under the domain of translational science, the goal of which is to speed the progression from scientific discovery to widespread application of scientific findings in clinics and communities. Within this broad umbrella, I have two main areas of expertise. The first is child mental health services and interventions research—here, I study treatment processes and outcomes within routine, community-based mental health service settings in order to identify key components of effective treatments and important emotional, behavioral, and cognitive changes that children and/or families go through in order to improve. My second area of expertise is the dissemination and implementation of research-supported treatment practices—here, I study strategies, such as clinician training and feedback systems, for improving the application of research-supported assessment and treatment practices within routine community mental health services.

What are some future trends you see in community mental health services for children and youth?
The explicit focus on strengthening the connection between science and practice in community mental health services is a notable trend. We are seeing positive changes both in how we conduct research and in how community mental health providers serve children and families. Treatment developers are beginning to involve community providers in the research process and design more representative studies to test and adapt new treatments under conditions that more closely approximate routine community-based practice. Among community mental health service providers, we are also seeing a greater focus on data-based decision making and the importance of assessing treatment processes and outcomes to ensure the quality of care provided.

Finally, both scientists and practitioners are beginning to tackle the wide array of implementation challenges inherent in any attempt to introduce and sustain new practices across diverse communities and service settings. Implementation science is a relatively new area of multidisciplinary research focused on developing strategies to support the implementation of research-supported treatments in practice settings. As we develop more effective methods for supporting and sustaining a close linkage between science and practice, we may begin to achieve access to effective treatment for every child and family in need.

Dr. Kristin Hawley

Kristin Hawley

by the program must be clearly specified, along with its prevalence, incidence, and costs to society. Next, risk and protective factors relevant to the problem or disorder are identified, and the existing research on the prevention or treatment of the condition is reviewed. Third, pilot studies to evaluate the efficacy of the planned intervention are designed and conducted. The fourth step involves planning and carrying out large-scale trials of the intervention program. Finally, assuming that the

BOX 16-2 Focus on Clinical Applications: The High/Scope Perry Preschool Program

The High/Scope Perry Preschool Program (HSPPP) was initiated in 1962 to help children who were deemed at risk for school failure, and its curriculum is used today by thousands of early childhood instructors (Schweinhart & Weikart, 1988). Based on the rationale that childhood poverty often leads to school failure, which in turn results in adult poverty and social problems (e.g., crime), the HSPPP targeted 3- and 4-year-olds from families of low socioeconomic status (SES) for intervention. These interventions were characterized by

1. A developmentally appropriate curriculum, based on Piaget's views of children as active and self-initiating learners
2. Classroom enrollment limits with adequate adult supervision (at least two adults who had training in early childhood development)
3. Supervisory support of staff and frequent in-service training opportunities
4. Emphasis on parental involvement in each child's education
5. Sensitivity to the needs of children and their families (Schweinhart & Weikart, 1988)

The 58 children, ages 3 to 4, in the Perry Preschool study intervention group attended the program for 2 years, which included classroom instruction 5 mornings a week for 7 months a year and home visits by the teacher once a week. Outcome data were also collected from a control group of 65 children matched on IQ, sex, and SES. The major findings from this study can be summarized as follows (Schweinhart & Weikart, 1988):

1. Program participants demonstrated better academic achievement throughout elementary and secondary school, were rated by teachers as more socially and emotionally mature, and endorsed more favorable attitudes toward high school.
2. Program participants as a group obtained more and better jobs and received higher wages by age 19. Further, they were more likely to be self-supporting, less likely to have dropped out of high school, less likely to be arrested, and more likely to have enrolled in college or vocational school.
3. A cost–benefit analysis of the program indicated significant benefits to society and to the taxpayer. For every dollar invested in the 2-year program, $3 in savings were returned. For example, the program resulted in a reduction of costs for special classes, welfare, and crime.

BOX 16-3 Focus on Clinical Applications: The JOBS Program

Loss of employment can lead to a number of problems, including depression, substance abuse, health problems, family conflict, suicide, and financial strain (Caplan, Vinokur, & Price, 1997). Programs that help individuals manage this difficult transition and assist them in obtaining new employment would clearly be beneficial. Caplan et al. (1997) provide an overview and evaluation of such an intervention: the JOBS program.

The JOBS program is administered in a group format and involves multiple 3.5-hour sessions over the course of 1 or 2 weeks. The program focuses on (a) training participants to seek reemployment effectively (e.g., training in behavioral skills such as interviewing effectively); (b) increasing the self-confidence of job seekers; and (c) stress inoculation training for coping with barriers to reemployment and setbacks.

Studies have shown that JOBS program participants who were still unemployed at follow-up demonstrated higher levels of self-confidence about their job-seeking ability and a greater sense of self-efficacy than did those who did not participate and remained unemployed. Further, among those at greater risk for depression, JOBS participants demonstrated lower levels of depressive symptoms at follow-up. Additional outcomes are also noteworthy. JOBS participants found reemployment sooner and were more likely to obtain better (i.e., in their field of interest) and more stable jobs than those who did not participate. Finally, the JOBS program appears to be cost-effective. Economic projections suggest that the program's costs are offset by participants' lifetime earning payouts to federal and state governments (through taxes).

BOX 16-4 Focus on Clinical Applications: Primary Prevention Mental Health Programs for Children and Adolescents

Durlak and Wells (1997) published a meta-analytic review of 177 primary prevention programs designed to prevent behavioral, emotional, and social problems in children and adolescents. Durlak and Wells found that these programs, on average, produced meaningful positive effects such that the average participant in a primary prevention program showed better (more adaptive) outcome than 59% to 82% of those in a control group. Most intervention programs not only reduced problems but they also significantly increased competencies across a number of affective/emotional, cognitive, academic, and behavioral domains. Finally, Durlak and Wells found that, in general, in those studies that collected follow-up data, these effects were durable over time. This study demonstrates that a wide range of primary prevention programs do work—that is, the mental health of children and adolescents improves significantly as a result of these programs.

trials yield encouraging results, the program is implemented in the community, and its effectiveness is again assessed. As can be seen from Figure 16-4, this last step does not mark the end of the process. Rather, information regarding the effectiveness of the intervention in the community (does it lead to decreases in the incidence of the problem or disorder?) leads to modification of the intervention, and the steps are repeated. In this way, prevention programs are refined with the ultimate goal of improving their effectiveness.

Empowerment

In their discussion of poverty, Gurin and Gurin (1970) emphasize the importance of a low expectancy of attaining valued goals and an expectancy of powerlessness. These notions are closely related to the

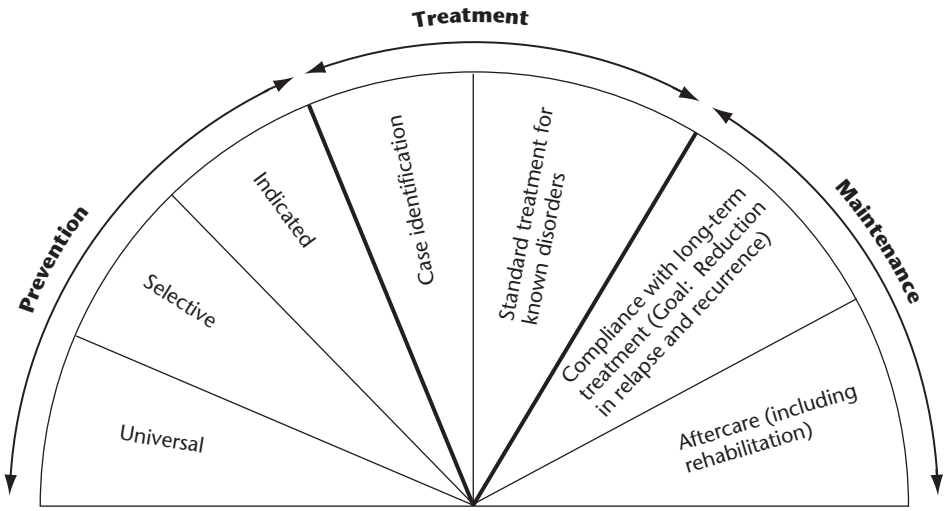

FIGURE 16-3 Prevention on a continuum of services addressing mental health needs

SOURCE: Institute of Medicine (1994). *Summary: Reducing risks for mental disorders.* Washington, DC: National Academy Press, p. 8. Reprinted with permission.

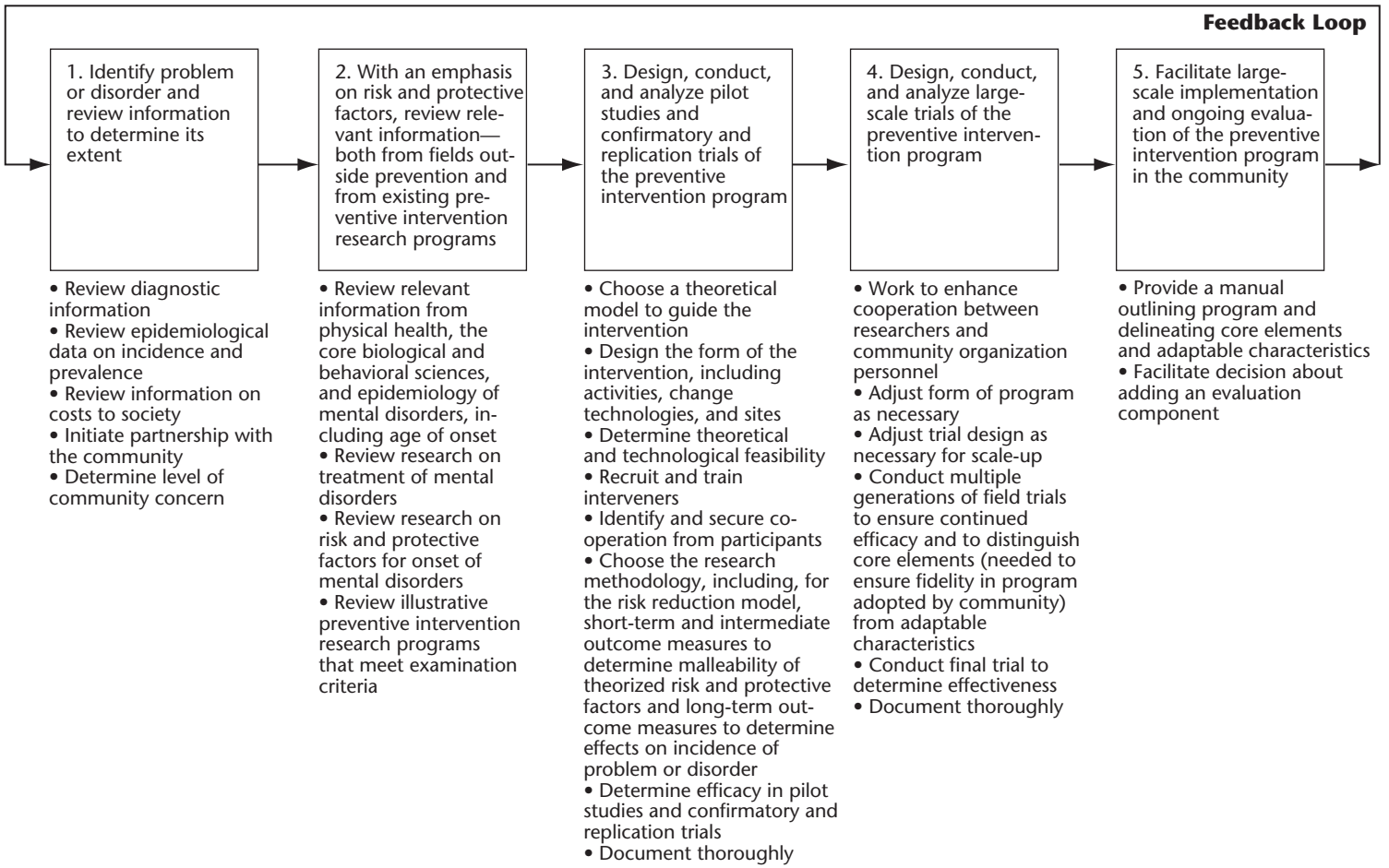

FIGURE 16-4 Recommended steps for designing, implementing, and evaluating prevention programs

SOURCE: Institute of Medicine (1994). *Summary: Reducing risks for mental disorders.* Washington, DC: National Academy Press, pp. 32–33. Reprinted with permission.

social learning concept of locus of control (Phares, 1976; Rotter, 1966). As Rappaport (1977) notes:

> What is important about this variable for community psychology is its connection to the sociological idea of power and its converse, alienation. Locus of control is one of the few variables in social science that may be shown to have a consistent relationship that ties research across levels of analysis. (p. 101)

For Rappaport (1981), a major goal of community psychology is the prevention of feelings of powerlessness. It is not easy to accomplish this goal of *empowerment*, and community psychologists have not been as conspicuously successful here as they would have liked (Heller, 1990). Gesten and Jason (1987) question whether any unique methods have been developed out of the empowerment concept. Still, Rappaport (1981) initially argued that strategies to enhance people's sense that they control their own destinies are preferable even to prevention or treatment approaches. Examples of attempts to enhance feelings of control range from reducing child and spouse abuse to eradicating exploitation of women, migrant workers, and the elderly and to decreasing bias against the disabled and the mentally ill.

Although he initially pitted empowerment and prevention approaches against each other, it appears that Rappaport (1987) has tempered his position. He now allows for the possibility that prevention interventions may be consistent with (rather than diametrically opposed to) empowerment. However, for this possibility to be realized, preventive interventions must be collaborative and delivered in a manner that avoids the paternalistic style that characterizes some traditional therapist–client interactions (Felner et al., 1983).

Diversity

Yet another important concept for community psychology, and clinical psychology more generally, is that of *diversity*. An understanding of and appreciation for human diversity are essential for community psychologists (Trickett, 1996, 2009). Dalton et al. (2001) present nine dimensions of human diversity that should be considered.

- *Culture*: Although difficult to define precisely, culture is often considered to be norms or traditions that a society or group attempts to pass along to younger generations or to immigrants.
- *Race*: Although originally thought of in terms of a biological variable, race is presently viewed as a psychological or social variable based on physical criteria.
- *Ethnicity*: Ethnicity concerns one's social identity, which is influenced by one's ancestry, culture of origin, or current culture.
- *Gender*: It is useful to distinguish between sex (a biological variable) and gender, which is a socially constructed set of assumptions about the behavior, attitudes, and roles of women and men.
- *Sexual orientation*: This involves sexual or romantic attraction to one or both genders.
- *Ability/Disability*: Humans differ in the degree to which they suffer from mental or physical disabilities.
- *Age*: Biological age is important to consider because different age groups have different psychological and physical concerns, and the aging process affects one's relationships with family members, communities, and institutions.
- *Socioeconomic status/Social class*: Consideration of social class is important because this dimension of diversity influences identity, relationships, educational and economic opportunities, as well as other psychological variables.
- *Religion and spirituality*: One's search for meaning in life relates to culture and ethnicity; it is not possible to understand a culture without an appreciation for the predominant modes of religion and spirituality.

Community psychologists must develop cultural competence and knowledge of human diversity to plan and institute programs for communities.

BOX 16-5 Graduate Student Perspective: Shawn C.T. Jones, M.H.S

Shawn Jones is a second-year doctoral student in the clinical psychology program at University of North Carolina-Chapel Hill. He completed his bachelor of science in psychology at Duke University in 2008, and most recently received a master of health science in mental health at the Johns Hopkins University Bloomberg School of Public Health. His research interests have focused on ethnic minority youth development, with an emphasis on risk and protective factors across a variety of contexts. His previous research has examined ethnic identity and parenting practices in the context of externalizing behaviors and substance use. Shawn is passionate about eliminating racial health disparities, particularly those related to mental health services.

Shawn agreed to share his thoughts about graduate school as well as his research interests.

What got you interested in clinical psychology?
I am an ex-pre-med kid. I entered college determined to major in psychology because I discovered that the field could help me to understand what drove people to think and act as they did. Nevertheless, my wish to "make a change" led me to believe I could best achieve my aspirations through medicine (psychiatry). Thankfully, advanced experiences in psych during undergrad (combined with not-so-hot natural science grades) lead me to pursue the Ph.D. in clinical as opposed to the medical degree!

What did you do as an undergraduate to prepare for graduate school in clinical psychology?
The main things I did to prepare for graduate school in clinical psychology were to gain a variety of research experiences (e.g., RA, independent research), take the required (and some advanced) coursework, study for and take the GRE (I took a brief prep course), and "interview" clinical psychologists at my undergraduate institution. I highly recommend these "interviews" as they really give you insight into aspects of the field that you will not otherwise have access to, namely the clinical piece.

What was the application process like for you?
I applied to graduate school three times. The first time was to master's programs in psychology (I decided to take an RA position instead); the second was to public health programs (I received a master's of health science in mental health); the third time was to clinical and clinical-community programs (10 to be exact). Though each application period came with its unique challenges, the consistent trends were that the process was (a) extremely busy and (b) expensive (both points also ring true for the interview process). The best way for you to account for these factors is by preparing well in advance. Many guides suggest a 2-year plan in terms of finding programs, taking necessary tests, and getting recommendation letters.

What was the interviewing process like for you?
I was fortunate to get interviews for the majority of schools to which I applied. These interviews came in three forms—the phone interview (4), the in-person interview (3), and an interview after I had already been accepted. Each of these formats contained

Social Intervention Concepts

The conventional strategy of intervention has always implied that one achieves good health exclusively through one's own efforts, and that when those efforts fail and ill health occurs, one visits a comprehensive mental health center for clinical help. But the community psychologist seeks to restructure roles and social organizations. For example, to reduce the problems created by crime and delinquency, community psychologists seek to change social institutions and organizations to make advantages and resources available to potential criminals and delinquents.

Inherent in such social intervention strategies is the idea that when individuals are given the necessary resources or alternatives, they will solve their problems themselves. Also inherent is the belief that people have competencies and strengths. When the environment is changed or when people are allowed to exert power to make their own decisions, these strengths and competencies will be evident. This emphasis on competencies rather than deficits allows the community psychologist to

essentially the same elements. I was asked questions about why I chose the programs; about how I saw the labs as a good fit given my interests; and about personal strengths and weakness. The toughest question I was asked: "given unlimited resources how would you specifically address your research questions/interests?" Lastly, (and consistently), I was asked what questions I had for my interviewers. It is important that you have a set of questions that you would like to ask of the programs to which you are applying, questions that are not already on a Web site or in a guide.

Looking back, what activities or experiences were most important in preparing you for your graduate school program?
I would say that my varied research experiences (including an independent research project and a summer internship with NIDA) and advanced coursework best prepared me for my program because of the skills they afforded me—a skill set I was able to carry to both my master's and now doctoral programs.

Any additional hints for applying to graduate school in clinical psychology?
Do Your Research. Consider applying to graduate school your first graduate research experience. Read the Web site of the programs in which you are interested. Familiarize yourself with the work of potential mentors. Learn about research other faculty at those programs are doing. Talk to current students. Your application process will be go much more smoothly if do your due diligence.

Tell us about the work you have conducted while in graduate school.
Currently, I am working on my master's thesis, which is an experiment designed to assess African American college students' emotional responses to discrimination and the potential protective effects of racial identity. I am very excited about this work, as it will be among the first to attempt to understand the impact of exposure to a specific race-related event on African Americans' psychological well-being in the laboratory setting, which could contribute to the importance of studying discrimination in context.

Shawn Jones

Shawn C.T. Jones

move toward creating a proper person–environment fit rather than changing the affected people so that they will fit the appropriate environment as determined by majority values.

Blaming the Victim. Particularly illustrative of the notions that have given rise to the strategy of social intervention is the contrast between blaming the victim and blaming the system. In a highly influential book, Ryan (1971) argued that society sees the economically disadvantaged, school dropouts, drug addicts, or the unemployed as individual failures whose healing will require remedial reading programs, drug counseling, and so on. According to Ryan, society misses the real message, which is bad social environments. Their problems are not clinical; they are community-social.

Why are we so prone to place responsibility on individuals who are disadvantaged rather than on society or the environment? Caplan and Nelson (1973) cite several reasons:

- Such explanations free the government and cultural institutions from blame.
- Institutions, therefore, cannot be held responsible for "solving" the problem.

TABLE 16-2 Strategies for Change as Determined by Theoretical Orientation and Level of Analysis

	Level of Analysis		
Theoretical Orientation	*Individual*	*Organizational*	*Community*
Deficit	Somatic therapies to correct biochemical or physiological imbalance	Group psychotherapy or sensitivity training to correct interpersonal problems	Institutionalization or special facilities built for the disabled or emotionally disturbed
Competence	Most forms of behavior therapy, particularly skill training	Training and consultation to increase job competencies of organization members	Creating new settings and alternative programs
	Prevention programs for high-risk persons	Prevention programs to reduce organizational stress and increase coping	Community-wide prevention programs to reduce environmental stress and increase citizen competencies

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- Placing responsibility on the individual gives a degree of legitimacy to attempts to intervene at the person level (as is common in traditional clinical psychology).

Caplan and Nelson (as well as others) hope to highlight these factors, which may serve to influence how we conceptualize the cause(s) of social problems. As a result, we may be better able to resist the temptation to "blame the victim" when it is not justified.

The Focus on Intervention Strategies. One way of contrasting traditional clinical and community orientations is by focusing on intervention strategies. Such strategies, according to Heller et al. (1984), can vary along two dimensions: theoretical (deficit vs. competence) and ecological (the individual, the organization, or the community). Table 16-2 summarizes the way these dimensions operate.

METHODS OF INTERVENTION AND CHANGE

We now shift our attention to methods of intervention. Here our focus is on patterns of service delivery.

Consultation

What is *consultation*? Orford (1992) offers the following definition:

> Consultation is the process whereby an individual (the consultee) who has responsibility for providing a service to others (the clients) voluntarily consults another person (the consultant) who is believed to possess some special expertise which will help the consultee provide a better service to his or her clients. (p. 139)

In a world short of mental health personnel, the basic advantage of consultation is that its effects are multiplied like the ripples from a stone thrown into a pond. Using individual techniques of intervention, the mental health specialist can reach only a very limited number of clients. But by consulting with other service providers, such as teachers, police, and ministers, he or she can reach many more clients indirectly (Orford, 1992).

Consultation can be viewed from several orientations, each springing from a somewhat different historical perspective (Brown & Schulte, 1987; Heller et al., 1984; Nietzel, Winett, MacDonald, & Davidson, 1977; Orford, 1992). First, there is mental health consultation. This grew out of the psychoanalytic and psychodynamic tradition. It was often

practiced in rural or underdeveloped areas where there was a shortage of mental health personnel. Consultation became a way of using existing community personnel (e.g., teachers or ministers) to help solve the mental health problems of such areas. A second orientation developed out of the behavioral tradition. To implement the technology of behavior modification that had been so successful in laboratory settings, it was necessary to move into real-life situations. To do that, people in the patient's environment (e.g., home or school) had to be trained to properly dispense reinforcements for the desired behavior. Consultation became a way of providing this training. The third orientation is an organizational one that emphasizes consultation to industry. Specialists work with management or work group leaders to improve morale, job satisfaction, and productivity or to reduce inefficiency, absenteeism, alcoholism, or other problems.

Types of Mental Health Consultation. Approaches to mental health consultation can be classified in many ways. Perhaps the most widely accepted classification is Caplan's (1970). It includes the following categories:

1. *Client-centered case consultation*. Here the focus is on helping a specific client or patient to solve a current problem. For example, a clinician might be asked to consult with a colleague on a diagnostic problem involving a specific patient.
2. *Consultee-centered case consultation*. In this instance, the aim is to help the consultee enhance the skills that he or she needs to deal with future cases. For example, a teacher might be advised on how to selectively reinforce behavior to reduce classroom disturbances.
3. *Program-centered administrative consultation*. The notion here is to assist in the administration or management of a specific program. For instance, a consultant might be hired to set up an "early warning system" in the schools to detect potential cases of maladjustment.
4. *Consultee-centered administrative consultation*. Here the aim is to improve the skills of an administrator in the hope that this will enable her or him to function better in the future. For example, a sensitivity group consisting of administrators might be monitored by a consultant to help enhance the administrators' communication skills.

Techniques and Phases. Several general techniques can enhance the effectiveness of the consulting process. In most cases, the consultation process will pass through the following phases:

1. *The entry or preparatory phase*. In the initial phase, the exact nature of the consultant relationship and mutual obligations are worked out.
2. *The beginning or warming-up phase*. In this phase, the working relationship is established.
3. *The alternative action phase*. This phase encompasses the development of specific, alternative solutions and strategies of problem solving.
4. *Termination*. When it is mutually agreed that further consultation is unnecessary, termination follows.

Unfortunately, community mental health centers have had difficulty providing consultation services, especially to schools and community agencies; the budgetary support has just not been there (Iscoe & Harris, 1984). What is particularly troubling about this state of affairs is that there is empirical support for the efficacy of consultation (Duffy & Wong, 1996; Medway & Updike, 1985; Orford, 1992).

Community Alternatives to Hospitalization

As noted earlier in this chapter, the nation's mental hospitals have long been objects of criticism. Despite the fact that there is a core of "undischargeable" patients, there are alternatives to our current hospital system—alternatives that will provide environments geared to the goal of enabling patients to resume a responsible place in society.

Examples of alternatives include the community lodge (Fairweather, Sanders, Maynard, & Cressler, 1969). This is akin to a halfway house

where formerly chronic, hospitalized patients can learn independent-living skills. The Mendota Program (Marx, Test, & Stein, 1973) was a pioneering attempt to help formerly undischargeable patients find jobs, learn cooking and shopping skills, and so on. Finally, there is the growing popularity of day hospitals that are often more effective and less expensive than traditional 24-hour hospitalization.

Intervention in Early Childhood

Public health workers and mental health workers have long been aware of the educational disadvantages experienced by the poor. Of great concern is the fear that early deprivation in crucial developmental periods will mark the child for life. Impoverished preschool environments and experiences may almost guarantee that the child will do poorly in school and thus become vulnerable to a wide variety of mental health, legal, and social problems. But if successful preschool interventions can be developed, then a truly preventive course of action will have been taken.

Head Start Programs. We have already discussed the High/Scope Perry Preschool Program in Box 16-2. However, probably the best-known early childhood program is *Head Start*. In the mid-1960s, President Johnson created the Office of Economic Opportunity (OEO). Head Start was one of the programs targeted specifically for disadvantaged children. It was designed to prepare preschool children from disadvantaged backgrounds for elementary school. Head Start programs are locally controlled but required to conform to general federal guidelines. Local programs vary in number of hours of attendance, number of months (summer vs. the entire year), background of teachers, and so on. The specific techniques used also vary, but basic learning skills are usually stressed. Physical and medical needs are also addressed, as are general school preparation and adjustment.

Evaluation. How effective are these early childhood programs? Gomby, Larner, Stevenson, Lewit, and Behrman (1995) find it useful to distinguish between child-focused programs and family-focused programs. In the former case, interventions are administered directly to the child; in the latter case, family members (e.g., parents) receive the intervention or training. A recent Institute of Medicine report (NRC-IOM, 2009) provides multiple examples of effective family, school, and community prevention programs. Here we mention a few examples.

Participation in a child-focused program results in an average IQ gain of about 8 points immediately after program completion (although these relative gains dissipate over time), makes it less likely that the child will be placed in special education or retained in grade, and makes it more likely that the child will graduate from high school (Barnett, 1995; Gomby et al., 1995). Positive social outcomes resulting from program participation have also been reported, including fewer contacts with the criminal justice system, fewer out-of-wedlock births, and higher average earnings than nonparticipants (Gomby et al., 1995; Yoshikawa, 1995).

Although family-focused programs appear to have more impact on parents' behaviors than do child-focused programs, it is not clear how much positive impact they have on children (Gomby et al., 1995; Yoshikawa, 1995). Not only is the focus of the intervention different, but so is its intensity and frequency. In the case of family-focused interventions, services may be rendered only once a week.

Self-Help

Not all help comes from professionals. Informal groups of helpers can provide valuable support that may stave off the need for professional intervention. Furthermore, such nonprofessional *self-help groups* as Alcoholics Anonymous, Parents Without Partners, La Leche League, Al-Anon, Narcotics Anonymous, and many others can be incorporated as an effective part of treatment by a referring professional.

What needs do self-help groups meet? Orford (1992) discussed eight primary functions of self-help groups: (a) They provide emotional support to

members; (b) they provide role models—individuals who have faced and conquered problems that group members are dealing with; (c) they provide ways of understanding members' problems; (d) they provide important and relevant information; (e) they provide new ideas about how to cope with existing problems; (f) they give members the opportunity to help other members; (g) they provide social companionship; and (h) they give members an increased sense of mastery and control over their problems.

Clearly, self-help groups serve several important functions for group members. However, research suggests that professionals should be available to serve as consultants to these groups for the groups to be maximally effective. Professionals should not control the group, but a total lack of involvement on the part of a community psychologist does not appear to be helpful either (Orford, 1992). Certain organizational features appear correlated with the appraisal of group success, including a certain degree of order and rules to govern the group as well as the capability and knowledge of group leaders (Maton, 1988), and a community psychologist can play an invaluable indirect role by serving as a consultant to group leaders.

Paraprofessionals

One of the more visible features of the community movement is its use of laypersons who have received no formal clinical training, or *paraprofessionals*, as therapists. The use of paraprofessionals in the mental health field has been growing, but this trend has generated controversy. In reviewing 42 studies, Durlak (1979) concluded that professional education, training, and experience are not prerequisites for becoming an effective helping person. However, Nietzel and Fisher (1981) took issue with this conclusion and urged caution in interpreting the results of many of the studies reviewed by Durlak. They argued that many of the studies included in the Durlak review were methodologically flawed and objected to Durlak's definitions of "professional" and "paraprofessional." With these and other criticisms in mind, Hattie, Sharpley, and Rogers (1984) reanalyzed the studies in Durlak's review. Results from their meta-analysis concurred with those of Durlak. The overall results favored paraprofessionals, especially those who were more experienced and received greater amounts of training. More recent summaries have also argued that the available evidence suggests that paraprofessionals may be as effective as (and in some cases more effective than) professionals (e.g., Christensen & Jacobson, 1994).

Besides effectiveness, there is also the issue of access to those who can provide help. Like it or not, most individuals who are in need of mental health services do not seek out mental health professionals. Instead, informal "therapy" takes place in many contexts and is provided by a variety of laypersons. For example, in an interesting and provocative set of studies, Cowen (1982) investigated the "helping behavior" of hairdressers and bartenders. Results indicated that a small but significant proportion of their customers raised moderate to serious personal problems, and both hairdressers and bartenders attempted a range of interventions (e.g., just listening, trying to be supportive and sympathetic, presenting alternatives). Many community psychologists view these and other studies as evidence supporting the idea that consultation programs might be aimed at laypersons who naturally come into contact with individuals with mental health needs. These needs might not otherwise be addressed because the target individuals are not likely to seek out help from a mental health professional.

Although it hardly seems wise to argue that professionally trained clinical psychologists are unnecessary, it certainly appears that there is a vital role for paraprofessionals in the mental health field today. Clinical psychologists are needed, at the very least, to serve as consultants. Further, research may ultimately indicate that certain types of mental health problems respond better to services provided by a mental health professional. To date, however, the research questions addressed (e.g., are paraprofessionals effective overall?) have been too broad to shed light on this issue. However, at least one recent meta-analysis that focused specifically on

depression found that those who participated in a peer-support intervention (usually a peer-support group) showed better outcomes than depressed individuals who received treatment as usual without peer support (Pfeiffer et al., 2011).

CONCLUDING COMMENTS

In a relatively short time, the community emphasis has become a force that has led clinical psychologists to reexamine many of their old assumptions. But there are important questions that must be confronted as we conclude our discussion of this field.

Questions of Effectiveness

Years ago, Cowen (1967, 1973, 1978) raised the question of how much the community movement has accomplished beyond that accomplished by more traditional mental health approaches. The question was whether excitement and rhetoric had masked what was really very little substantive change. For example, Cowen (1973) could find relatively few research reports in the *Community Mental Health Journal* that provided concrete data. The papers also notably failed to address issues of prevention—a notion central to the community approach. Rappaport (1977) stated that no evidence really existed that U.S. communities had shown improved mental health. He even went so far as to suggest that the community mental health movement's greatest accomplishment may have been that it opened up new careers for persons who were formerly not part of the movement.

Although for years there was more rhetoric than implementation with regard to prevention programs (Iscoe & Harris, 1984), intervention is one of the cornerstones of the community movement. The question remains, however, whether the field really knows enough about the causes of mental health problems to mount large-scale, successful preventive programs. Fortunately, recent reports evaluating the effectiveness of a wide range of prevention programs lead us to a state of cautious optimism (e.g., Durlak & Wells, 1997; Felner, DuBois, & Adan, 1991; Institute of Medicine, 1994). Whereas many early reports regarding the efficacy of prevention programs were disappointing, community psychologists were able to learn from these failures and incorporate changes into new programs (Felner et al., 1991). For example, increased focus was placed on modifying psychological processes underlying various mental disorders, and interventions were designed to be more intensive and to extend over longer periods of time. The Institute of Medicine report (1994) on preventing mental illness presented a group of 39 exemplary intervention programs (with demonstrated effectiveness) that targeted infants, preschoolers, elementary-age children, adolescents, adults, or the elderly. Likewise, a newer summary of prevention efforts (NRC-IOM, 2009) summarizes a number of effective prevention efforts aimed at childhood maltreatment, academic failure, violence, conduct disorder, depression, substance abuse, and anxiety, for example. Finally, Biglan and Hinds (2009) offer evidence for successful prevention programs reducing substance use and antisocial behavior and a directive for prevention programs that will simultaneously address multiple additional issues by focusing on cross-cutting community factors (e.g., prosocial behavior).

Issues remain, to be sure. For example, there are questions regarding how intervention programs should be disseminated and by whom, how the programs are to be maintained over time (funding issues), and the need to train more researchers who are qualified to design, implement, and evaluate preventive interventions (Institute of Medicine, 1994; NRC-IOM, 2009; Orford, 1992, 2008; Thornicroft et al., 2010). For example, the IOM report (1994) estimated that only about 10 new prevention experts are produced a year; training programs and financial support are needed to increase this woefully low number.

Values, Power, and Civil Rights

Clearly, the community movement seeks to bring about social change and the reorganization of social institutions. The goal of such changes is undoubtedly

laudable—better mental health for all. In case the reader had not noticed, this last statement almost sounds as if it might have been made by a candidate for public office. Indeed, some have argued that if community professionals want to bring about social change, they should run for political office. Those who take this position say that social change (especially when it is accomplished by public funds) is a political phenomenon and should be mandated by the public.

Obviously, there is much to be said on both sides. There is danger in adopting the narrow role of the patient's advocate rather than the broader role of advocate for the larger community. Adopting the narrow role may cause the real bases of patients' problems to be ignored. But there is also great danger in becoming a political advocate. Ideally, the individual practitioner and the community-oriented advocate will each carefully examine the potential for both harm and good that is inherent in their positions.

The Training of Community Psychologists

At present, many still have difficulty understanding exactly what a community psychologist is. Perhaps because of its multidisciplinary orientation, community psychology has yet to develop an adequate or identifiable theoretical framework apart from those of other disciplines. This, at times, creates role confusion. The community psychologist is part sociologist, part political scientist, part psychotherapist, part ombudsman, but lacks a specific identity. This ambiguity makes it difficult to design appropriate training programs.

Fortunately, there are some guidelines for training. The earlier IOM report (1994) recommends that future prevention research specialists should have a solid background in a relevant discipline (e.g., nursing, sociology, social work, public health, epidemiology, medicine, or clinical/community psychology). Training in the design of interventions and the empirical evaluations of interventions is essential. Finally, practicum or internship-like training in prevention is also recommended. Educational requirements for prevention field specialists (those that actually carry out the interventions) are less stringent. Often, a bachelor's degree in a relevant field (e.g., psychology) is sufficient. However, today there are many additional education opportunities available for training in community psychology. The Society for Community Research and Action (SCRA) provides an up-to-date listing of many of these undergraduate training and graduate training opportunities (see Web sites 16-1 and 16-4).

Given the increasing cultural and ethnic diversity in the United States, it is also important for community psychologists to receive training in how diversity issues may impact their work (Trickett, 2009). For example, a knowledge of and sensitivity to cultural and ethnic differences will inform the following activities and roles of a prevention researcher (Institute of Medicine, 1994):

1. Developing relationships with community leaders and organizations
2. Conceptualizing and identifying potential risk factors, mechanisms, and antecedents of problems or disorders
3. Developing interventions that will have maximum effect, and deciding how these should be disseminated and delivered to the target population
4. Determining the content and format of evaluation instruments

The Future of Prevention

Given the compelling rationale of prevention and, more recently, the documented effectiveness of preventive efforts (NRC-IOM, 2009), it may seem puzzling that more resources are not dedicated to these forms of intervention. In a classic but still highly relevant article, Cowen (1983) described a number of barriers and resistances to the prevention movement. To cite a few examples, those outside the field may remain skeptical because (a) the social and environmental focus of preventive interventions differs philosophically from the traditional focus on individual variables practiced by many clinical psychologists; (b) prevention, in a

sense, must compete with more established forms of intervention (e.g., one-on-one psychotherapy); and (c) preventive programs may appear impractical and too costly (Cowen, 1983). In addition, the prevention field itself has served as an "enemy from within" (Cowen, 1983) by being less than precise with its terminology, being slow to document the effectiveness of preventive interventions, and neglecting to coordinate efforts across programs (e.g., Hawkins & Catalano, 1992).

Ideally, these issues can be adequately addressed in the future so that the interventions characteristic of community psychology will be more widely used. Perhaps in the future, we should begin to focus as much on psychological wellness and health as on psychopathology and treatment of mental disorders (Biglan & Hinds, 2009; Cowen, 1991; NRC-IOM, 2009). If so, we will grasp the importance of such concepts as competence, resilience, prevention, modification of social systems, and empowerment.

CHAPTER SUMMARY

Community psychology is an approach to mental health that emphasizes the role of environmental and societal forces in creating and alleviating problems. The focus is on prevention of problems rather than on cure, and both individuals and the community are encouraged to take control of and master their own problems so that professional intervention is not necessary. A number of influences led to the development of the community psychology field, including the creation of the Joint Commission on Mental Health and Illness in 1955; the 1963 Kennedy Bill, which funded the construction of community mental health centers; deinstitutionalization; a shortage of mental health professionals; and a number of sociopolitical events in the 1960s.

Several concepts are central to community psychology. Ecological systems can be analyzed at one or more of several interrelated levels, ranging from the individual to macrosystems (e.g., a society or culture). The concept of community mental health refers to the conviction that communities are responsible for their members and that community mental health should provide services to prevent problems and help the community and its systems function better. Community psychologists focus on prevention because it is believed that, in the long run, prevention initiatives will be more efficient and effective than individual treatment administered after the onset of problems. Community psychologists also focus on strategies to increase levels of empowerment—that is, to enhance individuals' sense that they control their own destinies. A knowledge of the different dimensions of human diversity is important so that issues and problems can be better understood and interventions can be successful. Finally, community psychologists seek to make positive changes by restructuring roles and social institutions. Increasing positive alternatives and resources for individuals makes it more likely that individuals will succeed and that a good person–environment fit will be realized.

Community psychologists frequently serve as consultants to mental health professionals, teachers, ministers, and other community personnel by lending their advice and expertise. Additional types of services offered by or orchestrated by community psychologists include intervention in childhood and adolescence, self-help groups, and the enlistment of paraprofessionals to provide services to community members.

The future of community psychology is uncertain. Many prevention programs have been shown to be effective and cost-efficient, and consultation appears to be effective as well. There have been calls for training more community psychologists and prevention field specialists. Finally, it is likely that more and more interventions and programs designed and implemented by community psychologists will be recommended and financially supported by managed care companies in the future. However, funding for community mental health

centers has dwindled considerably, and few doctoral programs dedicated specifically to the training of the community-based perspective remain. Recent legislation designed to promote a community-based approach to mental health care may change the prospects for this important field.

KEY TERMS

client-centered case consultation A type of mental health consultation that focuses on helping to solve a current problem with a specific client.

community mental health A movement arising in the 1950s that viewed mental health problems as emerging from failures in the social system. This movement called for community control of mental health services and strong focuses on prevention, early detection, and the provision of services to populations who had traditionally been underserved.

community psychology A psychological approach that emphasizes the role of environmental forces in creating and alleviating problems. Community psychology is preventive rather than remedial in orientation. Furthermore, it attends to the fit between the person and the environment (rather than the inadequacies of either) and focuses on identifying and developing the strengths and resources of people and communities.

consultation The act by which a person who provides services to others (or oversees the provision of services) enlists the help of an expert for the purpose of improving these services.

consultee-centered administrative consultation A type of mental health consultation that focuses on helping an administrator enhance his or her skills so that he or she will be able to function more effectively in the future.

consultee-centered case consultation A type of mental health consultation that focuses on helping the consultee enhance the skills he or she will need to deal effectively with future cases.

diversity Dimensions along which individuals differ. It is important to be aware of these differences to better understand and to better serve individuals.

ecological analysis The examination of issues and problems at different levels of the human ecosystem, ranging from the individual to macrosystems (e.g., cultures or societies).

empowerment Providing individuals with the sense that they are in control of their own destinies or enhancing existing feelings of control.

head start programs Primary prevention, early childhood programs designed to prepare preschool children from disadvantaged backgrounds for elementary school by focusing on their basic learning skills, among other things.

indicated preventive interventions Preventive interventions that target people at high risk for developing the disorder (as determined by the presence of subthreshold symptoms or biological markers indicating a predisposition for developing the disorder).

paraprofessionals Persons with no formal clinical training who have been trained to assist professional mental health workers. The use of paraprofessionals has been growing in community psychology and in the mental health field as a whole, and the results of meta-analyses suggest that paraprofessionals may be as effective (or in some cases even more effective) than professionals.

prevention The principle that, in the long run, preventive activities will be more efficient and effective than individual treatment administered after the onset of disease or problems.

primary prevention Correcting negative conditions before significant problems emerge as a consequence of these conditions. The application of this prevention model often necessitates a degree of social change.

program-centered administrative consultation A type of mental health consultation that focuses on helping with the institution or management of a specific program.

secondary prevention Detecting and correcting problems early, while they are still amenable to intervention. This prevention model often entails screening large numbers of people, including people who are not seeking help and may not even appear to be at risk.

selective preventive interventions Preventive interventions that target individuals or subgroups of the population with a higher-than-average chance for developing the disorder in question (as determined by the presence of certain biological, psychological, or social risk factors).

self-help groups Informal groups that provide support for individuals facing specific problems and may stave off the need for professional intervention. Functions of self-help groups include providing important and relevant information to members, providing role models (individuals who have successfully confronted the problem at hand), providing emotional support and ideas for coping, and giving members an increased sense of mastery and control over their problems.

tertiary prevention Reducing the duration and negative effects of problems after they have occurred. This prevention model most often involves rehabilitation.

universal preventive interventions Preventive interventions that target the entire population.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

16-1 Society for Community Research and Action (Division 27 of the American Psychological Association)
http://www.scra27.org/

16-2 Society for Prevention Research
http://www.preventionresearch.org/about.php

16-3 The Future of Children (links to prevention articles)
http://futureofchildren.org/

16-4 Community Psychology Graduate Programs
http://www.scra27.org/resources/educationc/academicpr

17

Health Psychology and Behavioral Medicine

FOCUS QUESTIONS

1. What historical events influenced the development of the field of health psychology?
2. What are the major intervention methods used by health psychologists?
3. How are prevention techniques used to address problems related to smoking, alcohol abuse/dependence, and obesity?
4. What techniques are used to help patients cope with stressful medical procedures and surgery?
5. What major influences are likely to affect the future of health psychology?

CHAPTER OUTLINE

History and Perspectives
- Definitions
- History
- Linking Stress, Lifestyle and Behavior, Personality, Social Support, and Health
- BOX 17-1: *Focus on Clinical Applications: Stress and Everyday Life: What Are the Most Common Stressors for Undergraduate Students?*
- Range of Applications

Methods of Intervention
- Respondent Methods
- BOX 17-2: *Focus on Professional Issues: The Role of Health Psychology: HIV and Acquired Immune Deficiency Syndrome (AIDS)*
- Operant Methods
- Cognitive-Behavioral Methods
- Biofeedback

Prevention of Health Problems
- Cigarette Smoking
- BOX 17-3: *Focus on Professional Issues: Ethnicity and Cancer Outcomes*
- Alcohol Abuse and Dependence
- Obesity

Other Applications
- Coping with Medical Procedures
- Compliance with Regimens

Future Directions
- Health Care Trends

Training Issues
Other Challenges
BOX 17-4: *Clinical Psychologist Perspective: Beth E. Meyerowitz, Ph.D.*

CHAPTER SUMMARY
KEY TERMS
WEB SITES OF INTEREST

It seems that everyone realizes now that lifestyle affects our health and sense of well-being. Most health problems in the United States are related to chronic diseases (e.g., heart disease, cancer, and stroke), and these diseases are often associated with behavior or lifestyle choices (e.g., smoking or overeating) made by individuals (Brannon & Feist, 2010). Over the last 50 years, the costs of medical care have skyrocketed to more than 16% of the gross domestic product (GDP) in the United States (Pleis, Ward, & Lucas, 2010). The potential financial burden associated with health problems has led many to reevaluate their lifestyles and behavior. There has also been a shift in perception. Health has become associated with positive well-being rather than simply the absence of disease (Brannon & Feist, 2010). These trends, as well as others, have led Americans to focus much more intensely on behaviors and lifestyles that promote health and prevent disease.

Psychology, as a science of behavior, has much to contribute to the field of health, and health psychology has become a fast-growing area within clinical psychology. Many clinical doctoral programs have a "track" or emphasis dedicated specifically to clinical health psychology and/or pediatric psychology (also known as child health psychology). General textbooks on health psychology are now prevalent, as are specialized textbooks on clinical health psychology, women and health, and pediatric health psychology. In addition, several specialty journals (including *Health Psychology, Journal of Behavioral Medicine*, and the *Journal of Pediatric Psychology*) report on research in these fields. Finally, two separate divisions of the American Psychological Association (Divisions 38, Health Psychology, and Division 54, Pediatric Psychology) have been established as a way to publicize and advance the contributions of health psychologists in adults and youth, respectively.

HISTORY AND PERSPECTIVES

Although a variety of overlapping subdisciplines focus on health-related issues, we will focus primarily on two areas of psychology: behavioral medicine and health psychology. Recognition that mind and body are inextricably linked has been around since at least early Greek civilization. However, it was not until the late 1970s that definitions of behavioral medicine and health psychology began to crystallize.

Definitions

Although a variety of definitions have been offered over the years (e.g., Miller, 1983; Schwartz & Weiss, 1977), *behavioral medicine* basically refers to the integration of the behavioral sciences with the practice and science of medicine. Matarazzo (1980) uses the term to refer to the broad interdisciplinary field of scientific investigation, education, and practice that is concerned with health, illness, and related physiological dysfunctions.

Health psychology is a specialty area within psychology. It is a more discipline-specific term, referring to psychology's primary role as a science and profession in behavioral medicine. It includes health-related practice, research, and teaching by

many kinds of psychologists—social, industrial, physiological, and others. Health psychology has been specifically defined as

> the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction. (Matarazzo, 1980, p. 815)

This definition was later amended to include psychologists' roles as formulators of health care policy and contributors to the health care system (see, e.g., DeLeon, Frank, & Wedding, 1995). A recent definition of health psychology that incorporates these new roles has been offered by Brannon and Feist (2010), who state that health psychology "includes psychology's contributions to the enhancement of health, the prevention and treatment of disease, the identification of health risk factors, the improvement of the health care system, and the shaping of public opinion with regard to health" (p. 13).

History

Two major perspectives have influenced our views of health and illness (Rice, 1998). First is the *biomedical tradition*, which developed over time as people sought to gain knowledge through experience and observation. Early attempts were rather crude (e.g., the discovery of the benefits of acupuncture, Hippocrates' humoral theory of disease and treatment), but later biomedical scientists focused on anatomy, "germ theory," and ultimately genetics in their attempt to define and understand illness and disease. This Western tendency to focus solely on biological factors and to adopt a reductionistic approach is not without its limitations, however. For example, critics argue that we still do not know what causes disease; rather, we have simply discovered another malfunction at a smaller level of analysis (e.g., at the molecular genetic level). Biomedical research may be so enamored with somatic correlates (e.g., abnormal physical processes and biochemical imbalances) that psychosocial variables are often ignored. Finally, this tradition reinforces the mind–body dualism perspective, which is both outdated and limited in its utility. This is not to say that the biomedical tradition has been unimportant or irrelevant to medicine, science, and psychology. Rather, a strict biomedical viewpoint is at times too narrow because it cannot adequately account for widely encountered forms of illness and disease.

A second major influence on our views of health and illness is the *psychosocial perspective* (Rice, 1998). For centuries, medical literature has recognized that psychological and social processes may either cause or influence illness and disease. By the 1940s, this broad generalization had coalesced into the field of *psychosomatic medicine*. Psychosomatic medicine is based on the assumption that certain illnesses and disease states are caused by psychological factors. Researchers (e.g., Alexander, 1950) identified several "psychosomatic" diseases, including peptic ulcers, essential hypertension, and bronchial asthma. All illnesses were divided into those caused by "organic" or physical factors and those caused by psychological factors. Some who adopted this perspective believed that each psychosomatic illness had a different, specific underlying unconscious conflict predisposing the person to that disorder. For example, repressed hostility was believed to result in rheumatoid arthritis. Although initially appealing, these ideas (and psychosomatic medicine in general) began to flounder as it became apparent that such specific psychogenic factors were not very predictive; most empirical studies did not support the theories. In fact, psychosocial factors are involved in all diseases, but these factors may not necessarily have a primary causal role.

Psychosomatic medicine was largely the province of psychiatrists and physicians. However, behavioral psychologists began to extend the range of their therapy methods to the so-called medical disorders. Problems such as obesity and smoking came under the scrutiny of psychologists as well. Then came a rapid increase in the use of biofeedback (discussed later in this chapter) to help patients control or modify certain physiological responses.

Another set of factors was slow to develop but ultimately had a strong impact. By the 1960s, many major infectious diseases had been conquered. The helping professions began to turn their attention to two of the biggest killers: cardiovascular diseases and cancer. Behaviors such as overeating, smoking, and drinking were increasingly identified as major correlates of these diseases. The spotlight began to shine not just on the disease process itself but also on the associated behaviors whose reduction or elimination might reduce individuals' vulnerability to disease.

During the 1960s, stressful life events began to be implicated as specific risk factors for illness (e.g., Holmes & Rahe, 1967). The examination of how stressful major life events affect health led to an examination of the health consequences of daily hassles, which can also prove stressful (e.g., Lazarus, 1984). A related line of research demonstrated how personality and behavioral style can influence health. The impetus came from two cardiologists who were impressed with a common constellation of traits and behaviors shared by many who suffered from coronary heart disease. The so-called Type A personality (Friedman & Rosenman, 1974) is characterized by hostility, competitiveness, and being time-driven. Although subsequent research has failed to support a direct link between Type A personality and heart disease (Brannon & Feist, 2010; Suls & Bunde, 2005), the hypothesis stimulated research in health psychology and served to focus attention on other behavioral risk factors for coronary heart disease (e.g., smoking and lack of exercise) as well as on prevention efforts.

The recognition that both psychological and social factors influence illness and health is the basis of an influential perspective known as the *biopsychosocial model* (Engel, 1977). In many ways, this model can be viewed as an integration of the biomedical and psychosocial perspectives. As the name implies, the biopsychosocial model holds that illness and health are a function of biological, psychological, and social influences. Biological influences can include genetic predispositions, nutritional deficiencies, and biochemical imbalances. Psychological influences can include the individual's behaviors, emotions, and cognitions. Finally, social influences can include friends, family members, home environment, and life events. This biopsychosocial model represents how health psychologists conceptualize problems and plan interventions.

Many other factors were important in the development of the field of health psychology. The tremendous cost of health care has already been noted, along with the fact that infectious diseases were no longer the principal culprits. A large portion of health care costs are directly traceable to human behaviors and lifestyles that result in injuries, accidents, poisonings, or violence. Lifestyle choices such as alcohol and drug abuse, smoking, and dietary patterns contribute to a variety of illnesses and diseases.

The foregoing are just a few of the more prominent factors in the development of the health psychology field. We turn now to a discussion of how stress, lifestyle and behavior, personality, social support, and health are linked. These links form the basis of the field of health psychology and pediatric psychology.

Linking Stress, Lifestyle and Behavior, Personality, Social Support, and Health

What are the processes by which psychological and social factors influence health and disease?

Stress and Health. Although the term *stress* is frequently used, it is not often precisely defined (Brannon & Feist, 2010). Some use the term to refer to a quality of an external stimulus (e.g., a stressful interview), others to refer to a response to a stimulus (the interview caused stress), and still others believe stress results from an interaction between stimulus and response (stress resulted because the interview was challenging and I was not prepared). Most contemporary health psychologists adopt this third, interactionist viewpoint, seeing stress as a process that involves an environmental event (a stressor), its appraisal by the individual (is it challenging or threatening?), the various responses of the organism (physiological, emotional, cognitive, behavioral), and the reevaluations that occur as a result of these responses and changes in the stressor (Rice, 1998). This transactional

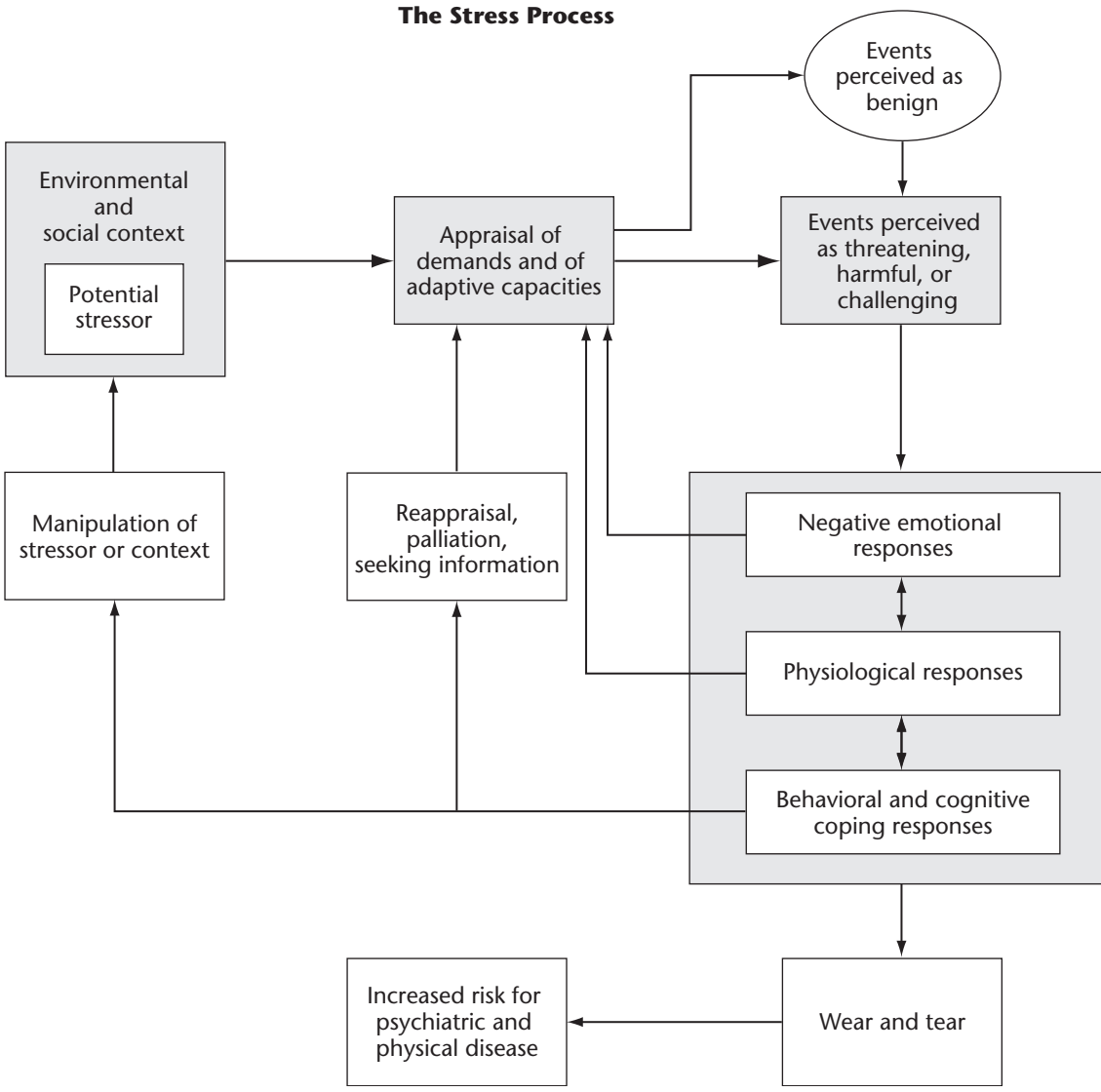

FIGURE 17-1 The stress process: An interactionist view

SOURCE: Rice, P. L. (1998). *Health psychology*. Pacific Grove, CA: Brooks/Cole, Page 177. Used with permission.

model of stress is depicted in Figure 17-1. These and other psychosocial stimuli may contribute to a stress process that can then directly affect the hormonal system, the autonomic system, and the immune system.

The physiological effect of stress on the body involves a complex chain of events (Brannon & Feist, 2010), illustrated in Figure 17-2. The perception of stress causes the *sympathetic nervous system*, a system responsible for mobilizing body resources in urgent situations, to stimulate the adrenal medulla of the adrenal gland. This results in the production of the catecholamines epinephrine (adrenaline) and norepinephrine, whose effects on the body include increased heart rate, respiration, blood flow, and muscle strength. Stress also causes the pituitary gland (a structure connected to the hypothalamus

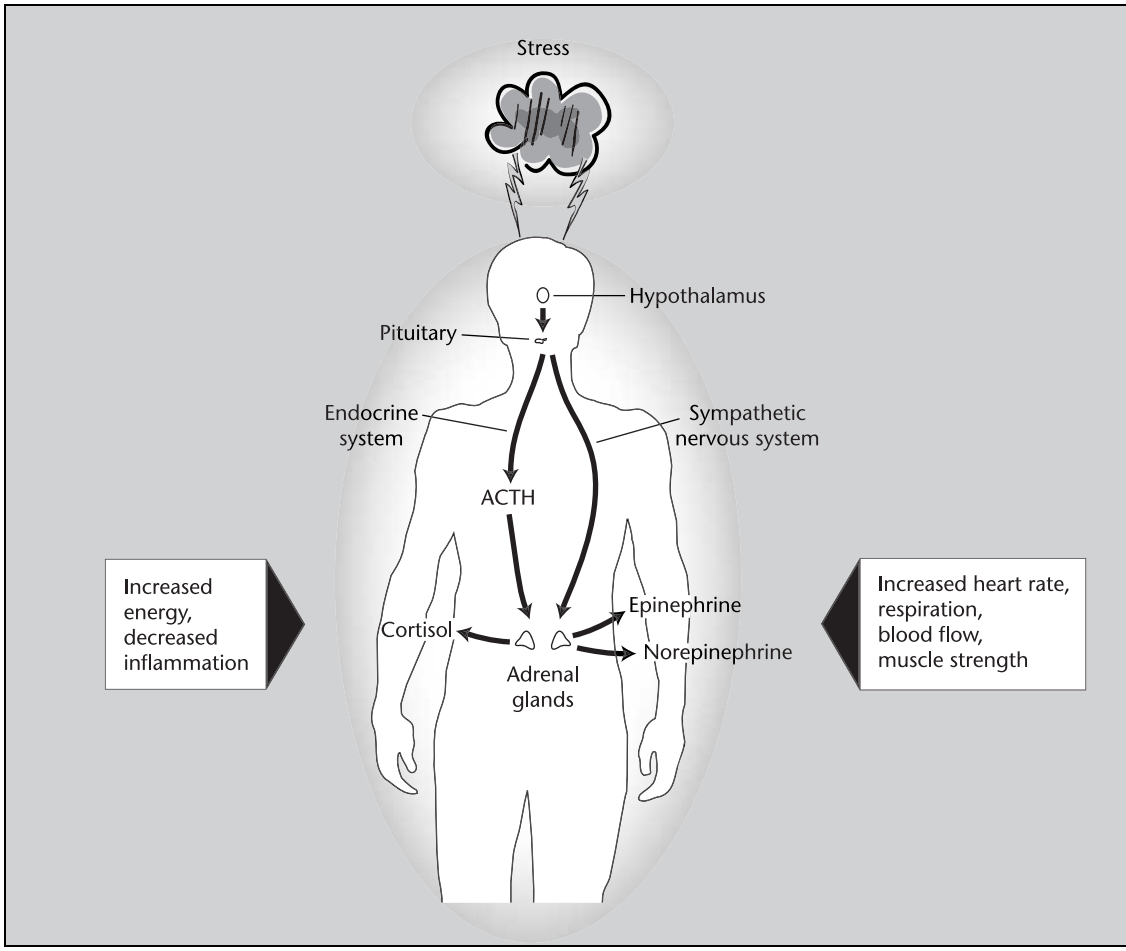

FIGURE 17-2 Physiological effects of stress

SOURCE: Brannon, L., & Feist, J. (2010). *Health psychology: An introduction to behavior and health* (7th ed.). Pacific Grove, CA: Brooks/Cole. Page 100. Used with permission.

in the forebrain) to release adrenocorticotropic hormone (ACTH), and ACTH stimulates the adrenal cortex of the adrenal gland to secrete glucocorticoids. The most important glucocorticoid where stress is concerned is cortisol. Cortisol is a hormone that, like epinephrine and norepinephrine, mobilizes the body's resources. Cortisol serves primarily to increase energy level and decrease inflammation. The latter function is particularly useful if injuries are sustained in an urgent situation.

Although responses of the body to stress can be helpful, severe stress and prolonged activation of these systems can have adverse effects on body organs, mental functions, and the immune system. For example, stress can affect the immune system so that it cannot effectively destroy viruses, bacteria, tumors, and irregular cells. More than two decades ago, Ader and Cohen (1975) presented evidence suggesting that the nervous system and the immune system interact and are interdependent by demonstrating that immune system responses in rats could be classically conditioned. This initial report eventually led to a number of studies investigating the relationship between physiological factors (e.g., reactions

BOX 17-1 Focus on Clinical Applications
Stress and Everyday Life: What Are the Most Common Stressors for Undergraduate Students?

Stressful life events impact both physical and psychological problems. Smyth and colleagues (2008) conducted a survey of thousands of college students to determine which types of life events were most prevalent and stressful or emotionally upsetting. They found that 84.5% of college students experienced an adverse life event at some time in their lives. Adverse life events primarily involved death of a loved one (62.7%), academic issues (39.6%), parental divorce or separation (24.4%), and traumatic sexual experience (18.4%).

Other researchers have examined daily hassles that college students encounter, such as traffic, missing class, time pressure, or disagreement with a friend. Brougham and colleagues (2009) found that daily hassles were more stressful for college students than academic, family, or financial problems, especially among women. Ross and colleagues (1999) examined the prevalence of recent stressful life events and hassles among college students, and these results appear below. You can see that the most common stressors for college students included such things as interpersonal conflict, sleep difficulties, public speaking, increased workload, grades, and even breaks from school.

Percent of College Students Reporting Each Source of Stress

Category	Percent
Interpersonal	
Change in social activities	71
Roommate conflict	61
Work with people you don't know	57
Fight with boyfriend/girlfriend	41
New boyfriend/girlfriend	36
Trouble with parents	21
Intrapersonal	
Change in sleeping habits	89
Change in eating habits	74
New responsibilities	73
Financial difficulties	71
Held a job	65
Spoke in public	60
Change in use of alcohol or drugs	39
Outstanding personal achievement	35
Started college	32
Decline in personal health	26
Minor law violation	14
Change in religious beliefs	13
Death of a family member	12
Death of a friend	6
Severe injury	5
Engagement/Marriage	2
Academic	
Increased class workload	73
Lower grade than anticipated	68
Change of major	24
Search for graduate school/job	21
Missed too many classes	21
Anticipation of graduation	20
Serious argument with instructor	11
Transferred schools	3
Environmental	
Vacations/breaks	82
Waited in long line	69
Computer problems	69
Placed in unfamiliar situation	51
Messy living conditions	50
Put on hold for extended period of time	47
Change in living environment	46
Car trouble	42
Quit job	8
Divorce between parents	1

SOURCE: Ross et al. (1999).

to stress) and immune system response (Brannon & Feist, 2010). Currently, it remains unclear whether immunosuppression is a direct effect of stress or whether it is simply part of the body's response to stressful events (Brannon & Feist, 2010). In any case, stress does appear to be an important (though not the only) influence on health and illness.

Behavior and Health. Behaviors, habits, and lifestyles can affect both health and disease. Everything from smoking, excessive drinking, or poor diet to deficient hygiene practices have been implicated. Such behaviors are often deeply rooted in cultural values or personal needs and expectations. In any event, they are not easily changed. Later in this chapter, we will discuss in more detail several behaviors or lifestyle choices that have been linked to health. These include cigarette smoking, alcohol abuse and dependence, and weight control.

Cognitive variables may influence our decisions about adopting healthy or unhealthy behaviors (Bandura, 2001). To cite one example, many health psychologists have focused on the variable self-efficacy. *Self-efficacy*, discussed in earlier chapters, refers to "people's beliefs about their capabilities to exercise control over events that affect their lives" (Bandura, 1989, p. 1175). Self-efficacy is relevant to a number of topics addressed by health psychologists, including major theories of health-related behavior change. This construct plays a major role in the most prominent social cognitive models of health behavior, including the health belief model (Rosenstock, 1974; Rosenstock, Strecher, & Becker, 1988), protection motivation theory (R. W. Rogers, 1975; Sturges & Rogers, 1996), and the theory of planned behavior (Ajzen, 1985, 1988).

Protection motivation theory (*PMT*), for example, posits that behavior is a function of *threat appraisal* (an evaluation of factors that will affect the likelihood of engaging in the behavior, such as perceived vulnerability and perceived potential for harm) and *coping appraisal* (an evaluation of one's ability to avoid or cope with negative outcome). Coping appraisal is influenced by one's self-efficacy, or belief that one can implement the appropriate coping behavior or strategy (Maddux et al., 1995).

An example that applies PMT to a real-life health decision may be instructive. Janey, an adolescent girl, faced a decision about whether or not to start smoking cigarettes because she would like to lose weight. According to PMT, Janey would engage in threat appraisal and coping appraisal. Threat appraisal might involve evaluating the dangers of smoking (e.g., lung cancer) as well as the likelihood of her own vulnerability to this outcome. To the extent that she does not perceive the danger to be severe or immediate to herself, Janey might be more likely to start smoking. Coping appraisal is also relevant. This process might involve Janey's evaluation of how likely she could refrain from smoking (the recommended coping strategy). To the extent that Janey believes she will not be able to refrain from smoking (e.g., because all her friends smoke and she would like to lose weight), it becomes more likely that she will engage in this behavior. Thus, the cognitive variable self-efficacy can play a prominent role in behavior and lifestyle choices that ultimately influence health.

Problems can also arise from the ways in which people respond to illness. Some people may be unable or unwilling to appreciate the severity of their illness and fail to seek timely medical help. When they do get medical advice, they may fail to heed it. Among youth, decisions become more complex, as both the perceptions of the youth and their caregivers influence health behavior decisions. All of these behaviors can indirectly foster adverse outcomes. We will discuss medical treatment compliance later in this chapter.

Personality Factors. Both directly and indirectly, personality characteristics can affect health and illness in many ways (Smith & MacKenzie, 2006; Suls & Bunde, 2005). For example, (a) personality features may result from disease processes; (b) personality features may lead to unhealthy behaviors; (c) personality may directly affect disease through physiological mechanisms; (d) a third, underlying biological variable may relate to both personality and disease; and (e) several causes and feedback loops may affect the relationship between personality and disease.

Perhaps the most widely studied association between a personality trait/behavior pattern and illness is that between Type A behavior and *coronary heart disease*. As mentioned previously, the notion of a possible link between personality or coping style and adverse health consequences, specifically coronary heart disease, was proposed by two cardiologists (Friedman & Rosenman, 1974). They identified a set of discriminating personality characteristics and behaviors and proposed that these constitute a *Type A behavior pattern*. Glass (1977) describes Type A individuals as those who tend to

- perceive time passing quickly,
- show a deteriorating performance on tasks that require delayed responding,
- work near maximum capacity even when there is no time deadline,
- arrive early for appointments,
- become aggressive and hostile when frustrated,
- report less fatigue and fewer physical symptoms, and
- are intensely motivated to master their physical and social environments and to maintain control.

Table 17-1 provides some examples of interview questions that are used to identify Type A individuals.

A number of early studies suggested a relationship between Type A behavior and coronary heart disease. However, more recent studies do not show as strong a relationship between Type A behavior and heart disease as was once thought (Smith & Ruiz, 2002), and it is clear that the vast majority of Type A individuals do not develop coronary heart disease (CHD). However, Type A individuals are at relatively greater risk for CHD. More recent studies suggest that the anger-hostility component of the Type A pattern does a better job of predicting coronary heart disease than the more global Type A categorization (Smith & MacKenzie, 2006).

In an important methodological and conceptual analysis of the research examining hostility and health, Smith (1992) presented several theoretical models that might explain the link between them. The *psychophysiological reactivity model* posits that hostile individuals experience larger increases in heart rate, blood pressure, and stress-related hormones in response to potential stressors. Increased psychophysiological reactivity is believed to encourage the development of coronary artery disease and the symptoms of coronary heart disease. The *psychosocial vulnerability model* proposes that hostile individuals are more likely to experience a more stressful psychosocial environment because they have higher levels of mistrust and are scanning their environments for possible future mistreatment. A *transactional model of stress* reflects a combination and integration of the psychophysiological and psychosocial models. This integrative model proposes that those high in hostility create potentially stressful situations in their lives because of their general mistrust and their subsequent actions.

TABLE 17-1 Selected Items from the Behavior Pattern Interview

4. Does your job carry heavy responsibility?
   a. Is there any time when you feel particularly rushed or under pressure?
   b. When you are under pressure, does it bother you?
6. When you get angry or upset, do people around you know about it? How do you show it?
12. When you are in your automobile, and there is a car in your lane going far too slowly for you, what do you do about it? Would you mutter and complain to yourself? Would anyone riding with you know that you were annoyed?
14. If you make a date with someone for, oh, two o'clock in the afternoon, for example, would you be there on time?
   a. If you are kept waiting, do you resent it?
   b. Would you say anything about it?
17. Do you eat rapidly? Do you walk rapidly? After you've finished eating, do you like to sit around the table and chat, or do you like to get up and get going?
19. How do you feel about waiting in lines: Bank lines, or supermarket lines? Post office lines?

SOURCE: From "The Interview Methods of Assessment of the Coronary-prone Behavior Pattern," by R. H. Rosenman, pp. 68–69. In T. M. Dembroski, S. M. Weiss, J. L. Shields, S. G. Haynes, and M. Feinleib (Eds.), *Coronary-prone Behavior*, Copyright © 1978 by Springer-Verlag. Reprinted by permission.

Finally, the *health behavior model*, unlike the previous models, does not assume that the physiological aspects of stress are the crucial link between hostility and health. Rather, the health behavior model proposes that hostile individuals tend to engage in poor health habits (e.g., smoking, excessive drinking of alcohol, poor exercise habits) and thus are more susceptible to coronary heart disease. This parsimonious explanation of the findings of an association between hostility and coronary heart disease needs further evaluation.

Social Support and Health. A topic attracting increased research interest is social support and its effects on health and well-being (Miller, Chen, & Cole, 2009; Stanton, Revenson, & Tennen, 2007). *Social support* refers not only to the number of social relationships but also to the quality of those relationships (can you confide in your friends, parents, and family members?). The basic idea is that interpersonal ties can actually promote health. They insulate people from harm when they encounter stress, decrease susceptibility to illness, and help people comply with and maintain treatment regimens. Social support is, in many ways, a kind of coping assistance. A number of studies have indicated that better health outcomes are positively related to social support (Miller, Chen, & Cole, 2009; Stanton, Revenson, & Tennen, 2007). For example, Williams et al. (1992) followed approximately 1,400 patients with coronary artery disease for an average of 9 years and found that patients who rated higher on measures of social support (e.g., married, able to confide in spouses) exhibited significantly lower rates of mortality over the follow-up period. This relation held even after controlling for demographic variables and medical risk factors. This study and others suggest that social support may act as a type of "buffer" against adverse health outcomes.

The relationships among social support, stress, and health may depend on a number of factors, including race, gender, and culture. For example, women (on average) seem to benefit more from social support than do men, perhaps because women tend to have more emotionally intimate relationships (Brannon & Feist, 2010).

Range of Applications

A full description of all the problems to which health psychology has addressed itself is beyond the scope of this chapter. A partial list culled from recent accounts would include the following: smoking, alcohol abuse, obesity, Type A personality, hypertension, cardiac arrhythmia, Raynaud's disease, Alzheimer's disease, acquired immune deficiency syndrome (AIDS), cystic fibrosis, anorexia nervosa, chronic vomiting, encopresis-fecal incontinence, ulcers, irritable bowel syndrome, spasmodic torticollis, tics, cerebral palsy, cerebrovascular accidents, epilepsy, asthma, neurodermatitis, psoriasis, chronic pain, headaches, insomnia, diabetes, dysmenorrhea, dental disorders, cancer, spinal cord injuries, and sexual dysfunction.

In the pages that follow, we deal with several of these disorders, especially as they illustrate methods of intervention and prevention. Box 17-2 suggests some of the issues that are within the province of health psychology and behavioral medicine, especially as applied to the problem of human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS).

METHODS OF INTERVENTION

In essence, health psychology, behavioral medicine, and pediatric psychology apply behavioral and cognitive-behavioral methods of assessment and treatment. We present brief overviews of general classes of interventions (respondent methods, operant methods, cognitive-behavioral methods, and biofeedback) and then present a few examples of how these techniques are used by health psychologists.

Respondent Methods

Over time, a neutral stimulus (conditioned stimulus) that is paired with a naturally eliciting stimulus (unconditioned stimulus) may itself become capable of eliciting a particular response. This is the classic Pavlovian paradigm. Emotional reactions may, for example, become associated with formerly neutral, innocuous stimuli. This process may then produce

BOX 17-2 Focus on Professional Issues
The Role of Health Psychology: HIV and Acquired Immune Deficiency Syndrome (AIDS)

The Centers for Disease Control (CDC) estimates that approximately 50,000 people are *newly infected* with HIV each year in the United States, and approximately 1.2 million of Americans age 13 or older are *currently* infected with HIV. Adolescence and young adulthood are developmental vulnerability periods for the acquisition of HIV. Once HIV infection reaches stage 3, a diagnosis of AIDS is made. Cumulatively, approximately 600,000 people have died in the United States from AIDS, with the annual figure now hovering at about 16,000 per year. Although these annual rates are lower than they were 10 years ago, HIV and AIDS continue to be a major public health problem because there is no known cure. Therefore, prevention of high-risk behavior (unprotected sex; injection drug use) is paramount.

The use of antiretroviral therapies (ART) has been shown to delay the clinical progression of HIV and to decrease AIDS-related deaths. In order for ART to be maximally effective, however, high levels of adherence to ART are necessary (Gonzalez, Barinas, & O'Cleirigh, 2011). Unfortunately, substance use and substance use disorders are frequent among those with HIV/AIDS, and these substance use problems are associated with significantly lower adherence rates for ART (Sandelowski, Voils, Chang, & Lee, 2009). For example, Hendershot et al. (2009) found that across 40 studies alcohol users with HIV or AIDS were only about half as likely to be adherent to ART than those who did not use alcohol. Similar patterns are observed for other substances like heroin, cocaine, marijuana, and even tobacco. Therefore, health psychologists are encouraging physicians to screen for substance use and abuse in those with HIV/AIDS so that cognitive-behavioral interventions to treat underlying depression and anxiety as well to promote adherence can be used when appropriate (Gonzalez, Barinas, & O'Cleirigh, 2011).

conditioned emotional reactions that, if chronic, can produce such persistent tissue changes as ulcers, neurodermatitis, or essential hypertension. These kinds of symptoms have been treated by health psychologists in various ways. In the case of respondent techniques, extinction or systematic desensitization interventions are commonly used.

In *extinction*, a conditioned emotional reaction is eliminated by creating a situation in which the conditioned stimuli are no longer associated with the environmental stimuli that generated the behavior. This approach can be used, for example, to eliminate children's fears of visiting the dentist. The child is brought to the dentist's office, familiarized with the office personnel, allowed to meet other children who have successfully negotiated the terrors of dentistry, and so on. In short, the child's emotional reactions are extinguished because, over time, less anxiety is aroused in the dentist's office. A variation would be exposure techniques, described in Chapter 14. Instead of the gradual approach just described, the child, under professional supervision, would be forced to remain in the "terrifying situation," the anxiety would peak and then rapidly diminish, and the child would thereby learn that the anxiety was needless. The result is extinction of the anxiety responses.

Systematic desensitization is a good example of counterconditioning (see Chapter 14). If the patient can be taught to relax in the face of anxiety-provoking stimuli, the anxiety diminishes. *Relaxation* techniques are designed to enable individuals to produce a state of lowered arousal through their own efforts. As a preliminary step, patients are usually taught the basic behavioral principles related to their symptoms and how therapy relates to the implementation of these principles. For example, a patient whose stressful lifestyle has led to some physical problems would be taught the relationship between lifestyle and illness by means of a fairly extensive verbal explanation (or reading material). Following this, a thorough psychophysiological assessment might be conducted using recording equipment, self-ratings of tension, and the therapist's own observation.

Next, patients are taught to self-monitor. For example, they might be trained in how and when

to record the presence of headaches. They would be taught to record data on the presence of environmental stimuli that precede the headache, their own response to the headache, and the consequences that follow from the symptoms.

Finally, patients receive specific training in relaxation. Chapter 14 provides detailed information on relaxation training. Positive expectancies for a good outcome are engendered, and the physical conditions are arranged so that relaxation will be easy to achieve (assuming a comfortable position, loosening tight clothing, adjusting lighting). Regular practice in the therapist's office is followed by practice at home.

How efficacious are relaxation techniques in treating problems addressed by health psychologists? Relaxation appears to be effective in treating hypertension, tension headaches, and anxiety (Brannon & Feist, 2010). When combined with guided imagery—a technique in which patients bring images of peaceful and calm situations to consciousness—relaxation has also proven effective for treating burn pain and the nausea and anxiety associated with chemotherapy (Brannon & Feist, 2010).

Operant Methods

Learned responses may be either maintained or eliminated through the consequences they bring about. As we discussed in Chapter 14, behaviors that are reinforced tend to recur, whereas behaviors that are not reinforced or are punished tend to decrease in frequency.

Operant conditioning can be used in health psychology and behavioral medicine either to increase behaviors said to lead toward health or to decrease those said to contribute to health problems. For example, health psychologists have used operant methods in addressing pain behaviors (Brannon & Feist, 2010; Roelofs, Boissevain, Peters, de Jong, & Vlaeyen, 2002). From an operant perspective, many of the behaviors displayed by pain patients (complaining, moaning, etc.) have been initiated and maintained because of positive reinforcement. Family members and medical staff may have paid more attention to the patient following these behaviors. Additional reinforcers might include sympathy, time off from work, or fewer expectations from the family. To change these pain behaviors, family members and medical staff may be trained to reinforce more desirable behaviors (e.g., attempts to become more physically active) and to ignore less desirable behaviors (e.g., constant complaining). Research suggests that these approaches to pain behaviors do show some success, as indicated by increased physical activity and decreased intake of pain medication (Brannon & Feist, 2010).

Finally, health psychologists may use contingency contracting. In this method, the therapist and patient draw up a formal agreement or contract that specifies the behaviors that are expected as well as the consequences for certain behaviors. For example, patients may be reinforced for participating more in physical therapy, taking their medication, or reducing their number of somatic complaints. Reinforcement may take the form of tokens that can be exchanged for something of value to the patient.

Cognitive-Behavioral Methods

Health psychologists use a variety of cognitive-behavioral techniques. These techniques may be used alone or in concert with other strategies, such as relaxation or biofeedback. Some of these methods were discussed in Chapter 14. All of them emphasize the role of thinking in the etiology and maintenance of problems. Cognitive-behavioral interventions seek to change or modify cognitions and perceptions that are believed to be related to a patient's problem.

The list of "well-established" empirically supported treatments (see the link at the end of the chapter) contains several cognitive-behavioral treatments for stress or other health problems. In Chapter 14, we discussed stress inoculation training (SIT) for coping with various stressors. This approach is used by health psychologists for a wide variety of patients (e.g., chronic pain patients). Other effective cognitive-behavioral treatments for health problems include those for headache, pain, smoking cessation, and bulimia.

Cognitive-behavioral therapy is a major component of a treatment for chronic headaches (Blanchard & Andrasik, 1985; Martin, Forsyth, & Reese, 2007; Nash et al., 2004; Thorn et al., 2007). For example,

Blanchard and Andrasik's treatment begins with a psychoeducational component, in which the following points are emphasized to the headache sufferer: (a) tension, anxiety, and worry can cause headache; (b) headache is a signal from the body that the person is not effectively coping with stress; (c) any situation can lead to stress—our interpretations and beliefs about a situation determine whether or not it produces stress; and (d) there are some common beliefs or expectations that may lead to stress and headache. In the treatment, patients are taught to monitor their thinking processes via a *self-monitoring record* whenever tension, worry, or anxiousness occurs. A sample self-monitoring record for events associated with headaches is shown in Figure 17-3. For each situation, patients list the cues that trigger tension and anxiety, the physical sensations, their thoughts right before the onset of the tension, a rating of their emotions, and their behavioral responses to the episode (e.g., withdrawal or attack).

The therapist uses these data to tailor specific interventions. First, attempts are made to connect situations, the patient's thoughts, and the emotional and behavioral responses. The therapist emphasizes that the patient's thoughts are a crucial link in the process that produces headaches and that these thought patterns can be modified. The patient's "maladaptive" thoughts, expectancies, and beliefs (those associated with stress and headache) are examined closely and their validity challenged. For example, a professor may report that thoughts regarding inadequacy ("I'm never going to get this chapter written") typically precede the experience of tension and anxiety that leads to headache. The therapist might challenge these thoughts ("Is it really true that you have never finished any articles or chapters?") and train the professor to disrupt the situation → thought → tension headache chain by using alternative thinking and coping strategies (repeating, internally, more adaptive thoughts such as "This task is difficult but I will get it done, just as I have been able to do in the past"). Finally, as the patient is able to implement these alternative ways of thinking and coping in real-life situations and achieves some success, the therapist reinforces progress through praise.

Biofeedback

Biofeedback is popular and, for some, has become almost synonymous with behavioral medicine itself. Under certain conditions, patients can learn to modify or control physiological processes, such as heart rate, blood pressure, and brain waves.

Biofeedback encompasses a wide array of procedures. Basically, however, some aspect of the patient's physiological functioning (e.g., heart rate, blood pressure, skin temperature) is monitored by an apparatus that feeds the information back to the patient in the form of an auditory, tactile, or visual signal. The idea is for the patient to then modify that signal by changing the physiological function. Thus, a patient experiencing severe headaches might have electrodes placed on the forehead. The electrodes pick up tiny muscle contractions in that region of the head, which are amplified and transformed into tones. The tones vary as the muscular activity changes. The patient's task is to voluntarily reduce or eliminate the tone, thus signifying a reduction of muscular tension and a corresponding reduction in the headache.

Biofeedback has been shown to be efficacious (better than placebo treatment) for a number of different problems (Brannon & Feist, 2010). For example, biofeedback has been used successfully in clinical studies to reduce migraine and tension headache pain, hypertension, and low back pain. However, several caveats must be acknowledged. First, in some cases, the effects of biofeedback are not superior to the effects obtained from relaxation. This is important because biofeedback requires expensive equipment and trained personnel. Thus, the cost of this treatment is much higher than some alternatives, like relaxation. Second, because biofeedback and relaxation are often included in the same treatment package, it is sometimes hard to separate the effects of one from the other. However, some studies have done so and reported that biofeedback may provide unique positive effects, especially for those who do not respond to relaxation techniques (Lehrer, Carr, Sargunaraj, & Woolfolk, 1994).

Still, many critics remain uncomfortable about the scientific status of biofeedback. Some are suspicious because of the cultish, faddish, or evangelistic

Time	Situation	Physical Sensations	Thoughts	Feeling (0–100)	Behavior
8:00 A.M.	Breakfast, husband says I look "scattered"		Worry about getting to work on time (e.g., If I'm late Mr. ___ will notice)	Anxiety (25) Hurt (20)	Rush through breakfast, leave dishes in sink.
10:00 A.M.	Given too many technical letters to type	Upset stomach from coffee, tense muscles	Everybody assumes I'm superwoman. No one takes account of other demands on my time	Anxiety (30) Annoyance (20)	Rushed typing, curt on telephone, take extra long break to calm down
12:00 noon	Jerry (fellow employee and supervisor) asks me to lunch. Talks suggestively about recent divorce	Lightheaded, tingling sensations in head and face, nausea	Jerry is on the make. I don't like fending him off—so why am I here? Am I seductive?	Anxiety (50) Awkwardness (40) Is that a feeling?	Try to offer sympathy but resent ulterior motive. Probably curt
2:00 P.M.	Spencer gives me a long report with 5 tables to be done by 5 P.M.	Headache—back of neck	F___ him—he didn't even ask what else I had to do. Fantasize Spencer stuck in elevator. No time to relax.	Anger (60) Anxiety (60)	Typing report—distractedly
4:00 P.M.	Report completed	Headache worsening, nausea	If I could quit ruminating and was more organized I would get more work done	Anger (40) Anxiety (50)	Give report for correction. Complain to Susan. Type letters

FIGURE 17-3 Example of a self-monitoring record for situations associated with tension headache

Reprinted from Holroyd, K. A., & Andrasik, F., "A cognitive-behavioral approach to recurrent tension and migraine headache," in P. E. Kendell (Ed.), *Advances in cognitive-behavioral research and therapy* (Vol. 1). Copyright © 1982 by Elsevier. Reprinted with permission.

pronouncements of some of its practitioners. In some cases, biofeedback seems to operate largely as a placebo. Biofeedback may not, by itself, lead to optimal therapeutic gains. When it is effective, it is usually part of a larger package that also includes relaxation or cognitive strategies; if removed from such a package, biofeedback may lose its effectiveness. However, it may serve as an example to the patient that self-regulation in life is possible. It may be that biofeedback works better in the clinic than in the research laboratory because the clinic places the biofeedback machine in a larger context of an understanding clinical relationship and additional therapeutic techniques. At the very least, biofeedback appears to be a useful technique to teach patients to become more aware of their bodily signals and what they may mean.

PREVENTION OF HEALTH PROBLEMS

Nearly everyone agrees that a few simple behaviors, if widely practiced, would dramatically reduce the toll of human misery and the torrent of dollars pouring into the health care system. These include reducing our consumption of salt and fatty foods, driving carefully and using seat belts, exercising regularly, avoiding cigarettes, and decreasing stress. But giving advice and having people take it are two very different things. Therefore, psychologists, other behavioral specialists, and medical professionals have mounted research programs to learn how to treat and prevent a variety of potentially harmful human behaviors. In this section, we discuss prevention efforts in several important areas related to health: cigarette smoking, alcohol abuse, and weight control.

Cigarette Smoking

Increased awareness of the dangers of cigarette smoking has led to a steady decline since the mid-1960s in the percentage of Americans who are habitual smokers. However, rates of smoking differ according to gender, level of education, and income. According to the Centers for Disease Control (CDC), it is estimated that 20% of high-school-aged adolescents smoke at least one cigarette a day within a 30-day period; data on adults suggest that 23% of males and 18% of females over 18 years of age smoke (Pleis et al., 2010). Current adult smokers were over-represented among younger adults (age 18–44; 23%), among those with a high school degree or less (29%), among those with a family income of $35,000.00 or less (28%), and among White males (25%).

Cigarette smoking has been linked to an increased risk of cardiovascular disease and cancer, the two leading causes of death in the United States. Even though smoking increases one's chances of premature death from diseases such as coronary heart disease, cancers of the respiratory tract, emphysema, and bronchitis, people still smoke. Why? Possible reasons include tension control, social pressure, weight control, rebelliousness, the addictive nature of nicotine, and genetically influenced personality traits such as extraversion (Brannon & Feist, 2010). Tension control, weight control, genetics, and social pressure are thought to be reasons for initiation of smoking, whereas rebelliousness, addiction, and personality are seen primarily as maintaining factors.

A variety of techniques have been used to induce people to stop smoking, including educational programs, aversion therapy (e.g., rapid smoking), behavioral contracts, acupuncture, pharmacologic interventions, cognitive therapy, and group support (Brannon & Feist, 2010). Relapse rates are high (70–80%), however, and research findings about which cessation approach is best are conflicting. Most smokers who quit do so on their own.

The best approach seems to be to prevent the habit from starting in the first place. Unfortunately, education alone (e.g., warning messages on packages) does not appear to deter young people from smoking (Brannon & Feist, 2010). What appears more effective is focusing on immediate rather than delayed negative consequences, providing information on social/peer influences, teaching refusal skills, and increasing feelings of self-efficacy (La Torre, Chiaradia, & Ricciardi, 2005).

One of the early encouraging multiple-component prevention programs aimed at children and teenagers was based on social learning principles and used peer role models (Evans, 1976).

BOX 17-3 Focus on Professional Issues: Ethnicity and Cancer Outcomes

An examination of the incidence and mortality rates of common forms of cancer among different ethnic groups reveals a number of striking differences (Meyerowitz, Richardson, Hudson, & Leedham, 1998). In general, African Americans have the highest incidence rates and mortality rates overall, whereas Latinos, Chinese Americans, and Native Americans have the lowest rates. However, incidence and mortality rates also vary according to gender and to anatomical site of the cancer. Thus, it is difficult to reach any general conclusions that focus on broad ethnic labels.

One particular form of cancer in women, breast cancer, provides an interesting paradox. On the one hand, African American women have a lower breast cancer incidence rate than do White American women. However, African American women have a significantly higher breast cancer mortality rate than do White American women. There are many potential explanations, including a higher overall mortality rate for African American women, the influence of relative socioeconomic disadvantage for this group, barriers to treatment, and biological susceptibility to breast cancer at earlier ages versus later ages.

In order to address whether socioeconomic disadvantage and inadequate health care access might explain this disparity in breast cancer mortality for African American women, Newman et al. (2006) conducted a meta-analysis of studies that provided breast cancer mortality data and data on socioeconomic factors for over 14,000 African American women as well as over 76,000 White American women. In this way, mortality rates could be compared between the two groups while controlling for differences in socioeconomic factors. There were several major findings of note. First, similar to previous studies, Newman et al. found that African American women were significantly more likely to die from breast cancer than were White American women. Second, this overall effect remained significant even after controlling for socioeconomic factors. These results are intriguing in that they suggest that socioeconomic disparities alone are not likely responsible for the increased mortality risk for African American women with breast cancer. Although more research is clearly needed to investigate environmental and cultural influences on mortality rates, these results also highlight the need for more research into breast tumor biology as a risk factor.

Videotaped presentations, peer modeling, discussion groups, role-playing, monitoring smoking, and checking repeatedly on attitudes and knowledge about smoking were all used with elementary schoolchildren. Such an approach seems superior to those used with adolescents that focus on long-term negative effects from smoking. The trick seems to be to focus on immediate negative consequences (e.g., from peers) rather than delayed ones (e.g., emphysema). More recent programs have supplemented these components with modules aimed at analyzing what leads children and adolescents to start smoking as well as training in refusal skills for dealing with pressure to smoke (La Torre et al., 2005).

Alcohol Abuse and Dependence

It is estimated that about 70–74% of adolescents have tried alcohol before high school graduation; over 40% of high-school-aged adolescents drink alcohol within a 1-month period, and 61% of adult men and 43% of adult women in the United States consume alcoholic beverages regularly (Pleis et al., 2010). Highest rates of regular alcohol consumption among adults are among those with a bachelor's degree or higher (64%), those with a family income of $100,000.00 or more (67%), and White males (66%). Although some studies have suggested positive health benefits from alcohol for light or moderate drinkers, consumption of alcohol has also been associated with a number of negative outcomes. Heavy alcohol use has been associated with increased risk for liver or neurological damage, certain forms of cancer, cardiovascular problems, fetal alcohol syndrome, physical aggression, suicide, motor vehicle accidents, and violence (Brannon & Feist, 2010). This extensive list of alcohol-related problems has made the treatment and prevention

of alcohol abuse and alcohol dependence (alcoholism) high priorities.

Over the years, many treatment approaches have been applied to problem drinkers; most of these treatments preach total abstinence. These have ranged from medical treatments and medications such as disulfiram (Antabuse) and naltrexone to traditional psychotherapy and group supportive strategies such as Alcoholics Anonymous. However, alcoholism is a problem that has been extremely resistant to virtually all intervention, and the relapse rate is high.

Another, more controversial, approach to the treatment of alcohol problems is *controlled drinking* (Sobell & Sobell, 1978). As the name implies, this approach has as its goal light to moderate (but controlled) drinking. Clients are taught to develop alternative coping responses (other than drinking) and to closely monitor alcohol intake. The field is divided as to the merits of this approach, but research does suggest that controlled drinking is a viable treatment option for *some* alcoholics (U.S. Department of Health and Human Services, 2000). Many alcohol treatment programs also incorporate *relapse prevention* training (Marlatt & Gordon, 1985). The majority of clients treated for alcohol problems have a relapse episode soon after treatment is terminated. Rather than see this as a failure (a sign that total relapse is imminent), clients are taught coping skills and behaviors they can use in "high-risk" situations to make total relapse less likely.

Alcohol abuse and dependence are complex problems that will probably require multimodal treatment strategies. Because of the difficulties with secondary and tertiary approaches to treatment or prevention, more and more professionals have turned to primary prevention to forestall the development of problem drinking. For both drinking and drug abuse, programs similar to those designed to prevent adolescents from smoking exist. Often, these programs are implemented through health education courses in high school or media campaigns. School-based prevention programs typically involve one or more of the following components: affective education (build self-esteem, increase decision-making skills); life skills (communication skills, assertiveness training); resistance training (learn to resist pressures to drink alcohol); and correction of erroneous perceptions about peer norms (Foxcroft & Tsertsvadze, 2011). Overall, the effectiveness of these programs varies greatly, and at the most only about half of the major studies of these programs show significant effects beyond what is seen from a standard school curriculum on alcohol and its effects (Foxcroft & Tsertsvadze, 2011).

Obesity

Behavioral treatments for obesity have been more common than for any other condition. One reason for this emphasis is that obesity is associated with such medical disorders as diabetes, hypertension, cardiovascular disease, and certain cancers (Brannon & Feist, 2010). It is also a socially stigmatizing condition that impairs the self-concept and inhibits functioning in a wide array of social settings. It is estimated that over 62% of adults in the United States are overweight (and 27% meet criteria for obesity—a body mass index of 30 or greater; Pleis et al., 2010). Often, problems of weight can be traced to childhood: 20% of all children are obese (National Center for Health Statistics, 2011), and 80% of these individuals become obese adults.

Although it is clear that obesity has a genetic component (Wadden, Brownell, & Foster, 2002), causes of obesity undoubtedly represent complex interactions among biological, social, and behavioral factors, and exact mechanisms are difficult to pin down. The increased prevalence of obesity appears to be more a function of changes in our eating habits and activity levels than in our gene pool (Wadden et al., 2002). Traditional medical and dietary methods of treatment have not been very effective; obese individuals lose weight but then quickly regain it. Furthermore, the dropout rate may be high in traditional weight-control programs. Most behavior modification programs include components aimed at restricting certain

types of foods, teaching when and under what conditions to eat, encouraging regular exercise, and maintaining modified eating patterns after the program has ended. Finally, pharmacologic and surgical treatments for obesity are on the increase (Wadden et al., 2002).

Again, however, early prevention may be the best and safest road to weight control. An excellent, classic example of such an approach is the Stanford Adolescent Obesity Project (Coates & Thoresen, 1981). A variety of strategies were used with adolescents in the hope that weight control at this age would lead to the prevention of obesity in adulthood. The strategies used were self-observation, cue elimination, and social and family support. These interventions were noticeably more effective when parents were involved. Many investigators are also exploring the possibility of using peer group discussion. A 10-year outcome study of a family-based behavioral treatment for childhood obesity suggests that early intervention in childhood can effect important and lasting changes in weight control (Epstein, Valoski, Wing, & McCurley, 1994).

Two recent meta-analyses of school-based obesity prevention programs suggested that the following components appear most likely to benefit children and youth: (a) modifying the home environment to limit food access, to increase access to physical activity, and to provide good behavior models for appropriate eating; (b) reducing television viewing; (c) modifying school policies and the school physical environment to support improved dietary practices (e.g., outlawing soft drinks) and encourage physical activity; and (d) providing classroom instruction on good dietary practices (Katz, O'Connell, Njike, Yeh, & Nawaz, 2008; Kropski, Keckley, & Jensen, 2008).

OTHER APPLICATIONS

Treatment and preventive initiatives must be supplemented with techniques that encourage patients to cope with medical procedures and follow medical advice.

Coping with Medical Procedures

The prospect of facing surgery, a visit to the dentist, or a variety of medical examinations can be enough to strike fear into the heart of even the strongest. Faced with such procedures, many patients delay their visits or even forgo them entirely. Health and pediatric psychologists specializing in behavioral medicine have developed interventions to help patients deal with the stress surrounding such procedures.

Medical Examinations and Procedures. Some medical examinations or procedures are especially stressful. Without them, however, the patient may not be properly diagnosed and may miss out on a health-saving intervention. A good example is sigmoidoscopy, a fairly common procedure designed to examine the mucous lining of the bowel to discover the presence of any pathological growths in the last 10 inches of the colon. This in turn can aid in the early detection and prevention of colon cancer. For many patients, however, the procedure is very stressful. It involves inserting a scope into the colon, with some stretching of the bowel. Although all of this is not very painful or dangerous, it does unnerve many people, and they perceive it as a humiliating procedure. Interventions have been developed that help patients cope with the stress of this and other procedures. For example, brief instructions might be given to prepare the patient for what to expect.

What kind of information is most likely to help patients cope with stressful medical procedures? Often, a distinction is made between *procedural information* (descriptions of what will occur) and *sensory information* (descriptions of the sensations that will be felt). Reviews of relevant studies indicate that although procedural preparation was superior to sensory preparation in reducing negative affect, pain reports, and other distress, combined procedural-sensory preparation was the most effective method (e.g., Jaaniste, Hayes, & von Baeyer, 2007; Suls & Wan, 1989).

In addition to informational interventions, evidence supports the use of behavioral interventions

in certain situations as well. For example, venipunctures are common in the course of cancer treatment, and this procedure can be quite distressing to children undergoing cancer treatment, their parents, and nurses who perform the procedure (Manne et al., 1990). Manne and colleagues developed a behavioral intervention to reduce the level of distress associated with the procedure. Its components include attentional distraction (using a party blower during the procedure), pacing of breathing, positive reinforcement (e.g., receiving stickers if the child cooperates), and parent coaching. The researchers found that this intervention package markedly reduced children's behavioral distress, parents' anxiety, and parents' ratings of child pain. Interestingly, however, this treatment did not significantly reduce children's self-reported pain.

Preparation for Surgery. A sizable amount of research has been done on ways to improve psychological preparation for surgery. Similar to those used to prepare patients for medical examinations and procedures, interventions include (a) relaxation strategies, (b) basic information about the procedures to be used, (c) information concerning the bodily sensations experienced during the procedures, and (d) cognitive coping skills (Brannon & Feist, 2010). For example, Wilson (1981) carried out a well-controlled study in which intensive training in relaxation was provided. In a sample of 700 patients undergoing either cholecystectomy (removal of the gall bladder) or abdominal hysterectomy, this relaxation intervention not only reduced hospital stays but improved both self-reports and physiological data.

Another technique was used with children about to undergo surgery. It was found that a film showing a *coping model* significantly reduced the children's emotional reactions during their time in the hospital (Melamed & Siegel, 1975). The model on the film was shown coping successfully with the procedure. Those who saw the film prior to surgery were less anxious before their operation and showed fewer behavior problems afterward. In general, the most effective modeling interventions involve models who (a) are undergoing the same procedure as the target, (b) appear initially anxious about the procedure, and (c) successfully cope with the anxiety and the procedure (Brannon & Feist, 2010).

Compliance with Regimens

Despite the availability of intervention strategies, the fact remains that many individuals do not comply with program interventions or else do not maintain their new behavior over any significant period of time. It is estimated that the rate of noncompliance with medical or health advice may be as high as 50% (Brannon & Feist, 2010), although there are some indications that the nonadherence rate has improved recently. Truly successful program strategies must generate compliance and long-term maintenance. Both behavioral and psychosocial factors must be considered.

In general, purported predictors of patient compliance can be broken down into four categories: disease characteristics, personal characteristics of the patient, environmental factors, and practitioner–patient interaction (Brannon & Feist, 2010). Table 17-2 summarizes research findings concerning the relationship between a variety of factors and patient compliance.

Educational and instructional methods have not been particularly helpful in improving compliance, but behavioral interventions have proved more successful (Brannon & Feist, 2010). For example, DiMatteo and DiNicola (1982) recommend several general strategies to improve patient compliance:

1. The use of prompts as reminders (e.g., taking medicine before each meal, telephone calls from providers).
2. Tailoring the treatment regimen to the patient's schedule and lifestyle.
3. Using written contracts that promise a reward to the patient for complying with treatment guidelines.

TABLE 17-2 Summary of Findings Relating Disease Characteristics, Personal Characteristics of the Patient, Environmental Factors, and Practitioner–Patient Interaction Factors to Adherence

	Findings
I. Disease Characteristics	
A. Severity of illness	
Illness interferes with appearance	Increases compliance
Review of many disorders	No relationship
Patients' perception of severity	Strongly related to compliance
Pain with the illness	Increases compliance
B. Side effects of medication	
Unpleasant side effects with HIV drugs	Decreases compliance
C. Complex treatment procedures	
Increasing number of doses	Decreases compliance
II. Personal Factors	
A. Increasing age	
Adults	
Aging	Curvilinear relationship
Older ages	Decreases compliance
Adolescents	
Growing older	Decreases compliance
B. Gender	
Keeping medical appointments	Men and women equal
Taking medication	Men and women equal
Eating a healthy diet	Women more compliant
C. Personality patterns	
Noncompliant personality	Situation, not personality, influences adherence
D. Emotional factors	
Stressful life events	Decrease compliance
Conscientiousness	Increases compliance
Depression	Decreases compliance
Optimism	Increases compliance
E. Personal beliefs	
Self-efficacy	Increases compliance
Belief in treatment effectiveness	Increases compliance
No confidence in treatment	Decreases compliance
Feelings of control	Increases compliance

TABLE 17-2 (*Continued*)

	Findings
No confidence in treatment	Decreases compliance
Feelings of control	Increases compliance
III. Environmental Factors	
A. Economic factors	
Low income	Decreases compliance
Insurance fails to cover all prescription costs	Decreases prescription filling and refilling
B. Social support	
Low social support among adolescents	Decreases compliance
Living alone	Decreases compliance
Support for specific health behaviors	Increases compliance
C. Cultural norms	
Belief in traditional healers	Decreases compliance
Acculturation to Western culture	Increases compliance
Culture places trust in physicians	Increases compliance
Physician's stereotype of African Americans and low-income patients	Decreases compliance
Physician disrespect of African Americans, Hispanic Americans, and Asian Americans	Decreases compliance
IV. Practitioner/Patient Interaction	
A. Verbal communication	
Poor verbal communication	Decreases compliance
Interrupting patients	Decreases compliance
Agreement about treatment	Increases compliance
Failing to receive expected information	Decreases compliance
Problems with language or terminology	Decreases compliance
B. Practitioner's personal qualities	
Patient's confidence in physician's competence	Increases compliance
Friendliness	Increases compliance
Practitioner disrespect	Decreases compliance
Gender	Female doctors provide more information

SOURCE: Brannon, L., & Feist, J. (2010). *Health psychology: An introduction to behavior and health* (7th ed.), pp. 84–86. Pacific Grove, CA: Brooks/Cole. Reprinted with permission.

FUTURE DIRECTIONS

Health psychology, behavioral medicine, and pediatric psychology are growing fields, and more psychologists are entering them every year. In this last section, we discuss several health care trends, training issues for future psychologists, and important issues for these fields to address in the future.

Health Care Trends

Today, approximately 90% of Americans belong to some kind of managed health care plan. In managed care systems, containing costs is a high priority. In previous chapters, we have noted the great impact managed care has had and will have on clinical psychologists. The impact on health psychologists will be even greater because these specialists often work in medical centers or primary care settings. Health psychologists, by virtue of their training, are well suited to provide interventions that will serve to cut the costs of medical care (Brannon & Feist, 2010). As business and industry realize the costs they must absorb from employees whose habits and lifestyles create absenteeism, inefficiency, and turnover, it is expected they will use the skills of health psychologists more often.

One way to assess future health trends is to consult the United States government's current set of goals and objectives to improve health over the next 10 years. The most recent set of priorities, *Healthy People 2020* (USDHHS, 2010), presents four overarching goals: (a) improve general health status; (b) eliminate health disparities and inequities; (c) create social and physical environments that promote good health; and (d) promote good health and quality of life across all developmental stages. Of these, (b) and (c) represent newer emphases, reflecting the increasing diversity in the United States as well as increasing recognition that health is influenced by a number of factors (e.g., biology/genetics, individual behavior and choices, health services costs and availability, social factors, and policies that influence health).

How might these priorities and related health trends influence the field of health psychology? Here we mention several likely impacts.

- Today, a larger percentage of U.S. residents are 65 years or older, and life expectancy is at an all-time high (>77 years old). This suggests that health psychologists will be increasingly called upon to target this population both in research and in services.
- As mentioned many times throughout this textbook, the costs of health care continue to rise. This is one major reason, perhaps, for the disparities we see in accessing health care. Health psychologists are likely to be intimately involved in improving access to health care and to promoting healthy behavior in a cost-efficient manner.
- As demands for health care increase, there is also likely to be an increased emphasis on prevention efforts (see Chapter 16). Pediatric and health psychologists will be asked to develop, to refine, and to implement prevention, especially in the general population (primary prevention) as well as among those at risk for health problems (secondary prevention).
- Finally, it seems likely that health and pediatric psychologists will increasingly be part of general medical teams in hospitals and clinics, given their expertise in psychological and behavioral influences on health and in health promotion in general.

Training Issues

A major source of health psychologists continues to be clinical psychology programs (Larkin, 2009). The scientist-practitioner and clinical scientist models adopted by most clinical psychology programs enable them to train clinicians well suited for health and pediatric psychology. Until recently, no other psychology specialty offered the combination of academic, scientific, professional, and hospital experiences required for work in medical settings. However, other psychology subspecialties are also well represented in health psychology. Many of the people cited in this chapter are social, experimental, or physiological psychologists—not just clinical psychologists.

For the most part, health psychology is still a kind of ad hoc appendage to doctoral programs in psychology (Larkin, 2009). The student enters a clinical, social, or experimental program and then, in addition to the core experience, does some specialized research or takes a practicum or two in a health-related topic. Perhaps this is augmented by an internship at a health care site. But essentially, the health experiences are grafted onto an already existing program in clinical psychology or some other related discipline. However, what is noteworthy is that the number of clinical doctoral programs that offer a clinical health psychology track is increasing, with recent estimates suggesting that about one-third of programs offer some training in this concentration (Larkin, 2009). At least six offer a formalized track in pediatric psychology. In addition, there at least seven doctoral training programs in clinical health psychology exclusively (Larkin, 2009).

Other Challenges

Any newly emerging field has problems in defining the roles of its members; health and pediatric psychology are no exception. Years ago, Taylor (1984) identified several of these problems. One is simply role ambiguity. No one is totally prepared to say just what a health or pediatric psychologist should do—especially in a practical work setting. Health and pediatric psychologists may actually find themselves without psychology colleagues or role models in the health setting, which only adds to their confusion. Second, issues of status also arise. In health settings, the physician is clearly at the top of the heap. Sometimes the psychologist enjoys much less status in a medical center setting than, for example, in an academic setting. Furthermore, the psychologist and the health care professional may have competing goals. The latter may be interested only in identifying immediate ways of helping the patient. The psychologist may be more tentative and contemplative while thinking about research, theoretical models, and interventions.

As one way of establishing their identity and presence in settings traditionally dominated by physicians, health psychologists need to document the cost-effectiveness of their interventions (Brannon & Feist, 2010). In this era of health care reform, insurance companies and government agencies are scrupulously examining ways to drive down the cost of health care. Given the many successful and cost-efficient interventions performed by those specializing in health psychology and behavioral medicine, Friedman et al. (1995) ask: Why haven't these interventions been integrated to a greater extent into our health care system? They suggest several possible reasons:

1. Many of the data supporting the role of health psychology are unknown to physicians.
2. Biological origins of diseases and illnesses have been emphasized, causing many to overlook the possible benefits of psychosocial explanations and behavioral interventions.
3. Patients may be resistant to psychological interventions (and explanations).
4. Clinical health psychology and behavioral medicine are still confused with traditional, long-term psychotherapy.

Clearly, physicians, insurance companies, the federal government, and the general public need to be educated regarding the role of health psychologists as well as the potential financial and clinical benefits of their interventions.

Another challenge for the field concerns ethnicity and health, as mentioned above. The health profiles (e.g., life expectancy and health status) of various ethnic minority populations in the United States appear to differ greatly from one another, and more research is needed on health-promoting and health-damaging behaviors among members of these groups. But as Brannon and Feist (2010) note, in the United States one cannot consider ethnicity separately from social, economic, and educational factors that impact health and health care. Economic disadvantage and lower educational level are also associated with poorer health outcome and with poorer access to appropriate health care. Therefore, it is important to consider a number of factors in addition to ethnicity when evaluating health and health needs.

BOX 17-4 Clinical Psychologist Perspective: Beth E. Meyerowitz, Ph.D.

Dr. Beth Meyerowitz is a Professor of Psychology in the Department of Psychology at the University of Southern California and Professor of Preventive Medicine at the University of Southern California School of Medicine. She also serves as Vice Provost for Faculty and Programmatic Development. Dr. Meyerowitz is an expert on quality-of-life issues and coping among cancer patients and their family members and has served as a member of the Executive Committee of APA's Division 38 (Health Psychology). She is a reviewer for a number of prominent journals in clinical psychology, and she has received several awards for her undergraduate teaching. Dr. Meyerowitz has published numerous articles and book chapters in her field and has obtained several federal grants to fund her research.

Dr. Meyerowitz responded to several questions we posed concerning her background and interests, and she offered her views on the future of clinical psychology and health psychology.

What originally got you interested in the field of clinical psychology?

Looking back, I realize that I became interested in clinical psychology when I was 14 years old. During that summer, I was a volunteer counselor at a day camp for children with cerebral palsy. I greatly enjoyed playing with and teaching the children, but mostly I found that I was fascinated by trying to understand the experience of these severely disabled children and their families. I was especially intrigued by the fact that some families seemed to cope so well, even in the face of what seemed to me to be overwhelming difficulties. How was it that some individuals, when faced with chronic problems over which they had little control, could appear to be happy and well adjusted? Throughout high school and college, I volunteered to work in different clinical settings. In each of these settings, I found myself wondering how some people managed to fare so well, whereas others faced ongoing distress and disruption in their lives. By the time I applied to graduate school, I knew that I wanted to focus on research about how psychologically "normal" individuals react to and cope with chronically stressful situations.

Describe what activities you are involved in as a clinical psychologist.

As a clinical psychologist in a university psychology department, my primary activities are teaching, research, and administration. My classroom teaching includes undergraduate courses in traumatic stress and graduate seminars in introduction to clinical interviewing, psychological interventions, and health psychology. I also spend a lot of time with graduate students supervising research projects.

My research activities involve planning and designing studies, developing collaborations with physicians and patient groups, writing grant proposals, overseeing data collection, analyzing research results, giving talks, and writing journal articles. As a vice provost, I work closely with faculty members throughout the university on a range of issues related to faculty and program development and review.

In addition to administration, research and teaching, I am involved with a number of organizations and committees both at the university level and nationally. I review grants for NIH and several foreign governments, and I review articles for psychological and medical journals. One of the things that I like best about being an academic clinical psychologist is that I am able to engage in a wide variety of interesting activities.

What are your particular areas of expertise or interest?

My research focuses primarily on quality of life and coping among patients and family members following the diagnosis of chronic illness, particularly cancer. I am interested in understanding the common reactions to diagnosis and treatment across quality-of-life domains, including emotional, cognitive, social, physical, and functional changes. What can patients, their families, and their health care providers expect at different stages of the disease? What personality, social, contextual, or medical factors predict who will adjust quickly and who will have ongoing problems? What are the psychological mechanisms through which these factors play a role in adjustment? My colleagues and I have developed and tested brief psychosocial interventions designed to improve quality of life and to

It is easy to become carried away with the enthusiasm generated by an exciting new field. This has been true in virtually every area of clinical psychology so far. However, there is still a gap between the field's promise and its accomplishments. As any experienced clinician will tell you, it is very hard to change human

enhance coping skills in patients with early-stage cancer and their partners. I also have been interested in issues of culture and ethnicity, which I investigate through research with diverse populations in the United States. In addition, I recently have begun to conduct research in Rwanda with survivors of the 1994 Rwandan Tutsi genocide.

What are the future trends you see for clinical psychology?

I believe that the most exciting possibilities for the future of clinical psychology lie in our expertise as clinical researchers. Clinical psychologists are involved in broadening the traditional boundaries of research and expanding methodologies to address a wide range of clinically relevant questions. We will be called upon to design research that is responsive to societal needs, as well as being firmly based on sound theory and methodology. Because research is a transportable skill, research activities can be housed in community settings through establishing scientist-community links both locally and internationally. I also expect that clinical psychologists will need to defend their role as service providers, in light of increasing demands to document those areas in which Ph.D.-level training is essential to optimal performance. Psychologists with doctoral degrees might be called on to develop effective treatments and psychometrically sound assessment tools to determine which treatments are best suited for which individuals. Cost-effectiveness will need to be taken into account in a variety of clinical domains.

What are some future trends you see in health psychology?

Health psychology and behavioral medicine are relatively new fields of study. As such, the field is wide open for development in numerous exciting directions. For example, we are learning a lot about the importance of psychological factors in causing illness, through the impact of stress and isolation on immunologic and hormonal functioning. In addition, health psychologists should continue to develop theories and interventions designed to increase healthy behaviors and decrease risky behaviors. After all, much of the premature death in industrial countries is related to individual failure to adopt guidelines for healthy living. Research in both of these areas needs to be extended to underserved populations, with a focus on identifying the role of culture in influencing health and quality-of-life outcomes.

Research on culture also should include investigation of the culture of the health care system and of ways to make health care more "user-friendly" for patients and their families. A comprehensive understanding will require considering health-related behaviors and quality of life within the context of the individual's ongoing life, rather than as separate and isolated domains. With this information, psychologists can continue to develop novel approaches to primary, secondary, and tertiary prevention. I anticipate that as researchers develop behavioral and psychosocial interventions that are effective and easily integrated into ongoing health care delivery, these interventions will gradually become components of standard care. To the extent that psychologists can demonstrate the money-saving benefits of health psychology and behavioral medicine, insurers will be more likely to reimburse for such services.

Dr. Beth E. Meyerowitz, Psych Dept., Univ. of Southern CA

Beth E. Meyerowitz

behavior over the long haul. Nevertheless, health psychology most assuredly deserves our enthusiasm as well as our caution (Keefe, Buffington, Studts, & Rumble, 2002). Many people are optimistic about the future of health psychology, given the pressing demands of improved health care.

CHAPTER SUMMARY

Health psychology and pediatric psychology (also known as child health psychology) are increasingly popular specialties that include psychology's contributions to health promotion, to prevention and treatment of health problems, and to the health care system. Most health psychologists adhere to a biopsychosocial model of health and illness, a model that integrates the more traditional biomedical model and the psychosocial model. The links among stress, lifestyle and behavior, personality, social support, and health form the basis of the health psychology field. The stress process has physiological, emotional, behavioral, and cognitive effects that may make one more vulnerable to illness. Behaviors and lifestyle choices can also have a major impact on health. Further, personality and coping styles have also been associated with illness. Finally, social support can influence one's vulnerability to adverse health outcomes.

Health and pediatric psychologists address a wide range of problems through assessment, intervention, and prevention initiatives. Most interventions are behavioral or cognitive-behavioral in nature and include techniques such as systematic desensitization, operant conditioning, stress inoculation training, and biofeedback. Specific interventions for chronic headache, cigarette smoking, alcohol abuse, obesity, coping with medical procedures, and treatment compliance were discussed.

The prospects for health and pediatric psychology look bright. There is an increasing need for better and more efficient interventions to cut health care costs. Further, data support the role of health psychologists in health care.

KEY TERMS

behavioral medicine A broad, interdisciplinary field of research, education, and practice that integrates the behavioral sciences with the discipline of medicine.

biofeedback A wide array of procedures through which a patient learns to modify or control certain physiological processes. Usually, the physiological process of interest is monitored by an apparatus, and the information is fed back to the patient in the form of an auditory, tactile, or visual signal. The patient then attempts to modify the signal (and thus change the physiological response) using a variety of techniques.

biopsychosocial model A theoretical model that holds that health and illness are a function of biological (e.g., genetic predispositions, nutritional deficiencies), psychological (e.g., the individual's cognitions and emotions), and social (e.g., friends and family, life events) influences.

cognitive-behavioral methods Techniques that emphasize the role of thinking in the etiology and maintenance of problems and attempt to modify the patterns of thinking that are believed to contribute to a patient's problem. Several cognitive-behavioral treatments for stress or other health problems appear on the current list of empirically validated psychological treatments.

controlled drinking A controversial approach to the treatment of alcohol problems that has as its goal light to moderate drinking. Clients are taught to monitor their alcohol intake closely and to develop coping responses that do not involve drinking.

coping appraisal In protection motivation theory, the evaluation of one's ability to successfully avoid or cope with negative outcomes. If one concludes that one is unlikely to cope effectively (by refraining from an undesired behavior), one will be more likely to engage in the behavior.

coping model An individual who demonstrates effective coping in a stressful situation (e.g., preparing for a medical procedure or surgery). Observing or playing a tape of such a model may

be useful for individuals who are about to experience similar procedures.

coronary heart disease A disease that involves damage to the heart muscle and is due to deficient blood supply.

extinction The elimination of an undesired conditioned response by creating a situation in which the conditioned stimulus is no longer associated with the environmental stimulus that initially generated the response.

health behavior model A theoretical model proposing that the relationship between a hostile predisposition and health is mediated by the performance (or lack of performance) of health behaviors rather than by the physiological aspects of stress.

health psychology A specialty area within psychology that applies the tools of the discipline to the prevention of illness, the enhancement and maintenance of health, the identification of the correlates of illness and health, the treatment of individuals in the health care system, and the formulation of health care policy.

operant conditioning The principle whereby behaviors that are reinforced tend to recur, whereas behaviors that are not reinforced or are punished tend to decrease in frequency.

prevention In health psychology, the idea that by performing a few simple behaviors consistently (e.g., exercising, avoiding smoking, using seat belts), people may dramatically reduce their risk for health problems and may significantly reduce health care costs.

procedural information Descriptions of what will actually occur when one undergoes a stressful medical procedure.

protection motivation theory A model of health behavior that posits that behavior is a function of both threat appraisal and coping appraisal.

psychosomatic medicine A field (popular in the 1940s and 1950s but currently out of vogue) that is based on the assumption that certain illnesses and disease states are caused by psychological factors. Some adherents believed that each "psychosomatic" illness corresponded to a specific unconscious conflict that predisposed the patient to that illness.

relapse prevention A range of strategies for preventing relapse, usually in the context of treating the addictive behaviors. Patients are directed to anticipate problem situations and are taught coping skills to navigate their way through these situations without engaging in the undesired behavior. Or in the event of a lapse, patients are taught how to respond so as to prevent a total relapse.

relaxation A state of lowered anxiety, stress, and physiological arousal. Relaxation may be induced in a number of ways, and it appears to be effective in the treatment of a number of health concerns.

self-efficacy People's beliefs about their capacity to control or gain mastery over the events that affect them. This construct plays a prominent role in most social-cognitive models of health behavior.

self-monitoring record A record often employed in cognitive-behavioral treatments on which individuals monitor the occurrence of a certain emotional response, including the situation that triggered it, the strength of the emotions, any physical or behavioral reactions, and their thinking processes at the time. By examining the data collected, the therapist may draw connections between certain situations and the patient's thoughts, emotions, and behaviors and may ultimately tailor specific treatment interventions.

sensory information Descriptions of the sensations that will be encountered when one undergoes a stressful medical procedure.

social support The number and quality of one's social relationships. Several studies have shown that social support is positively associated with better health outcomes.

sympathetic nervous system The portion of the nervous system that is responsible for mobilizing body resources in urgent situations. Prolonged

sympathetic activation can have adverse effects on body organs, mental functions, and the immune system.

systematic desensitization A respondent method for reducing anxiety in which patients practice relaxation while visualizing anxiety-provoking situations of increasing intensity. This technique is based on the principle that one cannot be relaxed and anxious simultaneously.

threat appraisal In protection motivation theory, the evaluation of negative factors (e.g., the potential for harm) that affect the likelihood of engaging in a particular behavior. If one concludes that there is little immediate threat to oneself, one will be more likely to engage in the behavior.

transactional model of stress A model that views stress as a process that involves an environmental event, its appraisal (as threatening or benign) by the individual, the individual's physiological, emotional, cognitive, and behavioral responses to the event, and the reappraisal of the event that occurs secondary to the person's responses as well as to changes in the stressor.

Type A behavior pattern A personality pattern that has been associated with increased risk for coronary heart disease. Among other things, Type A individuals exhibit a great sense of time urgency, work near maximum capacity even when there is no time deadline, become aggressive and hostile when frustrated, and are motivated to master their environments and to maintain control.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

17-1 Division 38 of the American Psychological Association (Health Psychology)
http://www.health-psych.org/

17-2 Division 54 of the American Psychological Association (Pediatric Psychology)
www.societyofpediatricpsychology.org/

17-3 Guide to Becoming a Health Psychologist
http://www.health-psych.org/AboutHowto-Become.cfm

17-4 Centers for Disease Control and Prevention
http://www.cdc.gov/

17-5 Society of Behavioral Medicine
http://www.sbm.org/

17-6 Health Psychology and Rehabilitation
http://www.healthpsych.com/

17-7 National Institute of Alcohol Abuse and Alcoholism
www.niaaa.nih.gov

17-8 American Obesity Association
www.obesity.org

17-9 National Cancer Institute
www.nci.nih.gov

18

Neuropsychology

FOCUS QUESTIONS

1. What features distinguish the field of neuropsychology and neuropsychological assessment?
2. Compare and contrast the localization-of-function, equipotentiality, and functional models of brain function.
3. What are the basic structures of the brain and the functions associated with each structure?
4. What variables may affect neuropsychological test performance? How are neuropsychological test results interpreted?
5. What forms of neuropsychological assessment and intervention are likely to be emphasized in the future? Why?

CHAPTER OUTLINE

Perspectives and History
- Definitions
- Roles of Neuropsychologists
- History of Neuropsychology
- BOX 18-1: *Clinical Psychologist Perspective: Brick Johnstone, Ph.D.*

The Brain: Structure, Function, and Impairment
- Structure and Function
- Antecedents or Causes of Brain Damage
- Consequences and Symptoms of Neurological Damage
- Brain–Behavior Relationships
- BOX 18-2: *Focus on Clinical Applications: Personality Changes Following Brain Injury: A Case Example*

Methods of Neuropsychological Assessment
- Major Approaches
- Interpretation of Neuropsychological Test Results
- Neurodiagnostic Procedures
- Testing Areas of Cognitive Functioning
- Test Batteries
- BOX 18-3: *Focus on Clinical Applications: A Brief Neuropsychological Report Based on Halstead-Reitan and Other Information*
- Variables That Affect Performance on Neuropsychological Tests

Intervention and Rehabilitation
- BOX 18-4: *Graduate Student Perspective: Andrew Wegrzyn*
- BOX 18-5: *Focus on Professional Issues: Cross-cultural Neuropsychology*

Concluding Remarks
- Training

The Future
BOX 18-6: *Clinical Psychologist Perspective: Paula Zuffante, Ph.D.*
CHAPTER SUMMARY
KEY TERMS
WEB SITES OF INTEREST

A very important growth area in clinical psychology over the past several decades has been the field of neuropsychology. This growth has been reflected in (a) increases in membership in professional neuropsychological associations; (b) the number of training programs that offer neuropsychology courses; and (c) the many papers, books, and journals now published on neuropsychological topics. Let us begin to examine this growing area of clinical psychology by taking a step back to get a better sense of how this field developed as well as the roles of neuropsychologists.

PERSPECTIVES AND HISTORY

As the term would suggest, neuropsychologists have a foot in both the psychological and neurological domains. Although some have received their basic training in clinical psychology, others have been trained by neurologists.

Definitions

What is *neuropsychology*? It can be defined as the study of the relation between brain function and behavior or as Zillmer, Spiers, and Culbertson (2008) put it, "The study of how complex properties of the brain allow behavior to occur" (p. 4). It deals with the understanding, assessment, and treatment of behaviors directly related to the functioning of the brain (Golden, 1984). *Neuropsychological assessment* is a noninvasive method of describing brain functioning based on a patient's performance on standardized tests that have been shown to be accurate and sensitive indicators of brain–behavior relationships (Golden et al., 1992). The neuropsychologist

> may address issues of cerebral [brain] lesion lateralizations, localization, and cerebral lesion progress. Neuropsychological evaluations have also provided useful information about the impact of a patient's limitations on educational, social, or vocational adjustment. Since many patients with neurological disorders, such as degenerative diseases, cerebrovascular accident, or multiple sclerosis, vary widely in the rate at which the illness progresses or improves, the most meaningful way to assess patients for the severity of their condition is to assess their behavior objectively via neuropsychological assessment procedures. (Golden et al., 1992, p. 19)

Roles of Neuropsychologists

Neuropsychologists function in a number of different roles (Golden et al., 1992; Howieson & Lezak, 2010; Zillmer et al., 2008). First, neuropsychologists are often called on by neurologists or other physicians to help establish or rule out particular diagnoses. For example, a patient may present with a number of symptoms that may have either a neurological or an emotional basis. Neuropsychological test results can help clarify the diagnosis in this situation. Second, because of an emphasis on functional systems of the brain (see below), neuropsychologists can often make predictions regarding the prognosis for recovery. A third major role involves intervention and rehabilitation. Information provided by neuropsychologists often has important implications for treatment; test results provide guidance as to which domains of functioning may support rehabilitative efforts. Finally, neuropsychologists may be asked to evaluate patients with mental disorders to help predict the course

of illness (based on, e.g., the degree of cognitive impairment present) as well as to help tailor treatment strategies to patients' strengths and weaknesses (Howieson & Lezak, 2010).

With these definitions and descriptions of the roles of neuropsychologists in mind, we now turn to a brief history of the field.

History of Neuropsychology

Theories of Brain Functioning. As in most areas of psychology, the historical roots of neuropsychology extend about as far back in time as we are inclined to look. Some authors point to the Edwin Smith Surgical Papyrus, a document thought to date between 3000 and 1700 B.C., which discusses localization of function in the brain (Walsh & Darby, 1999). Others suggest that it all began when Pythagoras said that human reasoning occurs in the brain. Others are partial to the second century A.D. when Galen, a Roman physician, argued that the mind was located in the brain, not in the heart as Aristotle had claimed.

However, the most significant early base for neuropsychology seems to have been laid in the 19th century (Zillmer et al., 2008). Researchers then were beginning to understand that damage to specific cortical areas was related to impaired function of certain adaptive behaviors. The earliest signs of this understanding came with Franz Gall and his now discredited phrenology. Gall believed that certain individual differences in intelligence and personality (e.g., reading skills) could be measured by noting the bumps and indentations of the skull. Thus, the size of a given area of the brain determines the person's corresponding psychological capacity. This was the first popularization of the notion of *localization of function*. Localization achieved much greater credibility with Paul Broca's surgical work in 1861. Observations from two autopsies of patients who had lost their powers of expressive speech convinced Broca that he had found the location of motor speech. Within the next 30 to 40 years, many books presented maps of the brain that located each major function (Golden, 1984).

Others, such as Pierre Flourens, would surgically destroy certain areas of the brains of animals and then note any consequent behavioral losses. Such work led Flourens and later, in the early 20th century, Karl Lashley to argue for the concept of *equipotentiality*. That is, although there certainly is localization of brain function, the cortex really functions as a whole rather than as isolated units. In particular, higher intellectual functioning is mediated by the brain as a whole, and any brain injury will impair these higher functions. Yet there is the ability of one area of the cortex to substitute for the damaged area.

Both the localization and equipotentiality theories presented some problems, however. Localizationalists could not explain why lesions in very different parts of the brain produced the same deficit or impairment, whereas those adhering to the equipotentiality theory could not account for the observation that some patients with very small lesions manifested marked, specific behavioral deficits.

An alternative theory that integrates these two perspectives is the *functional model*. First proposed by the neurologist Jackson and later adapted by the Soviet neuropsychologist Luria, the functional model holds that areas of the brain interact with each other to produce behavior. Behavior "is conceived of as being the result of several functions or systems of the brain areas, rather than the result of unitary or discrete brain areas. A disruption at any stage is sufficient to immobilize a given functional system" (Golden et al., 1992). The importance of this formulation is that it can account for many of the clinical findings that are inconsistent with previous theories. According to the functional model, the nature of the behavioral deficit will depend on which functional system (e.g., arousal, perception, or planning behavior) has been affected as well as the localization of the damage within that functional system. Finally, through a process called reorganization, recovery from brain damage is sometimes possible.

Neuropsychological Assessment. With regard to specific psychological assessment instruments, neurology was for a long time bewitched by notions of mass action of brain functioning. These ideas

BOX 18-1 Clinical Psychologist Perspective: Brick Johnstone, Ph.D.

Dr. Brick Johnstone is a professor in the Department of Health Psychology in the School of Health Professions at the University of Missouri-Columbia. He is board certified by the American Board of Clinical Neuropsychology, a former Fulbright Scholar at the National University of Ireland, Galway, and a fellow in both the National Academy of Neuropsychology and the Rehabilitation Psychology Division of the American Psychological Association. Dr. Johnstone's research focuses on vocational rehabilitation of persons with disabilities, training in rehabilitation and neuropsychology, and the neuropsychology of spiritual experience.

We asked Dr. Johnstone about his background and interests, as well as his take on the future of clinical psychology and neuropsychology.

What originally got you interested in the field of clinical psychology?

I became interested in clinical psychology as an undergraduate at Duke University, through both academic coursework and clinical practica. I developed a strong interest in psychopathology based on an abnormal psychology course I took, as well as volunteer activities I engaged in at Butner State Hospital. Coursework in cognitive and perceptual psychology led to my long-term interest in brain functioning, and eventually in neuropsychology. Finally, as an undergraduate, I was able to participate as a research assistant on a study determining psychometric correlates of popularity in children, which led to my interest in psychological research.

Describe what activities you are involved in as a clinical psychologist.

I currently serve as a professor in the University of Missouri–Columbia Department of Health Psychology. My current duties are split between clinical practice, research activities, and teaching/supervising students. I am board certified as a neuropsychologist, but view myself as a clinical psychologist who specializes in the rehabilitation of persons with brain dysfunction and physical disability. Although I work with a special needs population, the skills I employ are those I was taught in graduate school. My assessment of patients is based primarily on a detailed clinical interview and behavioral observations and secondarily on objective test data. My treatment of patients with brain dysfunction is based on all the behavioral treatment methods I learned in my clinical psychology graduate program at the University of Georgia.

I have also been involved in the regulation of the practice of psychology, as I served on the Missouri State Committee of Psychologists for 10 years. This committee ensures that only competent psychologists are allowed to practice and administers discipline for those psychologists who act unethically. My initial research focus was on improving the vocational successes of persons with disabilities, as I was a primary investigator (PI) for one of 17 national Traumatic Brain Injury Model Systems Centers from 1998 to 2002. It is important to note that 12 of the 17 PIs for these grants were psychologists. At the current time, my research focuses on the relationships among religion, spirituality, and health, as well as the neuropsychology of spiritual experience. Opportunities for clinical psychologists to expand in numerous areas of health care and health policy are extraordinary.

What are your particular areas of expertise or interest?

My main area of clinical expertise is rehabilitation psychology. In graduate school, I completed a summer externship at the Kansas City VA Hospital in neuropsychology, even though I had never even administered a WAIS before that. That experience solidified my interest in working with individuals with brain dysfunction. My current research interests relate to the manner in which religious activities and spiritual beliefs impact health, as well as the specific neuropsychological processes that are related to different spiritual traits. Specifically, our research has identified increased selflessness, related to decreased right parietal lobe

tended to make localization of function a secondary goal of diagnosis, and brain damage was often viewed as a unitary phenomenon. The psychological tests used (e.g., the Benton Visual Retention Test and the Graham-Kendall Memory-for-Designs Test) were oriented toward the simple assessment of the presence or absence of brain damage. Information about specific test correlates of specific brain lesions was not collected very efficiently.

Neuropsychology as a field began to grow immediately after World War II because of (a) the large numbers of head injuries in the war and

functioning, as being related to increased spiritual transcendence.

What are the future trends you see for clinical psychology?

It is always entertaining to project the future of psychology, particularly given the potential growth opportunities as well as stressors related to managed care. On the positive side, clinical psychologists continue to expand their expertise into areas outside of traditional mental health. At my current setting, clinical psychologists have been primary investigators on Robert Wood Johnson Foundation grants focusing on (1) developing Medicaid managed care programs for individuals with disabilities and (2) investigating the impact of managed care on children with disabilities in rural settings. Other psychologists in our department have been primary investigators on grants investigating the use of telemedicine applications for individuals with traumatic brain injury in rural settings, as well as the PI for one of 17 national Spinal Cord Injury Model Systems. In addition, many medical school psychologists are identifying numerous medical populations that can benefit from psychological services (including those with systemic illnesses, infectious diseases, chronic pain, and cardiovascular diseases).

Managed care trends and current economic difficulties have had positive effects in that they have forced all health care professionals to better demonstrate the effectiveness of our services. However, because we have not demonstrated that psychologists can provide superior and less expensive services than social workers and licensed professional counselors, there is a good chance that clinical positions for psychologists will decrease in the future. As past president of the Missouri Psychological Association, I have learned that the future of clinical psychology rests on our ability to advocate for our profession and demonstrate our value to others. If we do not do it for ourselves, no one else will.

What are some future trends you see in neuropsychology?

I see the specialty of neuropsychology diverging in two directions. The first will be toward an experimental focus, with more research identifying specific brain–behavior relationships such as the neuropsychological processes associated with specific spiritual experiences. Sophisticated neuroradiological techniques will allow us to gain a much better understanding of how the brain works. On the other hand, I foresee clinical neuropsychology focusing on the development of rehabilitation-based assessment and treatment. In the future, most individuals who are referred for neuropsychology evaluations will have known etiologies for their difficulties. Therefore, clinical neuropsychologists will need to develop specific treatment recommendations to assist individuals in their daily functions, at home, work, or school.

Dr. Brick Johnstone, Dept. of Physical Medicine & Rehabilitation at Univ. of Missouri Hospital

Brick Johnstone

(b) the development of the field of clinical psychology itself (Hartlage, 1987). An important development of the postwar period was the work of Ward Halstead. By observing people with brain damage in natural settings, Halstead was able to identify certain specific characteristics of their behavior. Next, he tried to assess these characteristics by administering a variety of psychological tests to these patients. Through factor analysis, he settled on ten measures that ultimately comprised his test battery. Later, Ralph Reitan, a graduate student of Halstead's, refined the battery by eliminating two

tests and adding several others. Subsequently, Reitan and his colleagues could relate test responses to such discrete aspects of brain lesions as lateralized motor deficits. This work culminated in the Halstead-Reitan Neuropsychological Test Battery. By 1980, the Luria-Nebraska Neuropsychological Battery had been developed, and it is now frequently used as an alternative to the Halstead-Reitan Battery. We'll have more to say about these and other neuropsychological tests in a later section.

An additional historical development deserves mention here. Contemporary clinical neuropsychologists have increasingly adopted a flexible battery approach to assessment. Flexible batteries allow each assessment to be tailored to the individual based on the clinical presentation and on the hypotheses of the neuropsychologist. Standard batteries, such as the Halstead-Reitan and the Luria-Nebraska, may be too time-consuming and are not easily modified to accommodate specific clinical situations. We will compare the standard battery and flexible battery approaches later in this chapter.

THE BRAIN: STRUCTURE, FUNCTION, AND IMPAIRMENT

Before proceeding, it will be helpful to review some important aspects of the brain. This will, of necessity, be a brief excursion. More extensive accounts can be found elsewhere (e.g., Yudofsky & Hales, 2010; Zillmer et al., 2008).

Structure and Function

The brain consists of two hemispheres. The *left hemisphere* controls the right side of the body and is thought to be more involved in language functions, logical inference, and detail analysis in almost all right-handed individuals and a good many left-handers as well. The *right hemisphere* controls the left side of the body. It is more involved in visual-spatial skills, creativity, musical activities, and the perception of direction. But again, note that some left-handers may reverse this hemispheric pattern. The two hemispheres communicate with one another via the corpus callosum, which helps to coordinate and integrate our complex behavior.

Each cerebral hemisphere has four lobes: the frontal, temporal, parietal, and occipital lobes (see Figure 18-1). The *frontal lobes* are the most recently developed parts of the brain, from both an evolutionary and developmental perspective. They enable us to observe and compare our behavior and the reactions of others to it in order to obtain the feedback necessary to alter our behavior to achieve valued goals. Also associated with the frontal lobes are executive functions—formulating, planning, and carrying out goal-directed initiatives. Finally, emotional modulation—the ability

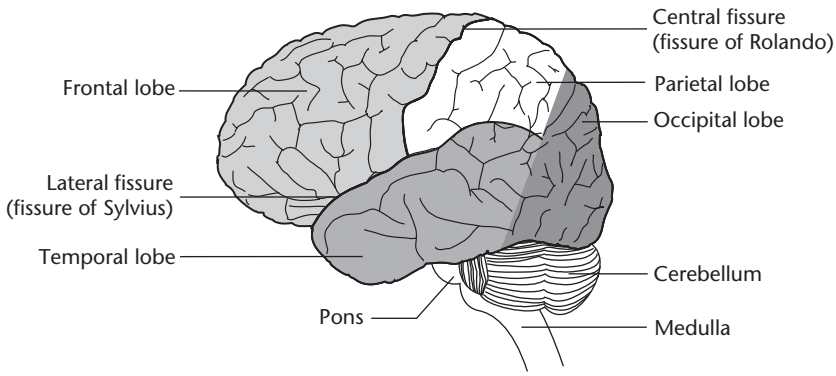

FIGURE 18-1 The cerebral cortex

to monitor and control one's emotional state—is also associated with frontal lobe functioning. Substantial frontal lobe development occurs in adolescence.

The *temporal lobes* mediate linguistic expression, reception, and analysis. They are also involved in auditory processing of tones, sounds, rhythms, and meanings that are nonlanguage in nature. The *parietal lobes* are related to tactile and kinesthetic perception, understanding, spatial perception, and some language understanding and processing. They are also involved in body awareness. The *occipital lobes* are mainly oriented toward visual processing and some aspects of visually mediated memory. Motor coordination, as well as the control of equilibrium and muscle tone, is associated with the *cerebellum*.

Antecedents or Causes of Brain Damage

What causes brain damage? There are a number of possibilities.

Trauma. It is estimated that brain injury occurs in more than 500,000 Americans every year (Zillmer et al., 2008). Incidents producing these injuries range from automobile accidents, to sports injuries, to falls off a stepladder. The outcomes are wide-ranging, and the nature of the head injury (e.g., closed vs. open/penetrating) may have implications as well. Although most head injuries are considered mild, a substantial percentage of cases require hospitalization. Head trauma is a leading cause of death and disability in young Americans (Zillmer et al., 2008).

The major effects of head trauma can be categorized as concussions, contusions, and lacerations. *Concussions* (jarring of the brain) usually result in momentary disruptions of brain function, although permanent damage is uncommon (unless there are repeated concussions, as might be the case in football, soccer, or boxing, for example). *Contusions* refer to cases in which the brain has been shifted from its normal position and pressed against the skull. As a result, brain tissue is bruised. Outcomes can often be severe and may be followed by comas and deliriums. *Lacerations* involve actual ruptures and destruction of brain tissue. They can be caused by bullets or flying objects, for example. These lacerations are, of course, exceedingly serious forms of damage.

Cerebrovascular Accidents. The blockage or rupture of cerebral blood vessels is often termed a "stroke." This is a very common cause of brain damage in adults, and stroke is one of the leading causes of death in the United States (and other countries). Although primarily occurring in the elderly, stroke is also one of the most common causes of death in middle-aged adults. In *occlusions*, a blood clot blocks the vessel that feeds a particular area of the brain. This can result in *aphasia* (language impairment), *apraxia* (inability to perform certain voluntary movements), or *agnosia* (disturbed sensory perception). In the case of a *cerebral hemorrhage*, the blood vessel ruptures and the blood escapes onto brain tissue and either damages or destroys it. The exact symptoms that ensue depend on the site of the accident and its severity. In very severe cases, death is the outcome. Those who survive often show paralysis, speech problems, memory and judgment difficulties, and so on.

It is very important to get stroke patients to the hospital immediately. Medications that essentially dissolve occlusions ("clot-busting" medications) can limit the permanent damage from occlusive strokes. In addition, new medications are being developed that prevent the cascade of chemical reactions responsible for neuronal damage or even death (e.g., tissue plasminogen activator, tPA). Therefore, in many cases, prompt action can be of major benefit.

Tumors. Brain *tumors* may grow outside the brain, within the brain, or result from metastatic cells spread by body fluids from some other organ of the body, such as the lung or the breast. Initial signs of brain tumors are often quite subtle and can include headaches, vision problems, gradually developing problems in judgment, and so on. As the tumor grows, so does the variety of other symptoms (e.g., poor memory, affect problems, or motor coordination). Tumors can be removed surgically, but the surgery itself can result in more brain damage. Some tumors are inoperable or located in areas too dangerous to operate on. In such cases, radiation treatments are often used.

Degenerative Disease. This group of disorders is characterized by a degeneration of neurons in the central nervous system. Common *degenerative diseases* include Huntington's chorea, Parkinson's disease, and Alzheimer's disease and other dementia. Alzheimer's disease is the most common degenerative disease (age of onset is typically 65 years old or older), followed by Parkinson's disease (age of onset 50 to 60 years old), and finally, Huntington's chorea (age of onset 30 to 50 years old). In all three cases, there is progressive cerebral degeneration along with other symptoms in the motor areas. Eventually, patients in these categories show severe disturbances in many behavioral areas, including motor, speech, language, memory, and judgment difficulties. More and more, neuropsychologists are attempting to identify and diagnose early stages of diseases like Alzheimer's in order to provide treatment that may have maximal impact on future functioning (Bondi, Jak, Delano-Wood, Jacobson, Delis, & Salmon, 2008).

Nutritional Deficiencies. Malnutrition can ultimately produce neurological and psychological disorders. They are most often observed in cases of Korsakoff's psychosis (resulting from nutritional problems brought about by poor eating habits common in longtime alcoholics), pellagra (niacin/vitamin B_3 deficiency), and beriberi (thiamin/vitamin B_1 deficiency).

Toxic Disorders. A variety of metals, toxins, gases, and even plants can be absorbed through the skin. In some instances, the result is a toxic or poisonous effect that produces brain damage. A very common symptom associated with these disorders is *delirium* (disruption of consciousness).

Chronic Alcohol Abuse. Chronic exposure to alcohol often results in tolerance for and dependence on the substance. Tolerance and dependence appear to have neurological correlates, including, for example, changes in neurotransmitter sensitivity and shrinkage in brain tissue.

Several regions of the brain seem especially vulnerable to damage from chronic exposure to alcohol (Oscar-Berman & Marinkovic, 2003, 2007; U.S. Department of Health and Human Services, 2000). We highlight only a few of the most consistent findings here. The limbic system is a network of structures within the brain associated with memory formation, emotional regulation, and sensory integration. Studies of alcoholics have indicated deficits in these areas of functioning. The diencephalon is a region near the center of the brain that includes the mammillary bodies of the hypothalamus. Studies suggest shrinkage or lesions in these areas as a result of chronic alcohol exposure, and memory deficits in alcoholics are consistent with these findings. Several studies have also reported findings that suggest alcoholics evidence atrophy of the cerebral cortex. Finally, damage to the cerebellum, responsible for motor coordination, is also well documented. A history of accidental falls or automobile accidents may suggest neurological damage resulting from alcohol abuse/dependence. Figure 18-2 depicts these brain regions that have been implicated in studies of the effects of alcoholism on the brain.

Consequences and Symptoms of Neurological Damage

Brain injury or trauma can produce a variety of cognitive and behavioral symptoms. Unfortunately for the diagnostician, many of these symptoms may also occur in connection with traditional mental disorders. Moreover, patients' responses to neurological impairment may give rise to psychological and emotional reactions. For example, an individual with neurological damage may become depressed over the inability to manage certain daily tasks. This in turn can easily obscure the process of differential diagnosis. These difficulties aside, several common symptoms associated with neurological damage are in the list that follows. However, each of these may occur in every disorder, and there is considerable variation among patients with the same disorder.

1. *Impaired orientation*: inability, for example, to say who one is, name the day of the week, or know about one's surroundings.

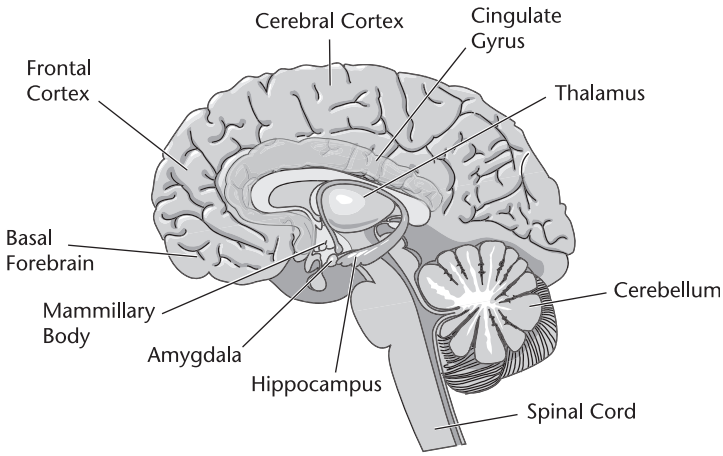

FIGURE 18-2 Brain structures affected by chronic alcohol abuse

SOURCE: Courtesy of the U.S. Department of Health and Human Services. (1997). *The Ninth Special Report to the U.S. Congress on Alcohol and Health,* p. 150.

2. *Impaired memory*: patient forgets events, especially recent ones, sometimes confabulates or invents memories to fill the gaps, and may show impaired ability to learn and retain new information.
3. *Impaired intellectual functions*: comprehension, speech production, calculation, and general knowledge may be affected (e.g., cannot define simple words, name the U.S. president, or add figures).
4. *Impaired judgment*: patient has trouble with decisions (e.g., cannot decide about lunch, when to go to bed, etc.).
5. *Shallow and labile affect*: person laughs or weeps too easily and often inappropriately; shifts from joy to tears to anger, for example, very rapidly.
6. *Loss of emotional and mental resilience*: patient may function reasonably well under normal circumstances, but stress (e.g., fatigue, mental demands, emotional upset) may result in deterioration of judgment, emotional reactions, and similar problems.
7. *Frontal lobe syndrome*: a group of personality characteristics often follow the destruction of frontal lobe tissue through surgery, tumor, or injury. Typical symptoms are impaired impulse control, poor social judgment and planning ability, lack of concern over the consequences of one's actions, apathy and indifference, some suspiciousness, and temper tantrums.

Box 18-2 illustrates the personality changes that can follow such injuries.

Brain–Behavior Relationships

Before describing specific assessment techniques, we should review at least briefly some basic ways of looking at brain–behavior relationships.

We observed earlier that in the second half of the 19th century, localization of function became a popular view. The idea that specific areas of the brain control specific behaviors is still an important operating principle among neuropsychologists. Such a principle means that in assessing brain damage, a chief concern is where the injury is located in the brain. Extent of an injury is important only to the degree that larger injuries tend to involve more areas of the brain (Golden, 1984). Indeed, some tumors may produce intracranial pressure that impairs areas located far from the tumor itself. The basic idea, however, is that same-sized lesions in different regions of the brain will produce different behavior deficits (Krech, 1962).

BOX 18-2 Focus on Clinical Applications
Personality Changes Following Brain Injury: A Case Example

A young Vietnam veteran lost the entire right frontal portion of his brain in a land mine explosion. His mother and wife described him as having been a quietly pleasant, conscientious, and diligent sawmill worker before entering the service. When he returned home, all of his speech functions and most of his thinking abilities were intact. He was completely free of anxiety and thus without a worry in the world. He had become very easygoing, self-indulgent, and lacking in general drive and sensitivity to others. His wife was unable to get him to share her concerns when the baby had a fever or the rent was due. Not only did she have to handle all the finances, carry all the family and home responsibilities, and do all the planning but she also had to see that her husband went to work on time and that he didn't drink up his paycheck or spend it in a foolish spending spree before getting home on Friday night. For several years, it was touch and go as to whether the wife could stand the strain of a truly carefree husband much longer. She finally left him after he stopped working altogether and began a pattern of monthly drinking binges that left little of his rather considerable compensation checks.

SOURCE: From *Neuropsychological Assessment,* 4th ed., by Lezak, M. D., Howieson, D., & Loring, D., p. 38. Copyright © 2004 by Oxford University Press, Inc. Reprinted by permission.

But according to equipotential theory, all areas of the brain contribute equally to overall intellectual functioning (Krech, 1962). Location of injury is secondary to the amount of brain injury. Thus, all injuries are alike except in degree. Equipotentialists tend to emphasize deficits in abstract, symbolic abilities, which are thought to accompany all forms of brain damage and to produce rigid, concrete attitudes toward problem solving (see K. Goldstein & Scheerer, 1941). Such views have led to the development of tests that attempt to identify the basic deficit common to all cases of brain damage. Unfortunately, such tests have not worked well enough for everyday clinical use (Golden, 1981).

Many investigators have been unable to accept either localization or equipotentiality completely. Thus, alternatives such as the one proposed by Hughlings Jackson (Luria, 1973) have become prominent. Although, according to Jackson, very basic skills can be localized, the observable behavior is really a complex amalgamation of numerous basic skills, so the brain as an integrated whole is involved. This functional model of the brain subsumes both localization and equipotential theory. Further, according to Luria (1973), very complex behaviors involve complex functional systems in the brain that override any simple area locations. Because our ability to abstract is a complex intellectual skill, for example, it involves many systems of the brain.

Brain damage can have many effects, involving visual perception, auditory perception, kinesthetic perception, voluntary motor coordination and functioning, memory, language, conceptual behavior, attention, or emotional reactions. Often, clinicians are called upon to determine the presence of intellectual deterioration. This goes beyond the measurement of present functioning because it involves an implicit or explicit comparison to a prior level. Generally speaking, intellectual deterioration may be of two broad types: (a) a decline resulting from psychological factors (psychosis, lack of motivation, emotional problems, the wish to defraud an insurance company, etc.) and (b) a decline stemming from brain injury. Of course, assessment would be a good deal easier if the clinician had available a series of tests taken by the patient prior to injury or illness. Such premorbid data would provide a kind of baseline against which to compare present performance. Unfortunately, clinical psychologists seldom have such data on the patients they most need to diagnose. They are left to infer patients' previous level of functioning from case history information on education, occupation, and other variables. Over the years, clinicians have used such signs of premorbid

functioning in a rather intuitive fashion, without much empirical evidence for their validity. However, all these methods are fallible.

METHODS OF NEUROPSYCHOLOGICAL ASSESSMENT

Assessment is a complex affair that involves many issues in addition to those already discussed. Let us consider a few of the more important ones (Zillmer et al., 2008).

Major Approaches

Should a standard test or test battery be administered to all patients referred for a neuropsychological workup, or should the test(s) be chosen on the basis of clinical judgment, the nature of the referral, or the clinician's special skills and proclivities? The first approach is sometimes termed the *standard battery approach* or *fixed battery approach*. It has the advantages of evaluating patients for all basic neuropsychological abilities, accumulating a standard database for all patients over time, and allowing for the identification of important patterns of scores. Major disadvantages include the time and expense involved, the potential for patient fatigue, and the inflexibility of this approach (in that assessments are not tailored to individual patients).

The second approach is called the *process/flexible approach* or the *hypothesis-testing approach*. Here, each assessment is tailored to the individual patient, with the neuropsychologist choosing tests based on her or his hypotheses about the case. In some cases, a test may be altered in the way it is administered to the patient so that additional hypotheses can be tested. Some argue that the individualized approach is a sensitive one that capitalizes on the clinician's best impressions. Others suggest that if a clinician picks the wrong test(s), it may result in a poor assessment. Also, the individualized approach hampers the systematic collection of data from specific tests on specific kinds of patients. Of course, some clinicians combine these two strategies by using one or more standard screening devices and then going to other specific tests depending on the outcome of the initial screening.

Interpretation of Neuropsychological Test Results

Zillmer and colleagues (2008) note a number of ways in which neuropsychologists interpret test data. First, a patient's level of performance may be interpreted in the context of normative data. For example, does a patient's score fall significantly below the mean score for the appropriate reference group, suggesting some impairment in this area of functioning? Second, some calculate *difference scores* between two tests for a patient; certain levels of difference suggest impairment. Third, *pathognomonic* signs of brain damage (e.g., failing to draw the left half of a picture) may be noted and interpreted. Fourth, a *pattern analysis* of scores may be undertaken; certain patterns of scores on tests have been reliably associated with specific neurological injuries or impairments. Finally, a number of statistical formulas that weight test scores differentially may be available for certain diagnostic decisions.

In a test of the diagnostic validity of four different approaches to interpreting test data, Ivnik et al. (2000) compared the absolute score/pathognomonic sign, difference score, and pattern of scores/profile variability approaches. Interestingly, the authors found that the absolute score approach resulted in the best diagnostic accuracy (predicting cognitive impairment in older adults). This suggests that cutoff scores on measures can be used instead of more complex indices like difference scores or score patterns.

A final point about interpretation has to do with the desirability of making qualitative evaluations of patients' responses. Should neuropsychologists depend on qualitative testing or quantitative methods that reduce the results to numerical values? Is the way a patient responds the important datum, or is it the scored responses that are critical? Many neuropsychologists probably combine the two approaches, which need not be mutually exclusive. Whether a patient scores zero points for barely

missing the proper reconstruction of a block design task or for pushing the blocks off the examiner's table in anger is likely to be significant for the patient's ultimate diagnosis. Although the point value obtained (zero) is the same in both cases, consideration and analysis of the quality or nature of the patient's response help the neuropsychologist in her or his case conceptualization.

Neurodiagnostic Procedures

By now, it may have occurred to the reader that the medical field already has a variety of *neurodiagnostic procedures*. They include the traditional neurological examination performed by the neurologist, spinal taps, X-rays, electroencephalograms (EEGs), computerized axial tomography (CAT) scans, positron emission tomography (PET) scans, and the more recent nuclear magnetic resonance imaging (NMR or MRI) technique. These are indeed valuable means for locating the presence of damage and disease. But not all of these procedures work equally well in diagnosing impairment. Likewise, these techniques sometimes produce evidence of abnormalities in the absence of actual brain damage. Finally, some of these procedures pose risks for the patient. Spinal taps can be painful and sometimes harmful; we all know about the dangers of too many X-rays.

Still, the neurologist's diagnostic procedures search directly for evidence of brain damage. In addition to these standard forms of neurodiagnostic procedure, several other imaging methods are available that provide a better sense of the "working" brain (Zillmer et al., 2008). Single photon emission computed tomography (SPECT) imaging is based on cerebral blood flow, and this provides a "picture" of how the brain is working. As another example, functional MR imaging (fMRI) also assesses blood flow changes in the brain. Both of these newer alternative neurodiagnostic procedures hold some promise in clinical neuropsychology because they are perhaps more likely to provide information on how different areas of the brain are working.

Many of these neurodiagnostic procedures are quite expensive, and some are invasive. Therefore, it may be helpful to use neuropsychological tests as screening measures, the results of which may indicate whether more expensive neurodiagnostic tests are indicated. Next, we consider some specific neuropsychological assessment devices and batteries.

Testing Areas of Cognitive Functioning

Many tests are available for assessing a wide range of cognitive and behavioral functioning. In this section, we discuss only a handful of the areas of functioning assessed by neuropsychologists. Further, because of space constraints (entire books on neuropsychological assessment are available), we only give a few tests as examples.

Intellectual Functioning. A number of techniques have been used over the years to assess levels of intellectual functioning. To estimate level of intellectual ability, many neuropsychologists use the WAIS-IV (see Chapter 7) and subtests from a modified version of the WAIS-R, called the WAIS-R-NI (Kaplan, Fine, Morris, & Delis, 1991). The modifications include, for example, changes in administration (e.g., allowing the patient to continue on a subtest despite consecutive incorrect answers) and additional subtest items. Because of these modifications, it is believed that the WAIS-R-NI provides more information regarding the patient's cognitive strategies (Anderson, 1994).

If it is not possible to administer the entire WAIS-IV, certain individual subtests may be used—most commonly, the Information subtest, Comprehension subtest, and Vocabulary subtest. These subtests are believed to be least affected by brain trauma or injury and thus can also provide estimates of premorbid intelligence. This is important because often no preinjury test data are available to serve as a baseline against which to compare present functioning.

Abstract Reasoning. For many years, clinicians observed that patients diagnosed with schizophrenia or those deemed cognitively impaired seemed to find it difficult to think in an abstract or conceptual fashion. Such patients seemed to approach tasks in a

highly concrete manner. Some of the more commonly used tests to assess abstract reasoning abilities include the Similarities subtest of the WAIS-IV (see Chapter 7) and the Wisconsin Card Sorting Test, or WCST (Heaton, 1981). The Similarities subtest requires the patient to produce a description of how two objects are alike. The WCST consists of decks of cards that differ according to the shapes imprinted, the colors of the shapes, and the number of shapes on each card (see Figure 18-3). The patient is asked to place each card under the appropriate stimulus card according to a principle (same color, same shapes, same number of shapes) deduced from the examiner's feedback ("that's right" or "that's wrong"). At various points during the test, the examiner changes principles; this can only be detected from the examiner's feedback regarding the correctness of the sorting of the next card.

Memory. Brain damage is often marked by memory loss. To test for such loss, Wechsler (1945) developed the Wechsler Memory Scale, or WMS. The Wechsler Memory Scale-III, or WMS-IV (Wechsler, 2009), is the most recent revision of the WMS. The WMS-IV was developed in conjunction with the WAIS-IV because clinicians often measure intellectual ability and memory concurrently. The WMS-IV is comprised of seven subtests, and performance on the WMS-IV is summarized using five index scores: Auditory Memory, Visual Memory, Visual Working Memory, Immediate Memory, and Delayed Memory. In addition to interpretations based on single subscale and single index scores, patterns of discrepancy between index scores are also informative. These are called contrast scores. For example, problems with retention of previously learned material might be indicated by relatively higher Immediate versus Delayed Memory index scores. Another example that incorporates intelligence test scores is a pattern of scores in which relatively lower Visual Working Memory and Immediate Memory index scores occur in the context of relatively higher intelligence scores. This pattern suggests that some impairment in attention is affecting the patient's ability to initially learn the material.

Two additional tests also assess memory loss. On these tests, the patient must demonstrate spatial perception and perceptual-motor coordination as well as recall. The Benton Visual Retention Test (Benton, 1963) is basically a test of memory for designs. Ten cards are presented for 10 seconds each. After a card is withdrawn, the patient must draw the design from memory. There are several variants of this procedure. Scoring instructions and some normative data are available (e.g., Benton, 1974).

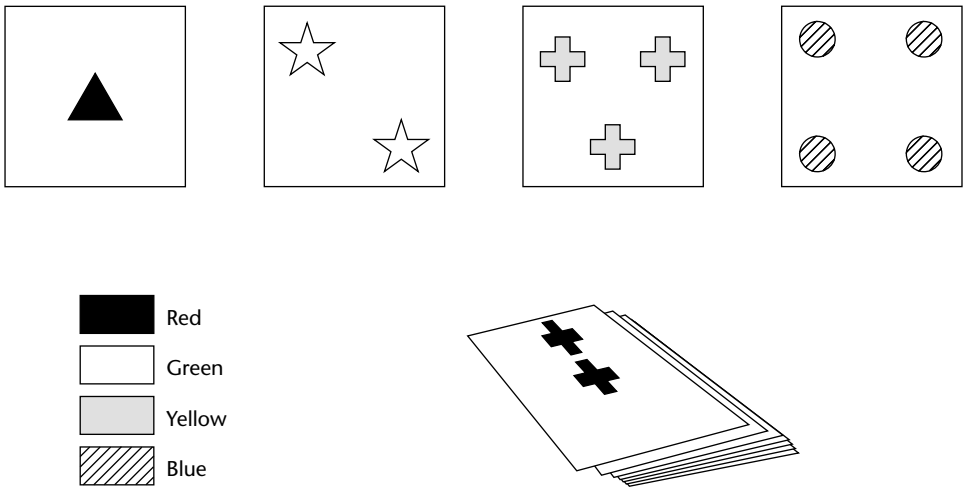

FIGURE 18-3 The Wisconsin Card Sorting Test

SOURCE: From *Neuropsychological Assessment*, 3rd edition, by Muriel Deutsch Lezak, p. 621. Copyright © 1995 by Oxford University Press, Inc.

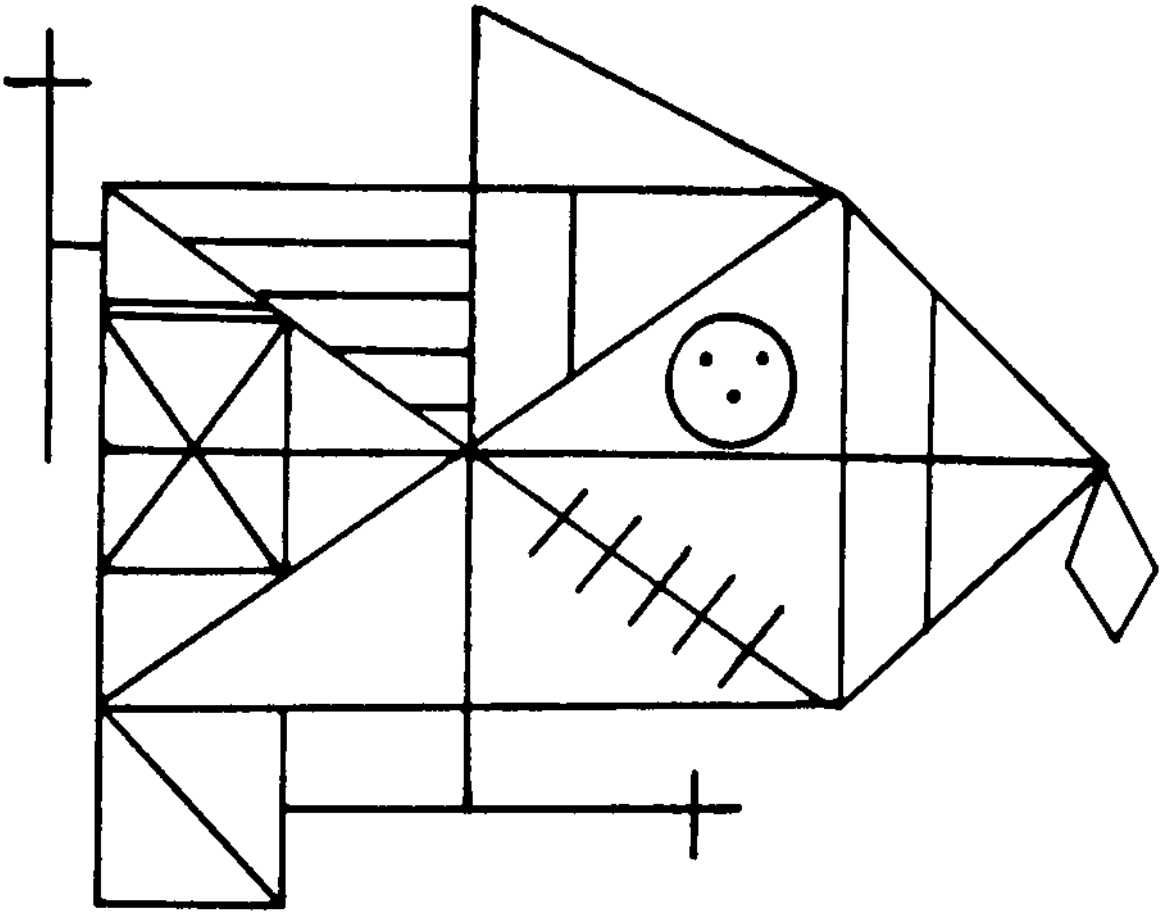

FIGURE 18-4 Rey-Osterrieth complex figure

SOURCE: From *Neuropsychological Assessment*, 3rd edition, by Muriel Deutsch Lezak, p. 570. Copyright © 1995 by Oxford University Press, Inc. Reprinted by permission.

The Rey-Osterrieth Complex Figure Test (Lezak, Howieson, & Loring, 2004) is used by many neuropsychologists to assess visual-spatial memory. Patients first copy a complex figure, then draw it from memory immediately, and then draw it again after a specified period of time. Thus, this test can assess how the figure was initially processed (immediate copy), and comparisons can be made between subsequent copies under different recall conditions (Kramer & Delis, 1997). Further, because the figure is characterized by both larger configural features (e.g., a large triangle) and smaller internal details (dots, small hash marks), differentiations can be made between those with right- versus left-hemisphere damage (Lezak et al., 2004). Different scoring systems and normative data across a broad range of ages are available (Kramer & Delis, 1997). Figure 18-4 presents the Rey-Osterrieth Complex Figure.

Visual-Perceptual Processing. Visual-spatial skills are necessary for a broad range of activities, including reading a map, parallel parking a car, and throwing a baseball from the outfield to a base. In addition to the Rey-Osterrieth Complex Figure Test, many neuropsychologists seeking to assess visual-spatial skills examine performance on

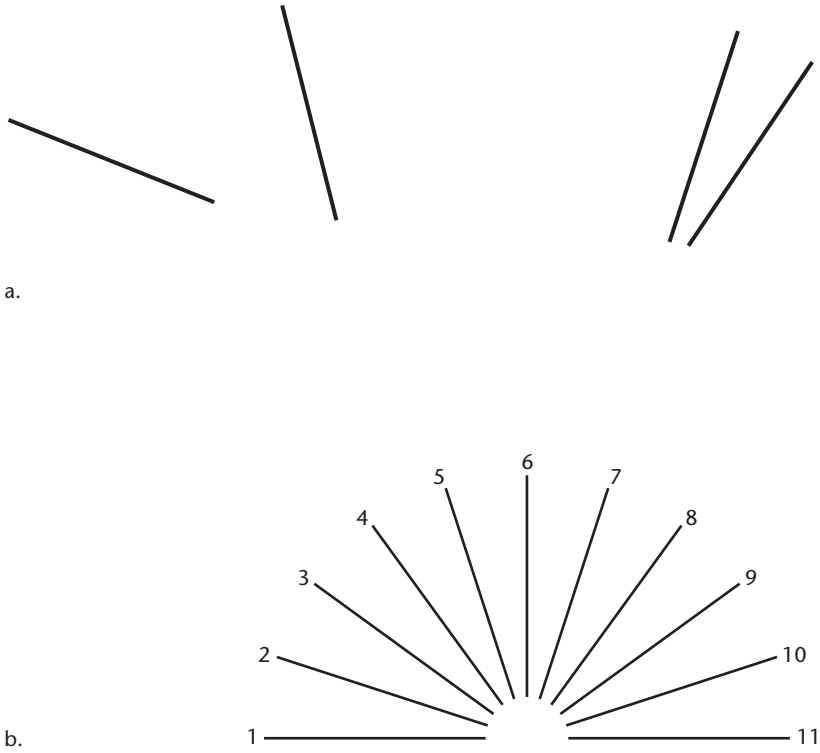

FIGURE 18-5 Sample items from the Judgment of Line Orientation Test

SOURCE: From *Neuropsychological Assessment*, 3rd edition, by Muriel Deutsch Lezak, p. 400. Copyright © 1995 by Oxford University Press, Inc.

certain WAIS-IV subtests, such as the Block Design subtest. Several specialized tests of these skills are also available. For example, the Judgment of Line Orientation Test (Benton, Hamsher, Varney, & Spreen, 1983) requires examinees to indicate the pair of lines on a response card that "match" (lie in the same orientation as) the two lines on the stimulus card. Figure 18-5 provides examples of items from this test.

Language Functioning. Various forms of brain injury or trauma can affect either the production or comprehension of language. Tests that require patients to repeat words, phrases, and sentences can assess articulation difficulties and paraphasias (word substitutions); naming tests can help diagnose anomias (impaired naming). Language comprehension can be assessed using the Receptive Speech Scale of the Luria-Nebraska (described in the following section). This subtest requires patients to respond to verbal commands (as by pointing to named body parts or objects or responding to simple commands). Speech and language pathologists do an excellent job of comprehensively assessing language dysfunction, and the neuropsychologist may choose to refer patients to these health professionals if a screening test indicates suspected problems in language production or comprehension.

Test Batteries

Let us now examine two commonly used neuropsychological test batteries: the Halstead-Reitan and the Luria-Nebraska.

The Halstead-Reitan Battery. To counter the criticism that single tests for brain dysfunction were too limited in their scope to provide definitive

answers, the *Halstead-Reitan Neuropsychological Battery* was developed (Halstead, 1947; Reitan & Davison, 1974). This is now undoubtedly the most widely used test battery. The battery, as generally used, consists of several measures: the Category Test, the Seashore Rhythm Test, the Finger Oscillation Test, the Speech-Sounds Perception Test, the Tactile Performance Test, the Trail-Making Test, the Strength of Grip Test, the Sensory-Perceptual Examination, the Finger Localization Test, the Fingertip Number Writing Perception Test, the Tactile Form Recognition Test, and the Aphasia Screening Test. These tests may be supplemented by the MMPI-2 and the WAIS-IV. The scale can be used with people aged 15 years and older; other versions can be used with children ages 9 to 14 and 5 to 8.

The Halstead-Reitan battery is used to provide information about the probable localization of lesions and whether they appear to be of gradual or sudden onset. It also suggests something about specific psychological deficits that a therapist should note. The battery can take more than 6 hours to administer. Many clinics have trained technicians to do this work so that clinicians are not bogged down in lengthy procedures of administration and can concentrate instead on the complexities of interpretation.

Both the validity and the reliability of the Halstead-Reitan are supported by a number of studies across a wide range of age groups (e.g., Goldstein, 1997). The major weaknesses of the test battery are its length, cumbersomeness, and relative neglect of certain areas of functioning, such as memory (Goldstein, 1997; Lezak et al., 2004). A brief case report summary based on the Halstead-Reitan and other tests is shown in Box 18-3.

The Luria-Nebraska Battery. As an alternative to the Halstead-Reitan, the *Luria-Nebraska battery* consists of 269 separate tasks comprising 11 subtests:

BOX 18-3 Focus on Clinical Applications: A Brief Neuropsychological Report Based on Halstead-Reitan and Other Information

Name: Mr. Y.
Date of Birth: 8-29-26
Occupation: Retired Air Force Pilot–USAF
Education: 18 Years (Master's Degree)

Referral Information

Mr. Y. is a 57-year-old white male who is retired from the United States Air Force. For the past several years he has noticed a decline in his perception, mechanical abilities, reaction time, driving abilities, and ability to read and produce cursive handwriting. He reports that the symptoms have been especially pronounced over the past two to three years. Dr. ——— requested a neuropsychological evaluation in order to evaluate the presence and/or extent of organic impairment.

Summary and Recommendations

1. Neuropsychological assessment reveals severe impairment in several areas of functioning, such as severe constructional difficulties and problems on all tasks requiring nonverbal and visual-spatial abilities, including memory for visual information. These areas of deficit point to a pathological process in the right parietal-occipital area of the brain. The possibility of major structural damage in this area should be investigated thoroughly.
2. Mr. Y.'s verbal abilities as well as verbal memory have been preserved and are, in general, in the superior range.
3. Personality assessment reveals that Mr. Y. is suffering from a moderate depression accompanied by worry and rumination. This appears to be of a rather long-standing nature rather than being an acute emotional reaction.
4. The patient's neuropsychological deficits cannot be attributed to his depression.
5. In light of our findings, a careful review of the patient's capabilities both at work and at home should be made with him and his wife.
6. As this information is worked through, supportive psychotherapy would be helpful.
7. A current neurological reevaluation is recommended.

SOURCE: From "Overview of the Halstead-Reitan Battery," by O. A. Parsons, pp. 179–180. In T. Incagndi, G. Goldstein, and C. J. Golden (Eds.), *Clinical Application of Neuropsychological Test Batteries.* Copyright © 1986 by Plenum Publishing Corporation. Reprinted by permission.

motor functions, rhythm functions, tactile functions, visual functions, receptive speech, expressive speech, writing functions, reading skills, arithmetic skills, memory, and intellectual processes. Studies assessing the battery's reliability and diagnostic validity have been supportive (e.g., Golden, Hammeke, & Purisch, 1978; Golden, Purisch, & Hammeke, 1985). The Luria-Nebraska shows substantial agreement with results obtained from the Halstead-Reitan method (Goldstein & Shelly, 1984; Kane, Parsons, Goldstein, & Moses, 1987; Sears, Hirt, & Hall, 1984). A children's version performed as well as the WISC-R in discriminating psychiatric and neurological cases (Carr, Sweet, & Rossini, 1986) and was also able to reliably diagnose attention deficit disorders in children (Lahey, Hynd, Stone, Piacentini, & Frick, 1989).

The main advantage of the Luria-Nebraska is that it takes only about 2.5 hours to complete, compared with the 6 hours sometimes required to complete the Halstead-Reitan battery. However, some clinical neuropsychologists believe that the Luria-Nebraska is limited because of its standardization and rationale (Goldstein, 1997). Specifically, many of the reliability and validity studies are based on small numbers of patients, and some critics feel that the Luria-Nebraska does not adequately translate A. R. Luria's theories and methods into a neuropsychological assessment instrument (Lezak et al., 2004).

Variables That Affect Performance on Neuropsychological Tests

A number of patient variables may influence neuropsychological test scores (Howieson & Lezak, 2010). Because test scores differ according to the biological sex, age, and educational level of the patient, appropriate norms should be used in interpretation. In addition, test scores will be influenced by handedness, by premorbid ability (before brain trauma or injury), by the chronicity of the neurological condition, and by the presence of other (nonneurological) physical conditions (e.g., a peripheral arm injury might affect performance on the Strength of Grip test of the Halstead-Reitan battery). Finally, motivational variables (arousal, level of cooperation) will also affect scores. For example, a patient who is taking medication that has a sedative effect will probably not be able to perform optimally.

A motivational variable that deserves additional comment is *malingering*. Detecting faking or malingering on psychological tests can be difficult for even the most astute clinician. There is controversy about how often malingering occurs in neuropsychological assessment. Recognizing that it may occur and improving clinicians' abilities to detect it are both very important, especially given the clinician's growing presence as an expert witness in court cases of various kinds (see Chapter 19). Several approaches have been suggested to address malingering on neuropsychological tests, ranging from the development and use of an objective malingering index (Reitan & Wolfson, 1996) to the use of strategies to evaluate test scores (Rogers, Harrell, & Liff, 1993). For example, Rogers et al. (1993) suggest that failure of very easy test items, differential performance on difficult versus easy test items, and below-chance performance on alternative-choice test items should raise suspicions of malingering.

INTERVENTION AND REHABILITATION

Issues of neurological impairment usually revolve around two principal questions. First, what is the nature of the deterioration or damage? For example, is it a perceptual loss or a cognitive loss? Second, is there any real brain damage that can account in some way for the patient's behavior? More specifically, is the damage permanent, or can recovery be expected after an acute phase? Is the damage focal or diffused throughout the brain? In general, focal damage results in more specific, limited effects on behavior, whereas diffuse damage can cause wide effects. Referral sources often need to know whether the damage will be progressive (as in diffuse brain involvement or in damage caused by

BOX 18-4 Graduate Student Perspective: Andrew Wegrzyn

Andrew Wegrzyn earned his B.S. from the University of Illinois at Champaign-Urbana in 2007, where he completed his honors thesis with Professor Ed Diener on declining marginal utility and the nature of satisfaction. More recently, Andrew has worked as a research coordinator in the Department of Neurology at the Washington University School of Medicine. Andrew joined the Clinical Neuropsychology Lab at the University of Missouri in the fall of 2010. His graduate research focuses on neurodevelopment and neuroanatomy in autism spectrum disorders through behavioral techniques as well as functional and structural imaging.

Andrew provided his thoughts about his graduate school experience.

What has graduate school in clinical psychology been like for you?

Graduate school thus far has been an opportunity to refine my research skills, contribute to the field, and discern my future role as a psychologist. The main thing graduate school has been for me is an opportunity to explore the field and find where I will ultimately fit within it.

What things have you least expected about graduate school?

I don't think I anticipated or planned adequately for the sheer number of hours that are required to be successful in graduate school. I was told by various individuals that the time commitment was about 55–60 hours per week. However, I've found the real number of hours to be closer to 70–75 hours per week. Different advisors have different policies and strategies when it comes to hours in class and in the lab. But, in order to be successful, especially in research, the time commitment required is substantial.

Has graduate school changed you? If yes, how so?

Yes, graduate school has given me a much clearer view of what I want to do with my life. There are ways to view what life as a clinical psychologist might be like as an undergraduate: internships, shadowing a professional, talking with a professor, etc. But, there are certain things you won't be able to learn until graduate school. Personally, graduate school has forced me, so to speak, to be more efficient and considerate with my time as well as more disciplined.

Are your professional or research interests similar or different now than they were when you started graduate school?

Essentially, my research interests are the same. However, it is crucial for those hoping to enter graduate school and those just starting graduate school to realize that their research interests operate within a frame of reality. Your actual research practices in graduate school, and perhaps beyond, will be mitigated by many factors: what can and cannot be funded, your advisor's interests, your need to publish, the time you have, and even the realm of what is possible. My interests are in neuroimaging with persons with autism spectrum disorders. And, while thus far I have been fortunate enough to engage in research in these areas, for the most part, I also have had to adapt to the forces around me.

Tell us about the work you have conducted in neuropsychology and neuroscience while in graduate school.

Thus far, I have worked on an imaging project with traumatic brain injury (TBI) patients and MRI in which we were trying to discern which areas of the brain influence spirituality and altruism. My own research

disease) or nonprogressive (as is often true in the case of strokes or head traumas). Answers provided by clinical neuropsychologists significantly affect the kinds of rehabilitation programs designed for various patients.

Rehabilitation is becoming one of the major functions of neuropsychologists (Boake, 2008; Zillmer et al., 2008). The neuropsychologist is often thrust into the role of coordinating the cognitive and behavioral treatment of patients who have shown cognitive and behavioral impairment as a result of brain dysfunction or injury. First, a thorough assessment of the patient's strengths and deficits is conducted; this may include not only neuropsychological test results but also observations from other staff members, such as nurses, physicians, and physical therapists. A program of rehabilitation is then developed that will be maximally beneficial to the patient,

deals in autism spectrum disorders and movement deficiencies, specifically motor learning deficits. We are hoping to pair behavioral motor data with diffusion tensor imaging (DTI) to investigate the motor pathways in the brain and learn more about how persons with autism spectrum disorders may differ from neurotypicals.

Looking back, what activities or experiences were the most important in preparing you for your graduate school program?
Research experience is crucial. I worked for three professors as an undergrad; one of which, Dr. Ed Diener, I worked with for three-and-a-half years. After graduation, I worked for a year as a research assistant at the Washington University School of Medicine in St. Louis—a stellar location for exciting research. The application process for graduate school is becoming increasingly competitive in psychology. Advisors are looking for applicants who are versed in the nuts and bolts of research and publication. However, I apply to the theory that other nonacademic experiences are incredibly valuable as well. I volunteered for a year in the Appalachian Mountains after graduation and also worked at a winery. While some advisors place more value on nonresearch activities than others, it's beneficial to not be entirely one-dimensional.

Any additional hints for those trying to make it through graduate school in clinical psychology?
Regarding long-term goals, keep your focus on how your training is preparing you for the career you want. Regarding the short term, be efficient with the use of your time (you might want to think about quitting Facebook, for example …). It's important to look forward into the future on a fairly regular basis, but when it comes to the day to day, try to keep your attention focused on the present. In many ways, graduate school is like a marathon. If you find yourself looking to mile 26 when you have just crossed the starting line, you're sure to be overwhelmed and see graduate school as an insurmountable task reserved only for geniuses. But, if you focus on putting your best foot forward, in any way you are able, for all of your daily tasks, you will gradually build skills and confidence.

Andrew Wegrzyn

Andrew Wegrzyn

given her or his deficits, as well as one that will be efficient in the sense of requiring a minimum amount of staff time and supervision (Zillmer et al., 2008).

As noted by Golden et al. (1992), rehabilitation can take place through spontaneous recovery of functioning. However, the neuropsychologist and the rehabilitation team are more likely to be involved when rehabilitation is to be accomplished by having the patient "relearn" via developmentally older and intact functional systems, the development of new functional systems, or changing the environment to ensure the best quality of life possible. In this last case, the judgment may be that it will not be possible to develop alternative or new functional systems that will significantly reduce the level of cognitive or behavioral impairment.

In the case of developing alternative or new functional systems, rehabilitation tasks are formulated

BOX 18-5 Focus on Professional Issues: Cross-cultural Neuropsychology

Neuropsychologists are becoming increasingly sensitive to the possibility that normative data for traditional neuropsychological tests may not apply to individuals from different ethnic or cultural backgrounds. The field of cross-cultural neuropsychology seeks to identify differences in neuropsychological performance that may be at least partially due to differences in ethnic or cultural backgrounds. Neuropsychological tests may have tasks or items that are at least partially influenced by culturally learned abilities, and these tests have typically been standardized using individuals who are native English speakers and Caucasian, for example. Given the increasing diversity in the United States and other countries, the field of neuropsychology is being faced with the challenge of demonstrating that the interpretation of neuropsychological test scores is appropriate for individuals from diverse language and cultural backgrounds.

But how do we know if test results are "biased" against certain cultural groups? Pedrazza and Mungus (2008) remind us that simply showing mean differences in scores on tests is not, in and of itself, sufficient to demonstrate bias. Rather, evidence for bias is obtained if a test score has a significantly different meaning for one cultural group versus another. This can be assessed in different ways including making sure the similar cognitive abilities are being assessed in different cultural groups using the same tests, as well as ensuring that test scores predict relevant outcomes (e.g., diagnosis of brain injury) with equal strength regardless of an individual's cultural background. In the absence of such evidence, it is necessary to adapt or modify tests to accommodate cultural and language diversity so that persons from all backgrounds can profit from clinical neuropsychological services (Boake, 2008).

to "treat" the patient's deficits. Golden et al. (1992, pp. 214–215) offer the following general guidelines for formulating this type of rehabilitation task:

1. It should include the impaired skill that one is trying to reformulate. All other skill requirements in the task should be in areas with which the subject has little or no trouble.
2. The therapist should be able to vary the task in difficulty from a level that would be simple for the patient to a level representing normal performance.
3. The task should be quantifiable, so that progress can be objectively stated.
4. The task should provide immediate feedback to the patient.
5. The number of errors made by the patient should be controlled.

Golden and colleagues (1992) give examples of rehabilitation programs for various cognitive and behavioral deficits. For example, verbal memory impairment might be treated by administering simple memory problems (those involving one unit of information) to the patient and then, later, more complex tasks (e.g., a problem requiring the memorization of six or seven units of information). The complexity of the task can be varied further by, for example, using unrelated words or decreasing the time of exposure to the stimulus words.

More recently, Wilson (2008) has argued that rehabilitation programs should incorporate several components to increase the likelihood of success. First, in collaboration with the patient goal setting at the beginning and periodic evaluation of goals throughout the rehabilitation program should be conducted. Second, the link between cognitive, emotional, and physical deficits due to brain injury must be explored and incorporated into more "holistic" approaches to rehabilitation. Finally, rehabilitation psychologists should take advantage of recent advances in technology, including the use of electronic diaries and pagers that can prompt individuals to use cognitive skills as well as the use of virtual reality to simulate real-life experience for both assessment and treatment.

CONCLUDING REMARKS

Training

Without doubt, neuropsychology as a specialty area within clinical psychology is dynamic and exciting. At the same time, however, the procedures in this subfield have become so sophisticated that specialty training is necessary (Boake, 2008).

Some clinical psychologists do not feel very comfortable doing neuropsychological assessment, nor are they qualified. Their training in such assessment is often limited, as is their knowledge of brain–behavior relationships. As Lezak and colleagues (2004) point out, the success of any neuropsychological assessment will depend on how well examiners understand not only normal brain–behavior relationships but also the psychological effects of brain dysfunction. Therefore, experts are needed. Reitan and Davison (1974) some time ago remarked on the necessity for developing a new field of clinical neuropsychology. Clinical neuropsychology is now a specialty that is formally recognized by both the American Psychological Association and the Canadian Psychological Association (Boake, 2008).

The September 1997 *Houston Conference* convened leaders involved in the training of future clinical neuropsychologists. Guidelines for the graduate (doctoral) internship and postdoctoral training of future clinical neuropsychologists were offered. Briefly, these guidelines recommend a Ph.D. from a graduate program with a specialty track in clinical neuropsychology. As a required knowledge base, the Houston Conference recommended (a) a generic psychology core (statistics, learning, social psychology, physiological psychology, developmental psychology, history); (b) a generic clinical core (psychopathology, psychometrics, assessment, intervention, ethics); (c) neurosciences and basic human and animal neuropsychology (functional neuroanatomy, neurodiagnostic techniques, neurochemistry, neuropsychology of behavior); and (d) specific clinical neuropsychological training (research design in neuropsychology, specialized neuropsychological assessment techniques, specialized neuropsychological intervention techniques). Further, the conference recommended that skills be acquired in assessment, treatment and interventions, consultation, research, and teaching and supervision. Knowledge and skills in these areas can be acquired and mastered through coursework, supervised experience, internship experience, and a required 2-year residency/postdoctoral training. Those completing such a rigorous training experience in clinical neuropsychology should, at the end of their training, be able to demonstrate advanced skill in neuropsychological assessment, treatment, and consultation and should be eligible for board certification in clinical neuropsychology by the American Board of Professional Psychology.

The Future

In the future, neuropsychology may hope for the development of increasingly more sophisticated individual tests and batteries. Better assessment devices and procedures, including enhanced provisions for planning, therapy, and rehabilitation for patients with brain dysfunction, are highly desirable. Assessment obviously means more than pinning labels on people; it is meant to enable clinicians to help the patient adjust to the future. In particular, then, the field must concern itself more with predicting and facilitating recovery from brain injury. Fortunately, this is exactly what is beginning to happen. Training procedures that help foster rehabilitation, tests that predict the extent and rate of recovery, and general information on the course of debilitating injury can offer hope and structure to patients and their families. Even bad news, offered sensitively and constructively, can facilitate adjustment.

Almost two decades ago, Johnstone and Frank (1995) urged more neuropsychologists to shift their focus to rehabilitation. Although the need for rehabilitation services has increased over the years, relatively few neuropsychologists have received specific training in rehabilitation. Moreover, traditional neuropsychological tests have not generally been used (or adapted) to provide information that is clinically useful to rehabilitation specialists. Johnstone and Frank argue, for example, that many important cognitive abilities (e.g., attention, executive functions, and memory) are poorly understood and poorly measured. In their view, neuropsychological test results need to be clearly tied (via empirical research) to real-world functions so that rehabilitation can address deficits or impairments that, if improved, will lead to positive outcomes. If heeded, these suggestions will likely affect research, training, and clinical applications in the field of neuropsychology.

Changes in the way that health care is delivered and reimbursed will also have a great impact on the field of neuropsychology. Neuropsychological assessment may no longer be routinely conducted when

BOX 18-6 Clinical Psychologist Perspective: Paula Zuffante, Ph.D.

Dr. Paula Zuffante is a pediatric neuropsychologist. She completed her graduate training in clinical psychology with a specialty in neuropsychology at the University of Florida in Gainesville. She completed a 1-year clinical internship in neuropsychology at Brown University and a 2-year postdoctoral fellowship in clinical neuroimaging and neuroscience at Long Island Jewish Medical Center. Her doctoral research focused on structural magnetic resonance imaging and cognitive functioning in schizophrenia and functional magnetic resonance imaging of auditory processing and working memory. Dr. Zuffante's first postgraduate job was at Schneider Children's Hospital at Long Island Jewish Medical Center, where she helped to establish the pediatric neuropsychology program. While there, she continued her work as a researcher, clinician, and educator. In 2002, she moved to the Albany, New York area, where she started a private practice, Children's Neuropsychological Services.

We asked Dr. Zuffante about her background and interests, as well as her take on the future of clinical psychology and neuropsychology.

What originally got you interested in the field of clinical psychology?

I became interested in psychology in college when I took classes on physiological psychology and sensation and perception. I was fascinated by optical illusions, brain development, and cognition. I decided to complete an independent study in physiological psychology. I had the good fortune to work as a research assistant to a physiological psychologist, Dr. Michael Numan, who was studying the neurological mechanisms of maternal behavior in rats. I learned about stereotactic surgery and functional neuroanatomy. I also worked as research assistant to another psychologist, Dr. Randolph Easton, who was studying how mental practice facilitates athletic performance. Through these experiences, I generated an enthusiasm for studying the brain, which led me to seek a position in the Memory Disorders Research Center at the Boston VA Medical Center after graduating from college. I was there for 2 years working as a research assistant to Drs. Laird Cermak and Mieke Verfaellie, who were studying memory disorders in neurologic conditions such as alcoholic Korsakoff syndrome and encephalitis. I was able to see firsthand how these patients forgot their experiences from moment to moment while maintaining intact attention/working memory and intellectual abilities. I also learned about agnosia, working with a man who was able to copy a picture of an object but, despite having intact intellectual abilities, could not tell me anything about what he drew; he was not able to access the name of it or any semantic knowledge about it. I was in awe of the way the brain works and of the researchers who so elegantly demonstrated what was happening in the brains of their patients. It was the combination of these experiences that led me to pursue a Ph.D. in clinical neuropsychology.

Describe what activities you are involved in as a clinical psychologist.

Currently, I share a private practice, Children's Neuropsychological Services, with my husband, Dr. Andrew Labarge, who is also a neuropsychologist. I conduct neuropsychological evaluations of children with known or suspected brain injuries, learning disabilities, developmental conditions, and psychiatric conditions. I also conduct diagnostic autism spectrum evaluations. Most of the children I evaluate have difficulty with learning or behavioral regulation resulting from or related to their condition. My neuropsychological evaluations often extend to the classroom, which I visit to observe how the child functions in the world and to see how my evaluation findings play out in real life. I consult with physicians regarding treatment planning and with educational teams regarding academic planning. I also consult with schools on remediating executive dysfunction in the classroom.

What are your particular areas of expertise or interest?

I have strong interests and experience in working with individuals with autism spectrum disorders and disorders involving frontal-striatal circuits such as attention deficit hyperactivity disorder, Tourette's syndrome, and obsessive-compulsive disorder. I have always been interested in executive functions, which are impacted in all of the above conditions. I am interested in helping families and schools apply effective interventions to remediate executive deficits.

brain–behavior issues are raised, nor is it likely that it will be routinely reimbursed. Rather, neuropsychological assessment is likely to be seen by managed care companies as a luxury—to be conducted only when absolutely necessary. This may be why fewer and fewer neuropsychologists report administering neuropsychological batteries (e.g., the Halstead–Reitan) routinely, instead using a more efficient and focused flexible approach to testing (Boarke, 2008). Finally, neuropsychologists are now more

What are the future trends you see for clinical psychology?

Our understanding of the brain is still young, but it is expanding rapidly. As we develop more precise tools for examining brain–behavior relationships and as new treatments are developed, neuropsychology will play an even greater role in the diagnosis and treatment of neurological, developmental, and psychiatric conditions.

The tools that we have to study functional neuroanatomy and brain disorders are becoming more sophisticated over time. Neuropsychologists have been working closely with other neuroscientists to develop cognitive-behavioral tests and structural and functional neuroimaging techniques that target specific cognitive skills and behaviors. These methods are increasingly being used to help diagnose various brain conditions and to assess response to treatment. I anticipate that in the near future, they will play even greater roles in diagnosis and treatment for a variety of neurologic, developmental, and psychiatric conditions.

More and more neuropsychologists are starting to provide direct treatment of cognitive dysfunction, and they are extending their treatments into classrooms and homes. Unfortunately, there are few well-controlled studies that demonstrate the efficacy of available treatment options. It will be important for our field to continue to conduct well-designed studies to increase the pool of effective research-based treatment options. I anticipate that clinical researchers and educators will develop more effective behavioral interventions for cognitive deficits and executive dysfunction in particular.

What do you enjoy most about a career in neuropsychology?

I enjoy the field of neuropsychology because it is evolving so quickly. I started graduate school at the start of the Decade of the Brain in 1990, and I have been amazed by the huge scientific leaps that our field has made since then. I have enjoyed watching our field evolve from one that used to make distinctions between neurologic or so-called organic conditions and those that are considered "psychological" to one that recognizes common underlying neurological mechanisms between different conditions, whether they are acquired or developmental. Nonetheless, there is still much more to learn about the brain and I am excited to be part of the generation that will be unlocking so many of the brain's mysteries.

Another reason I enjoy my career in neuropsychology is that I greatly enjoy working with children, not only because they are fun but because there is such a huge range of skills, behaviors, and personalities in the children I see every day. I am continually learning new things about brain development just by interacting with children and watching how they interact with the world and test materials. I often feel like I am back at the Boston VA as an investigator, analyzing cognitive functions and deficits, trying to understand how it all fits with functional neuroanatomy and brain development. It really never gets old for me. I am still in awe.

Paula Zuffante

Paula Zuffante

likely to specialize in the fields of forensic neuropsychology (e.g., assessing for brain injury in civil or criminal cases), sports neuropsychology (e.g., evaluating the effects of sports-related concussions), and military neuropsychology (e.g., assessing for traumatic brain injury), to name a few of the emerging areas of application (Zillmer et al., 2010). Trends such as these suggest that the demand for the services of neuropsychologists will continue to be in high in the future.

CHAPTER SUMMARY

The field of neuropsychology has witnessed tremendous growth over the past several decades. Neuropsychology is the study of the relations between brain function and behavior. Neuropsychologists are called on to consult with neurologists or other physicians to assess functioning, to make predictions regarding prognosis and course, and to plan interventions and rehabilitation. Models of brain functioning have evolved from localization of function to equipotentiality and, finally, to the functional model. The functional model holds that different areas of the brain interact to produce behavior and that behavior is a result of several different functional systems of brain areas.

We have briefly reviewed the major structures of the brain, a number of antecedents or causes of brain damage, and various consequences of neurological damage. Neuropsychological assessment involves the use of noninvasive standardized testing methods that are sensitive to various forms of brain functioning. A critical distinction is that between the standard (or fixed) battery approach, in which a standard set of tests is given to all patients regardless of the clinical picture, and the flexible (or hypothesis-testing) approach, in which only selected tests are administered. Major areas of functioning that are targeted by neuropsychologists include intellectual functioning, abstract reasoning, memory, visual-perceptual processing, and language functioning. Neurodiagnostic tests may also be used to diagnose problems. A clinical neuropsychologist's evaluation can then be used to formulate and implement a plan of intervention or rehabilitation tailored to the individual patient. The program of rehabilitation should be maximally beneficial to the patient and efficient in terms of staff time and supervision.

Specialty training in clinical neuropsychology is necessary because of the complexity and sophistication of the procedures involved. Most graduate programs are not able to devote sufficient time, coursework, and practicum experience to the study of brain–behavior relationships. Therefore, an integrated model for the training of clinical neuropsychologists has been adopted that includes predoctoral, internship, and postdoctoral experiences. Many challenges lie ahead for the field, including the need for more sophisticated and more economical assessment and rehabilitative techniques, as well as a tightening in the job market as a result of managed care.

KEY TERMS

agnosia Impairment in sensory perception.

aphasia Impairment in language ability.

apraxia Impairment in the ability to perform certain voluntary movements.

cerebellum A subcortical structure associated with motor coordination and the control of muscle tone, posture, and equilibrium.

cerebral hemorrhage A situation in which a blood vessel ruptures and the blood escapes onto brain tissue, either damaging or destroying it. The symptoms of a hemorrhage are determined by its site and severity.

concussion Jarring of the brain sufficient to result in a momentary disruption of brain function. A single concussion usually does not cause permanent damage, but repeated ones may.

contusions Bruises. In the brain, contusions result when the brain has been shifted from its normal position and pressed against the skull. Brain contusions may be severe and may result in delirious or comatose states.

degenerative disease A group of disorders—such as Alzheimer's disease, Parkinson's disease, and Huntington's chorea—that result from the degeneration of neurons in the central nervous system. These disorders are characterized by progressive cerebral degeneration and disturbance in several behaviors or functions.

delirium A disruption of consciousness often caused by exposure to toxins.

difference scores A method for interpreting neuropsychological test data that focuses on the difference between a patient's scores on two separate tests. Difference scores above a certain level are suggestive of impairment.

equipotentiality The notion that the cortex functions as a whole and that all areas of the brain contribute equally to overall intellectual functioning. On the basis of this perspective, when one area of cortex is damaged, the functions of that area may be assumed by another area of cortex.

frontal lobes The most recently developed part of the human brain. The frontal lobes are associated with executive functions such as formulating, planning, and carrying out goal-directed behavior, monitoring and controlling behavior, and modulating emotions.

functional model A theory that integrates the localization-of-function and equipotentiality perspectives. This theory holds that any behavior is due to the interaction of several brain systems and that the nature of a behavioral deficit will depend on which functional system is affected as well as the localization of damage within that functional system.

Halstead-Reitan battery The most widely used neuropsychological test battery. The Halstead-Reitan consists of several measures and is used to provide data about specific deficits, the probable localization of lesions, and whether lesions appear to be of gradual or sudden onset. Although the reliability and validity of this battery have been supported, a significant disadvantage is the time required for administration.

Houston Conference A conference on clinical neuropsychology training that convened in September 1997. As a result of this conference, specific guidelines were offered for the graduate training, predoctoral internship, and postdoctoral training of future clinical neuropsychologists.

lacerations Cuts, tears, or ruptures. Lacerations of brain tissue may occur when the skull has been breached by a bullet or other object.

left hemisphere The hemisphere of the brain that controls the right side of the body and for most people is more involved in the language functions, logical inference, and detail analysis.

localization of function The idea that certain portions of the brain are responsible for specific functions or behaviors.

Luria-Nebraska battery A neuropsychological test battery that assesses abilities over 11 subtest groupings. Studies have supported the reliability and diagnostic validity of the battery, which takes less time to administer than the Halstead-Reitan.

neurodiagnostic procedures Procedures (e.g., spinal taps, CAT scans, and functional MRIs) for detecting the presence and location of brain damage. These procedures vary in their expense, their sensitivity, their invasiveness, and the risk they pose to the patient.

neuropsychological assessment The assessment of brain functioning based on a person's performance on noninvasive, standardized tests that are believed to be accurate and sensitive indicators of brain–behavior relationships.

neuropsychology The study of the relationship between brain function and behavior. Neuropsychologists study, assess, and/or treat behaviors directly related to the functioning of the brain.

occipital lobes The portion of the cortex involved with visual processing and some aspects of visually mediated memory.

occlusions Blockages in blood vessels caused by clots. The vessels serving particular areas of the brain may become occluded, resulting in one type of "stroke."

parietal lobes The portion of the cortex related to tactile and kinesthetic perception and understanding, spatial perception, and some language comprehension and processing.

pathognomonic Indicative of a specific disease or condition. One method for interpreting neuropsychological test data notes and draws inferences about pathognomonic signs.

pattern analysis A method of neuropsychological test interpretation in which the basic pattern of scores on tests is examined to see whether it matches a pattern that has been reliably associated with a specific neurological injury or impairment.

process/flexible approach or hypothesis-testing approach In this approach, the neuropsychologist selects the tests to be administered to each patient based on his or her hypotheses about the case and may even alter the administration of one or more tests.

rehabilitation In the context of neuropsychology, the treatment of patients with cognitive and behavioral impairment due to brain dysfunction or injury. Rehabilitation may involve helping the patient "relearn" skills and/or changing the patient's environment to best compensate for the impairment. Rehabilitation planning/coordination is a major function of neuropsychologists.

right hemisphere The hemisphere of the brain that controls the left side of the body and for most people is more involved in visual-spatial skills, the perception of direction, creativity, and musical activities.

standard battery *or* fixed battery approach. In this approach, all referred patients are administered the same set of neuropsychological tests.

temporal lobes The portion of the cortex that mediates linguistic expression, reception, and analysis and is involved in processing tones, sounds, rhythms, and meanings that are nonlanguage in nature.

tumors Abnormal tissue growths that may grow inside or outside the brain or spread to the brain from other areas of the body. Symptoms are usually subtle at first and become more noticeable as the tumor grows and exerts pressure on surrounding areas of the brain.

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

18-1 Division 40 of APA—Clinical Neuropsychology
http://www.div40.org/

18-2 Training Programs in Clinical Neuropsychology (doctoral, internship, postdoctoral)
http://www.div40.org/training/index.html

18-3 Neuropsychology Central
http://www.neuropsychologycentral.com/

18-4 The Whole Brain Atlas
http://www.med.harvard.edu/aanlib/home.html

19

Forensic Psychology

FOCUS QUESTIONS

1. What historical events influenced the development of the forensic psychology specialty?
2. What are the major roles engaged in by forensic psychologists?
3. What are the similarities and differences among the three major legal standards of insanity?
4. What role might a clinical psychologist play in a child custody decision?
5. How might a forensic psychologist contribute to the following processes: jury selection, preparing a witness, aiding an attorney who will cross-examine an eyewitness?

CHAPTER OUTLINE

Perspectives and History
- Definitions
- History
- BOX 19-1: *Focus on Professional Issues: Munsterberg on Trial*
- Professional Issues

Some Major Activities of Forensic Psychologists
- The Expert Witness
- Criminal Cases
- BOX 19-2: *Clinical Psychologist Perspective: David DeMatteo, J.D., Ph.D.*
- Civil Cases
- Rights of Patients
- Predicting Dangerousness
- BOX 19-3: *Focus on Clinical Applications: Legal Controversies: Forcible Medication*
- Psychological Treatment
- Consultation
- BOX 19-4: *Clinical Psychologist Perspective: Marina Tolou-Shams, Ph.D.*
- Research and Forensic Psychology
- BOX 19-5: *Graduate Student Perspective: Lizzy Foster*

CHAPTER SUMMARY

KEY TERMS

WEB SITES OF INTEREST

Because clinical psychologists are said to be "experts" in human behavior, it is not surprising that some of them would begin to specialize in the application of psychological knowledge to the problems that face judges, attorneys, police officials, and indeed, anyone who must face or deal with issues related to civil, criminal, or administrative justice—victims and violators alike. This domain of clinical psychology, now called *forensic psychology*, underwent a highly visible growth spurt in the 1970s, and it continues to thrive (DeMatteo, Marczyk, Krauss, & Burl, 2009). It has gained all the trappings of a significant subspecialty: graduate training programs, professional organizations and boards, an APA division (Division 41—The American Psychology-Law Society), and journals and textbooks. Many of these entities are distinctly interdisciplinary and span the fields of both law and psychology.

PERSPECTIVES AND HISTORY

Let us begin our description of the field by defining it, briefly tracing its history, and then discussing a few professional matters.

Definitions

Forensic psychology involves the application of the science and profession of psychology to issues relating to law and the legal profession (ABFP, 2006). Just how broad these applications are is illustrated in Table 19-1, which lists several examples. A variety of settings and clients may be involved, including children and adolescents as well as adults. All manner of institutions, including corporations, government agencies, universities, hospitals and clinics, and correctional facilities, may be involved as clients or objects of testimony.

History

In 1908, Hugo von Munsterberg published his book *On the Witness Stand* (see Box 19-1). Despite this notable event, psychology had relatively little direct influence on the law until 1954—the year the Supreme Court finally paid attention to the social sciences in the *Brown v. Board of Education* desegregation case. Then, in 1962, Judge Bazelon, writing for the majority on the U.S. Court of Appeals for the District of Columbia Circuit, held for the first time that psychologists who were appropriately qualified could testify in court as experts on mental disorder (*Jenkins v. United States*, 1962). Finally, the forensic psychologist was about to appear on the scene, even though psychiatrists had enjoyed the privilege of providing expert testimony for many years. Today, psychologists regularly testify as experts in virtually every

TABLE 19-1 Areas of Testimony and Expertise of Forensic Psychologists

Commitment to mental hospitals
Child custody issues
Psychological damages suffered as the result of another's negligence
Release from involuntary confinement
Determination of the need for a conservator due to incapacity
Predicting dangerousness
Rights of a person with a mental disability in an institution
Competency to stand trial
Criminal responsibility (insanity defense)
Determination of disability for Social Security claims
Workers' compensation claims
Conditions affecting accuracy of eyewitness testimony
Advice to attorneys regarding factors that will affect jurors' behavior
Extent to which advertising claims are misleading
Battered woman syndrome
Rape trauma syndrome
Accuracy of eyewitness identification
Sexual harassment
Police psychology
Jury selection
Offender treatment programs
Criminal profiling

BOX 19-1 Focus on Professional Issues: Munsterberg on Trial

Munsterberg (1908) complained that no one (teacher, artist, businessperson, physician, minister, politician, or soldier) could be as resistant as an attorney to the idea that psychologists might be of help. He charged that lawyers, judges, and even members of juries seemed to think that all they needed to function correctly was common sense.

Professor John Wigmore (1909), an eminent professor of law at Northwestern University, considered Munsterberg's claims the height of arrogance. Reflecting the feelings of many attorneys, Wigmore wrote a clever yet scathing parody in response. He sketched a fictional libel suit filed against Munsterberg, accusing him of overstating what psychology had to offer, ignoring the many disagreements among psychologists themselves, and failing to understand the difference between laboratory results and the realities of legal requirements.

The "suit" was filed in "Windyville" in "Wundt County." Munsterberg's attorneys were named "R. E. Search, Si Kist, and X. Perry Ment." "Judge Wiseman" heard the case against Munsterberg and his claim that "lawyers are obdurate."

Of course, the proceedings went against Munsterberg. After only a few minutes of whispered consultation, the jury agreed on the verdict and found for the plaintiffs. Munsterberg was fined $1 in damages. All in all, Wigmore's attack was so clever and devastating that it took 25 years for psychologists to once again be considered fit as expert witnesses. In fact, however, shortly before his death some 30 years later, Wigmore softened his critique. He asserted that courts should be ready to use any methods that psychologists themselves agree are sound, accurate, and practical. Now, of course, Wigmore's change of heart is reflected in everyday court procedures. But it may be true that had Munsterberg been a little more restrained in his original claims, the entire Munsterberg-Wigmore episode would never have occurred.

area of criminal, civil, family, and administrative law. In addition, they serve as consultants to agencies and individuals throughout the legal system.

Of course, the foregoing thumbnail sketch of forensic history from Munsterberg to Bazelon leaves out many details and controversies. Even before Munsterberg, William Stern reported in 1901 that he was studying the "correctness" of recollection—an early precursor of today's research on eyewitness testimony. And even Freud, in a 1906 speech to some Austrian judges, claimed that psychology has real applications to the law. Later, John Watson also asserted that the law and psychology have common interests.

Lest the reader think that forensic psychology marched inexorably toward professional respectability, it is important to note that not everyone thought psychology had much to offer the legal system. Even Munsterberg was hardly without critics. Because he tended to promote the role of psychology before he had much empirical data to back his claims, many dismissed his book out of hand. In a 1931 address, Lewis Terman noted "that Munsterberg's error was in exaggerating the importance of psychology's contributions based on research then at hand. He went on to suggest that in light of significant scientific advances the ultimate significance of psychology for the legal profession could not be overestimated" (Blau, 1998, p. 3). Box 19-1 illustrates just how harsh some members of the legal community could be regarding Munsterberg's thesis. Certainly into the 1950s, before Judge Bazelon's ruling took hold, judges as often as not failed to qualify psychologists as experts in the courtroom.

The standoff between psychology and law has been characterized by Loh (1984) as a phase during which psychologists wanted to contribute to the legal system but attorneys were having none of it. In the 1930s, psychology was primarily applied to a critique of legal doctrine and decisions. In the 1950s, psychologists were mainly occupied in trying to serve as expert witnesses and, in the 1970s and 1980s, as consultants on matters pertaining to juror behavior (Loh, 1984).

Now, as noted at the outset, forensic psychology has arrived at a point where there are specialists in psycholegal research, interdisciplinary training programs are commonplace, and numerous specialty books are published. The many journals in this area include *Law and Human Behavior, Criminal*

Justice Journal, Law and Psychology Review, Criminal Justice and Behavior, Behavioral Sciences and the Law, American Journal of Forensic Psychology, and *Psychology, Public Policy, and Law.*

Professional Issues

For some years, many were concerned that forensic psychologists lacked status and recognition in the eyes of their peers in other specialties (e.g., Kurke, 1980). The establishment of the American Board of Forensic Psychology (ABFP) in 1978, to help the public identify qualified practitioners and to promote the discipline, has served to allay some of these concerns. Nevertheless, professional matters such as certification and licensing have long been issues of importance to forensic psychologists.

Training. Training in forensic psychology primarily occurs at the doctorate and postdoctoral level. DeMatteo and colleagues (2009) recommend that clinical psychology graduate students interested in forensic psychology obtain training and experience in the foundations of clinical psychology, in research methodology and statistics, in legal knowledge, in integrative law-psychology, in ethics and professional issues, and in clinical forensics. Increasingly, academic psychology departments are offering forensic courses. Currently, the Web site of Division 41 of the American Psychological Association (American Psychology-Law Society) identifies 16 clinical Ph.D./Psy.D. programs with a psychology and law emphasis as well as 9 nonclinical programs with this emphasis. There are currently 6 joint programs awarding both psychology doctorates and the J.D. degree. In addition, 17 master's programs with a focus on forensic psychology are available, as are postdoctoral training opportunities. Each year, the number and kinds of programs continue to grow. Web site 19-2 at the end of this chapter presents the most up-to-date information on training opportunities.

Ethics and Standards. All of the ethical principles and guidelines explored in previous chapters are relevant here as well. In addition, it is recommended that the forensic scientist follow the code of the American Academy of Forensic Sciences. This code stresses (a) completeness and accuracy in stating one's professional qualifications, (b) technical and scientific accuracy and honesty in reports and testimony, and (c) impartiality. As a further resource, Division 41 (American Psychology-Law Society) of APA has developed a set of *Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, in press) that elaborate on APA's Ethical Principles of Psychologists as they apply to the practice of forensic psychology (see Web site 19-4). These include guidelines in the areas of responsibilities, competence, relationships, fees, informed consent/notification and assent, conflicts in practice, privacy and confidentiality, and privilege, assessment, and communications.

Still, as we will discuss later in this chapter, the ethical issues encountered by forensic psychologists in the adversarial legal system can be formidable (Wrightsman et al., 1998). Finally, Blau (1998) has proposed several very explicit guidelines for the expert witness activities of psychologists. They involve matters of work quality, competence and decorum, and financial arrangements. Blau's standards for financial arrangements are presented in Table 19-2.

TABLE 19-2 Standards for Financial Arrangements Applicable to the Expert Witness

1. The psychologist should never accept a fee contingent upon the outcome of a case.
2. The fee structure and details of reimbursement should be established between the psychologist and the retaining attorney during the initial consultation. The understanding should be in writing between the two parties.
3. All outstanding fees should be paid before the psychologist testifies.
4. Misunderstandings or disagreements about fees should be resolved before proceeding in the case.
5. Psychologists who testify regularly as expert witnesses should devote some portion of their professional time to *pro bono publico*[*] cases.

[*]Cases without compensation for the purpose of advancing a social cause or representing someone who cannot otherwise afford it.

SOURCE: Blau (1998), p. 402.

Issues of ethics and standards will weigh heavily in any professional arena that allows for so many role conflicts, biases, distortions, and subjectivity. Forensic psychology is just such an arena.

SOME MAJOR ACTIVITIES OF FORENSIC PSYCHOLOGISTS

The growth of forensic psychology has thrust the psychologist into many different roles. We focus on eight such roles, beginning with the forensic psychologist as expert witness.

The Expert Witness

Consider the following scenario:

> Ms. Ferris, an employee of the Diego Pan Company, was working at her desk on April 28, 1999. Her supervisor, a Mr. Smith, stopped by her desk. He had a history of telling dirty jokes in her presence, commenting on her physical attributes, and asking about her dating activities. This day, however, he explicitly propositioned her and made it clear that if she wanted to advance in the company, and indeed even remain employed, she had better agree to have sexual relations with him. She refused. Two weeks later, she was fired. Subsequently, she filed sexual harassment charges against Mr. Smith and also sought damages for emotional suffering.
>
> Dr. Miller, a clinical psychologist, was retained by Ms. Ferris's attorney. He conducted extensive interviews with Ms. Ferris and several of her coworkers. He also administered several tests. Mr. Wright, a coworker, had inadvertently overheard the April 28 conversation between Ms. Ferris and her supervisor and had also previously observed some of the alleged sexual harassment.

During the trial, Mr. Wright served as a witness, testifying to the facts with reference to his own observations. Dr. Miller testified as to his opinions and inferences about emotional damage that were within the scope of his training and experience. This illustrates the basic difference between a lay witness and an *expert witness*. The former may testify only to events witnessed. The latter may offer opinions and inferences. This goes beyond merely stating a conclusion. The expert witness must help the court understand and evaluate evidence or determine a fact at issue (Gutheil, 1998).

Qualifications. An expert witness can be anyone who can provide information that, by its uniqueness in relation to some science, profession, training, or experience, is unlikely to be known to the average juror and that requires expertise to understand (Greene & Heilbrun, 2011). Initially, the court will decide whether the expert witness may in fact claim expert status. Often, in the case of physicians, psychologists, or psychiatrists, a license is taken as evidence of competence. But if opposing counsel objects to the witness's claim to be an expert, further evidence will typically be presented regarding competence. Ultimately, it is up to the judge to decide (Greene & Heilbrun, 2011).

A 1993 decision by the U.S. Supreme Court, *Daubert v. Merrell Dow*, established what many thought would be a more liberal standard for the admissibility of an expert's evidence. Briefly, the standard was changed from "general acceptance" in the relevant scientific community (the *Frye v. United States,* 1923, standard) to one of "relevance and validity" as determined by the trial judge. In other words, the burden now falls on the judge to determine what expert evidence is admissible (Faigman & Monahan, 2005; Faust, Grimm, Ahern, & Sokolik, 2010). Although this new standard was intended to be more liberal and flexible, in many cases *Daubert* has resulted in more restrictive criteria for the admissibility of expert testimony. Trial judges have used the *Daubert* decision to exclude various kinds of social science evidence as "not scientific enough," even though it would have been admissible under *Frye*. Indeed, the field of

forensic psychology continues to debate whether *Daubert* promotes science in expert testimony, confuses judges and juries, or opens the door for dubious theories and findings (Faigman & Monahan, 2005; Faust, Grimm, Ahern, & Sokolik, 2010).

In general, the bases of clinical psychological expertise may include (a) education, formal training, and subsequent learning; (b) relevant experience, including positions held; (c) research and publications; (d) knowledge and application of scientific principles; and (e) use of special tests and measurements. What is accepted as evidence will vary from jurisdiction to jurisdiction. Finally, many trial judges use the following admissibility criteria to decide the admissibility of expert testimony (Faust et al., 2010):

- *Relevance*: The testimony will help prove or disprove an important issue in the case.
- *Reliability:* The testimony must be trustworthy and valid.
- *Helpfulness:* The testimony will aid the jury in understanding the evidence and in deciding issues of fact.
- *Fit:* The testimony must "fit" the case at hand and assist the jury in doing its job.

Topics for Expert Testimony. We have already seen from Table 19-1 how wide the range of topics suitable for expert testimony really is. This list is by no means exhaustive, and additional areas for expert psychological opinion exist. However, experts are not allowed to state opinions that are the legal prerogative of the jury. For example, the Federal Rule of Evidence 704(b), while allowing experts to give their opinions regarding defendants' mental states and the possible influences on behavior and cognition, does not allow experts to give conclusions as to the defendants' sanity or insanity. Therefore, expert witnesses are prevented from providing "ultimate opinion" testimony (Green & Helibrun, 2011).

Testifying. Regardless of the topic, testifying in court can be a harrowing experience for the expert witness. Anxiety and self-doubt are common as the expert is tugged by attorneys on both sides of the issue. Just as the neuropsychologist rarely gets the easy cases to diagnose, the behavioral expert in court rarely testifies about simple matters. Publicity, sensationalism, and the adversarial legal process are companions not calculated to make the life of the expert witness an easy one.

An important prelude to testifying is pretrial preparation. This can sometimes involve many hours of study, interviewing, testing, and conferences, depending on the case. The expert may be asked to testify by the court or by counsel for either a defendant or a plaintiff.

Cross-Examination. Consider the following two gems that illustrate what cross-examination can be like (Schwitzgebel & Schwitzgebel, 1980, p. 243):

> "Good morning, doctor. I see you are here on behalf of an accused killer (or 'your fellow psychologists') again. How are you today?"
>
> "Doctor, were you paid to perform your examination? [Yes] How much? [$200 an hour.] How many hours did you spend in all? [20 hours.] That's $4,000, isn't it, doctor? [Yes] And in your opinion the patient was insane on the night of January 26, 1975? [Yes] That's all, doctor."

Other equally provocative questions that have been asked of psychologists serving as expert witnesses include the following:

> "Isn't it true that most of your experiments are done with rats?"
>
> "You are not a real doctor, are you?"
>
> "You can't tell what's going on up here, can you?" (Opposing attorney points to his head.)

Several authors (e.g., Blau, 1998; Gutheil, 2004) provide numerous hints about how the expert witness should behave in the courtroom, even to the point of appropriate dress. Schwitzgebel and Schwitzgebel (1980) summarize their recommended strategies for coping with cross-examination as follows:

- Be prepared.
- Be honest.
- Admit weaknesses.

- Talk in personally meaningful terms.
- Listen carefully to the wording of questions.
- Take time to think.

Criminal Cases

For generations, society has grappled with questions of how best to deal with people who have committed criminal acts but who were so disturbed at the time that it is debatable whether they were personally responsible. Also difficult are decisions as to whether an accused person is really competent to understand the trial proceedings and thus to cooperate in his or her own defense.

The Insanity Plea. If the accused is judged to have been sane at the time of the alleged crime, then conviction will bring with it imprisonment, fines, or probation. But the individual adjudged insane at the time of the alleged crime will, if convicted, be regarded as not responsible and thereby held for treatment rather than punishment. However, despite popular conceptions to the contrary, the *insanity plea* is seldom successful (Greene & Heilbrun, 2011). The defendant is typically assumed to be responsible. Thus, an insanity plea places the burden of its proof on the accused. In most states and in the District of Columbia, the *burden of proof* is on the defense; the defendant must prove that she or he was insane at the time of the criminal offense. It should be noted that "insanity" is a legal term, not a medical, psychiatric, or psychological term. The legal system assumes that people make premeditated and rational choices. Therefore, to behave irrationally is evidence of insanity. But most psychologists would not agree that all normal behavior is rationally chosen. The deterministic view of science creates problems for such a simple notion.

So, then, how is it decided that the accused was insane? Although standards vary from state to state, one of three standards typically prevails. The oldest standard is the *M'Naghten rule*, promulgated in England in 1843. It states that a successful insanity defense must prove that the person committed the unlawful act while "labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."

A second standard is the *Durham standard* (*Durham v. United States*, 1954). This standard was developed by Judge David Brazelton of the U.S. Court of Appeals because of the perception that the M'Naghten rule was outdated and in need of revision. The *Durham* standard states that "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." However, many judges and lawyers expressed dissatisfaction with this new standard because, in their view, the expert testimony of mental health professionals weighed too heavily in the decision (Constanzo, 2004).

The third standard is that the defendant is not responsible for a criminal act if it was the result of a mental disease or defect such that substantial capacity to appreciate the criminality of the act or to conform to the law was lacking. This is the so-called *ALI standard* of the American Law Institute. The ALI standard is viewed as the most liberal or expansive in that criminal responsibility can be excused if mental illness causes a lack of substantial capacity to understand what one is doing (a cognitive deficit) or an inability to control one's behavior (a volitional deficit).

The famous *Hinckley* case (the attempted assassination of President Reagan) changed the judicial scene in the United States (Greene & Heilbrun, 2011). The *not guilty by reason of insanity* (NGRI) verdict angered many, and the fallout over this case once again changed the legal standard for insanity. Its first impact was to encourage a return to the M'Naghten rule where cognitive factors rather than volitional ones are paramount. Its second impact is seen in the Supreme Court's ruling that it is constitutional to automatically and indefinitely confine someone who is acquitted of a crime as the result of an insanity plea. Third, the verdict "guilty but mentally ill" was introduced into the defense statutes of several states as well as the federal government. Finally, more states began to place the

BOX 19-2 Clinical Psychologist Perspective: David DeMatteo, J.D., Ph.D.

Dr. DeMatteo is an Assistant Professor of Psychology and Co-Director of the JD/PhD Program in Law and Psychology at Drexel University. He also has a secondary faculty appointment at Drexel University's Earle Mack School of Law. Dr. DeMatteo's primary research interests include drug policy, interventions for criminal offenders, and psychopathy, and his research has been funded by several state and federal agencies. Dr. DeMatteo has published more than 70 articles and book chapters, co-authored 3 books, and given over 100 professional presentations. He serves on the Editorial Boards of two journals and is an Associate Editor for *Law and Human Behavior*. Dr. DeMatteo is currently Chair of APA's Committee on Legal Issues, and he is the representative for APA Division 41 (American Psychology-Law Society) on the APA Council of Representatives.

Dr. DeMatteo provided responses to several questions we posed concerning his background and assessment of the field of forensic psychology.

What originally got you interested in the field of forensic psychology?

During college, I developed an interest in how social science research and psychological practice could be used to influence the legal process. This stemmed from longstanding interests in how mental health disorders and criminal behavior may be related, and how mental health professionals might be useful in addressing some of the causes and correlates of criminal behavior. So I was torn between pursuing a career in law or psychology because my interests seemed to lie squarely at the intersection of both of these professions. Fortunately, I found out about a graduate program—one of only three such programs in the U.S. at that time—that enabled students to simultaneously pursue a JD and a PhD in clinical psychology over a 7-year course of study. Although my primary professional identity was firmly on the psychology side, I wanted to attend law school so I could develop the analytical and writing skills of a lawyer. Plus, my research and clinical interests were clearly forensic in nature, and although a law degree is not necessary for forensic research or practice, I believed that legal training would strengthen my skill set, enhance my credibility among legal professionals, and ultimately improve my marketability.

Describe what activities you are involved in as a forensic psychologist.

As a faculty member at a large university, I maintain an active schedule of teaching, research, writing, and service activities. I teach courses to a variety of students at Drexel, including undergraduates, MS students in psychology, PhD students in clinical psychology, JD/PhD students, and law students. My undergraduate course focuses on substance abuse, while my graduate teaching load includes courses on advanced statistics and psychopharmacology. I also teach a course on mental health law to law students and JD/PhD students. Besides teaching, I maintain an active research agenda supported by various sources of state and federal funding, and I spend a good deal of time doing internal administrative and committee work (e.g., thesis/dissertation committees, departmental committees, co-directing the JD/PhD Program) and work in the field of forensic psychology (e.g., editorial boards, Executive Committee of APA Division 41, Chair of APA's Committee on Legal Issues).

In terms of applied work, I conduct forensic mental health assessments of both juveniles and adults involved in the state and federal criminal justice systems. These evaluations address a variety of legal issues, including state and federal sentencing, capital sentencing, mental state at the time of the offense, competence to stand trial, competence to waive *Miranda* rights, risk for violence, and juvenile waiver (i.e., whether a juvenile's case should be heard in adult court or juvenile court). After being hired by an attorney or appointed by the court, I conduct a thorough evaluation (the elements of which differ based on the legal issue being addressed), and then typically communicate my findings to the attorney or court via a written report and sometimes court testimony. I also occasionally consult with attorneys by reviewing

burden of proving the defendant's insanity on the defense rather than requiring the prosecution to prove the defendant's sanity. In several states now, a verdict of *guilty but mentally ill* (GBMI) is available to jurors in addition to the guilty, not guilty, and NGRI verdicts (Constanzo, 2004). Under the GBMI verdict, the convicted is sent to a psychiatric facility for treatment. If eventually judged to be sane, the individual is sent to prison to serve what is left of the sentence.

forensic reports or assisting them in preparing to cross-examine a forensic mental health expert.

What are your particular areas of expertise or interest?
My research interests all fall under the law-psychology umbrella, and the thread that runs throughout my research interests is improving the quality of practice by influencing policy. My current research interests include (1) drug policy (i.e., developing and evaluating judicially based treatments for drug-involved criminal offenders); (2) interventions for criminal offenders (i.e., examining the clinical appropriateness and effectiveness of interventions for offenders in the criminal justice system, and promoting diversion from the criminal justice system for offenders with mental illness); and (3) psychopathy (i.e., examining how psychopathy evidence is used in forensic assessments and legal proceedings, studying psychopathy in under-studied populations, and examining the relationship between psychopathy and treatment outcome). These research interests enable me to work in a variety of settings and with a range of populations, including drug-involved criminal offenders and individuals with mental health disorders. An important aspect of my research agenda is trying to influence practice and policy based on the results of my research, so I try to disseminate my research findings to a wide variety of audiences and in a variety of ways (e.g., publications, presentations, continuing education workshops, talks to planning/steering committees).

What are some future trends you see in forensic psychology?
On the clinical side, the development of specialized forensically relevant instruments has had an extremely positive impact on certain areas of forensic practice. For example, although mental health professionals have historically struggled to predict whether a criminal offender or psychiatric patient was likely to be violent in the future, the development of new risk assessment instruments (based on many years of impressive research) has greatly improved our ability to predict future violence. There are now conceptually sound and empirically validated instruments that can help forensic practitioners address a variety of legal issues, and this will no doubt greatly improve forensic practice. Over the next few years, I anticipate the development of even more instruments that will assist forensic practitioners in conducting a wide range of forensic mental health assessments.

On the research side, researchers continue to examine core issues that have the potential to assist courts to make better informed decisions. For example, research on the reliability of eyewitness testimony, jury decision-making, and false confessions, to name just a few areas, can be used to help legal decision-makers (judges and juries) reach decisions that are based on sound scientific evidence. Having a researcher educate the court in a particular area is an obvious way to influence the legal process, and I expect that attorneys and courts will increasingly rely on forensic experts in the coming years.

David DeMatteo

David DeMatteo

To conduct an evaluation for criminal insanity, the psychologist must address whether the person has a mental disorder or defect and what the person's mental status was at the time of the alleged crime. In the process, the psychologist will assess many factors, including the defendant's history and that of the defendant's family, intellectual status, neuropsychological factors, competency to stand trial, reading skills, personality, and measures of faking or malingering (Blau, 1998).

Competency to Stand Trial. For this question, the issue is the defendant's state of mind at the time of the trial, not when the offense was allegedly committed. A defendant may have been insane when the crime was committed but later be competent to stand trial. The reverse is also possible. In fact, issues of *competency to stand trial* are raised much more often than the insanity defense. Competency to stand trial was defined by the U.S. Supreme Court in the case *Dusky v. United States* (1960) as "… sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him." Thus, in contrast to the assessment of insanity, the assessment of competency to stand trial focuses on present mental state.

In answering questions of competency, several basic issues commonly come to the fore (Greene & Heilbrun, 2011): (a) Can the person appreciate the nature of the charges? (b) Can the person cooperate in a reasonable way with counsel? (c) Can the person appreciate the proceedings of the court? In most instances, the evaluation factors noted in the previous paragraph will apply here as well.

Civil Cases

A very large number of civil issues engage the attention of forensic psychologists, running the gamut from trademark litigation to class action suits. Two areas that are especially important for clinical psychologists are (a) commitment to and release from mental institutions and (b) domestic issues such as child custody disputes. Let us focus on these areas as examples of activity in the civil arena.

Commitment to Mental Institutions. Picture this scenario. Not too long ago, a disheveled man in his late 30s entered a restaurant and began haranguing customers as they approached the cashier to pay their checks. He was incoherent, but it was possible to pick out the obscenities and references to God that peppered his remarks. He did this for about 5 minutes, whereupon the manager appeared and unceremoniously escorted him to the door. Outside, he continued his tirade while pacing back and forth before the door. He repeatedly accosted customers and tried to make them listen to him. The manager finally called the police. After a brief interrogation, they "helped" him into the patrol car and subsequently deposited him in the emergency ward of the local psychiatric hospital.

This and related scenarios are repeated thousands of times, day after day, across the nation. After an examination (sometimes a rather cursory one), the individual may be involuntarily detained for hours or days depending on particular state laws. But in a few states, even emergency detentions require judicial consent.

Hospitalization that occurs against the will of the individual is referred to as an *involuntary commitment*. Some, such as Szasz (1970), have argued strenuously that involuntary hospitalization is a dangerous and often misused power that has been repeatedly exercised by psychiatrists and others to maintain control over those who will not conform to certain social dictates. The permissible length of involuntary commitment typically varies from 1 day to 3 weeks or so depending on the jurisdiction. After that, a hearing must be held to decide whether detention should continue.

In a *voluntary commitment*, the individual agrees to admission and may leave at any time. Some hospitals require patients to sign a form stating that their leaving is "against medical advice." Others demand that such patients indicate their intention to leave several days in advance. This enables the hospital to initiate commitment proceedings if the patient is believed to be dangerous to self or others or so disturbed as not to be responsible. It should be noted that "voluntary" admission is often not as voluntary as it might appear at first glance. Most often, there is strong pressure from relatives, friends, police, court authorities, or mental health personnel.

For the court to commit someone, a hearing must be held to determine whether the person involved meets the criteria laid out by law and whether treatment will be helpful. Most often, these criteria refer to a person who (a) is dangerous to self or others, (b) is so disturbed or disabled as to be incapable of making responsible decisions about self-care and hospitalization, or (c) requires treatment

or care in a hospital. An additional criterion is that no less restrictive alternative (other than hospitalization) is available or feasible. But above all, the person must be determined to be mentally ill.

Literally anyone can petition the court for an examination of someone he or she believes requires commitment. Usually, it is family or friends, or sometimes the police or welfare officials, who act as petitioners. If the court agrees, an order is issued and the person is required to submit to a professional examination (Greene & Heilbrun, 2011). Such an examination should be based on personal observations of the individual by professionals and not just on what others have reported. Common matters to note are general appearance, clarity of thinking, presence of delusions or hallucinations, how well the patient understands the complaints, the person's use of drugs or alcohol, employment status, intelligence, prior history of mental and criminal problems, and kindred factors.

Domestic Issues. Many domestic issues these days require intervention by the courts. Child custody, parental fitness, visitation rights, child abuse, juvenile misbehavior, and adoption are but a few of these issues. As an example, we discuss the issue of child custody.

Because divorce has become so prevalent in our society in recent years, it is only natural that problems of child custody have proliferated as well. The fact that marital roles and norms have likewise changed also complicates matters. Increasingly, fathers have assumed child care responsibilities, and mothers are now commonly employed outside the home. These and other factors have made custodial questions much more complex than before.

Today, the doctrine of the "best interests of the child" always takes precedence in custody disputes. To better articulate exactly what standards are involved here, the Michigan Child Custody Act of 1970 established the following factors that are typically relied on by the courts in making custodial decisions:

1. The love, affection, and other emotional ties existing between the competing parties and the child.
2. The capacity and disposition of competing parties to give the child love, affection, and guidance, and continuation of educating and raising the child in his religion or creed, if any.
3. The capacity and disposition of competing parties to provide the child with food, clothing, medical care, or other remedial care recognized and permitted under the laws of this state in lieu of medical care or other material needs.
4. The length of time the child has lived in a stable satisfactory environment and desirability of maintaining continuity.
5. The permanence, as a family unit, of the existing or proposed custodial home.
6. The moral fitness of the competing parties.
7. The home, school, and community record of the child.
8. The mental and physical health of the competing parties.
9. The reasonable preference of the child, if the court deems the child to be of sufficient age to express preference.
10. Any other factor considered by the court to be relevant to a particular child custody dispute.

Although 150 years ago children of divorce were automatically awarded to the father and 50 years ago almost always awarded to the mother, such reflexive decisions no longer hold today. The present norm is *joint custody*, which rests on the belief that children should maintain ties with both parents. In fact, many divorces culminate in informal joint custody decisions by the divorced couple; a formal ruling by the court never occurs. When the court does issue an order for joint custody, this probably means that a dispute of some sort has arisen between competing parties. In the final analysis, however, the only way joint custody can really work is when competing parents set aside their animosity and anger toward each other and act in concert and with sensitivity to the best interests of the child.

Joint custody, however, may not always be in the best interests of the child. Specifically, joint

custody may be contraindicated in situations where parents have an emotionally charged, conflictual relationship. In these instances, legal custody may be granted to one parent, while the other parent is granted visitation rights.

In making a child custody evaluation, the psychologist must remember that the critical element is a system of past, present, and future relationships among parents, children, and sometimes other relatives. Custody evaluations should consider information from multiple sources so that three major issues can be addressed (American Psychological Association, 1994): (a) the child's development and psychological needs; (b) each parent's strengths and limitations; and (c) the way each member of the family interacts with the others. The ultimate goal is identifying a situation in which the best interests of the child are served. Other specific issues, such as changes in previously established custody arrangements or visitation rights, follow the same overriding principle.

Rights of Patients

The rights of hospitalized mental patients have come under increasing judicial scrutiny. Beginning in the early 1970s, courts have held that patients who are involuntarily hospitalized have a constitutional right to individualized treatment that offers them a realistic chance for "cure" or at least improvement (Schwitzgebel & Schwitzgebel, 1980). The courts have been less attentive to the rights of voluntary patients because it is assumed they can leave the hospital if they so choose.

Additional rights and standards involve the physical environment (dayrooms, lavatories, dining rooms, etc.), personal clothing, and personal activities (opportunities for physical exercise, regular outdoor opportunities, or social activities). In addition, involuntary labor is prohibited, and when labor is undertaken voluntarily, appropriate wages must be paid. Although many states recognize patients' rights to correspondence and visitation, institutional personnel often have wide discretion in controlling visits (except by lawyers, physicians, or clergy). Statutes have also generally asserted the patient's right to dignity and privacy. In practice, however, these rights tend to be subject to wide interpretation and discretion. Indeed, as observed earlier, statutes and court orders are one thing; their actual implementation in practice is another.

A controversial and complex issue is the right to refuse treatment or medication. The question is one of informed consent. Not every involuntarily hospitalized patient is mentally incompetent, and these individuals have the right to decide their own fate. But what about patients who are incompetent? How does one protect the rights of the competent while also ensuring that the incompetent can experience the benefits of treatment? These are truly complex problems, as indicated in Box 19-3.

Predicting Dangerousness

As we saw in Chapter 3, the *Tarasoff* case resulted in a California court decision that therapists have a duty to protect potential victims from their patients' violent behavior. Beyond this, many would agree that, by law or moral imperative, we all have the obligation to protect others from those who are deemed dangerous. But how accurately can psychologists or anyone else predict dangerous behavior? Although a history of violence is more common among those with mental disorder diagnoses (especially substance use disorders), 90% of those with mental illness have no history of violence (Monahan, 1992). The reality is that to truly protect against those individuals who are dangerous, we would have to fish with a very large net—a net that would snare large numbers of individuals who would never actually commit a violent act (Ogloff, 1998).

Violent acts are highly overpredicted—a large percentage of those predicted to become violent do not do so (Monahan, 1981). But many people seem willing to sacrifice many to protect society from one. There are undoubtedly many reasons people tend to see danger when none exists (Monahan, 1976). But as much as anything, it is probably the television program or news story that describes how a mental patient was released only to kill someone,

BOX 19-3 Focus on Clinical Applications
Legal Controversies: Forcible Medication

Over 20 years ago, *Perry v. Louisiana* (1989) raised the issue of whether state officials may forcibly administer psychotropic medications to a death row inmate to render him mentally competent for his own execution. A macabre yet real-life question!

Who should decide whether prison inmates may be administered antipsychotic drugs against their will? This question has been argued before the U.S. Supreme Court. In the case of *Washington v. Harper* (1990), the Supreme Court ruled that a mentally ill prisoner could not be medicated without his or her consent unless there was a consensus of professional opinion that safety would otherwise be compromised. More recently, however, the Supreme Court has ruled that an individual could be forcibly medicated in an attempt to make him competent to stand trial (*Sell v. United States*, 2003).

Charles Sell, a dentist, had a long history of mental illness, including multiple psychotic episodes. In May 1997, he was charged with insurance fraud. At that time, he was deemed "currently competent," but the federal judge noted that Sell might have a psychotic episode in the future. Sell was released on bail. In early 1998, Sell was charged with trying to intimidate a witness, and a bail revocation hearing followed. At this hearing, Sell's behavior was irrational, bizarre, and physically threatening. Further, a psychiatrist reported that Sell was psychotic and that his condition had worsened. Sell's bail was revoked. In 1998, Sell was also charged with attempting to murder an FBI agent who had arrested him as well as for attempting to murder an associate who might testify in Sell's fraud trial. In early 1999, Sell requested that the judge reconsider his competency to stand trial. Based on a psychiatric evaluation at a federal prison, the magistrate found Sell incompetent to stand trial. The medical staff recommended that Sell take antipsychotic medication, but he refused to do so. The medical staff then sought permission to medicate Sell against his will.

The main issue addressed in the *Sell v. United States* decision was whether involuntary medication violated Sell's constitutional rights. The U.S. Supreme Court upheld the trial court's ruling that Sell could be involuntarily medicated for the purposes of attempting to restore his competency to stand trial. In addition, the court set out the following criteria for future decisions on this issue:

1. In such cases, the interest of the government must outweigh the individual's interest in remaining medication-free.
2. There must be no less intrusive way of fulfilling this interest.
3. The medication must be medically appropriate (e.g., likely to render the defendant competent, benefits outweigh the risks, and it is in the best medical interests of the defendant).

sexually abuse a child, or otherwise behave so as to lead the lay public to question the competence (and often the common sense) of the psychiatrist or psychologist involved in the release decision. All this leads to the conclusion that predicting dangerousness is very, very difficult. Although it is perhaps true that all of us have the potential to commit dangerous acts, given the right conditions, the fact remains that unless someone has previously behaved in a dangerous fashion, the ability to accurately predict such behavior is extremely limited.

Difficult though such predictions are, psychological evaluation for this purpose may constitute the largest single category of evaluation requested of the clinician by the criminal justice system (Blau, 1998). Evaluations can range from predicting sexual violence, child abuse, and workplace violence to predicting suicidal or homicidal behavior. These evaluations are used for many decisions, ranging from holding a prisoner without bail, to granting work-release status to hospitalized defendants, to invoking special sentencing options for violent offenders, just to name a few. As noted by Greene and Heilbrun (2011), research suggests that the following types of predictions of violent behavior are likely to be the most accurate:

1. Predictions for specific kinds of violent behavior
2. Predictions for certain settings or circumstances that the clinician already has historical data on
3. Predictions based on the clinician's knowledge of the individual's past history of violent behavior

Finally, it is worth noting that the debate over clinical versus statistical prediction discussed in Chapter 10 also applies to the issue of how best to predict dangerousness. Quinsey, Harris, Rice, and Cormier (1999) argue strongly that the clinical prediction of dangerousness (i.e., a prediction based on clinical impression) should be replaced by actuarial methods. Litwack (2001), however, counters that there is not enough empirical evidence to date to suggest that actuarial prediction is clearly superior to clinical prediction of dangerousness. Further, he proposes that the prediction of dangerousness is sufficiently different from other prediction tasks performed by psychologists such that actuarial prediction may not offer much of an advantage.

This is not to say that research efforts to improve the actuarial prediction of dangerousness are futile and should cease. Rather, because of the tremendous implications for public policy, to say nothing of human values, much more research is needed in this broad area of forensic psychology. A number of recent efforts are encouraging (e.g., Constanzo, 2004; Greene & Heilbrun, 2011).

Psychological Treatment

In the case of prisoners, legally established rights to psychological treatment or rehabilitation are still somewhat in a state of flux. Such persons have the right to medical treatment, and juvenile prisoners generally have the right to both psychological and medical treatment. When the right to psychological treatment for adult prisoners is recognized, it is most often for individuals who are severely disturbed mentally. Some experts are reluctant to promote treatment rights for prisoners because they believe that sometimes punishment and deprivation occur under the label of "treatment" or perhaps "behavior modification."

People have a right to refuse treatment. In such instances, the state must show a compelling interest that will override the prisoner's refusal. Because of the ambiguities and potential for violations of human rights, many correctional institutions now have committees to protect the rights of prisoners. These committees typically include a majority of members who are not affiliated with the institution.

There are wider forensic treatment implications, however. In criminal cases, therapy may focus on restoring an incompetent person to a state of mental competence. Or therapy may be undertaken to provide emotional support for one who faces imprisonment. For criminal offenders, the focus is often on personality problems, sexual behavior, and aggressiveness. Sometimes therapy is conducted while the person is incarcerated, but other times it is on an outpatient basis as a condition of parole or probation. The forms of therapy employed include both individual and group methods that involve everything from insight-oriented and supportive methods to behavioral techniques, biofeedback, and cognitive approaches. One of the major problems for the forensic clinician is the knowledge that testimony may be required later in court. What the court wants, what the client's attorney will permit, what is best for the client, and what the clinician sees as most desirable may conflict and lead to many problems. In child custody issues, the treatment problems and conflicts among parents and child may be especially difficult and poignant. They can often lead to real professional dilemmas. For example, to best help the child, the parents should undergo therapy themselves, but sometimes one or both will refuse to do so.

Consultation

Another common activity of forensic psychologists is consultation. Of course, many of the activities discussed previously also involve some manner of consultation. In this section, we focus on several additional aspects of consultation.

Jury Selection. A consulting psychologist may work with attorneys in the process of *jury selection* (Constanzo, 2004; Greene & Heilbrun, 2011). The legal term *voir dire* refers to that part of a trial in which a jury is impaneled. During this phase, attorneys have the opportunity to discover biases in potential jurors; to obtain information for *peremptory challenges* (a set number of challenges allowed each side in a trial to remove jurors thought to be biased

against a given side); to ingratiate themselves with jurors or get them to identify with a given side; or to indoctrinate jurors so they will be receptive to an attorney's presentation of the case. All this is designed to give an attorney an edge. The consulting psychologist will work with attorneys to help them in a variety of ways to achieve better jury selection or deselection. Table 19-3 summarizes the goals and techniques of jury consultation.

Jury Shadowing. Another form of consultation is *jury shadowing*. Here, the jury consultant hires analogous jurors (i.e., individuals similar to those actually serving on the jury) and monitors their reactions to the testimony as it is presented at the trial. In this way, the consultant and attorneys can anticipate the reactions and impressions of the actual jurors and prepare a better-informed courtroom strategy.

Public Opinion Surveys. Public opinion surveys have been used in many ways over the years. In a trademark suit, for example, an attorney might hire a psychological consultant to determine the public's recognition of some company name or symbol. One way to do this is through a survey. In other cases, an opinion survey might be administered to a representative sample of people from the same geographical area in which the trial will be held, asking for their opinions about a certain case and about the trial tactics planned by the attorney. In a sense, this survey allows the trial attorney to pretest the significant trial issues and to hone the proposed method of presenting evidence. Another use of surveys is to determine whether a change in venue (location) for the trial might be in order. Attitudes in the community about the trial, and particularly toward the defendant, can be elicited to help convince the court to change the location and also to help in the jury selection process.

TABLE 19-3 Goals and Techniques of Jury Consultation

Stage of Consultation	Goals	Techniques
Stage I: Voir dire preparation	Learn about the case.	Hold planning sessions with attorneys.
	Educate attorneys about contributions that consultants can make.	Review media, interview client, observe courtroom procedures.
	Develop instruments.	If necessary, develop juror questionnaires, survey questionnaires, trial simulations, and interviews with key informants.
	Formulate initial theory of jury selection.	Analyze data from above and propose theory of jury selection that is integrated with attorneys' theory of case.
Stage II: Improving voir dire conditions.	Structure voir dire in a manner that improves chances to uncover juror bias and to identify juror prejudice.	Provide affidavits, expert testimony on: change of venue; individual, sequestered, attorney-conducted voir dire; struck vs. "as you go" system; and composition challenge.
	Improve voir dire skills of attorney.	Preparations of voir dire topics and training of attorneys in interviewing techniques.
Stage III: Juror deselection.	Develop final theory of jury selection.	Coordinate pretrial data with in-court observation of *venire* persons.
	Impanel a jury as favorably disposed toward client and theory of case as possible.	Develop rating system to identify jurors for peremptory challenge by juror experience, intelligence, sentiment, and social influence.

SOURCE: From *Psychological Consultation in the Courtroom*, by M. T. Nietzel and R. C. Dillehay, p. 24. Copyright © 1986 by Pergamon Press. Reprinted by permission.

BOX 19-4 Clinical Psychologist Perspective: Marina Tolou-Shams, Ph.D.

Dr. Tolou-Shams is an Assistant Professor (Research) at The Warren Alpert Medical School of Brown University, a staff psychologist at Rhode Island Hospital and the Bradley Hasbro Children's Research Center, and director of the Rhode Island Family Court, Mental Health Clinic. Dr. Tolou-Shams received her Ph.D. in clinical psychology in 2004 from the University of Illinois at Chicago. She completed her postdoctoral clinical and research training through the Brown University Psychology Training Consortium. She is trained as a pediatric and forensic psychologist and has many years of clinical experience with assessing and treating high-risk adolescents and their families. Dr. Tolou-Shams is also an active clinical researcher who focuses on developing evidence-based mental health, substance abuse, and HIV risk-reduction interventions for juvenile drug court offenders. She is currently developing a family-based program for substance-abusing offenders. This program emphasizes teaching young offenders and their parents how to regulate their emotions and improve parenting skills to reduce adolescent substance abuse and the co-occurrence of other high-risk behaviors, such as unprotected sexual activity.

What originally got you interested in the field of clinical psychology?

When I was in the eighth grade, I was required to do a project called the "I-Search" for which you ask a question about something you are really interested in and you research the answer to it. My question was: "How could anyone be an executioner?" I conducted interviews with death penalty advocates and those who felt the death penalty should be abolished. I also interviewed an individual who used to be on death row but was released when the Supreme Court upheld the death penalty as unconstitutional (in the 1970s). My research study ultimately taught me a great deal about the death penalty and how individuals do or don't end up on death row. This launched my interest in understanding human behaviors, particularly criminal human behavior.

Describe what activities you are involved in as a clinical psychologist.

As a clinical psychologist in an academic medical setting, my activities include teaching and supervising, administrative work, leading clinical research trials, writing up research results for publication, clinical work (assessment and therapy), and consultation. My teaching activities include providing clinical and/or research supervision and mentoring for psychology residents and fellows as well as leading didactic seminars. Research activities include managing clinical research studies (in court or community-based settings), delivering HIV prevention interventions to high-risk youth and their families, data analysis/management, submitting presentations and publications with colleagues, as well as writing up grant applications to secure funding for my faculty position. Administrative work includes directing a juvenile court clinic and collaborating with court administrators to ensure the clinic runs smoothly. My administrative role involves managing multiple systems and facilitating clear communication between psychology and legal systems. Clinical and consultation activities include providing assessment and therapy for juveniles and their families. I also provide consultation to judges and court administrators regarding various forensic clinical issues (e.g., reviewing past records and psychiatric evaluations to provide a second opinion for the judge concerning clinical recommendations). Specific assessment activities include conducting forensic assessments of juveniles and adults (e.g., competency, criminal responsibility, child custody/visitation) and providing emergency mental health assessments for juveniles who present at imminent risk for harm to self or harm to others in front of the court. Given my training as a pediatric psychologist, I also have a small caseload of therapy outpatients for whom the chief complaint is related to chronic health concerns.

What are your particular areas of expertise or interest?

My interest and expertise are generally in the areas of pediatric and forensic psychology. More specifically, my pediatric focus is on adolescent HIV prevention and my forensic psychology focus is on the juvenile justice system. I have recently merged these two interests to develop a program of research to reduce HIV/STD risk among substance abusing juvenile offenders. My area of expertise is in primary prevention and I continue to be very interested and invested in developing health promotion interventions that can be delivered to juvenile offenders at first contact with the juvenile justice system (as part of a "diversion" approach).

My goal is to capitalize on the opportunity (at first contact with the juvenile courts) to deliver an evidence-based intervention to a very high-risk population, thereby reducing the development of juvenile substance use disorders, HIV/STD infection, and recidivism. Given my role as director of a juvenile court clinic, I am also collaborating with colleagues to develop some treatment interventions. We are currently testing an integrated mental health, substance use, and HIV prevention interventions for juvenile offenders with identified mental health concerns.

What are the future trends you see for clinical psychology?

I think the future trends for clinical psychology include innovation and creativity when it comes to career options and fundable research ideas. Clinical psychologists must be flexible and adaptive when it comes to career options and realize that their clinical and/or research skill set can be used in multiple different domains. In the forensic realm, clinical psychologists are being used more and more at the policy level, which is something that is typically not "taught" at the graduate level. However, the basic clinical consultation skills that graduate students gain through their clinical experiences can easily be applied here and provide an interesting and novel career option. Additionally, as the status of domestic and global economies wax and wane, in order to gain federal funding, research ideas must include significant populations, innovative research questions, and novel approaches to testing these research questions. Clinical psychologists will likely need to submit grants to a myriad of funding agencies, which requires learning about how those grants are written perhaps differently from other agencies. Grant funding will likely become more competitive and thus clinical psychologists in academic medical settings will likely see that they need to diversify their career portfolio to include multiple different ways of satisfying their intellectual interests and earning their salaries.

Why should students consider a career in forensic psychology?

I think forensic psychology is a rapidly growing area for clinical psychologists, particularly for those with a strong clinical research background. Clinical psychologists must get training in forensic psychology (as forensic assessments differ greatly from standard clinical assessments, for instance). But forensic training combined with a strong clinical research background can really help inform the development of forensic assessment measures as well as the development of evidence-based mental health and health promotion interventions (e.g., substance use, HIV prevention) for criminally involved individuals. Such forensic psychologists would be at the "cutting edge" of research and would be contributing to a nascent area of literature.

In addition, a forensic psychologist has many different career options (none of which are mutually exclusive). Options include providing forensic assessment for court-referred individuals; providing consultation services (e.g., to attorneys, judges, police departments); teaching at the undergraduate, graduate, and/or postdoctoral levels; developing pre- and postdoctoral forensic clinical training programs (especially with an emphasis on research); designing and conducting research trials for assessment and intervention; administrative work (e.g., role as clinical director for a court clinic, directing a child advocacy center); and/or doing policy work (e.g., related to forensic mental health statutes or laws) at local, national, and/or international levels.

Dr. Marina Tolou-Shams

Marina Tolou-Shams

Witness Preparation. It would be unethical for the consultant to work with a witness in any way designed to encourage any alteration in the facts of testimony. Although the line is a very thin one, the idea of *witness preparation* is to help witnesses present their testimony better without changing the facts to which their testimony is directed. Because this is such a delicate matter, some consultants will not work with witnesses in criminal proceedings—only in civil cases. Nietzel and Dillehay (1986) have discussed many aspects of witness preparation, including the manner in which facts are presented, associated emotions on the part of the witness, preparation for the sheer experience of being a witness in a courtroom, cross-examination, appearance, and threats by the opposing attorney to the credibility of the witness. However, there remains a great deal of "gray area" between providing proper assistance to potential witnesses and encouraging the potential witness to change testimony (Wrightsman, 2001).

Convincing the Jury. Finally, consultants can often help attorneys in the way they present their cases and evidence (within the allowable constraints of the judicial system) to jurors. Consultants can assist attorneys in predicting how jurors will respond to certain kinds of evidence or methods of presentation, especially in opening and closing arguments. In effect, the beliefs, feelings, and behavior of jurors are the targets here. The consultants then help attorneys find the very best way to present their cases.

Research and Forensic Psychology

In a real sense, virtually all research in psychology is relevant to some forensic issue. For example, research on the genetic components of schizophrenia may be very important in a mental competency hearing. The nature of prejudice or the basic elements of the persuasive process are as germane to the attorney as they are to the social psychologist. Consumer research may have direct application to a product liability suit. And recently, research on attributions and interpersonal relationships has been applied to the law on searches and seizures. However, several research areas have become particularly identified with forensic psychology, and we have chosen to sample two of them here.

Eyewitness Testimony. Nothing can be so dramatic or damaging as an eyewitness who identifies the person accused of a crime. Such *eyewitness testimony* has been a powerful factor in the conviction of countless individuals over the years. But such testimony has all too often convicted the innocent as well as the guilty (Brewer & Wells, 2011; Green & Heilbrun, 2011; Wells & Olsen, 2003). The reason, put simply, is that eyewitness testimony is often unreliable and inaccurate. A case in point occurred in 1979 in Wilmington, Delaware. A Catholic priest was put on trial because a citizen told police that the priest looked very much like an artist's sketch of a robber being circulated by the police. Later, seven eyewitnesses to the robbery positively identified the priest as the robber. The trial was halted, however, when another man confessed to the crime. What had happened with these eyewitnesses? Apparently, before showing pictures of suspects to the witnesses, the police had quietly revealed that the robber might be a priest. And the priest's picture was the only one with the subject wearing a clerical collar!

Over the years, Loftus and her colleagues have conducted a number of experiments that together show that eyewitnesses' memory can easily be distorted by subsequent information. For example, Loftus, Miller, and Burns (1978) had subjects view a series of color slides of an auto accident. Half the subjects were shown a series in which there was a stop sign present; the other half saw a yield sign. Afterward, subjects answered questions about the slides. The critical question asked whether a particular sign (either stop or yield) was present. For half the subjects, the sign asked about was consistent with what subjects had seen earlier; for the other half, it was inconsistent. Still later, the subjects were shown 15 slides and were asked to pick out the one they had seen before. Interestingly, subjects whose question was consistent with the sign they had actually seen chose the correct slide 75% of the time,

whereas those in the inconsistent group made the correct choice only 41% of the time.

It is clear that people often make inferences on the basis of their expectations. Also, as Loftus (1979) points out, an eyewitness to an accident or crime is almost always questioned prior to the trial. In these conversations, something may easily be said to alter the witness's recollection. It is the role of the forensic psychologist to help identify the conditions in a specific case that might produce distortions in veridical testimony.

Experience has taught us that eyewitnesses to events all too often cannot agree among themselves. They differ in their descriptions of subjects' height, weight, hair color, clothing, and even race. A dramatic illustration of this axiom was provided by Buckhout (1975), who staged a demonstration as part of a television program. Viewers watched a staged purse-snatching episode that lasted but 12 seconds. Following this, viewers saw a police lineup of six men that, the viewers were told, might include the assailant. Viewers could call in and render their judgments. What happened? More than 2,000 callers responded, and 1,800 of them were mistaken! Of course, none of the foregoing is meant to suggest that eyewitnesses are never correct. But it does suggest that caution should be exercised in accepting accounts uncritically. At the very least, our legal system can use improvement in its procedures for identifying suspects (Brewer & Wells, 2011; Greene & Heilbrun, 2011). Factors of stress levels, information storage, identification procedures, personal biases and stereotypes, whether a weapon was present, the age of the eyewitness, and even unconscious integrative processes all need further study (Brewer & Wells, 2011; Greene & Heilbrun, 2011).

In response to the concerns over false eyewitness identification, a subcommittee was appointed by the American Psychology-Law Society (Division 41 of the American Psychological Association) to review scientific evidence in this area and to formulate recommendations (Wells et al., 1998). Web site 19-5 at the end of this chapter provides a link to the subcommittee's report. Briefly, the subcommittee made the following recommendations:

- The person who conducts the lineup or photo-spread in the case should not know the identity of the suspect.
- Eyewitnesses should be told that a suspect in the case may or may not be in the lineup or photo-spread and that the person conducting the lineup or photo-spread does not know which person (if any) is the suspect in the case.
- The suspect in a lineup or a photo-spread should not stand out (in appearance or dress) as being different from the others.
- The eyewitness's confidence in the identification should be assessed at the time of the identification and prior to any feedback.

In this way, it is hoped that eyewitness identification errors will be reduced (Wells et al., 1998).

Jury Behavior. The better we understand the conditions that affect how juries think and reach decisions, the better our judicial system will be. A great deal of research has been done on just how jurors make sense out of evidence and process information, how they respond to instructions from the bench, and how they react to certain kinds of arguments (Greene & Heilbrun, 2011). Let us consider several examples.

Jurors are often confused by instructions from the judge. Severance and Loftus (1982) modified the pattern of instructions given to the jury. They wrote instructions in active rather than passive sentences and made the messages short and concise. In addition, they gave abstract notions such as "reasonable doubt" greater elaboration than usual. The result was a more accurate application of the law by jurors than is usually the case.

Even such a simple condition as the order in which the judge's instructions are presented can have an effect on jurors. For example, Kassin and Wrightsman (1979) used mock jurors who watched a videotaped trial. They found that informing jurors as to the requirements of proof before presenting the evidence rather than after had definite effects. Jurors under the former condition were more likely to hold to the dictum of presumed innocence than were jurors under the latter condition.

BOX 19-5 Graduate Student Perspective: Lizzy Foster

Lizzy Foster is a fourth-year student specializing in forensic psychology in the clinical psychology Ph.D. program at Drexel University. Lizzy received a B.A. in psychology from Tufts University. After college and before beginning graduate school, she spent 2 years working on research projects: first, a study at Brown University Medical School examining stress reactivity in at-risk children; second, a study through UCLA evaluating a medical treatment for ischemic strokes. Since starting at Drexel, she has provided psychological services in a variety of clinical settings, including a correctional facility and an outpatient anxiety disorder clinic. She is also experienced in conducting forensic assessments. Her current research interests include forensic assessments, experiences of correctional personnel within the criminal justice system, and how character evidence influences jury decision making.

We asked Lizzy to share her thoughts about graduate school.

What has graduate school in clinical psychology been like for you?

I was told before I started graduate school that clinical psychology graduate programs are 100% clinical work and 100% research, and after 3 years I have to say that I agree. Graduate school has been an amalgam of experiences: I've taught classes, helped write articles, done hundreds of hours of clinical work, helped out on others' research projects, worked on my own research projects, and more. It has been a constant learning experience, and an experience that I've loved.

What things have you least expected about graduate school?

First, I didn't expect how much work graduate school would be. In college I was immersed in extracurricular activities and classes, and I was very busy as a result. I expected graduate school to be similar. I knew it would be a lot of work, but I believed I would be able to manage it in the same way. I was wrong. During the week, I run from classes to meetings to seeing clients. During the weekends, you can almost always find me in a coffee shop (as I am now!) trying to get work done. I'm still just as busy as I was during undergrad, but this time without an excessive number of extracurricular activities.

Second, I thought that I would be seen as a student who didn't know much, but my experience has been entirely different. My mentor treats me like a junior colleague. Although that can come with pressure and responsibility, it has built my confidence. It also has come with incredible opportunities. I've published with my mentor, done forensic assessments with him, reviewed manuscripts for him, and given my opinion on research projects and papers!

Has graduate school changed you? If yes, how so?

There is no question that graduate school has changed me. I'm more independent than I was before starting graduate school. This is particularly true when it comes to my area of specialization (forensics). When working with a correctional or forensic population, you cannot be timid. Although I had some experiences with forensic and correctional populations before graduate school, I had never been inside a correctional facility. It was a steep learning curve, but I quickly learned how to be confident in that setting and how to assert myself when necessary.

Are your professional or research interests similar or different now than they were when you started graduate school?

I came into graduate school knowing I wanted to focus on forensic psychology, but not knowing what specifically I wanted to do within that area. My research interests have since become crystallized. Although I find a lot of areas fascinating within forensic psychology, I've come to realize that you can only really study a few things at a time! Thanks to my mentor's research, and classes that I've taken (such as forensic

There are also many conditions that may bias jury decisions. For example, an individual may be charged with several instances of a crime. Sometimes these instances are joined into one indictment; in other cases, the defendant is tried separately for each instance. Greene and Loftus (1981) discovered that when charges are joined into one indictment, the jury is more likely to hand down harsher verdicts than when the charges are tried separately.

psychology), I found my own interests and began researching and studying those areas.

Furthermore, I didn't know that much about forensic assessments until I started graduate school. Forensic assessments are comprehensive assessments that often take place in the pretrial stage of legal proceedings. For example, we can assess an offender's competence to stand trial, mental state at the time of the offense, etc. It's challenging and often sad, but I also find it interesting to conceptualize and assess an individual's case, and I believe it's important to help courts make more informed decisions about offenders.

Looking back, what activities or experiences were the most important for you in your graduate school program?

To become a competent forensic clinical psychologist, the first step is becoming a competent clinician. I've attempted to develop my clinical skills as a foundation to becoming a forensic psychologist. Before I began assisting with forensic assessments or seeing clients on my own, I took classes in which I practiced basic clinical skills, studied theories of psychotherapies and different clinical orientations (e.g., cognitive-behavioral therapy), and sat in with other therapists. I feel that taking things slowly and not jumping in right away has been the key to understanding clinical work and becoming a competent forensic practitioner.

Any additional hints for those trying to make it through graduate school in clinical psychology?

First, a healthy work–life balance has been one of the most important things for me to maintain. I've found that at the end of the day, there's always more that can be done, but I think making time for my own life has been essential to my happiness. Although I love what I do, I also love my friends and family, and making time for them has been a priority for me during graduate school.

Second, my classmates have become some of my best friends. We've created a collaborative environment where we help each other out academically but also have become support systems both in and out of school. If you can make friends out of your peers, it will make your graduate experience much healthier and much more fun.

Finally, I've found that your mentor can help make or break your graduate experience. I've been lucky that my mentor and I have similar styles. He has tried to make graduate school as manageable as possible and has let me choose what I'm capable of doing and not doing. Although everyone has different styles, make sure you assess your own and your potential mentor's style before starting a graduate program.

Lizzy Foster

CHAPTER SUMMARY

Forensic psychology is concerned with the application of psychological methods, theories, and concepts to the legal system. Although Hugo von Munsterberg's 1908 book proclaimed that psychology had much to offer to the legal system, little influence was observed until the 1950s. Today, the influence and popularity of forensic psychology are apparent; many journals, books, and

specialty training programs exist. However, forensic psychologists are a target of harsh criticism as well.

In this chapter, we have discussed eight activities of the forensic psychologist. Forensic psychologists may serve as expert witnesses or as consultants for both criminal and civil cases. Forensic psychologists may also be called on to represent hospitalized patients' rights or to evaluate and predict whether a patient is likely to be a danger to self or to others. Forensic psychologists also serve as consultants regarding jury selection and witness preparation. Finally, forensic psychologists may conduct research on important issues such as eyewitness testimony and jury behavior.

KEY TERMS

ALI standard The most liberal standard for determining the insanity of a defendant. This standard attests that the defendant is not responsible for an unlawful act if it resulted from a mental disease or defect such that he or she lacked substantial capacity either to appreciate the criminality of the act (a cognitive deficit) or to conform to the law (a volitional deficit).

burden of proof The obligation to establish the truth of an assertion in a court of law. In the case of the insanity plea, the burden of proof is usually on the defense.

competency to stand trial The defendant's state of mind at the time of trial. To be deemed competent, it must be shown that the defendant appreciates the nature of the charges and can report on his or her behavior at the time of the alleged offense, has a basic understanding of the court proceedings, and is capable of cooperating with his or her attorney.

expert witness An individual who, by his or her unique profession, training, or experience, is called on to help the court understand and evaluate evidence or offer opinions and inferences on an issue.

eyewitness testimony Testimony given by an individual who has witnessed part or all of an event (e.g., a crime, an accident). Eyewitness testimony is often inaccurate, unreliable, and distorted by subsequent information. One role of forensic psychologists is to help identify the conditions in a specific case that might produce distortions in testimony.

forensic psychology A psychology subspecialty that focuses on applying psychological concepts and methods to questions/problems arising within the context of the legal system. Forensic psychologists may be called upon to provide expertise on matters of child custody, jury selection, the prediction of dangerousness, etc.

insanity plea The assertion of someone accused of a crime that he or she was not "sane" or rational at the time of the alleged crime. If this plea is successful, an individual is regarded as not responsible for his or her actions and is held for treatment rather than punishment.

joint custody An arrangement in which both parents share in the custody of a child following divorce. Many "joint custody" arrangements are determined informally by the parents; formal court orders tend to be issued only in cases where the parties could arrive at no satisfactory agreement on their own.

jury selection A process in which attorneys for the prosecution and defense choose jurors for a case from a larger pool of possible jurors. Forensic psychologists may be consulted to assist attorneys with jury selection (e.g., to come up with a theory for jury selection, to improve the voir dire skills of the attorney).

jury shadowing The process of hiring individuals similar to those who are serving on a given jury and monitoring their reactions to the testimony as it is presented at the trial. The reactions of the shadow jurors are used to anticipate the reactions of the actual jurors and may serve as the basis for a shift in courtroom strategy.

M'Naghten rule The oldest standard for determining the insanity of a defendant. This rule requires the defense to prove that at the time of the unlawful act, the defendant's reasoning was so impaired by "a disease of the mind" that he or she either did not appreciate what he or she was doing or did not comprehend that it was wrong.

peremptory challenges A set number of challenges allowed each side (prosecution and defense) during voir dire to remove jurors suspected of bias against that side.

voir dire A legal term that refers to that part of the trial in which a jury is impaneled, or selected.

voluntary commitment The circumstance in which the individual agrees to be admitted to a psychiatric hospital and is permitted to leave at any time.

witness preparation Helping witnesses present their testimony more effectively without changing the facts to which their testimony is directed. Forensic psychologists may be consulted to assist with many aspects of witness preparation (e.g., preparing them for the sheer experience of being a witness in the courtroom; making recommendations as to their appearance, the manner in which they present facts, etc.).

WEB SITES OF INTEREST

To visit any of the following Web sites, go to www.wadsworth.com and click Links.

19-1 American Psychological Association Division 41: The American Psychology-Law Society
http://www.ap-ls.org/

19-2 Careers and Training in Psychology and Law
http://www.ap-ls.org/education/EducationTraining.php

19-3 Links to Graduate Programs in Psychology and Law
http://www.ap-ls.org/education/GraduatePrograms.php

19-4 Specialty Guidelines for Forensic Psychologists
http://www.ap-ls.org/aboutpsychlaw/SpecialtyGuidelines.php

19-5 Eyewitness Identification Procedures: Recommendations for Lineups and Photospreads
http://www.psychology.iastate.edu/~glwells/Wells_articles_pdf/whitepaperpdf.pdf

Appendix

A Primer for Applying to Graduate Programs in Clinical Psychology[1]

Psychology is the most popular major on a large proportion of college campuses. Many thousands of students apply to graduate schools with hopes of pursuing a career in the science or practice of mental health services. Yet, as compared to other types of graduate programs (e.g., law, medicine), remarkably little information is available to help students determine the career path that offers the best match to their interests. Specific practical advice on how to successfully navigate the application process also is lacking.

This appendix is designed to provide an overview of different types of possible career options in the science and practice of clinical psychology. An important disclaimer should be mentioned here. The text in this chapter focuses mostly on our opinions and impressions of the current state of the field and of the application process for clinical Ph.D. programs. We feel best prepared to comment on Ph.D. programs in clinical psychology that subscribe to the scientist-practitioner or clinical science models of training. Our experience is exclusively with the admissions processes and training goals of these types of programs, and we cannot speak directly to programs that have adopted distinctly different training models.

[1]This appendix has been reprinted with permission from Mitch Prinstein, Ph.D. Special thanks to Sophia Choukas-Bradley and Karen Guan for their contributions to this appendix.

However, because so little information is available to students interested in mental health careers, we have offered some general opinions and impressions below that we hope will be beneficial, if used in the proper context. In many places, we have offered links to Web sites that can provide more detailed information.

Do You Really Want to Be a Clinical Psychologist?

Students often state an interest in applying to doctoral programs in clinical psychology. Indeed, applications to clinical psychology programs often outnumber applications to all other types of psychology doctoral programs combined. At many universities, clinical doctoral programs receive from 100 to 600 applications. Far fewer apply to programs in developmental, social, cognitive, biological, and quantitative psychology programs, roughly in descending order of popularity. This apparent preference for clinical psychology often is based on students' general desire to work as a therapist, perhaps in a private practice type of setting (e.g., a home office or group practice). Sometimes, students will state an interest in research. Other times, students might indicate that they are somewhat afraid of statistics and "turned off" by the idea of writing a dissertation.

We would say that these impressions of the field of clinical psychology, and of the training activities included during graduate school, are somewhat accurate, but in some ways quite inaccurate. An accurate and thorough description of the field of clinical psychology is somewhat difficult to articulate because the field is changing quite dramatically and quickly. Nevertheless, we think it is important to briefly reconsider what your career goals are (or at least what you are *not* interested in) before talking about graduate applications and deciding on the type of graduate program that is the best match. We divide this portion of the chapter into two sections: a discussion of careers that include the option for clinical practice, and a discussion of careers that do not involve work as a practitioner.

Potential Careers and Graduate Degrees

Let's assume that you know that you are interested in gaining training as a practitioner, and you are intrigued by the mental health field. There are then at least six different mental health fields and many different graduate degrees available to you to pursue these interests. The differences between these fields and degrees are quite dramatic. Each involves somewhat distinct training expectations and opportunities as well as different types of career activities.

Are you interested in research? Teaching? Practicing (e.g., offering therapy or conducting assessments)? Consulting? Mentoring students? Working with children, adolescents, adults, the elderly? Do you want to work in a hospital? A university? A teaching college? An elementary or secondary school? A business corporation? Who will your colleagues be?

What kind of job stability do you want? What salary? A consistent salary or one based on billable hours?

How many years are you willing to dedicate toward training? Are you willing to move, perhaps several times, in order to complete all aspects of training?

Not sure yet? Keep reading for more details about which options may be a good match.

You can also find resources on the Careers page of the American Psychological Association's Web site: http://www.apa.org/careers/resources/guides/careers.aspx.

We will offer some brief descriptions (and links) to discuss the six fields below:

1. Social work (terminal master's or doctoral degree)
2. School psychology (terminal master's or doctoral degree)
3. Master's in general psychology (note: work as an independent practitioner rarely is possible with this option)
4. Counseling psychology (doctoral degree)
5. Psychiatry (medical degree)
6. Clinical psychology (doctoral degree)

For doctoral degrees in clinical psychology, we also will offer some comments on the choice between a Ph.D. degree and a Psy.D. degree.

1. SOCIAL WORK

What Do Social Workers Do?

The master's in social work (MSW) is a very versatile degree. Social workers can be involved in many different types of careers and in many different types of settings. Visit the Web sites of the National Association of Social Workers (http://www.naswdc.org/ and http://www.helpstartshere.org/). As you will see on these Web sites, social workers include: *social caseworkers* (providing case management, assessing needs and applying agency services and resources to address social, health, or economic problems); *medical social workers* (working with the special needs of patients and families in hospitals, long-term care facilities, and other medical care facilities); *school social workers* (helping with emotional, social, and economic problems so that students can focus on getting an education); *clinical social workers* (providing psychotherapy and counseling in private practice, psychiatric and mental health care settings, or employee assistance programs within larger companies); *administration and management* (overseeing the programs and systems that provide social, health, and public welfare services); *community organization* (working in cooperation with the community to identify needs and to develop or improve services and systems to meet those needs); *social policy and research* (analyzing social problems, designing and conducting in-depth research studies, and developing ways for social programs and systems to overcome those problems).

What Is the Training Like?

Although you can obtain a doctorate in social work (DSW or Ph.D), it is completely possible to be an autonomous, practicing social worker with a master's degree. With only two years of schooling (plus an internship), it also can be a quick way to get into the workforce. Master's programs generally can accept a much higher proportion of applicants for admission than doctoral programs; thus, it is somewhat easier to gain admission if going this route.

2. SCHOOL PSYCHOLOGY

What Do School Psychologists do?

The National Association of School Psychologists (NASP; http://www.nasponline.org/) has a great Web site that describes the field, the roles, and the salaries of school psychologists.

School psychologists generally are focused on helping children succeed in the school setting, both academically and emotionally. Most work in a school setting. Their work can involve individual consultation with children and families, designing programs to assist teachers with specialized classroom instruction needs, and program development to help train basic skills like anger management and social skills. In these ways, school psychologists are like the ambassadors of psychology in a school setting. When a child is experiencing difficulties, if there is a crisis in the school (e.g., trauma, death), or if administrators are setting a policy that will affect children's educational lives, school psychologists are there to ensure that psychological well-being is maintained and to help educate other professionals on children's psychological needs or limitations.

Another major task for many school psychologists is to conduct assessments of children's academic and social-emotional functioning. Every child who may be eligible for giftedness placement or for learning disability (LD) services needs to be evaluated using standardized assessments. School psychologists typically are the only professionals within the school setting with the training to administer and interpret these types of standardized assessments. LD evaluations in particular have important implications not only for children but also for school policy and funding. Public law mandates that children receive the services they need to

obtain an adequate education, and each child meeting LD criteria must have an individualized educational plan developed and evaluated periodically. School psychologists often serve the lead role in this endeavor.

What Is the Training Like?

You may have heard that to practice as a psychologist, you must have a doctoral degree. That is true for all fields except school psychology. School psychologists can be hired with only a master's degree (plus a year-long internship). This may be, in part, because there is a tremendous shortage of school psychologists working in the United States, and the field is reducing barriers to getting new, bright students into the profession! Keep in mind, however, that master's-level school psychologists are not able to practice autonomously; but they can be hired and even tenured within a public school system (e.g., elementary, middle, or high school).

3. MASTER'S IN GENERAL PSYCHOLOGY

What Is the Master's in General Psychology?

There are not too many terminal master's programs in psychology left, but those that exist offer a nice option for students who wish to gain advanced experience in psychology before pursuing a doctoral degree. Each master's program varies in its training goals. However, many offer graduate coursework and require the completion of a master's thesis to obtain a degree. Programs typically last 1 to 2 years.

There are benefits and drawbacks to the terminal master's degree. The good news is that this is an opportunity for structured education in psychology. The coursework is taught at the graduate level and may even include some specialty work (e.g., training in clinical psychology specifically). The master's thesis offers an opportunity to learn more about psychological research. Students who did not major in psychology during their undergraduate years, or who feel like their interests are not yet well developed, may find this structured educational opportunity enormously helpful.

Unfortunately, the terminal master's degree in itself does not offer many career options. It should be noted that many doctoral programs in psychology offer a master's degree en route to the doctoral degree. Thus, within the 4 to 6 years of doctoral training, a master's thesis may be required, and the degree will be granted—somewhat marking the half-way point of doctoral training. The terminal master's degree is different. Many students in terminal master's programs go on to a doctoral program. Some of these doctoral programs will credit the time in the terminal master's program toward the doctoral training requirements (e.g., some courses or the need to write a new thesis may be waived). However, other doctoral programs will not waive requirements; thus, there is the potential for some repetition in training. A final drawback pertains to the cost of training. Many schools will charge tuition for terminal master's training. In contrast, most Ph.D. doctoral programs in psychology waive tuition and typically offer a stipend. Thus, for students who are certain that they are interested in doctoral training and can gain admission into a Ph.D. program, the terminal master's may not always be a wise option. However, for other students, this can be a very valuable experience!

4. COUNSELING PSYCHOLOGY

What Is Counseling Psychology?

The American Psychological Association's Division 17 is specifically focused on counseling psychology. This division's Web site has a section specifically dedicated to students (http://www.div17.org/students.html) with pertinent information.

A long time ago, a clear distinction between clinical psychology and counseling psychology was offered. The field of clinical psychology was meant to address serious mental illness, such as any of the

disorders that might be found in the DSM. In contrast, counseling psychology sometimes was referred to as a field that addressed "normal people with normal problems," often including vocational counseling.

This distinction remains somewhat true, but the boundaries between clinical and counseling psychology are certainly a bit more blurred. Both require a doctoral degree for independent work. Both are referred to among the public as "therapists" or "psychologists." And few potential clients discriminate between the fields when selecting a therapist. A great many clinical psychologists primarily offer "counseling" to clients with no obvious DSM symptoms. Counseling psychologists also have substantial contact with individuals who meet criteria for some specific disorders (e.g., depression, anxiety, substance use, and eating disorders, for instance).

Counseling psychologists may work in private practice; they also often work in counseling centers (e.g., college student mental health services; community clinics; community mental health centers). Some counseling psychologists also work in academia as professors or clinical supervisors in counseling psychology graduate programs. Counseling psychologists also can conduct and interpret assessments.

To a large extent, counseling psychologists and counseling graduate training programs are less heavily involved in research activities than are clinical psychologists. Counseling psychologists also are less likely to work as professors within university departments of psychology or as instructors in undergraduate classes. As compared to clinical psychologists, counseling psychologists also are less likely to work with severe forms of mental illness, such as autism, schizophrenia, bipolar disorder, etc. See the Web link above for more information on counseling psychology, its mission, and training emphases.

What Is the Training Like?

Like clinical psychology, counseling psychology requires a doctoral degree. Doctoral programs typically require 4–6 years to complete in addition to a year-long internship. A dissertation is required, although the research expectations for this project sometimes are lower compared to those for the clinical psychology dissertation. Counseling programs often involve more coursework and practica than clinical psychology programs.

5. PSYCHIATRY

As you may already be aware, the fields of psychiatry and clinical psychology have some overlap in the types of patients or clients who are seen, the types of services offered, and the types of settings in which members of these professions may work. However, several prominent differences exist between psychiatrists and clinical psychologists; these are briefly outlined here.

First, psychiatry is a medical specialty requiring a medical degree (M.D.), an internship, a residency, and sometimes a fellowship. In contrast, clinical psychologists obtain a doctorate degree (either Ph.D. or Psy.D.) in clinical psychology, complete an internship, and complete an additional year of supervised clinical experience (e.g., postdoctoral fellowship) before obtaining licensure.

Second, psychiatry has traditionally focused on the use of psychotropic medications more than psychosocial treatments (e.g., therapy) to ameliorate mental health symptoms, while the opposite is true for clinical psychology. Many psychiatrists do conduct therapy, although they often use a somewhat different approach that relies on a different theoretical discipline than is emphasized in clinical psychology. Likewise, some states in the United States now are allowing clinical psychologists to obtain prescription authority, if they participate in specialized postdoctoral training. Within the next decade, many psychologists may live in regions that will allow them to prescribe medications to their clients. However, psychologists' training regarding medications will likely be less thorough in scope than the training offered within psychiatry programs.

Third, the majority of clinical psychology training programs adopt a scientist-practitioner or

clinical science training model. This model emphasizes both the science and practice of psychology based on the premise that these educational experiences reciprocally inform one another and are conjointly needed to produce a qualified professional. In contrast, training models in psychiatry typically do not subscribe to scientist-practitioner models; few involve research training or activities.

6. CLINICAL PSYCHOLOGY PH.D. DEGREE

Many describe the clinical psychology Ph.D. degree as one of the most versatile graduate degrees available. Clinical psychologists with a Ph.D. degree are qualified to work as practicing clinicians, professors in academia conducting research or teaching, consultants, and supervisors to other mental health professionals.

As described above, clinical psychologists often are trained in scientist-practitioner programs (often referred to as the "Boulder Model" of training). However, this model often causes some confusion among students evaluating career options. In a scientist-practitioner model (or the somewhat distinct "clinical science" model; see below), students are trained both as researchers and practitioners. In other words, in addition to the research expertise required to complete a master's thesis and dissertation, students' experiences include many "clinical hours" conducting assessments and therapy in a variety of structured, supervised clinical placements to develop practitioner skills. Doctoral Ph.D. programs almost exclusively are located within university departments of psychology that employ clinical psychology professors who themselves are dedicated largely towards research and teaching endeavors. Thus, many clinical psychology Ph.D. students feel that they receive excellent exposure to research experiences during graduate school and perhaps even implicit pressure to pursue a research-oriented career following graduate studies. Indeed, many graduate programs specifically examine graduate applications for information confirming an interest in research.

Yet, the majority of graduates of clinical psychology Ph.D. programs nevertheless pursue careers that involve primarily practitioner experiences. This raises a common question regarding the pursuit of a Ph.D. degree in clinical psychology: Is this the best option for you if you are not at all interested in research?

The short answer is: No. But a longer answer is necessary.

The scientist-practitioner model is based on the idea that clinical psychologists should have expertise in both science and practice. It also is based on the idea that education in both areas is necessary to be fully competent in either. The model suggests that a psychologist who is unable to critically evaluate theories and methods related to practice will be inadequate as a clinician. Similarly, a researcher who has not had exposure to actual clients experiencing psychopathology will be unable to develop and test appropriate hypotheses regarding psychological symptoms or treatment.

An apt analogy may come from a description of graduate training in law. Many who have pursued a law degree state that the curriculum is not specifically designed to teach trial room strategies or jury selection techniques, etc., but rather that graduate training is meant to help students learn "to think like a lawyer."

Doctoral Ph.D. training often is based on the idea that students must learn to "think like a psychologist." This means that students must be extremely comfortable with the scientific method, including the generation of hypotheses, the development of standardized procedures that can be used to evaluate these hypotheses, and the ability to draw appropriate conclusions that may inform future hypotheses. These skills are necessary not only for research endeavors but also when interacting in a therapeutic context. Case conceptualization skills involve a similar set of procedures as described above, and it is this approach that necessitates dual training as a scientist-practitioner during graduate school in clinical psychology. Unlike law school, however, graduate school in clinical psychology involves direct application of coursework learning in real-world situations. Within a year of admission in most programs, clinical psychology graduate

students will begin seeing clients, conducting assessments, and offering treatment (all with supervision, of course).

Thus, the reason why many Ph.D. graduate programs emphasize and even select students who are interested in research is because it is believed that research training helps students develop the critical thinking skills that are needed in any activity as a clinical psychologist.

Having said this, it is important to note that research training is a major emphasis of the graduate curriculum (including a master's thesis, dissertation, etc.). Students who do not enjoy research or the research process will not be happy graduate students. Students who do not anticipate any openness to the possibility of conducting research in their careers, even if only as a small proportion of their job responsibilities, also may not be a good match for Ph.D. training. It is important to be very honest with yourself at this stage in your professional development. The Ph.D. application process is somewhat arduous, and graduate training can be demanding. It is very important to carefully determine whether this is a good match for you.

The "Clinical Science" Option in Clinical Psychology

Although most doctoral programs in clinical psychology have adopted the Boulder Model or Scientist-Practitioner Model of training, an increasing number of programs have adopted a philosophy that emphasizes scientific training above clinical practice. Specifically, these programs have a unified commitment emphasizing the promotion, training, and dissemination of clinical psychology as a scientific discipline. Clinical science programs therefore emphasize training in evidence-based treatments (i.e., those that have substantial evidence supporting their efficacy) and offer opportunities for students to gain exceptionally strong training in cutting-edge research methods. Many of the philosophies of the clinical science movement are reflected in the writings of Dr. Dick McFall, which can be found through the Web site of the Society for a Science of Clinical Psychology (SSCP), in the About the Society section: http://sites.google.com/site/sscpwebsite/Home/manifesto-for-a-science-of-clinical-psychology. Clinical psychology programs that have successfully adopted a clinical science training perspective are members of the Academy of Psychological Clinical Science; a list of these programs can be found on the Members page of the Academy's Web site: http://acadpsychclinicalscience.org/index.php?page=members. The astute student may notice that Academy member programs also are among the most popular in the country, receiving perhaps more applications than non-Academy programs on average. Clinical science programs are believed to produce more graduates who pursue academic careers in clinical psychology and who are more likely to offer evidence-based treatment options to their clients in practice.

Research and Clinical Work in Clinical Psychology

Perhaps you still are unsure whether you are interested in research, or you would like to know more about different possibilities for research activity in clinical psychology. This section discusses three clinical psychology subfields that offer distinct opportunities for research and clinical work.

Most clinical psychology programs offer experiences that could be broadly categorized as fitting the subfields of clinical child/adolescent, clinical adult, or clinical health psychology (or combinations, such as child health psychology). Some programs have specific "tracks" or "concentrations" in these subfields, and some offer more varied experiences across two or more of these areas in a more generalist training model. A brief description of each is included below.

Clinical Child/Adolescent Psychology. Clinical child/adolescent psychology generally is concerned with psychopathology among youth, such as the types of disorders that are discussed in the DSM. *Note*: Although many refer to the field using the term *clinical child psychology*, research and clinical work usually involves exposure to youth at all

developmental levels, including infants, toddlers, school-aged youth, and adolescents. Clinical child/adolescent psychologists may work as practitioners, in academia as professors, or in a variety of settings (e.g., universities, medical centers, counseling centers) in which research, teaching, and/or clinical work is possible.

Examples of Clinical Child/Adolescent Psychology Research and Clinical Work. Much of the work done by clinical child/adolescent psychologists can be organized into general themes of psychological symptoms:

Externalizing disorders (e.g., conduct disorder, oppositional defiant disorder, ADHD)

Internalizing disorders (e.g., anxiety, depression)

Mental retardation and pervasive developmental disorders (e.g., autism)

Serious mental illness (e.g., childhood schizophrenia, bipolar disorder)

For each disorder, there are bodies of literature that examine:

a. Causes and consequences of symptoms, including (1) the study of individual biological, cognitive, and social factors that may be associated with symptoms; and (2) the study of family, peer, school, community, or cultural factors that may affect the onset, presentation, maintenance, or reduction of symptoms
b. Efficacious and effective modes of treatment (i.e., different theoretical orientations), including factors that may modify treatment efficacy or specific therapist and client behaviors that affect the outcome of therapy
c. Prevention strategies
d. Comorbidity
e. Increasingly, research in this area has integrated findings on biological, neurological, and genetic factors that may interact with psychosocial factors in the course of each disorder.

A good idea is to visit the Web site for the *Journal of Clinical Child and Adolescent Psychology* (www.jccap.net) or the *Journal of Abnormal Child Psychology* (http://www.springerlink.com/content/104756/), or to examine these journals using the PsycInfo tool at your university's Web site. Read over the titles and abstracts of some recent issues, and you will get a good sense for the kind of work that clinical child/adolescent psychologists do.

Clinical Adult Psychology. Much like clinical child/adolescent psychology, clinical adult psychology also generally is concerned with psychopathology; however, the population of interest typically is above 18 years of age. Psychologists interested in working with the elderly specifically may focus on *geropsychology*. Clinical adult psychologists represent the majority of all clinical psychologists, although interest in the three subfields of clinical psychology has been becoming more evenly distributed in recent years. Like clinical child/adolescent psychologists, clinical adult psychologists may work in a variety of settings (e.g., universities, medical centers, counseling centers) in which research, teaching, and/or clinical work is possible.

Examples of Clinical Adult Psychology Research and Clinical Work. Clinical adult psychologists' work also is often divided by disorder and diagnosis. Perhaps the most common themes of research and clinical work in clinical adult psychology include:

Mood and anxiety disorders (e.g., OCD, phobias, depression)

Axis II (personality) disorders (e.g., borderline, narcissism, antisocial)

Substance use disorders—sometimes included in clinical health psychology

Eating disorders—sometimes included in clinical health psychology

Serious mental illness (e.g., schizophrenia, bipolar disorder)

For each disorder, there are bodies of literature that examine:

a. Causes and consequences of symptoms, including (1) the study of individual biological, cognitive, and social factors that may be associated with symptoms; and (2) the study of family, community, or cultural factors that may affect

the onset, presentation, maintenance, or reduction of symptoms

b. Different modalities of treatment that may be useful for reducing symptoms in adults, such as individual, group, or couples treatment

c. Efficacious and effective approaches to treatment (i.e., different theoretical orientations), including factors that may modify treatment efficacy or specific therapist and client behaviors that affect the outcome of therapy

d. Comorbidity

e. Increasingly, research in this area has integrated findings on biological, neurological, and genetic factors that may interact with psychosocial factors in the course of disorder.

A quick review of the table of contents in the *Journal of Abnormal Psychology* (http://psycnet.apa.org/journals/abn/) or the *Journal of Consulting and Clinical Psychology* (http://psycnet.apa.org/journals/ccp/) will help to gain a greater sense of the types of research areas that are common in clinical adult psychology. These journals also include articles on clinical child/adolescent psychology and clinical health psychology.

Clinical Health Psychology. Clinical health psychology also is concerned with psychopathology but with a particular emphasis on symptoms or adjustment that is related to some aspect of physical health. Clinical health psychologists interested in working with youth are referred to as *pediatric psychologists*. Clinical health psychologists tend to work in general hospital settings more often than do other clinical psychologists. However, clinical health psychologists also may open a private practice or work in academia as professors, and both options offer a wide range of areas for research and clinical work. Some examples are discussed below.

Examples of Clinical Health Psychology Research and Clinical Work. Much of the work done in clinical health psychology is associated with one of the following questions:

1. Do individuals with a physical illness (e.g., cancer, HIV) or physiological irregularity (e.g., chromosomal abnormality) experience psychological adjustment difficulties?
2. Can psychological interventions be used to help increase individuals' adherence to medical regimens (e.g., for diabetes, asthma)?
3. Can psychological interventions be used to help reduce health symptoms (e.g., encopresis, pain associated with medical procedures)?
4. What factors are associated with individuals' engagement in health risk or injurious behaviors, such as substance use, sexual risk behaviors, and weight-related behaviors?
5. What is the association between psychological and physical health (e.g., stress, immunity)?

Be sure to check out *Health Psychology* (http://www.apa.org/pubs/journals/hea/index.aspx) or the *Journal of Pediatric Psychology* (http://jpepsy.oxfordjournals.org/) for some specific examples of work in this area.

THE PH.D VERSUS THE PSY.D.

A final issue to discuss pertains to two types of doctoral degrees that are available in clinical, counseling, and school psychology. All of the information above describing doctoral training has been focused specifically on the Ph.D. degree. However, a separate option exists for doctoral training. Although we are not experts on this type of degree, we offer a general description of this option here.

The Psy.D. was developed as a new type of doctoral degree several decades ago in response to some opposition regarding the Boulder Model (i.e., scientist-practitioner). Specifically, it was argued by some that the training in science was not necessary to become a practicing clinician, and a new training model largely emphasizing clinical work was developed.

Today, many Psy.D. programs are available. Like other doctoral degrees, Psy.D. programs typically take about 4–6 years to complete (plus an internship year). The vast majority of training experiences are clinical in nature, and involve as well some coursework. Some programs require a "dissertation" document; however, this usually is smaller in scope than what is expected in Ph.D. programs.

Many students ask whether Psy.D. programs are less prestigious than Ph.D. programs. Although it is difficult to comment on this specifically, there are some important differences between these programs that should be noted.

As mentioned above, Ph.D. programs are almost exclusively located within university settings, which are not-for-profit institutions. Some Psy.D. programs, however, are located in for-profit institutions, such as freestanding "Professional Schools of Psychology." Most Ph.D. programs typically waive tuition costs for graduate students and offer assistantships that provide a modest annual stipend (typically between $12,000 and $18,000); many Psy.D. programs charge tuition to students, which can cost approximately $10,000–$20,000 annually.

There currently are no formal rankings of doctoral programs in clinical psychology that are generally considered to be reliable or valid. However, attempts have been made to document the quality of graduate programs in a variety of ways. For example, since all North American psychologists who wish to obtain a license to practice must take a standardized exam (called the EPPP), one metric for examining the quality of graduate training and graduate admissions may be to compare average scores on the EPPP among graduates of each program. Results from this analysis, conducted over 10 years ago, can be found on the Web site of the Social Psychology Network, at http://www.socialpsychology.org/clinrank1997.htm. These data should be interpreted with caution. However, a notable trend is evident. The average mean of EPPP scores from Psy.D. programs is notably lower than that of Ph.D. programs.

Overall, the Psy.D. option can be an excellent choice for students who are interested in obtaining a doctoral degree in psychology and have decided that they do not wish to be involved in research—either during graduate training or during their career. However, the Psy.D. option should be exercised cautiously. Some very high quality programs are available (often those that are at not-for-profit institutions), and excellent training is certainly possible. However, applicants will need to do their homework to thoroughly investigate the adequacy of training if pursuing this type of degree.

The Council of University Directors of Clinical Psychology (CUDCP) has produced a set of guidelines for students who are interested in pursuing clinical psychology careers. This document can be found on the Web site of the CUDCP, under Graduate Training: http://cudcp.us/files/Reports/CUDCP_2011_Psy_Grad_School_Fact_sheet.pdf

Deciding Where and When to Apply

We hope you have begun to gain some insight into the type of career you may wish to pursue and that you have considered various possible graduate programs that may be right for you. You may be wondering whether you can apply to more than one type of graduate program.

In short: Yes. Application to different types of graduate programs is somewhat common. Given how low admissions rates are for clinical psychology Ph.D. programs, applicants sometimes also apply to other types of graduate programs in related disciplines.

Some applicants apply to graduate school during their senior year in college. However, an increasing number of applicants wait for 1 to 3 years, during which time they work as a postbaccalaureate research assistant or in a related position. Neither of these options in itself is likely to determine the outcome of your applications; however, obtaining a "postbac" position may help you gain needed experience. Apart from CV (curriculum vitae)-building, the decision to take time away from school may be a personal decision based on your readiness. Some pros/cons are listed next.

Taking Time Away from School: Pros

- Being a graduate student is a very different experience from being an undergraduate student, and for many people it can be difficult to make this transition with only a summer in between. Graduate school in psychology is not about studying well for tests and maintaining a high GPA. In a doctoral program, you will be

working with professors as colleagues. You will likely be responsible for organizing and running large projects. You will be expected to balance these duties with your coursework. You will be expected to actively participate in most of your classes, some of which may have only a handful of students. In many clinical psychology programs, you will likely begin conducting assessments and/or therapy with real clients very early in your graduate training (possibly at the end of your first year).

- It can be challenging to apply to graduate school while balancing college coursework and perhaps a senior honors thesis. Applying once out of school (especially if working a "9 to 5" job) may allow an applicant more time to complete applications.
- Working in a psychology lab after college may be necessary for admission to a top clinical psychology program if you received little research training as an undergrad.
- Working in a psychology lab or a related organization after college can help you refine your research interests, figure out what you want to study in graduate school, and figure out which type of graduate program might be best for you.
- Applying to graduate programs after completing all undergraduate coursework and projects allows applicants to discuss their completed undergraduate honors thesis (if applicable) during the application process (e.g., in personal statements and during interviews).
- Working a full-time job before graduate school may allow applicants to save up money that can be very helpful to have as a graduate student.
- It is not a good idea to enter graduate school immediately following college "just to get it done." In the larger scheme of your life, it probably will not matter if you get your doctoral degree at age 28 or age 30, and you will probably not be a happy graduate student if you try to race through graduate school with the goal of just *finishing*.

Taking Time Away from School: Cons

- Some people do not want to lose momentum: They are ready to begin graduate school and have no interest in taking time off in between.
- Trying to find a psychology-related job for the year or two in between college and graduate school may be challenging and stressful.
- If you apply to graduate school while still in college, you will be able to consult professors and graduate students in person as you decide which schools to apply to, work on your personal statements, and complete your applications.
- If you apply to graduate school while still in college, you will be able to distribute materials for letters of recommendation in person, pick up transcripts in person, perhaps visit your college's Writing Center for help with your personal statement, and have access to all the resources a college campus offers.
- It is easier to defer student loans if you remain a full-time student without a break in between.
- If you go straight through from college to graduate school, you will finish grad school earlier; if you graduate from college at age 22, you could have your Ph.D. by age 27. This is very appealing to many people.

Before You Apply: Enhancing Your Application

Years before you submit your application to doctoral programs in clinical psychology, you can accrue experiences that will help build your credentials. Two such opportunities are discussed next: research and clinical experience.

Obtaining Research Experience. Perhaps the single most important thing you can do to improve your chances of graduate school admission is to obtain research experience. However, note that research experiences can vary considerably. As an undergraduate student, you may have opportunities to become involved in a faculty member's lab and

to engage in a variety of possible tasks. It is quite common for undergraduate students to assist with data entry, library research, data coding, data collection—perhaps involving interactions with research participants or other tasks that may be specific to the type of research you are interested in (e.g., computer programming, creation of study materials or stimuli, statistical analysis).

What is the best research experience to get? No single type of research experience is necessarily better than another (although some are admittedly tedious, perhaps). More important is that your research experience helps you to accomplish three goals. First, it is important for you to become exposed to the research process to determine whether you enjoy this type of work. You will undoubtedly observe that research is a very time-consuming, detail-oriented, meticulous endeavor that may take months or even years before achieving results. Research also can be remarkably invigorating, allowing you to examine ideas that are important to you, rigorously test these ideas, and then disseminate your results to the international community of psychologists through conferences or manuscripts! Research is not for everyone, and this exposure may help you to learn whether this is an activity that you want to become thoroughly involved in for many years to come. If you do not find that you have a passion for at least one aspect of the research process, it may be challenging to retain the stamina needed to successfully complete independent research projects as a graduate student.

A second goal of your research experience is to learn about the type of research questions that interest you the most. Assistance on a study related to adolescent girls' depression may help you to learn that you enjoy, or do not enjoy, working with adolescents, examining gender-related issues, or studying internalizing disorders, for instance. Your work on a project examining therapy process variables that increase the efficacy of behavioral treatment of externalizing symptoms may help you appreciate applied research questions or increase your desire to study precursors that predict the onset of oppositional behaviors. Importantly, when you apply to graduate programs, it will be necessary for you to have some focus regarding the type of research you would like to conduct.

Third, and perhaps most important, it is essential that your research experience allow you to become educated regarding the scientific questions under investigation. Too many undergraduate students gain research experience that helps to develop specific skills (which is certainly very important!), but not a broader understanding of what the research is about or why it is being conducted.

Offering a scientific contribution to the research project can be difficult and intimidating, however. Some students feel reluctant to offer ideas and input during lab meetings that include mostly graduate students, postdocs, and faculty members. It also may feel somewhat challenging to schedule an individual meeting with your faculty mentor to discuss your ideas. We strongly recommend that you attempt to do so, however, to get the most out of your research experience. A good start is to request some articles that will help you to read a bit about the area under investigation. Then, it is worth spending a few hours on PsycInfo looking for related articles that help you to understand how multiple investigators have thought about the issue you are studying. Then try asking some questions or offering some opinions and thoughts during a lab discussion. Your ideas do not need to be revolutionary; they should simply help you to understand more of what is going on and indicate your interest and curiosity. For instance, you may want to know: "Why are we measuring variable X this way?" "Is this related to theory Y that is discussed in this article I read?" "I wonder if examining Z would help us to understand the issue better."

Your research experience should help you to "think like a scientist," and even if you are simply entering data, you might be able to observe something that allows you to develop a question about the nature of whatever it is that you are studying (e.g., "Everyone responds with a '1' to this item; perhaps we are not assessing this well"). Incidentally, demonstrating this ability to your faculty supervisors also will help them write you a letter of recommendation when you apply to graduate school.

As we have discussed, admission to psychology Ph.D. programs is quite competitive. Successful applicants now typically have amassed considerable research experience before applying to doctoral programs. In addition to work in a research lab as a volunteer, or for a semester of course credit, other options include the completion of an honors thesis or taking a full-time research assistant position for 1 to 2 years following the completion of the undergraduate degree. The honors thesis is a particularly excellent opportunity to gain research experience; the thesis helps you to develop and demonstrate independent research skills by developing and testing your own hypothesis. The thesis also helps you to gain substantial exposure to a faculty member who can provide mentorship on your thesis and later write you a letter of recommendation. A full-time research assistant position also can be a terrific opportunity. In this role, you will develop advanced knowledge and skill in the detailed procedures required to conduct an investigation, to work closely with a faculty member, and often to supervise undergraduate research volunteers. While neither the honors thesis nor the research assistant position is *required* for entry into graduate school, a remarkably high proportion of successful applicants to top Ph.D. programs do have one or both of these experiences.

Obtaining Clinical Experience. Many students ask whether they need to obtain clinical experience to gain entry into doctoral Ph.D. programs in clinical, counseling, or school psychology. In our opinion, the short answer is: No.

Clinical experience allows you to gain exposure to populations who are experiencing psychological symptoms. For this reason, it can be a good experience, and perhaps one that you should have before embarking on a clinical career. This experience also will help you learn to develop rapport with individuals of different ages and in different settings. Some clinical experiences occur in excellent treatment facilities (or in treatment/research summer camps for youth with psychopathology), and these particularly can be excellent experiences.

However, since your role during this clinical placement will not be that of a true clinician, the skills you develop are not necessarily going to increase the attractiveness of your application significantly. In other words, you will learn all you need to know about clinical work during graduate school, so these experiences are not needed to demonstrate any specific expertise. If you believe this experience will help you determine your interests and career choice, then it is a terrific idea. If you have already decided to apply to clinical Ph.D. programs, and you have a choice between a research and clinical experience, then choose research, research, research.

Applying to Ph.D. Programs in Clinical Psychology

Table 1 offers a sample timeline to help accomplish the many tasks that are required when applying to doctoral programs in psychology. This section offers a few considerations for several of these steps.

Selecting Potential Schools and Mentors

For most graduate programs in psychology, you will be working with a primary research advisor, becoming immersed in various projects in his or her lab. In most cases, the match between you and your advisor is even more important than the characteristics of the overall program. It is important that this person's research *thrills you*, because you will be working on that research for 4 to 6 years! Keep in mind that if you do not have research experience in a potential advisor's area of expertise, you will need to be able to explain clearly in your personal statement how your interests have led you to apply to work with this person and why you think you are a good match for the lab.

This reflects a general issue related to your decisions on how to select graduate programs. You probably are already aware that at the next stage of your career, your graduate school experience will be evaluated not simply based on the reputation of your Ph.D. program but also on the reputation of your mentor and your productivity

TABLE 1 Monthly Tasks for Successfully Managing the Clinical Psychology Graduate School Application Process

Prior to August of the year in which you are applying

- Obtain research experience
- Choose type(s) of programs to apply to
- Study for and take the General GRE
  - Send score reports to schools you are most interested in
  - Keep track of which schools are sent these scores; as score reports are sent following each test, some schools may not receive both your general and psychology scores, so it will be necessary to send another score report after you have taken both tests
- (If necessary) Study for and take the Psychology GRE
  - Send score reports to schools you are most interested in
  - Keep track of which schools are sent these scores (see above)

August

- Research schools and advisors
- Read sample personal statements
- Create a draft of your CV
  - Ask for comments from mentors, university career center, etc.

September

- If not listed on their Web site, contact potential advisors to see if they will be taking students
- Finalize list of schools to apply to
- Create an organizational system for applications
  - Obtain and file paper copies of all application materials for reference
- Ask professors to write your letters of recommendation
  - Include a copy of CV, list of schools, and deadlines
  - Ask for writers' preferences (e.g., whether they want to submit materials online or through the mail; when they would like to receive reminder e-mails)
  - If sending paper rather than online letters, provide recommenders with prestamped, preaddressed envelopes, and be sure it is clear which envelope goes with which school
- Brainstorm and write first draft of personal statement

October

- Solicit feedback from mentors on personal statement draft
- Order remaining GRE score reports
- Order transcripts
- Write drafts of supplemental essays
- Begin filling out application forms online

November

- Final draft of personal statement and supplemental essays
- Complete application forms for all Dec. 1 deadline schools
  - If mailing forms, make sure to mail several weeks in advance
  - Check to make sure all materials have been received
- Check with recommenders about letters
- Last chance to take the Psychology GRE
  - Order remaining GRE score reports

December

- Complete application forms for remaining schools (if mailing forms, make sure to mail several weeks in advance)
  - Check to make sure all materials have been received
- Thank everyone who helped you with the application process
- Breathe a sigh of relief and enjoy the holidays!

January, February, March

- Receive interview offers (phone interviews and official visits)
- Prepare for interviews:
  - Look up work by potential advisors
  - Make lists of questions for potential advisors and current graduate students
- Go to interviews:
  - Dress professionally
  - Ask lots of questions
  - Be gracious towards everyone you meet

February, March, April

- Thank people who interviewed you and reiterate your interest in the program
- Hear back from schools after interviews
  - If multiple offers, narrow down as quickly as possible

April

- Make your decision!

with that mentor during graduate school. This is different from the undergraduate application experience, which can be discussed in terms of various ranking systems of university reputations (e.g., *U.S. News and World Report*). Remember, rankings are not generally considered to be very reliable for Ph.D. psychology programs (at best, one might use existing graduate ranking systems to identify programs in the top quartile, second quartile, etc., but rankings more specific than that are somewhat arbitrary). Ph.D. programs in clinical psychology sometimes are located within universities with excellent reputations for undergraduate training, but sometimes not. Similarly, the best possible mentor with whom to study a particular area of research sometimes will be located at a graduate program generally regarded to be of high quality, but sometimes not. Thus, your application decisions may reflect an interest in a program, a mentor, or both. Your personal statement should reflect these interests.

You can learn a lot about a potential advisor through online searches. Here are some specific things to look for while deciding whether to apply to work with a psychology professor:

- How many publications does he or she have? If there are many, then it may be more likely that you will have an opportunity to earn authorship on many publications during your time in graduate school.
- Are the publications in good journals? (You can ask a graduate student or professor for help in determining this.) Both quantity and quality of publications will be important when people evaluate your research productivity later in your career.
- Are the graduate students in this person's lab also authors on the publications?
- Is this person an assistant, associate, or full professor? People differ in their opinions about whether it's better to work with a young professor or a tenured professor. Assistant professors need to produce high-quality research and high-quality publications in order to get tenure, which will likely have benefits for their graduate students' productivity and CVs. On the other hand, assistant professors are less likely to have job stability and connections in the field than tenured professors, and they may have less energy to focus on their graduate students' careers, compared to tenured professors who are no longer struggling to build their own careers and reputations. However, yet another factor to consider is that very senior faculty members may not be as actively involved in new research projects as professors earlier in their careers.

When evaluating the quality of clinical psychology Ph.D. programs, pay attention to the program statistics posted on their Web sites. All APA-accredited psychology doctoral programs (i.e., clinical, counseling, and school psychology only) are required to report statistics such as average GRE scores and GPAs, acceptance rates, and average time it takes students to get through the program. Be wary of programs that do not have a high completion rate; it may be a bad sign if many students are not finishing the program. Also, a less-understood but very informative statistic is the match rate—the percentage of students who were placed in one of their top-choice internship sites after completing their coursework and dissertation. Most top-quality programs have average match rates (across 5 years) of at least 75%.

The General GRE

GRE scores are used as an important marker of potential success in graduate school. As with GPA, the higher the score, the better. The General exam has recently changed in format and scoring. Consequently, percentile scores are often evaluated more closely than the standardized scores. The program Web sites mentioned above include data regarding the averages and ranges of GRE scores for admitted students. Also, the APA offers a book with information on every program, as well as data regarding admission criteria, called *Graduate Study in Psychology*. You can find the latest edition through the APA Web site: http://www.apa.org/pubs. In practice, we believe most all successful applicants

achieve scores exceed the 75th percentile on each section; however, *significant deviation* in these scores is allowed when considering cultural and language limitations of the GRE. The more competitive the program (i.e., the smaller the ratio between accepted applicants/total applications), the higher the GRE score that is needed to gain admission.

The Psychology GRE

The Psychology GRE used to be relatively unimportant to most doctoral programs in psychology. However, this may be changing as the Psychology GRE may be used to help fulfill competencies required within the doctoral training sequence for clinical, counseling, and school psychology programs. In addition, a minority of doctoral programs place very high priority on the Psychology GRE during the admissions process.

The Psychology GRE is very different from the General GRE. The Psychology GRE straightforwardly assesses your knowledge of the subfields of psychology. There are fewer strategies and "tricks" you can learn for this test; you simply have to learn the material. If you are a psychology major, you likely will already have learned most of the relevant material but will need to refamiliarize yourself with it, and there may be areas of psychology to which you have had less exposure. If you were *not* a psychology major, you will have to learn more new material. Also, if you were not a psychology major, your score on this test will be more important than it is for psychology majors; for nonpsychology majors, the score demonstrates to admissions committees whether you have the appropriate background knowledge that psychology majors should have learned during college.

Contacting Potential Mentors

With the advent of e-mail, students more commonly began to write potential mentors to inquire whether applicants would be accepted in the lab this year and/or to generally express an interest in the graduate program. This is a terrific idea, and many mentors will be very appreciative of such e-mails.

However, it is important to remember that some mentors may receive a large number of e-mails from applicants during high peak months of the application process. Therefore, it is important to be patient and forgiving when waiting for a response from faculty. It also is often a good idea to carefully review information available on the program and the faculty member's Web sites, as answers to some of your questions may be available online. Most faculty will be happy to answer your questions and correspond when possible. Be aware, however, that such correspondence is certainly not necessary and often plays little to no role in your admissions outcome.

If you do e-mail professors, make sure your e-mails are professional, are not overly wordy, contain no typos, and do not include questions that are answered on the program's Web site.

If you e-mail a professor to ask if he or she is taking students because the info is not on the Web site and if the professor does not respond, you can contact the program administrative assistant or you can go ahead and apply. Some faculty members do not know if they will accept students until later in the year; they may be waiting to hear about funding, or they may want to see the applicant pool before deciding whether or not they want to interview people.

Keep in mind when you write to and/or talk on the phone with program administrative assistants that they often play a *huge* role in the application process. In some programs, it is the administrative assistant who first reviews all applications and decides which ones will be passed on to faculty. If you are rude or condescending in your e-mail or phone contact with an administrative assistant, the director of the program will probably hear about it.

Letters of Recommendation

Most schools ask for three letters of recommendation. At least two should be from people with doctoral degrees in psychology. The people whom you ask to write your letters should know you well as a student. At least one of your letter writers should be able to comment on your research skills and

experiences as well. It sometimes may make sense to include four letters, but please keep in mind that doing so requires more reading for bleary-eyed application reviewers, and an extra letter does not gain you any extra credit.

Letters of recommendation are extremely important, so choose your recommenders wisely. These letters are the tools potential mentors will use to decide whether you would be a good person to have in the lab for 4 to 6 years; this is not trivial decision. A bad or even a lukewarm letter of recommendation can substantially diminish your chances of admission. Potential advisors will not be impressed by letters that offer "faint praise"; your letters should come from people who know you very well and who will be able to offer very detailed and enthusiastic comments and praise about your strengths as a student, research assistant, and lab member.

It is a good idea to send your letter writers the full list of schools to which you are applying as soon as it is final. Depending on your relationship with each letter writer and how organized they seem, it may be a good idea to send reminders about upcoming deadlines as they approach (but refrain from sending an annoying number of reminders!). It also may be helpful to give each of your letter writers a copy of your curriculum vitae (CV) or résumé, depending on how well they know you.

No matter how or when you are asking someone to write you a letter of recommendation, remember that they are doing you a favor. Your goal should be to make your letter writers' job as smooth and easy as possible. Make sure to ask exactly how they would like you to send them the materials. Many professors are willing to submit recommendation materials online (and many programs now highly encourage or even require this), but some professors prefer to submit the materials offline (i.e., printing the letters and sending them through the mail). From your perspective, it will be much easier and simpler if your letter writers submit their materials online, but you should respect their preferences, unless you are applying to a program that *requires* materials to be submitted online.

The Personal Statement

The vast majority of personal statements follow an identical format. First, a brief anecdote is offered describing a watershed moment in which the applicant fully realized an interest in psychology. Next, a brief section describes the applicant's enthusiasm for one or more psychology undergraduate courses. Research experiences then are described in succession. For each experience, the title and principal investigator of the project are listed, followed by a list of the applicant's responsibilities and tasks on the project. The statement often ends with a brief paragraph describing research interests, career interests, admiration of the graduate program, and perhaps the name of a specific potential mentor or two.

This type of personal statement is fine. It accomplishes many of the main objectives that the personal statement is meant to serve. It indeed is important to clearly state research experiences, to express enthusiasm for and a match to a specific aspect of the graduate program, and to articulate clear research and career goals. It also often is a good idea to identify a potential mentor.

Yet, this type of statement is not quite as effective as it may be, in part because so very many statements appear to be remarkably similar to one another. We believe that the statements that truly distinguish themselves are those that demonstrate evidence of the potential to become an independent investigator. As a graduate student, you will be expected progressively to develop research skills that will establish you as an independent scholar. To the extent that it is possible to convey this within the personal statement, you may be able to make your potential to excel as a graduate student very clear to the reader.

Listing research experiences, principal investigators, and project responsibilities can accomplish an important goal. Often, your experiences will reflect exposure to a project with goals that are particularly relevant to the potential mentor's own research; a large, impressive project; or an undergraduate mentor who is known for producing excellent training experiences among their students. This can indeed be very helpful to your application

in that it expresses a great foundation on which to build during graduate training. If your potential graduate mentor is familiar with your undergraduate mentor's work and reputation, you may benefit from positive assumptions and attributions made about you and your undergraduate work.

Conveying an accounting of your various responsibilities on research projects also can be useful to help describe your readiness to assist in ongoing projects in your graduate mentor's lab. You may even possess a particular skill that is lacking and needed in the lab; thus, you will be a particularly strong asset to your new environment.

Graduate mentors may differ in their selection criteria. Many are extremely excited to have an enthusiastic and experienced applicant join the lab. Others may be mostly concerned with your academic ability and interest in their research, knowing that they can train you to complete whatever tasks are needed in their lab. However, all graduate mentors likely are invested also in seeing you succeed as an independent scholar. Thus, we believe an applicant "can't go wrong" by going a step beyond this common format and clearly conveying an aptitude for independent research.

Perhaps more important than a list of prior research experiences and responsibilities is a brief description of *what you learned* from each of these research experiences. What was the project about? What were the hypotheses that interested you the most? Are you familiar with any of the literature that is related to the research project? How did your experience in this research project help shape your interests?

In other words, the personal statement should not simply restate your CV or résumé, but rather should help the admissions committee understand what is "between the lines" of your CV/résumé. A description of your responsibilities might indicate that you "coded and entered data using SPSS on a project examining autism." But in addition to this information, you might also indicate that "the project was designed to examine the efficacy of IBT treatment" and that you were "particularly excited by the opportunity to examine different treatment approaches in an applied research setting," or that you "observed that children's intellectual ability notably changed the presentation of PDD symptoms," leading to your "strong interest in studying Asperger's disorder."

As you can see, the inclusion of these statements is perhaps somewhat subtle. However, we believe it can be quite helpful for the admissions committee to "see how you think," understand the motivations behind your research interests, and also your knowledge of the literature or theories involved in your past work. The applicants who do this successfully have personal statements that appear qualitatively different and often are more successful.

Should You Mention a Specific Mentor? Short answer: Yes. But keep in mind that programs vary considerably on how graduate students are selected. Some programs allow each faculty member to make unilateral decisions regarding graduate admissions. Thus, your application is really meant to convince a single person to admit you, and your potential match with that person will be evaluated directly. Other programs make group-based decisions to varying degrees. It still may be important to express a match to a specific mentor, but your general match with the program, and perhaps with other potential mentors, also will be evaluated.

When listing the name of a specific potential mentor, this statement should be accompanied by a discussion of why you want to work with this professor, what you specifically hope to study with this person in graduate school, and how your background and interests make you a great match for this person's lab. Some professors will do a search for applications that contain their name and then read those personal statements. It can also be a good idea to name a second professor whose research interests you, but if that person studies something completely different from the first person you mentioned, this will suggest that you have not focused your research interests. For example, if you say you are interested in the research of a professor who studies adult anxiety disorders and at the end of the essay you state that you are also interested in the work of a professor who studies

childhood externalizing disorders, these two professors might question your commitment to their specific areas of research. You want to convince the person reading your essay that he or she is the best match for your research interests and that you are the applicant who can offer the best contributions to that lab. To do this successfully, it is important to create a clear picture of how your interests developed. Many people make the mistake in these essays of talking about their general interest in psychology, then their coursework, then their lab work, then their specific research interests, in discrete paragraphs with no clear "arc" showing how all these experiences are linked.

Some applicants apply to work with a professor whose research interests are quite different from those the applicant has studied in the past. For example, perhaps you are interested in studying ADHD in grad school, but as an undergrad you studied bipolar disorder. If this is the case, your job in the personal statement is to clearly explain why you would nevertheless be a good match for this lab. The person reading your personal statement may be reading essays from dozens of other applicants who have worked for two or more years in an ADHD lab, so you will need to convince this professor that there are other excellent reasons to offer you an interview. Think about the aspects of your training that have prepared you for research in ADHD and that have more broadly prepared you for success as a graduate student. Put yourself in the shoes of the potential future advisor reading dozens of essays and then critically read your own essay from the perspective of this specific professor, asking yourself: "Would I want to offer this applicant an interview?"

After Applications Are Submitted: How the Admissions Process Works

Admission into psychology clinical Ph.D. programs is highly competitive. In fact, admission to clinical programs is more competitive than any other type of graduate program, including law, medicine, etc. For many clinical programs, approximately 2–5% of applicants (often about 3 to 8 out of 150 to 350) are admitted. Every graduate program in psychology differs in their evaluation and admissions procedures, but most all programs use some type of multiple hurdle system that evaluates applicants in several stages based on different sets of criteria. These hurdles and criteria are discussed below.

Educational Background

Typically, the evaluation of applications begins with a review of basic educational credentials. Sometimes this stage of the evaluation process is conducted by the university's graduate school, or an administrative person, rather than a psychology faculty member. Thus, the review is fairly brief, blunt, and admittedly imperfect. Factors evaluated include the quality of the undergraduate institution, the undergraduate GPA, and the GRE scores.

At this stage, you likely already have selected, and perhaps are close to graduating from, your undergraduate institution. There is little you can do to change that now.

Which GPA? Students often ask whether their overall GPA or their psychology (major) GPA will be evaluated. In our experience, the overall GPA is given far more weight than the psychology GPA. In many cases, however, undergraduate students began school with hopes of pursuing a premed curriculum, then, after several low grades, switch career aspirations. In such cases, an applicant's overall GPA may suffer from these few low grades. In this situation (particularly if this has been noted somewhere in the application; most appropriately by a professor writing a letter of recommendation), the evaluator may briefly glance at the transcript to see if a single outlier grade or two is contributing to a low overall GPA. To be frank, however, we believe that even in this situation evaluators will focus only on the overall cumulative GPA. For clinical Ph.D. programs, it is extremely rare for students to be admitted with a GPA below 3.0. The vast majority of admitted students have a GPA above 3.4 or 3.5. As noted above, you can visit the Web site of almost any accredited clinical, counseling, or school psychology program to obtain GPA averages and ranges

from the last few classes of admitted students (look for links that indicate "performance and outcome data"). A link to data for all programs in clinical psychology can be found on the Web site of the Council of University Directors of Clinical Psychology (CUDCP): http://cudcp.us/address/univlinks.php.

Students sometimes ask whether specific undergraduate courses might increase or decrease the likelihood of admission. In reality, transcripts are infrequently scrutinized, particularly for psychology majors. Because the psychology major typically includes a similar set of classes in most all undergraduate institutions (e.g., research methods, statistics), it often seems unnecessary to examine the course choices of every applicant. You will not get into graduate school simply because you took one or two advanced or difficult courses, and you will not be denied admission simply because you took Advanced Basketweaving as an elective.

What If You Didn't Major in Psychology? The vast majority of admitted students have majored in psychology. But a significant minority has not. Applicants who have not majored in psychology likely need to have even more research experience to demonstrate a familiarity with the field. The psychology GRE score also may be more heavily weighted for these applicants.

General Match to Program Values and Training Experiences

Students who make it past the first hurdle of application evaluation (anywhere between 20% and 50% of applicants do) next are evaluated to determine a general match to the overall program values and possible training experiences. There are three main reasons why an application would not make it past this hurdle:

1. The students' career interests simply do not reflect the values of the program. Perhaps most commonly, an applicant applies to a program that emphasizes research training yet expresses no interest in research and/or has no research experience. Or, conversely, it may be that a student with an exclusive interest in research applies to a clinical program that emphasizes clinical training. Or, a student may express an interest in a specific theoretical orientation that is not emphasized by the graduate program.
2. The student expresses an interest in an activity (e.g., studying schizophrenia) that simply is unavailable. This may be for one of four common reasons:
   a. First, it may be that this training experience never has been offered in the program, and the application appears to have been submitted merely due to the reputation or location of the program.
   b. Second, it may be that the activity was directed by a faculty member who has since retired or left the university. It is essential that you check the Web site regularly for each program to which you apply.
   c. Third, it may be that the faculty member providing this activity is still in residence but will not be accepting a student this year.
   d. Fourth, the faculty member is in residence and accepting students but has changed research interests recently.

   Regarding points (c) and (d), please see information above regarding suggested strategies for contacting potential faculty mentors before the application process.
3. The application contains information that is widely inappropriate and unprofessional. Applicants who disclose their own psychopathology, for example, are often "screened out" at this stage.

Specific Match to a Mentor and Research Program

At this stage during the admissions process, each faculty mentor who is accepting students usually offers input regarding 5 to 20 applicants who have excellent educational credentials and are a general match to the program. At some programs this is referred to as the "short list." This stage of the

admissions procedure becomes remarkably difficult for the faculty member and/or admissions committee. Quite frankly, there are many extremely well-qualified applicants, and by this stage of the process, it often is apparent that any one of the short-list members would do quite well in graduate school. Similarly, many faculty feel that they would likely be happy with any of these highly talented applicants.

Yet, decisions nevertheless need to be made, and the types of factors that go into admissions decisions at this point can be inconsistent or even unpredictable. In other words, students who make it to the short list and then the interviewing stage should not feel personally offended if later denied admission. This is truly a difficult process.

Despite some of the idiosyncrasies and serendipity involved in this stage of the process, there are some clear factors that still can make a difference in your fate, including the personal statement described in the previous section and the interview, described next.

The Interview

Waiting to receive interview offers from schools can be a very stressful, anxious time for applicants. Interview offers may come by e-mail or phone between early January and mid-February. In some rare cases, they might arrive earlier or later. They might come at any time of day. In most all Ph.D. programs in clinical psychology, the interview occurs before final admissions decisions have been made.

Note that it is becoming increasingly common for professors to have phone interviews with their top applicants prior to offering invitations for in-person interviews. Sometimes professors who want to conduct phone interviews will e-mail their applicants in advance to schedule a phone date. However, other professors may call you unexpectedly to have a spontaneous phone interview.

At most universities that conduct in-person interviews prior to admissions decisions, about 3 to 6 applicants are invited for an interview for every one admissions slot available. Suddenly, the odds are looking much better for you! The 100 to 600 applications received by some doctoral-level psychology graduate programs have been narrowed to just a few dozen, and for the lab you are most interested in, just a small handful of applicants will be coming for an interview. However, referring to this next stage of the process as an "interview" incorrectly portrays the experience as a process in which faculty are exclusively selecting students. In reality, a large proportion of interview-invited applicants have more than one site to visit, which means that students are evaluating and selecting programs as much as vice versa. You have a lot of "power" in this situation, and you will need to gather a lot of information to make one of the most important decisions of your professional life.

Scheduling the Interviews

Although occasionally a program may be able to help defray the costs of your interview travel, it is most likely the case that you will need to pay for all travel expenses on your own. Once you hear about an interview, you will probably get some details from the program about ways that they can help you make your travel as easy as possible. Many programs will have someone take you to/from the airport, and most all will give you the opportunity to stay with a graduate student to eliminate hotel expenses. Keep in mind that flights are commonly delayed in winter, and luggage is lost frequently. Plan to wear a suit on your interview day, and consider packing it in your carry-on bag.

One of the first questions that arises when applicants begin hearing about interviews pertains to inevitable dilemmas in scheduling. Most interviews occur in the months of January, February, and March. With just a few possible weekends to organize a day for applicant interviews, it is quite likely that you will experience a scheduling conflict between two schools that have extended invitations. Sadly, there is no easy solution to this dilemma. Some schools may offer multiple dates for you to visit; others will not. Sometimes you can arrange your own informal visit on a date that is convenient for you; however, the depth of

information and number of people who will meet you likely will be reduced as compared to the experience you would have on the formal "Interview Day." In some cases, you may learn of an impending conflict between a site that has offered you an interview and another site that has not yet but might soon extend an invitation for the same date. It is perfectly appropriate to call a site and ask when their interview dates may be, but of course, do not assume that you will be getting an interview, and be sure not to sound presumptuous in your request for information.

When dealing with such scheduling conflicts, please be extremely sensitive to the difficulties involved for the program in coordinating a large interview day for its applicants. A tremendous amount of planning and expense is dedicated to these days; be sure to request exceptions only with great care and consideration for how much work is involved for your hosts. Also, if wrestling with a scheduling conflict, make sure your communication with a program clearly expresses your interest level in the site accurately. If you must cancel, rearrange, or decline an interview invitation, be sure that the faculty understand whether this is a reflection of your interest in their program.

Thanks to modern technology, sometimes it is possible to be at two places at once. For instance, if you request early-morning interviews at one site, you may be able to schedule late-afternoon interviews at another by Skype or phone. Although this is certainly not a perfect solution, and could require some flexibility and understanding among your sites, it may be a workable solution in today's technology age that helps to resolve a conflict. If a site invited you for an interview, they know that you are a strong applicant and should not be surprised to learn that you have gotten other interview offers as well.

What Will Happen During These Interviews?

Most applicants return from interviews quite surprised at how little they were interviewed! In other words, most expect to be asked many questions, but in fact find that they are doing most of the asking during these visits. This is an extremely important reality that will help you prepare for the interview in a way that is different from what you may have expected.

No faculty member will quiz you on statistics, the details of their own recent publications, or the names of historical figures in psychology. Preparing for the interview should not feel like studying for a psychology midterm. Rather, you should create a list of many questions that you would like to ask while on the interview. In fact, we would suggest that you never run out of questions! Asking questions is a great way to get answers, but for interviewing purposes, it also is a terrific way to convey that you know what you are getting into, you understand what graduate training will involve, you are enthusiastic about this opportunity, and you are conscientious enough to have done your homework about the program and its training opportunities.

But how do you know what type of questions to ask? Unfortunately, most all graduate programs in clinical psychology sound very similar on paper and on the Web. It is hard to get a sense of the factors on which programs vary until you have visited a few. This will not be a problem when you arrive at your fourth interview, but how will you know what to ask on your initial interviews?

One recommendation is to download the program handbook from two to three graduate programs; it does not matter if they are programs you applied to. Any handbooks will do. Skim through them, and you will start to notice differences. Some may mention multiple practicum opportunities; others will have a standardized training sequence. Some may give students many choices in coursework; others may provide more structure in students' schedules. Some programs offer teaching and research assistantships (TAs and RAs); others may offer fellowships too. Some may have a comprehensive exam, a qualifying exam, an area paper, or none of these. Some may require students to complete a master's thesis; others do not. As you look through handbooks, you may notice a few factors that are especially important to you, and this will give you some ideas of what things to ask when meeting with faculty and graduate students.

Questions to ask potential advisors:

- What is your mentoring style?
- How does one earn authorship in this lab?
- How do students select research topics for their own thesis/dissertation, and what role do you play in this process?
- What role do you see me having in this lab if I come here? Is there a grant on which I could work?
- Are there opportunities for summer funding?
- What opportunities are there to get involved in research collaborations with other labs?
- To what extent can my interests as a student be incorporated into the broader interests of your lab, versus how much I would be expected to carry out an existing line of research?
- What supports exist in the department for students wishing to write their own grants?
- What are the current projects in this lab, and in what directions do you expect the lab research to go over the next 5 years?
- How many classes are typically offered to graduate students in (statistics, methods, therapeutic techniques, etc.) each semester/year?
- (For clinical, counseling, and school programs) What practicum opportunities are offered?
- Do most students finish their dissertation before internship or during the internship year?
- What types of statistical consultation are available on campus?
- What type of collaboration (if any) occurs among the clinical faculty (or between the clinical and other faculty if a student has a strong interest in another area)?
- Is it possible and/or typical for students to work with more than one faculty member? How does this work?
- What type of internship placements do students get?
- What types of jobs have graduating students from the program received in the past few years?

Questions to ask other students:

- Is it possible to live comfortably on the stipend salary in this town?
- What areas are best for grad students to live?
- Timeline questions: What are the expectations and norms for completion of various program milestones, e.g., master's, comps, dissertation?
- What are faculty/student relations like? What's the general climate of the clinical division and the department as a whole?
- What is it like to work with [advisor you are applying to work with]? (E.g., how often does your advisor meet with you? Do you feel like your advisor is either unavailable or a micromanager?)
- (If single and interested in starting a relationship during graduate school) What is life like here for single students? Is this an easy place to meet other young people?
- (If LGBTQ) What is the scene here for LGBTQ individuals? How supportive is the community?
- (If minority) What kinds of resources/supports are available to minority students at this university/program?
- How competitive versus cooperative are grad students in this program?
- To what extent does the training in this program focus on students' development as researchers versus clinicians versus teachers?
- What sorts of teaching opportunities exist here for graduate students? Is there training for new teachers as part of the program?
- Is funding guaranteed for the time I am here? For how long is it guaranteed?

Talking About Research

Perhaps most important, your "interviews" for clinical psychology Ph.D. programs will include reciprocal discussions regarding mutual research interests. Because this is such an important part of the interview process, this section offers some special suggestions and tips.

First, do your homework. When you initially applied to graduate programs, you likely looked for faculty mentors with whom you shared some research interests. Admittedly, in many cases, your match with that faculty member may have been based on a fairly broad understanding of their work (i.e., from a sentence or two on their Web page) and a fairly large range of your own interests. Now that you have been selected for an interview, it is expected that your interests will have matured and narrowed somewhat. Also, it is somewhat expected that your knowledge of this professor's work has become more thorough and informed. Luckily, there are some very easy tools available to help you do this.

You likely will begin your investigation into a faculty member's research interests by looking at that person's Web site and downloading recent abstracts and articles from PsycInfo. This remains a terrific approach for learning about faculty members' work. In addition to reading about the most common themes in their work, as well as understanding the methods they typically use in research (e.g., observational studies, clinical trials, questionnaire-based data collection), be sure also to note whether they seem to be publishing at a reasonable rate (this can vary from 0 to 20 publications within a single year, with a range of 1 to 5 being quite common) and whether they are publishing with their students as coauthors (or even first authors). This may give you some insight into whether there will be publication opportunities while you are working together and whether you will be given a chance to collaborate on these publications.

Keep in mind, however, that PsycInfo and many faculty members' Web sites may give you somewhat "old" information. PsycInfo lists articles currently "in print," which means they were written at least one year ago, about a study that may have started many years before then. If the faculty member does not keep a Web site current, the information listed here also may not reflect recent work.

One solution to help you learn about ongoing research is NIH Reporter (formerly CRISP; see http://projectreporter.nih.gov/reporter.cfm). If the faculty member has a current grant funded by NIH, you can find out all kinds of terrific information about current work from this site. Do a search by name, and you can read an abstract of the grant, read recent publications, and even get a sense of how much longer this grant will last. This will give you a great idea of exactly what the faculty member is working on and what project you may be involved in should you attend this school. If the faculty member has a grant funded by a private foundation, you may be able to find similar information from the foundation's Web site.

If the faculty member listed any publications on a Web site or CV as being "in press" in a specific journal, be sure to check that journal's site. Many journals currently preview an "in press" article online for months before it is in print. This will give you an opportunity to read about research that has recently been accepted for publication.

As you read through the faculty member's publications and descriptions of the lab's current projects, read "actively." Rather than thinking of this person as a "perfect" researcher who is studying exactly what you want to study, try to think about the ideas you might be able to bring to the lab, and take notes! Some faculty members will be interested during the interview in hearing *your* ideas for research (some may ask you to brainstorm on the spot), and most will be interested in seeing how you think about research. Importantly, any research ideas you propose during the interview should fit with the general research interests of the lab. (For example, if you are interviewing with a faculty member who specializes in ADHD in young boys, you might ask whether she has considered studying gender differences in ADHD; you would probably not want to discuss your interest in eating disorders in adolescent girls—unless the researcher has demonstrated a broad range of interests.)

Second, speak up! During your visit, you will receive an overwhelming amount of information about ongoing research. Every faculty member and current graduate student will have much to say about their current work and upcoming projects. To succeed during this interview process, make sure you

talk about your own research experience and interests in detail—at least insomuch as it helps you demonstrate how you are a match to this lab. Although some of this information was written in your personal statement, some of the people you meet may not have had access to it or may not have read it very recently. In addition, you may be able to share more details in a manner that helps to more thoroughly explain your experiences. This is important, particularly when considering what the interview process is like for the faculty member.

From the faculty perspective, the Interview Day can be quite confusing and difficult. Faculty members rarely describe their admissions decisions as easy. Rather, most agree that there are an overwhelming number of outstanding students, that the students who arrive for any given Interview Day all are quite likely to be very successful, and that the decision of how to rank-order these uniformly excellent candidates is painstaking, frustrating, and even sometimes idiosyncratic. In short, faculty would like a student who (1) they generally get along with—someone who will be pleasant to interact with nearly every day for the next 5 years, and then quite frequently for the rest of their careers; (2) someone with initiative, who will be as passionate and committed to the research in the lab as they are and who will be invested in the research outcomes you are working on together; and (3) someone who is intellectually stimulating—who will bring great ideas to the table, expand the lab in creative and innovative directions, and augment the caliber of intellectual discussions within research meetings.

This may sound intimidating, but if you express your interests, ideas, and enthusiasm, your natural talents will shine through. If a faculty member describes research you have read about, share you opinions or ideas (e.g., "Have you ever thought of studying X within that framework?" "Why did you decide to use this/that approach?" "How do you think this connects with the X theory?" "I'm interested in seeing how that idea may work differently in X population"). It is common for applicants to feel like everyone else in the room is qualified to be there, but they secretly are the imposter who got invited to the interview due to some computer malfunction. Do not believe this! You have been invited because your experience is exemplary, you have much to contribute, and several faculty members wrote glowing letters about your potential. Be sure to speak your mind, and you will help to show the faculty member and graduate students that you can be a terrific member of their lab!

Third, be specific—maybe. When discussing their approach to admissions, some faculty indicate that they prefer a "blank slate" (i.e., someone who can be taught from scratch and will be shaped mostly by their experiences in the graduate lab). More commonly, however, faculty are looking for someone who may arrive on campus with their own ideas, experiences, and emerging areas of expertise. This is a tricky balance that you will want to think about before you attend an interview. If you are open to literally anything the faculty member offers as a potential research topic, you may not seem "ready" for graduate school. Some may say that you are more interested in gaining admission than actually doing the work once you get there. On the other hand, if you seem overly fixed on a certain topic or method, despite what you hear during the Interview Day, then some may feel that you are not a match to the research lab or that you are not interested in integrating old with new experiences.

This is a very personal issue, in that there is no "wrong" answer or approach to the interview process. If you indeed are universally interested in all experiences, then it is certainly preferable to be honest about that, rather than portray your interests inaccurately. Conversely, if you are strongly committed to a specific topic, then you should hold out for experiences that will help you grow in your desired direction. Keep in mind that a "balance" probably is a good approach to match with most potential faculty members. Before you attend an interview, therefore, consider what research topics you are most interested in and which are less crucial for your graduate training. Think about what you are most strongly committed to and how you will represent your research interests when asked. It is quite common for you to be asked what your future career goals may be, what you do or do not like about the research process, and what your

research interests are (you may want to plan a 2- to 4-minute response to this question). Most important, think about the research that excites you the most, and use the Interview Day to determine whether you think you can get that research done at the place you are visiting.

Other Interviews

You will not be talking extensively about research in all of your interview meetings. In fact, this may occur mostly with your potential mentor (i.e., the person you requested to work with); yet, there will be other interviews scheduled during the day with other faculty and students. Some of these other people may have research interests that diverge from your own, and you are not necessarily expected to be knowledgeable about all of their work. What, then, will you talk about?

The purpose of these interviews often is twofold. First, the program would like to get to know you better to determine whether you are a good match to their overall ideology and "vibe." Are you competitive or collaborative? Do you seem very research-oriented or clinically focused? Do you seem interested in this program?

Second, these interviews are meant to give you a chance to learn as much as you can about the program and your advisor. Be sure to ask lots of questions to help you learn exactly what it would be like to spend the next 4 to 5 years in this new environment. When meeting with students, be sure to ask very direct questions about your potential mentor and her or his availability, style, and expectations. Students will give you the most direct and helpful information. Make sure to maximize this opportunity to get information!

Other Factors

A few other issues to keep in mind during the Interview season:

1. Interviews can be exhausting. You may have a day of "chain" interviewing, i.e., each meeting may end with an introduction to your next interviewer, or you may have only a very brief break between each meeting. For many people, it is difficult to be "on" for many hours in a row, and if you need to excuse yourself to use the restroom, take some notes, process the information you just heard, or eat a PowerBar on the run, it is perfectly OK to do so. You may want to plan for this in advance.
2. Bring along a nice leather folio that you can carry around with you during the interview day. This will give you something to do with your hands. Fill the folio with a few copies of your CV (occasionally, someone may ask for a copy), some notes on the faculty members' research, and your list of many questions. It is perfectly appropriate to open your folder and remind yourself of a few questions in the middle of an interview. No one expects you to have everything memorized. It's also fine to jot a note or two down while talking. As long as you are able to engage in a comfortable, socially skilled conversation while you do so, feel free to refer to this folder throughout the interview day, if you think it will help you stay focused and sharp.
3. **Everyone you speak to is part of the admissions process.** The faculty, the students, the staff, all will be part of your graduate program environment and all have valuable information to share with the admissions committee. And they will!
4. If the Interview Day includes an informal time for students and faculty to socialize, take the opportunity to talk with faculty members who may not have been on your schedule. Ideally, you will end up at a program where you have a good rapport with many faculty members including your primary advisor; these other faculty members will likely be your professors in classes, they may serve on your master's and dissertation committees, and you may collaborate with them on research projects. Additionally, many faculty members will have a say in your admissions decision, and if they remember you as a friendly, intelligent, and interesting person, it can help your chances.

5. At many graduate programs, applicants may be invited to an informal reception hosted by graduate students. Although it may look just like a party you attended in college, it is not. Grossly inappropriate behavior at this party will reflect poorly on you and will likely hurt your chances of admission.
6. Most programs will offer the opportunity to stay with a graduate student during your visit to their site. This is a terrific way to get to learn about the program and get to know a student well, but it is not mandatory that you stay with a student. If you do stay with a student in his or her home, remember that anything you tell that student may be reported back to the admissions committee.
7. Thank-you notes are not required, and certainly it will make no difference if they are sent by e-mail or snail mail, are handwritten, typeset, etc. Most commonly, students send a thank-you e-mail to a few of the people they met with during the Interview Day to express gratitude for their visit and to express their level of interest in the site. Although it is not required, it is a good idea to send a thank-you note of some sort to the faculty member you are applying to work with and to the student you stayed with (if applicable) and to reiterate how much you enjoyed your visit and how interested you are in the program.
8. Keep in mind that you are not only interviewing for a graduate school position; you also are creating a professional network. The faculty and students you meet on Interview Day are the experts in your area of research who will likely be your reviewers when you submit articles and grants, your colleagues and collaborators in future symposia or projects, your search committee when you apply for jobs or postdoctoral positions, and perhaps even your letter writers when you are reviewed for promotion. This realization has several implications. First, of course, make sure you act as professionally and graciously as you can throughout the application process. Second, be considerate if you find yourself in a position of declining an offer or interview. In other words, do not "burn bridges." If writing a note to decline an opportunity, be sure you express your gratitude and continuing interest in their work more broadly. You may decide that this lab or person's research is not the best match for your graduate training, but your paths may indeed cross again.
9. Once you have completed your interview, the waiting begins. In many cases, it will take several weeks until you hear an admissions decision. In some cases, this may mean that the department has not made a final decision (i.e., although your potential mentor may have selected someone, the decision has not yet been ratified by the program, department, or graduate school). In other cases, it may mean that you are not the first-choice candidate; however, many applicants successfully gain offers from programs that had initially offered a slot to someone else. Remember: Almost all applicants invited to an interview are excellent, and the final decision is usually very difficult for faculty. They often are equally happy with several interviewees and simply have to choose an order in which to extend admissions offers.
10. Lastly, once interviews have been completed, you hope to start receiving offers of admission. A few tips: (1) You should never, ever feel pressured to make a final decision before April 15. No program or individual should tell you otherwise. (2) Do not officially accept any offer until you have received the details of the offer in writing (by e-mail or mail). There is no fine print to be worried about, but it is still important to be sure that your offer is guaranteed before you start declining other opportunities. (3) If you do hold multiple offers, it is your responsibility to try to narrow your options as quickly as possible. In other words, try not to hold more than two offers at any one time. Someone out there who is just as nervous

about this process as you were is still waiting on an offer and cannot hear the good news until you have made your decision. If you can narrow your choices down to two, and release any additional offers you may be holding, it will help the system move smoothly for everyone else.

If you have made it this far, congratulations! Admission to clinical psychology Ph.D. programs is an impressive accomplishment! If you have not been admitted, try, try again. In late spring, it is appropriate to contact a program or director of clinical training to get some brief, informal feedback about your application. Not all programs will be able to provide this, but in some cases the feedback you receive will help you evaluate your chances of future admission and steer your career decisions. Many students apply for several years before gaining admission in clinical psychology; you are in good company.

We hope that at some point you will enter the field you are most interested in and begin the journey towards a career in the mental health field. You may even find yourself teaching a class in clinical psychology one day!

Good luck!

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