

Chapter in Review

1. Psychotherapy is a unique healing personal relationship that differs from other helpful relationships in a number of ways. Psychotherapists' training varies widely, and the term *psychotherapist* is unprotected by laws governing its use in most cases. Although many therapists receive extensive training and have advanced degrees, in many cases paraprofessionals with little training perform therapy just as successfully. The psychotherapy occupations requiring the most rigorous training and education are clinical psychologist and counseling psychologist, both of which require a Psy.D. or Ph.D. degree.
2. People enter therapy for many reasons, including psychological disorder, but also to treat ordinary suffering arising from a distressing event, or various sorts of conflicts and problems of ordinary life. There are many styles of psychotherapy, including psychoanalysis, psychodynamic therapy, behavior therapy, rational emotive behavior therapy, cognitive and cognitive behavior therapy, client-centered therapy, family therapy, and integrative therapy. No one style of legitimate psychotherapy has proved superior overall, a finding known as the dodo bird verdict.
3. Psychoanalysis was the first "talk therapy," and was highly influential throughout the first part of the 20th century. Classical psychoanalysis is based on the notion that psychological problems are caused by unconscious, intrapsychic conflicts. The goal of psychoanalysis is insight. Psychoanalysis has been severely criticized, and it is also expensive and lengthy in course. However, psychoanalysis has evolved since Freud's day, and neo-Freudian psychoanalysis based on object relations theory and other theories is more commonly seen in psychoanalytic practice than is classical Freudian psychoanalysis. Psychodynamic therapy is based on theories of psychoanalysis and shares many of its assumptions, but its therapeutic techniques differ greatly from psychoanalysis. Some briefer types of psychodynamic therapy also have been devised.
4. Behavior therapy (behavior modification) was created in opposition to psychoanalytic and psychodynamic therapy. It is based on the behaviorist (learning theory) view that psychological disorders are learned patterns of maladaptive behaviors. According to this view, insight is useless unless it helps to substitute adaptive behaviors and associations for maladaptive ones. Following in the footsteps of Mary Cover Jones, the "mother" of behavior therapy, Joseph Wolpe created a number of techniques to treat anxiety—particularly phobia—through controlled exposure of the phobic person to the feared object or situation while the client simultaneously practices relaxation or substitution of fearful thoughts for rational thoughts. Systematic desensitization is one such technique, flooding another. These techniques are used less frequently than in the past, and new exposure therapies accomplish results similar to the older therapies, but in a much shorter time. Two other important techniques of behavior therapy are aversion therapy, often used for problems such as sex offending or drug addiction; and operant therapies (e.g., contingency management, token economy), where rewards or punishments for a person's spontaneous behavior are used to shape desired behaviors.
5. Cognition-based therapies include rational-emotive behavior therapy, cognitive therapy, cognitive-behavior therapy, and mindfulness-based cognitive therapy (MBCT). Rational-emotive behavior therapy (REBT), devised by Albert Ellis, is

based on the idea that psychological disorders such as depression and anxiety originate in a person's illogical, absolutist, and counterproductive ideas about living. REBT therapists can be highly confrontational and forceful, compelling their clients to face reality squarely. Cognitive therapy (CT), devised by Aaron Beck, somewhat similarly proposes that emotional problems are brought on by "automatic thoughts" that are highly unrealistic, self-defeating, and biased against the self. According to Beck, these automatic thoughts emerge when a person possesses dysfunctional, underlying core beliefs about the self, the world, and the future—termed the *negative cognitive triad*. Unlike REBT therapists, who offer rational advice to their clients in a forceful manner, CT therapists do not offer advice but attempt a gentler "scientific collaboration" with their clients, whereby clients' distorted beliefs are "tested" against real-world evidence. Cognitive behavior therapy (CBT) is based on the view that there is a complex link between cognition and emotion that includes behavior. CBT therapists blend techniques of cognitive therapy and behavior therapy. Mindfulness-based cognitive therapy (MBCT) is a brief therapy for depression that blends techniques of CBT with meditation techniques based on Buddhist practices. CBT is part of an influential movement to create therapies whose worth can be objectively evaluated in randomized controlled trials. Psychotherapies that demonstrate superiority over no treatment for a given disorder are known as empirically supported treatments (ESTs). Such therapies are efficacious—a term that describes a treatment that is superior to placebo in research studies—but they may or may not be effective in real-world settings.

6. Integrative therapy (eclectic therapy) draws from more than one current of psychotherapeutic theory and technique. Integrative therapists may adhere generally to one established style of therapy, but utilize techniques of other styles as they seem appropriate; or they may create their own form of therapy by integrating many strands of theory and technique from seemingly unrelated styles. Because integrative therapists are not tied to a single theoretical orientation, they are free to conduct therapy as they believe would be most helpful. In addition to using techniques of many of the therapies already mentioned, integrative therapists are often influenced by client-centered therapy of humanistic psychologist Carl Rogers.
7. In group therapy, at least three but as many as 10 or more clients engage in therapy with one or two therapists. People enter group therapy for a number of possible reasons. It is less costly, for one thing. Also, a therapist may believe that exposure to a number of others with similar problems may be helpful to a client. The very experience of offering help to others can also be therapeutic. Group therapy also allows the therapist to directly observe how a client relates to other people. Self-help support groups, while potentially therapeutic, do not constitute psychotherapy because the groups are usually free, often ongoing indefinitely, and are only occasionally facilitated by a mental health professional.
8. In family therapy, generally based on family systems theory, no particular individual is singled out for treatment—the whole family is treated. This is because the family is considered an integrated, organic unit (system), where each person plays a role or several roles—interacting dynamically with each other member. The problems of one family member affect the behavior and emotional lives of the other family members. Couple therapy is a form of therapy involving married, dating, or cohabitating

couples and a therapist. Although couples generally enter couple therapy because of problems in their relationship (relationship distress), they sometimes enter therapy to address the mental health problems of a specific member of the couple.

9. Psychotherapy does not always work, but it has been shown to be superior to no treatment in 35 years of research, and it is at least as efficacious a treatment for depression and anxiety as medication. However, its effectiveness in real-world settings has not been established to the same degree. Merely showing statistical superiority to no treatment in research is not enough in a case such as this because a treatment can be superior to no treatment (efficacious) yet not offer substantial relief or cure a problem. In such a case, results for studies showing efficacy may lack clinical significance. Dismantling studies have suggested that psychotherapy may work not as a result of any specific “ingredients” of a given therapy style, but as a result of factors common to all legitimate therapies. The most frequently suggested common factors are therapeutic alliance, therapist allegiance, and therapist competence.
10. Calling something “therapy” does not make it therapeutic, and psychotherapy may sometimes cause harm. This is particularly true for the group of treatments known as potentially harmful psychotherapies (PHPs). Additionally, culture plays a role in psychotherapy, and “one size fits all” treatments may ignore important differences based on culture.
11. Pharmacotherapy is the use of drugs or other substances to treat psychological distress. Although these drugs usually fall into one of three categories—anxiolytics, antidepressants, mood stabilizers, and antipsychotics—the drugs are often prescribed “off-label” to treat conditions for which they were not intended.
12. Anxiolytic drugs are used to treat anxiety. Ordinarily, these drugs are in the benzodiazepine class of drugs. Benzodiazepines produce their effects in part through regulation of the neurotransmitter GABA. At high doses these drugs produce symptoms similar to drunkenness, and the drugs are frequently abused. Serious dependence and addiction can result from abuse of benzodiazepines, and withdrawal can be very difficult and sometimes dangerous. Although these drugs may be useful, their therapeutic effects may decrease over time, whereas unwanted side effects may increase. The drugs were intended only for short-term use, but many people use them for years or decades.
13. Antidepressants are the most commonly prescribed of all drug types in the United States, and their use has quadrupled in the past 20 years, particularly among those with less severe symptoms. There are four principal classes of antidepressants: MAO inhibitors, tricyclic drugs, selective serotonin reuptake inhibitors (SSRIs), and third-generation drugs including serotonin/norepinephrine reuptake inhibitors (SNRIs). MAO inhibitors were the first antidepressants to be developed. Although they are just as effective as the newer drugs, they may have serious side effects (including death) if certain seemingly harmless foods are eaten during the drug therapy. Brand-name MAO inhibitors include Marplan, Nardil, and Parnate. Tricyclic antidepressants (TCAs) are safer than MAO inhibitors. They receive their name because of their typical “three-ring” chemical structure. These drugs include (generic names) imipramine, amitriptyline, and nortriptyline. Like all antidepressants, it may take TCAs weeks or even months to work. Like all antidepressants, TCAs often have

troublesome side effects. Collectively, MAO inhibitors and TCAs are considered “first-generation” antidepressants.

14. Selective serotonin reuptake inhibitors (SSRIs) selectively act on serotonin systems rather than several neurotransmitter systems simultaneously, as with the TCAs and MAO inhibitors. SSRIs were developed in an attempt to produce antidepressants with fewer side effects than TCAs and which might work more quickly. However, SSRIs do not have fewer side effects than TCAs (just different side-effects) and are not faster acting. Brand-name SSRIs include Prozac, Paxil, Celexa, Lexapro, and Zoloft. Despite the fact that they are neither safer, nor more effective, nor faster acting than TCAs, the SSRI drugs have “left TCAs in the dust” due to pharmaceutical industry marketing campaigns. SSRI drugs may produce serious withdrawal symptoms (SSRI discontinuation syndrome), making it difficult to stop using the drugs.
15. The most frequently prescribed “third-generation” antidepressants are the serotonin-norepinephrine reuptake inhibitors (SNRIs), for example, Effexor and Cymbalta. The SNRI drugs are based on the idea that combining selectivity for the neurotransmitter norepinephrine as well as for serotonin might produce superior results to those produced by serotonin selectivity alone. However, SNRIs are not superior overall in efficacy or side effects profiles.
16. The possibility that the use of antidepressants might increase the risk of suicide is a highly controversial question that may not be able to be answered unequivocally using current research methods. The FDA has issued warnings for all antidepressants that the drugs might increase the risk of suicidal behavior, but this idea is hotly contested by many researchers (yet supported by many others). Both sides have produced evidence to support their positions.
17. Regression to the mean describes the statistical fact that any variable which deviates from its usual value when measured on one occasion will tend to return to that usual value when measured on subsequent occasions. People who are psychologically distressed may appear to improve after they enter psychotherapy or pharmacotherapy merely due to regression effects—not because the treatments are working. The more extreme the symptoms, the more improvement will occur if regression to the mean is the cause of improvement.
18. Bipolar disorders are treated with mood stabilizers including lithium, anticonvulsant drugs such as Depakote, and antipsychotic drugs. Antidepressants are not generally used. When these drugs do work, they are better at controlling mania than depression, but those with bipolar disorder suffer more frequently from the depression than from mania.
19. Schizophrenia is treated with antipsychotic drugs. First-generation antipsychotics (e.g., Thorazine) altered the way psychotic conditions were treated by reducing the severity of positive symptoms. However, these drugs were less useful but much more dangerous and unpleasant to use than initially believed. Second-generation antipsychotics (e.g., Seroquel, Abilify) have been promoted by manufacturers as more effective and safer than first-generation drugs, but extensive research has demonstrated that these claims lack validity.
20. The pharmaceutical industry powerfully influences public and medical professionals’ beliefs about pharmacotherapy through the hiring of ghostwriters to author scientific studies of drug efficacy and by holding back from publication studies that fail to show

drug efficacy. Meta-analytic research using data bases that include studies held back from publication or FDA viewing by the pharmaceutical companies shows that with the exception of cases of the most extremely severe depressions, antidepressants are no more efficacious than placebos. Even in cases of extremely severe depressions, antidepressants do not always work. Nonetheless, some researchers suggest that these statistical findings underestimate the drugs' usefulness.

21. Other biology-based treatments for psychological disorder include electroconvulsive therapy (ECT), which is safer and more effective than opponents suggest, but less safe and effective than proponents suggest; repetitive transcranial magnetic stimulation, a treatment for severe depression that has yet to show convincing evidence of effectiveness; vagus nerve stimulation, a costly treatment for treatment-resistant depression that has failed to show convincing evidence of effectiveness; and psychosurgery. Early psychosurgery techniques of lobotomy were ineffective, dangerous, and caused brain damage, mental disability, and personality change. Most societies consider these techniques to have been barbaric. One new technique known as deep brain stimulation is promoted as being less dangerous than ordinary psychosurgery with more manageable side effects. However, these claims have yet to be borne out in research.
22. The future of treatment for psychological disorders is integrative—including biological, psychological, and social aspects.

Section Summaries

What is psychotherapy?

1. Psychotherapy is a healing personal relationship created during the 20th century. Although it bears certain things in common with other types of confidential conversations in times of trouble, it is unique in a number of ways.
2. Advanced education is not necessary to practice psychotherapy, but most therapists have received extensive training of some sort, and many hold advanced graduate degrees. About half of advanced degrees in psychology are held by clinical and counseling psychologists.
3. Different styles of therapy have emerged from differing theories about the causes of psychological disorders and different philosophies about the appropriate relationship of therapist to client.
4. People enter therapy for many reasons, including issues not related to the treatment of psychological disorders—for example, crisis intervention, self-improvement, and betterment of the quality of life.

How do styles of psychotherapy differ?

1. Psychoanalysis was the first form of therapy and is the most expensive and lengthy. Important concepts in psychoanalysis include insight, transference, the unconscious, dream analysis, and free association. Psychodynamic therapy shares some ideas in common with psychoanalysis, principally the importance of intrapsychic conflict and insight, but it uses therapy techniques that are much more varied and flexible.
2. Behavior therapists attempt to teach the client to substitute adaptive behaviors for maladaptive behaviors. Behavior therapy techniques include systematic desensitization, flooding, and contemporary exposure therapies; aversion therapy; and operant therapies such as the token economy and contingency management interventions.
3. Cognitive therapies are based on the idea that changing a person's thoughts can change the way he or she feels. Cognitive therapies include rational emotive behavior therapy (REBT), cognitive therapy (CT), and cognitive behavior therapy (CBT).
4. Empirically supported treatments (ESTs) are those that have demonstrated superiority over no treatment in randomized controlled trials. ESTs are usually relatively brief and use highly specific techniques that can be described in treatment manuals.
5. Integrative, or eclectic, therapy draws from many currents of psychotherapeutic thought, sometimes including ideas and techniques drawn from the client-centered therapy of Carl Rogers.
6. Bibliotherapy may be therapeutic, but primarily when it is used under the guidance of a psychotherapist who has "prescribed" material that is science-based.

What are group, couple, and family therapies?

1. Group therapy, family therapy, and couple therapy are all forms of therapy that involve more than two people in the therapeutic relationship.

2. Group therapy involves three or more people and at least one mental health professional. Self-help support groups are therapeutic endeavors involving groups, but they are technically not considered to be group therapy and they generally (but not always) lack the participation of a mental health professional.
3. Family therapy emerged from family systems theory. Family systems theorists view the entire family as an integrated organic unit or system. In family therapy it is the entire family that is the “client” rather than a given individual.
4. People may enter couple therapy either to treat the mental health of one member of the couple, or to treat marital distress.

Does psychotherapy work?

1. Meta-analyses consistently show that psychotherapy is efficacious. However, research studies have not yet established that psychotherapy is effective in the world outside the laboratory.
2. All legitimate therapies seem about equally efficacious, as long as the therapy is based upon legitimate psychological principles and is appropriate to the condition being treated. One explanation for this “dodo bird verdict” is that therapy works due to common factors, not specific ingredients.
3. The most important common factors are likely the therapeutic alliance, therapist allegiance, and therapist competence.
4. Psychotherapy can cause harm as well as healing. Therapies that have the potential to cause harm (iatrogenesis) are known as potentially harmful psychotherapies (PHPs).
5. Most people in need of psychological services do not have access to them.

What is pharmacotherapy?

1. Pharmacotherapy is the treatment of psychological symptoms with drugs or other substances.
2. Anxiety is treated with anxiolytics, primarily benzodiazepine drugs. Azapirone drugs such as buspirone are also used, and may be preferable for long-term use.
3. The principal classes of antidepressant drugs are MAO inhibitors; tricyclic antidepressants (TCAs); selective serotonin reuptake inhibitors (SSRIs); and the “third-generation” antidepressants, including the serotonin/norepinephrine reuptake inhibitors (SNRIs).
4. MAO inhibitors were the first of the modern antidepressant drugs. Tricyclics were the next group to be developed. SSRIs and SNRIs were originally promoted as being more effective, faster acting, and causing fewer side effects. However, none of these claims is supported by research.
5. The issue of possible increases in suicidal thoughts and/or behavior (suicidality) associated with antidepressants has not been resolved.
6. Bipolar disorder is treated with mood stabilizers, including lithium, anticonvulsants, and atypical antipsychotics. These drugs are generally better at controlling mania than depression, although depression is much more typical of bipolar disorder than mania.
7. Schizophrenia is treated with first- and second-generation antipsychotics. Although the second-generation drugs are promoted as having fewer or more mild side effects and being more effective, as with the antidepressants research has not borne out these claims.

Does pharmacotherapy work?

1. The pharmaceutical industry influences how drugs are prescribed, how research on drugs' efficacy is designed and conducted, how the data are analyzed and the articles written, which studies are published, and the conclusions drawn by the authors of research articles. Two techniques used by pharmaceutical corporations to exert this influence are ghostwriting and publication bias.
2. Recent research has shown that 80 percent to 90 percent of the effects of antidepressants are duplicated by placebos; or, stated another way, antidepressants only hold a 10 percent to 20 percent advantage over placebos. This slight numerical edge is accounted for by the lack of placebo response among a small group of the most severely depressed individuals. For most people currently using antidepressants, the drugs are indistinguishable from placebos.
3. Some argue that even if antidepressants hold only a slight statistical edge over placebos they ought to be prescribed so that they may help the small group of extremely severely depressed placebo nonresponders. Others counter that the potential negative side effects of antidepressants outweigh their usefulness.
4. The herb St. John's wort, physical exercise, and psychotherapy all have efficacy approximately equal to that of antidepressants with many fewer negative side effects.

What other biological treatments are available?

1. Electroconvulsive therapy (ECT) is the most controversial of all nonsurgical treatments for psychological disorders. Used primarily in cases of extremely severe, treatment-resistant depression, ECT consists of passing a split-second, low voltage electric shock through the brain. This triggers seizures and convulsions which last for several minutes.
2. Opinions are extreme regarding ECT, and evidence regarding its safety and efficacy, while extensive, is not of very good quality. The worst side effect of ECT is serious memory loss, which, while generally of short duration, can be permanent.
3. Repetitive transcranial magnetic stimulation (rTMS) involves the placing of an electromagnetic coil on the scalp which sends short pulses through the skull, stimulating the cerebral cortex. In vagus nerve stimulation (VNS), a tiny generator is implanted under the skin which delivers mild electrical pulses to the left vagus nerve. In deep brain stimulation (DBS), electrodes are surgically implanted in regions of the brain in which it is thought that neuronal signals are blocked. These treatments are all experimental.
4. The future of treatment for psychological disorders appears to involve integrated methods and significant input from the patient.