Unit XIII

Treatment of Abnormal Behavior

Modules

Kay Redfield Jamison, an award-winning clinical psychologist and world expert on the emotional extremes of bipolar disorder, knows her subject firsthand. "For as long as I can remember," she recalled in *An Unquiet Mind*, "I was frighteningly, although often wonderfully, beholden to moods. Intensely emotional as a child, mercurial as a young girl, first severely depressed as an adolescent, and then unrelentingly caught up in the cycles of manic-depressive illness [now known as bipolar disorder] by the time I began my professional life, I became, both by necessity and intellectual inclination, a student of moods" (1995, pp. 4–5). Her life was blessed with times of intense sensitivity and passionate energy. But like her father's, it was also at times plagued by reckless spending, racing conversation, and sleeplessness, alternating with swings into "the blackest caves of the mind."

Then, "in the midst of utter confusion," she made a sane and profoundly helpful decision. Risking professional embarrassment she made an appointment with a therapist, a psychiatrist she would visit weekly for years to come.

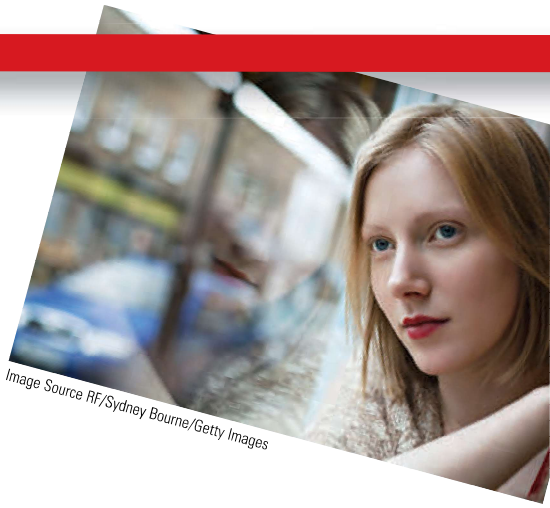
> He kept me alive a thousand times over. He saw me through madness, despair, wonderful and terrible love affairs, disillusionments and triumphs, recurrences of illness, an almost fatal suicide attempt, the death of a man I greatly loved, and the enormous pleasures and aggravations of my professional life. . . . He was very tough, as well

> as very kind, and even though he understood more than anyone how much I felt I was losing—in energy, vivacity, and originality—by taking medication, he never was seduced into losing sight of the overall perspective of how costly, damaging, and life threatening my illness was. . . . Although I went to him to be treated for an illness, he taught me . . . the total beholdenness of brain to mind and mind to brain (pp. 87–88).

"Psychotherapy heals," Jamison reports. "It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility from it all."

Module 70

Introduction to Therapy, and Psychodynamic and Humanistic Therapies



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Module Learning Objectives

70-1 Discuss how *psychotherapy, biomedical therapy,* and an *eclectic approach* to therapy differ.

70-2 Discuss the goals and techniques of psychoanalysis, and describe how they have been adapted in psychodynamic therapy.

70-3 Identify the basic themes of humanistic therapy, and describe the specific goals and techniques of Rogers' client-centered approach.

The long history of efforts to treat psychological disorders has included a bewildering mix of harsh and gentle methods. Well-meaning individuals have cut holes in people's heads and restrained, bled, or "beat the devil" out of them. But they also have given warm baths and massages and placed people in sunny, serene environments. They have administered drugs and electric shocks. And they have talked with their patients about childhood experiences, current feelings, and maladaptive thoughts and behaviors.

Reformers Philippe Pinel and Dorothea Dix pushed for gentler, more humane treatments and for constructing mental hospitals. Since the 1950s, the introduction of effective drug therapies and community-based treatment programs have emptied most of those hospitals.

Introduction to Therapy

70-1 How do *psychotherapy*, *biomedical therapy*, and an *eclectic approach* to therapy differ?

Today's therapies can be classified into two main categories. In **psychotherapy,** a trained therapist uses psychological techniques to assist someone seeking to overcome difficulties or achieve personal growth. **Biomedical therapy** offers medication or other biological treatments.

Many therapists combine techniques. Jamison received psychotherapy in her meetings with her psychiatrist, and she took medications to control her wild mood swings. Many psychotherapists describe themselves as taking an **eclectic approach,** using a blend of psychotherapies. Like Jamison, many patients also can receive psychotherapy combined with medication.

Let's look first at the psychotherapeutic "talk therapies." Among the dozens of types of psychotherapy, we will look at the most influential. Each is built on one or more of psychology's major theories: psychodynamic, humanistic, behavioral, and cognitive. Most of these techniques can be used one-on-one or in groups. We'll explore psychodynamic and humanistic therapies in this module, and behavior, cognitive, and group therapies in Module 71.

AP® Exam Tip

Most of the treatments discussed in this unit come from the perspectives you've been learning about since Unit I. As you reach each major section—like the upcoming one on psychoanalytic and psychodynamic therapy—try to anticipate how someone from that perspective would approach therapy (for example, "What would Freud do?"). This should help you organize and retain the information as you read.

The history of treatment Visitors to eighteenth-century mental hospitals paid to gawk at patients, as though they were viewing zoo animals. William Hogarth's (1697–1764) painting captured one of these visits to London's St. Mary of Bethlehem hospital (commonly called Bedlam).

Psychoanalysis and Psychodynamic Therapy

70-2 What are the goals and techniques of psychoanalysis, and how have they been adapted in psychodynamic therapy?

Sigmund Freud's **psychoanalysis** was the first of the psychological therapies. Few clinicians today practice therapy as Freud did, but his work deserves discussion as part of the foundation for treating psychological disorders.

Goals

Psychoanalytic theory presumes that healthier, less anxious living becomes possible when people release the energy they had previously devoted to id-ego-superego conflicts (see Module 55). Freud assumed that we do not fully know ourselves. There are threatening things that we seem to want not to know—that we disavow or deny. "We can have loving feelings and hateful feelings toward the same person," notes Jonathan Shedler (2009), and "we can desire something and also fear it."

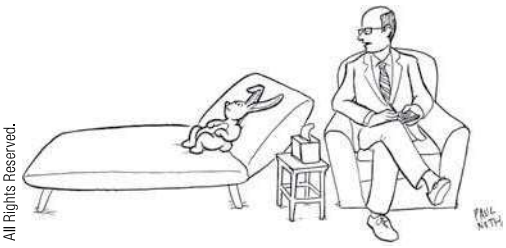
psychotherapy treatment involving psychological techniques; consists of interactions between a trained therapist and someone seeking to overcome psychological difficulties or achieve personal growth.

biomedical therapy prescribed medications or procedures that act directly on the person's physiology.

eclectic approach an approach to psychotherapy that, depending on the client's problems, uses techniques from various forms of therapy.

psychoanalysis Sigmund Freud's therapeutic technique. Freud believed the patient's free associations, resistances, dreams, and transferences—and the therapist's interpretations of them—released previously repressed feelings, allowing the patient to gain self-insight.

Freud's therapy aimed to bring patients' repressed or disowned feelings into conscious awareness. By helping them reclaim their unconscious thoughts and feelings and giving them *insight* into the origins of their disorders, he aimed to help them reduce growth-impeding inner conflicts.



"I'm more interested in hearing about the eggs you're hiding from yourself."

Techniques

Psychoanalysis is historical reconstruction. Psychoanalytic theory emphasizes the formative power of childhood experiences and their ability to mold the adult. Thus, it aims to unearth one's past in hope of unmasking the present. After discarding hypnosis as an unreliable excavator, Freud turned to *free association*.

Imagine yourself as a patient using free association. First, you relax, perhaps by lying on a couch. As the psychoanalyst sits out of your line of vision, you say aloud whatever comes to mind. At one moment, you're relating a childhood memory. At another, you're describing a dream or recent experience. It sounds easy, but soon you notice how often you edit your thoughts as you speak. You pause for a second before uttering an embarrassing thought. You omit what seems trivial, irrelevant, or shameful. Sometimes your mind goes blank or you find yourself unable to remember important details. You may joke or change the subject to something less threatening.

To the analyst, these mental blocks indicate **resistance.** They hint that anxiety lurks and you are defending against sensitive material. The analyst will note your resistances and then provide insight into their meaning. If offered at the right moment, this **interpretation**—of, say, your not wanting to talk about your mother—may illuminate the underlying wishes, feelings, and conflicts you are avoiding. The analyst may also offer an explanation of how this resistance fits with other pieces of your psychological puzzle, including those based on analysis of your dream content.

Over many such sessions, your relationship patterns surface in your interaction with your therapist. You may find yourself experiencing strong positive or negative feelings for your analyst. The analyst may suggest you are **transferring** feelings, such as dependency or mingled love and anger, that you experienced in earlier relationships with family members or other important people. By exposing such feelings, you may gain insight into your current relationships.

Relatively few U.S. therapists now offer traditional psychoanalysis. Much of its underlying theory is not supported by scientific research (Module 56). Analysts' interpretations cannot be proven or disproven. And psychoanalysis takes considerable time and money, often years of several sessions per week. Some of these problems have been addressed in the modern psychodynamic perspective that has evolved from psychoanalysis.

AP® Exam Tip

Psychoanalytic treatment is the public image of psychology. If you were to ask people to sketch a psychologist at work, you would see lots of sketches of therapists taking notes while they were seated behind patients on couches. Keep in mind that most modern therapy is very different from this image, and psychology careers stretch well beyond therapy.

"I haven't seen my analyst in 200 years. He was a strict Freudian. If I'd been going all this time, I'd probably almost be cured by now." -Woody Allen, after awakening from suspended animation in the movie *Sleeper*

resistance in psychoanalysis, the blocking from consciousness of anxiety-laden material.

interpretation in psychoanalysis, the analyst's noting supposed dream meanings, resistances, and other significant behaviors and events in order to promote insight.

transference in psychoanalysis, the patient's transfer to the analyst of emotions linked with other relationships (such as love or hatred for a parent).

psychodynamic therapy therapy deriving from the psychoanalytic tradition that views individuals as responding to unconscious forces and childhood experiences, and that seeks to enhance self-insight.

Psychodynamic Therapy

Therapists who use **psychodynamic therapy** techniques don't talk much about id, ego, and superego. Instead they try to help people understand their current symptoms. They focus on themes across important relationships, including childhood experiences and the therapist relationship. Rather than lying on a couch, out of the therapist's line of vision, patients meet with their therapist face to face. These meetings take place once or twice a week (rather than several times per week), and often for only a few weeks or months (rather than several years).

In these meetings, patients explore and gain perspective into defended-against thoughts and feelings. Therapist David Shapiro (1999, p. 8) illustrates with the case of a young man who had told women that he loved them, when knowing well that he didn't. They expected it, so he said it. But later with his wife, who wishes he would say that he loves her, he finds he "cannot" do that—"I don't know why, but I can't."

Therapist: Do you mean, then, that if you could, you would like to?

Patient: Well, I don't know. . . . Maybe I can't say it because I'm not sure it's true. Maybe I don't love her.

Further interactions reveal that he can't express real love because it would feel "mushy" and "soft" and therefore unmanly. He is "in conflict with himself, and he is cut off from the nature of that conflict." Shapiro noted that with such patients, who are estranged from themselves, therapists using psychodynamic techniques "are in a position to introduce them to themselves. We can restore their awareness of their own wishes and feelings, and their awareness, as well, of their reactions against those wishes and feelings."

Psychodynamic therapies may also help reveal past relationship troubles as the origin of current difficulties. Jonathan Shedler (2010a) recalls his patient Jeffrey's complaints of difficulty getting along with his colleagues and wife, who saw him as hypercritical. Jeffrey then "began responding to me as if I were an unpredictable, angry adversary." Shedler seized this opportunity to help Jeffrey recognize the relationship pattern, and its roots in the attacks and humiliation he experienced from his alcohol-abusing father—and to work through and let go of this defensive responding to people.

Interpersonal psychotherapy, a brief (12- to 16-session) variation of psychodynamic therapy, has effectively treated depression (Cuijpers, 2011). Although interpersonal psychotherapy aims to help people gain insight into the roots of their difficulties, its goal is symptom relief in the here and now. Rather than focusing mostly on undoing past hurts and offering interpretations, the therapist concentrates primarily on current relationships and on helping people improve their relationship skills.

The case of Anna, a 34-year-old married professional, illustrates these goals. Five months after receiving a promotion, with accompanying increased responsibilities and longer hours, Anna experienced tensions with her husband over his wish for a second child. She began feeling depressed, had trouble sleeping, became irritable, and was gaining weight. A therapist using psychodynamic techniques might have helped Anna gain insight into her angry impulses and her defenses against anger. A therapist applying interpersonal techniques would concur but would also engage her thinking on more immediate issues—how she could balance work and home, resolve the dispute with her husband, and express her emotions more effectively (Markowitz et al., 1998).

Véronique Burger/Science Source

Face-to-face therapy
In contemporary psychodynamic therapy, the couch has disappeared. But the influence of psychoanalytic theory continues in some areas, as the therapist seeks information from the patient's childhood and helps the person bring unconscious feelings into conscious awareness.

Humanistic Therapies

70-3 What are the basic themes of humanistic therapy? What are the specific goals and techniques of Rogers' client-centered approach?

The humanistic perspective (Module 57) has emphasized people's inherent potential for self-fulfillment. Like psychodynamic therapies, humanistic therapies have attempted to reduce growth-impeding inner conflicts by providing clients with new insights. Indeed, the psychodynamic and humanistic therapies are often referred to as **insight therapies.** But humanistic therapy differs from psychoanalytic therapy in many other ways:

insight therapies a variety of therapies that aim to improve psychological functioning by increasing a person's awareness of underlying motives and defenses.

- *Humanistic therapy aims to boost people's self-fulfillment by helping them grow in self-awareness and self-acceptance.*
- *Promoting this growth, not curing illness, is the focus of therapy.* Thus, those in therapy became "clients" or just "persons" rather than "patients" (a change many other therapists have adopted).
- *The path to growth is taking immediate responsibility for one's feelings and actions, rather than uncovering hidden determinants.*
- *Conscious thoughts are more important than the unconscious.*
- *The present and future are more important than the past.* The goal is to explore feelings as they occur, rather than achieve insights into the childhood origins of the feelings.

Carl Rogers (1902–1987) developed the widely used humanistic technique he called **client-centered therapy,** which focuses on the person's conscious self-perceptions. In this *nondirective therapy,* the therapist listens, without judging or interpreting, and seeks to refrain from directing the client toward certain insights.

AP® Exam Tip

You can remember *A*cceptance, *G*enuineness, and *E*mpathy as "AGE."

Believing that most people possess the resources for growth, Rogers (1961, 1980) encouraged therapists to exhibit *acceptance, genuineness,* and *empathy.* When therapists enable their clients to feel unconditionally accepted, when they drop their façades and genuinely express their true feelings, and when they empathically sense and reflect their clients' feelings, the clients may deepen their self-understanding and self-acceptance (Hill & Nakayama, 2000). As Rogers (1980, p. 10) explained,

> Hearing has consequences. When I truly hear a person and the meanings that are important to him at that moment, hearing not simply his words, but him, and when I let him know that I have heard his own private personal meanings, many things happen. There is first of all a grateful look. He feels released. He wants to tell me more about his world. He surges forth in a new sense of freedom. He becomes more open to the process of change.
>
> I have often noticed that the more deeply I hear the meanings of the person, the more there is that happens. Almost always, when a person realizes he has been deeply heard, his eyes moisten. I think in some real sense he is weeping for joy. It is as though he were saying, "Thank God, somebody heard me. Someone knows what it's like to be me."

"We have two ears and one mouth that we may listen the more and talk the less." -Zeno, 335–263 B.C.E., *Diogenes Laertius*

"Hearing" refers to Rogers' technique of **active listening**—echoing, restating, and seeking clarification of what the person expresses (verbally or nonverbally) and acknowledging the expressed feelings. Active listening is now an accepted part of therapeutic counseling practices in many high schools, colleges, and clinics. The counselor listens attentively and interrupts only to restate and confirm feelings, to accept what is being expressed, or to seek clarification. The following brief excerpt between Rogers and a male client illustrates how he sought to provide a psychological mirror that would help clients see themselves more clearly.

> **Rogers:** Feeling that now, hm? That you're just no good to yourself, no good to anybody. Never will be any good to anybody. Just that you're completely worthless, huh?—Those really are lousy feelings. Just feel that you're no good at all, hm?
>
> **Client:** Yeah. *(Muttering in low, discouraged voice)* That's what this guy I went to town with just the other day told me.
>
> **Rogers:** This guy that you went to town with really told you that you were no good? Is that what you're saying? Did I get that right?
>
> **Client:** M-hm.
>
> **Rogers:** I guess the meaning of that if I get it right is that here's somebody that—meant something to you and what does he think of you? Why, he's told you that he thinks you're no good at all. And that just really knocks the props out from under you. *(Client weeps quietly.)* It just brings the tears. *(Silence of 20 seconds)*
>
> **Client:** *(Rather defiantly)* I don't care though.
>
> **Rogers:** You tell yourself you don't care at all, but somehow I guess some part of you cares because some part of you weeps over it.
>
> *(Meador & Rogers, 1984, p. 167)*

client-centered therapy a humanistic therapy, developed by Carl Rogers, in which the therapist uses techniques such as active listening within a genuine, accepting, empathic environment to facilitate clients' growth. (Also called *person-centered therapy.*)

active listening empathic listening in which the listener echoes, restates, and clarifies. A feature of Rogers' client-centered therapy.

unconditional positive regard a caring, accepting, nonjudgmental attitude, which Carl Rogers believed would help clients to develop self-awareness and self-acceptance.

Can a therapist be a perfect mirror, without selecting and interpreting what is reflected? Rogers conceded that one cannot be *totally* nondirective. Nevertheless, he believed that the therapist's most important contribution is to accept and understand the client. Given a nonjudgmental, grace-filled environment that provides **unconditional positive regard,** people may accept even their worst traits and feel valued and whole.

Michael Rougier, *Life* Magazine, © Time Warner, Inc.

Active listening Carl Rogers (right) empathized with a client during this group therapy session.

If you want to listen more actively in your own relationships, three Rogerian hints may help:

1. ***Paraphrase.*** Rather than saying "I know how you feel," check your understanding by summarizing the person's words in your own words.
2. ***Invite clarification.*** "What might be an example of that?" may encourage the person to say more.
3. ***Reflect feelings.*** "It sounds frustrating" might mirror what you're sensing from the person's body language and intensity.

Before You Move On

► ASK YOURSELF

Think of your closest friends. Do they tend to express more empathy than those you don't feel as close to? How have your own active listening skills changed as you've gotten older?

► TEST YOURSELF

In psychoanalysis, what does it mean when we refer to transference, resistance, and interpretation?

Answers to the Test Yourself questions can be found in Appendix E at the end of the book.

Module 70 Review

70-1 How do *psychotherapy*, *biomedical therapy*, and an *eclectic approach* to therapy differ?

- *Psychotherapy* is treatment involving psychological techniques; it consists of interactions between a trained therapist and someone seeking to overcome psychological difficulties or achieve personal growth.
- The major psychotherapies derive from psychology's psychodynamic, humanistic, behavioral, and cognitive perspectives.
- *Biomedical therapy* treats psychological disorders with medications or procedures that act directly on a patient's physiology.
- An *eclectic approach* combines techniques from various forms of psychotherapy.

70-2 What are the goals and techniques of psychoanalysis, and how have they been adapted in psychodynamic therapy?

- Through *psychoanalysis,* Sigmund Freud tried to give people self-insight and relief from their disorders by bringing anxiety-laden feelings and thoughts into conscious awareness.
  - Techniques included using free association and *interpretation* of instances of *resistance* and *transference.*
- Contemporary *psychodynamic therapy* has been influenced by traditional psychoanalysis but is briefer, less expensive, and more focused on helping the client find relief from current symptoms.
  - Therapists help clients understand themes that run through past and current relationships.
  - Interpersonal therapy is a brief 12- to 16-session form of psychodynamic therapy that has been effective in treating depression.

70-3 What are the basic themes of humanistic therapy, and what are the specific goals and techniques of Rogers' client-centered approach?

- Both psychoanalytic and humanistic therapies are *insight therapies*—they attempt to improve functioning by increasing clients' awareness of motives and defenses.
- Humanistic therapy's goals have included helping clients grow in self-awareness and self-acceptance; promoting personal growth rather than curing illness; helping clients take responsibility for their own growth; focusing on conscious thoughts rather than unconscious motivations; and seeing the present and future as more important than the past.
- Carl Rogers' *client-centered therapy* proposed that therapists' most important contributions are to function as a psychological mirror through *active listening* and to provide a growth-fostering environment of *unconditional positive regard,* characterized by genuineness, acceptance, and empathy.

Multiple-Choice Questions

1. Many clinical psychologists incorporate a variety of approaches into their therapy. They are said to take a(n) _____ approach.

a. transference
b. biomedical
c. psychoanalytic
d. eclectic
e. psychodynamic

2. What do psychodynamic therapists call the blocking of anxiety-laden material from the conscious?

a. Resistance
b. Interpretation
c. Transference
d. Face-to-face therapy
e. Interpersonal psychotherapy

3. Which of the following is one of the ways humanistic therapies differ from psychoanalytic therapies?

a. Humanist therapies believe the past is more important than the present and future.
b. Humanist therapies boost self-fulfillment by decreasing self-acceptance.
c. Humanist therapies believe the path to growth is found by uncovering hidden determinants.
d. Humanist therapies believe that unconscious thoughts are more important than conscious thoughts.
e. Humanist therapies focus on promoting growth, not curing illness.

4. Which of the following is a feature of client-centered therapy?

a. Free association
b. Active listening
c. Resistance
d. Freudian interpretation
e. Medical/biological treatment

Practice FRQs

1. Explain what psychoanalysis is, and then discuss the relationship of transference and resistance to the therapy.

Answer

1 point: Psychoanalysis is a Freudian therapy that seeks to get patients to release repressed feelings to gain self-insight.

1 point: Transference is the patient's transfer of emotion to the analyst.

1 point: Resistance is the blocking of consciousness (by the patient) of anxiety-laden material.

2. Explain what client-centered therapy is, then describe the two major techniques of the therapy.

(3 points)

Module 71

Behavior, Cognitive, and Group Therapies


Richard T. Nowitz/CORBIS

Module Learning Objectives

71-1 Explain how the basic assumption of behavior therapy differs from those of psychodynamic and humanistic therapies, and describe the techniques used in exposure therapies and aversive conditioning.

71-2 State the main premise of therapy based on operant conditioning principles, and describe the views of its proponents and critics.

71-3 Discuss the goals and techniques of cognitive therapy and of cognitive-behavioral therapy.

71-4 Discuss the aims and benefits of group and family therapy.

behavior therapy therapy that applies learning principles to the elimination of unwanted behaviors.

Behavior Therapies

71-1 How does the basic assumption of behavior therapy differ from those of psychodynamic and humanistic therapies? What techniques are used in exposure therapies and aversive conditioning?

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The insight therapies assume that many psychological problems diminish as self-awareness grows. Psychodynamic therapies expect problems to subside as people gain insight into their unresolved and unconscious tensions. Humanistic therapies expect problems to diminish as people get in touch with their feelings. Proponents of **behavior therapy,** however, doubt the healing power of self-awareness. (You can become aware of why you are highly anxious during tests and still be anxious.) They assume that problem behaviors *are* the problems, and the application of learning principles can eliminate them. Rather than delving deeply below the surface looking for inner causes, therapies using behavioral techniques view maladaptive symptoms—such as phobias or sexual dysfunctions—as learned behaviors that can be replaced by constructive behaviors.

Classical Conditioning Techniques

AP® Exam Tip

Before you read the next several pages of this module, you may want to quickly review the material on classical and operant conditioning in Unit VI.

One cluster of behavior therapies derives from principles developed in Ivan Pavlov's early twentieth-century conditioning experiments (Module 26). As Pavlov and others showed, we learn various behaviors and emotions through classical conditioning. Could maladaptive symptoms be examples of conditioned responses? If so, might reconditioning be a solution? Learning theorist O. H. Mowrer thought so and developed a successful conditioning therapy for chronic bed-wetters. The child sleeps on a liquid-sensitive pad connected to an alarm. Moisture on the pad triggers the alarm, waking the child. With sufficient repetition, this association of bladder relaxation with waking up stops the bed-wetting. In three out

of four cases the treatment is effective, and the success provides a boost to the child's self-image (Christophersen & Edwards, 1992; Houts et al., 1994).

Another example: If a claustrophobic fear of elevators is a learned aversion to the stimulus of being in a confined space, then might one unlearn that association by undergoing another round of conditioning to replace the fear response? **Counterconditioning** pairs the trigger stimulus (in this case, the enclosed space of the elevator) with a new response (relaxation) that is incompatible with fear. Indeed, behavior therapists have successfully counterconditioned people with such fears. Two specific counterconditioning techniques—*exposure therapy* and *aversive conditioning*—replace unwanted responses.

counterconditioning behavior therapy procedures that use classical conditioning to evoke new responses to stimuli that are triggering unwanted behaviors; include *exposure therapies* and *aversive conditioning.*

exposure therapies behavioral techniques, such as *systematic desensitization* and *virtual reality exposure therapy,* that treat anxieties by exposing people (in imagination or actual situations) to the things they fear and avoid.

systematic desensitization a type of exposure therapy that associates a pleasant, relaxed state with gradually increasing anxiety-triggering stimuli. Commonly used to treat phobias.

EXPOSURE THERAPIES

Picture this scene reported in 1924 by psychologist Mary Cover Jones: Three-year-old Peter is petrified of rabbits and other furry objects. Jones plans to replace Peter's fear of rabbits with a conditioned response incompatible with fear. Her strategy is to associate the fear-evoking rabbit with the pleasurable, relaxed response associated with eating.

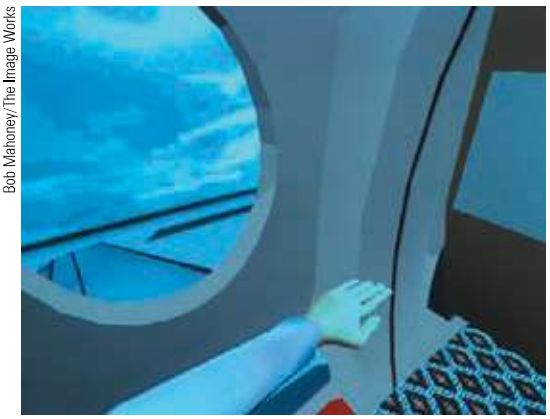
As Peter begins his midafternoon snack, Jones introduces a caged rabbit on the other side of the huge room. Peter, eagerly munching away on his crackers and drinking his milk, hardly notices. On succeeding days, she gradually moves the rabbit closer and closer. Within two months, Peter is tolerating the rabbit in his lap, even stroking it while he eats. Moreover, his fear of other furry objects subsides as well, having been *countered,* or replaced, by a relaxed state that cannot coexist with fear (Fisher, 1984; Jones, 1924).

Unfortunately for those who might have been helped by her counterconditioning procedures, Jones' story of Peter and the rabbit did not immediately become part of psychology's lore. It was more than 30 years later that psychiatrist Joseph Wolpe (1958; Wolpe & Plaud, 1997) refined Jones' technique into what are now the most widely used types of behavior therapies: **exposure therapies,** which expose people to what they normally avoid or escape (behaviors that get reinforced by reduced anxiety). Exposure therapies have them face their fear, and thus overcome their fear of the fear response itself. As people can habituate to the sound of a train passing their new apartment, so, with repeated exposure, can they become less anxiously responsive to things that once petrified them (Rosa-Alcázar et al., 2008; Wolitzky-Taylor et al., 2008).

One widely used exposure therapy is **systematic desensitization.** Wolpe assumed, as did Jones, that you cannot be simultaneously anxious and relaxed. Therefore, if you can repeatedly relax when facing anxiety-provoking stimuli, you can gradually eliminate your anxiety. The trick is to proceed gradually. Let's see how this might work with social anxiety disorder. Imagine yourself afraid of public speaking. A therapist might first ask for your help in constructing a hierarchy of anxiety-triggering speaking situations. Yours might range from mildly anxiety-provoking situations, perhaps speaking up in a small group of friends, to panic-provoking situations, such as having to address a large audience.

Next, using *progressive relaxation,* the therapist would train you to relax one muscle group after another, until you achieve a blissful state of complete relaxation and comfort. Then the therapist would ask you to imagine, with your eyes closed, a mildly anxiety-arousing situation: You are having coffee with a group of friends and are trying to decide whether to speak up. If imagining the scene causes you to feel any anxiety, you would signal your tension by raising your finger, and the therapist would instruct you to switch off the mental image and go back to deep relaxation. This imagined scene is repeatedly paired with relaxation until you feel no trace of anxiety.

The therapist would progress up the constructed anxiety hierarchy, using the relaxed state to desensitize you to each imagined situation. After several sessions, you move to actual situations and practice what you had only imagined before, beginning with relatively easy tasks and gradually moving to more anxiety-filled ones. Conquering your anxiety in an actual situation, not just in your imagination, raises your self-confidence (Foa & Kozak, 1986; Williams, 1987). Eventually, you may even become a confident public speaker.



Virtual reality exposure therapy Virtual reality technology exposes people to vivid simulations of feared stimuli, such as a plane's takeoff.

When an anxiety-arousing situation is too expensive, difficult, or embarrassing to re-create, **virtual reality exposure therapy** offers an efficient middle ground. Wearing a head-mounted display unit that projects a three-dimensional virtual world, you would view a lifelike series of scenes that would be tailored to your particular fear and shift as your head turned. Experiments led by several research teams have treated many different people with many different fears—flying, heights, particular animals, and public speaking (Parsons & Rizzo, 2008). People who fear flying, for example, can peer out a virtual window of a simulated plane, feel vibrations, and hear the engine roar as the plane taxis down the runway and takes off. In studies comparing control groups with people experiencing virtual reality exposure therapy, the therapy has provided greater relief from real-life fear (Hoffman, 2004; Krijn et al., 2004).

Developments in virtual reality therapy suggest the likelihood of increasingly sophisticated simulated worlds in which people, using avatars (computer representations of themselves), try out new behaviors in virtual environments (Gorini, 2007). For example, someone with social anxiety disorder might visit virtual parties or group discussions, which others join over time.

virtual reality exposure therapy an anxiety treatment that progressively exposes people to electronic simulations of their greatest fears, such as airplane flying, spiders, or public speaking.

aversive conditioning a type of counterconditioning that associates an unpleasant state (such as nausea) with an unwanted behavior (such as drinking alcohol).

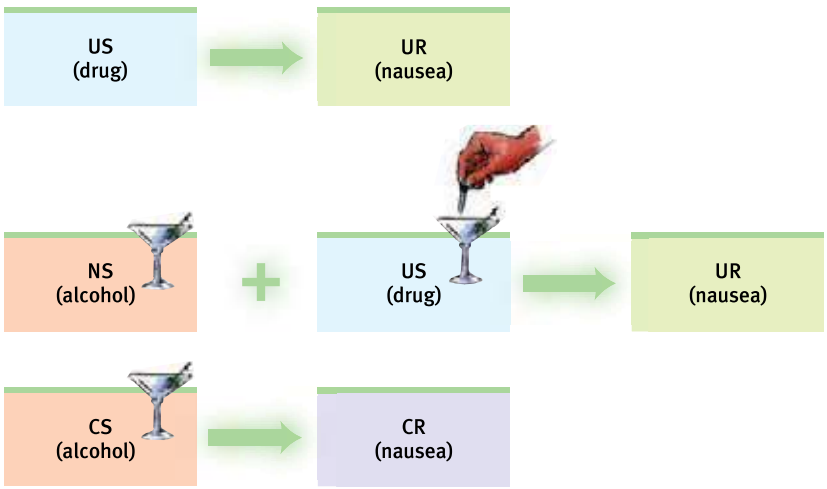
AVERSIVE CONDITIONING

In systematic desensitization, the goal is substituting a positive (relaxed) response for a negative (fearful) response to a *harmless* stimulus. In **aversive conditioning,** the goal is substituting a negative (aversive) response for a positive response to a *harmful* stimulus (such as alcohol). Thus, aversive conditioning is the reverse of systematic desensitization—it seeks to condition an aversion to something the person *should* avoid.

The procedure is simple: It associates the unwanted behavior with unpleasant feelings. To treat nail biting, one can paint the fingernails with a nasty-tasting nail polish (Baskind, 1997). To treat alcohol use disorder, an aversion therapist offers the client appealing drinks laced with a drug that produces severe nausea. By linking alcohol with violent nausea (recall the taste-aversion experiments with rats and coyotes in Module 29), the therapist seeks to transform the person's reaction to alcohol from positive to negative (**FIGURE 71.1**).

Figure 71.1

Aversion therapy for alcohol use disorder After repeatedly imbibing an alcoholic drink mixed with a drug that produces severe nausea, some people with a history of alcohol use disorder develop at least a temporary conditioned aversion to alcohol. (Remember: US is unconditioned stimulus, UR is unconditioned response, NS is neutral stimulus, CS is conditioned stimulus, and CR is conditioned response.)



Does aversive conditioning work? In the short run it may. Arthur Wiens and Carol Menustik (1983) studied 685 patients with alcohol use disorder who completed an aversion therapy program at a Portland, Oregon, hospital. One year later, after returning for several booster treatments of alcohol-sickness pairings, 63 percent were still successfully abstaining. But after three years, only 33 percent had remained abstinent.

The problem is that cognition influences conditioning. People know that outside the therapist's office they can drink without fear of nausea. Their ability to discriminate between the aversive conditioning situation and all other situations can limit the treatment's effectiveness. Thus, therapists often use aversive conditioning in combination with other treatments.

Operant Conditioning

71-2 What is the main premise of therapy based on operant conditioning principles, and what are the views of its proponents and critics?

Pioneering researcher B. F. Skinner helped us understand the basic concept in operant conditioning (Modules 27 and 28) that voluntary behaviors are strongly influenced by their consequences. Knowing this, today's therapists can practice *behavior modification*—reinforcing desired behaviors, and withholding reinforcement for undesired behaviors. Using operant conditioning to solve specific behavior problems has raised hopes for some otherwise hopeless cases. Children with intellectual disabilities have been taught to care for themselves. Socially withdrawn children with autism spectrum disorder (ASD) have learned to interact. People with schizophrenia have been helped to behave more rationally in their hospital ward. In such cases, therapists use positive reinforcers to shape behavior in a step-by-step manner, rewarding closer and closer approximations of the desired behavior.

In extreme cases, treatment must be intensive. One study worked with 19 withdrawn, uncommunicative 3-year-olds with ASD. Each participated in a 2-year program in which their parents spent 40 hours a week attempting to shape their behavior (Lovaas, 1987). The combination of positively reinforcing desired behaviors, and ignoring or punishing aggressive and self-abusive behaviors, worked wonders for some. By first grade, 9 of the 19 children were functioning successfully in school and exhibiting normal intelligence. In a group of 40 comparable children not undergoing this effortful treatment, only one showed similar improvement. (Ensuing studies suggested that positive reinforcement without punishment was most effective.)

Rewards used to modify behavior vary. For some people, the reinforcing power of attention or praise is sufficient. Others require concrete rewards, such as food. In institutional settings, therapists may create a **token economy.** When people display appropriate behavior, such as getting out of bed, washing, dressing, eating, talking coherently, cleaning up their rooms, or playing cooperatively, they receive a token or plastic coin as a positive reinforcer. Later, they can exchange their accumulated tokens for various rewards, such as candy, TV time, trips to town, or better living quarters. Token economies have been successfully applied in various settings (homes, classrooms, hospitals, institutions for juvenile offenders) and among members of various populations (including disturbed children and people with schizophrenia and other mental disabilities).

token economy an operant conditioning procedure in which people earn a token of some sort for exhibiting a desired behavior and can later exchange the tokens for various privileges or treats.

Critics of behavior modification express two concerns. The first is practical: *How durable are the behaviors?* Will people become so dependent on extrinsic rewards that the appropriate behaviors will stop when the reinforcers stop? Proponents of behavior modification believe the behaviors will endure if therapists wean patients from the tokens by shifting them toward other, real-life rewards, such as social approval. They also point out that the appropriate behaviors themselves can be intrinsically rewarding. For example, as a withdrawn person becomes more socially competent, the intrinsic satisfactions of social interaction may help the person maintain the behavior.

The second concern is ethical: *Is it right for one human to control another's behavior?* Those who set up token economies deprive people of something they desire and decide which behaviors to reinforce. To critics, this whole process has an authoritarian taint. Advocates reply that some patients request the therapy. Moreover, control already exists; rewards and punishers are already maintaining destructive behavior patterns. So why not reinforce adaptive behavior instead? Treatment with positive rewards is more humane than being institutionalized or punished, advocates argue, and the right to effective treatment and an improved life justifies temporary deprivation.

Cognitive Therapies

71-3 What are the goals and techniques of cognitive therapy and of cognitive-behavioral therapy?

AP® Exam Tip

Behavior therapies focus on what we do. Cognitive therapies focus on what we think. That's a very basic distinction, but it is critically important for your understanding.

We have seen how behavior therapies treat specific fears and problem behaviors. But how do they deal with major depression? Or with generalized anxiety disorder, in which anxiety has no focus and developing a hierarchy of anxiety-triggering situations is difficult? Therapists treating these less clearly defined psychological problems have had help from the same *cognitive revolution* that has profoundly changed other areas of psychology during the last half-century.

Lara Jo Regan

Cognitive therapy for eating disorders aided by journaling Cognitive therapists guide people toward new ways of explaining their good and bad experiences. By recording positive events and how she has enabled them, this woman may become more mindful of her self-control and more optimistic.

cognitive therapy therapy that teaches people new, more adaptive ways of thinking; based on the assumption that thoughts intervene between events and our emotional reactions.

"Life does not consist mainly, or even largely, of facts and happenings. It consists mainly of the storm of thoughts that are forever blowing through one's mind." -Mark Twain, 1835–1910

The **cognitive therapies** assume that our thinking colors our feelings (**FIGURE 71.2**). Between the event and our response lies the mind. Self-blaming and overgeneralized explanations of bad events are often an integral part of the vicious cycle of depression (see Module 67). The depressed person interprets a suggestion as criticism, disagreement as dislike, praise as flattery, friendliness as pity. Ruminating on such thoughts sustains the negative thinking. If such thinking patterns can be learned, then surely they can be replaced. Cognitive therapists therefore try in various ways to teach people new, more constructive ways of thinking. If people are miserable, they can be helped to change their minds.

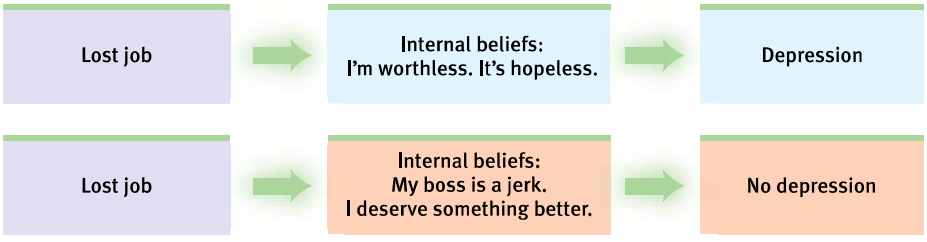


Figure 71.2
A cognitive perspective on psychological disorders The person's emotional reactions are produced not directly by the event but by the person's thoughts in response to the event.

Rational-Emotive Behavior Therapy

rational-emotive behavior therapy (REBT) a confrontational cognitive therapy, developed by Albert Ellis, that vigorously challenges people's illogical, self-defeating attitudes and assumptions.

According to Albert Ellis (1962, 1987, 1993), the creator of **rational-emotive behavior therapy (REBT),** many problems arise from irrational thinking. For example, he described a disturbed woman and suggested how therapy might challenge her illogical, self-defeating assumptions (Ellis, 2011, pp. 198–199):

> [She] does not merely believe it is undesirable if her lover rejects her. She tends to believe, also, that (a) it is awful; (b) she cannot stand it; (c) she should not, *must* not be rejected; (d) she will never be accepted by any desirable partner; (e) she is a worthless person because one lover has rejected her; and (f) she deserves to be rejected for being so worthless. Such common covert hypotheses are illogical, unrealistic, and destructive. . . . They can be easily elicited and demolished by any scientist worth his or her salt; and the rational-emotive therapist is exactly that: an exposing and nonsense-annihilating scientist.

Change people's thinking by revealing the "absurdity" of their self-defeating ideas, the sharp-tongued Ellis believed, and you will change their self-defeating feelings and enable healthier behaviors.

Aaron Beck's Therapy for Depression

Cognitive therapist Aaron Beck also believes that changing people's thinking can change their functioning, though he has a gentler approach. Originally trained in Freudian techniques, Beck analyzed the dreams of depressed people. He found recurring negative themes of loss, rejection, and abandonment that extended into their waking thoughts. Such negativity even extends into therapy, as clients recall and rehearse their failings and worst impulses (Kelly, 2000). With cognitive therapy, Beck and his colleagues (1979) have sought to reverse clients' *catastrophizing* beliefs about themselves, their situations, and their futures. Gentle questioning seeks to reveal irrational thinking, and then to persuade people to remove the dark glasses through which they view life (Beck et al., 1979, pp. 145–146):

> **Client:** I agree with the descriptions of me but I guess I don't agree that the way I think makes me depressed.
>
> **Beck:** How do you understand it?
>
> **Client:** I get depressed when things go wrong. Like when I fail a test.
>
> **Beck:** How can failing a test make you depressed?
>
> **Client:** Well, if I fail I'll never get into law school.
>
> **Beck:** So failing the test means a lot to you. But if failing a test could drive people into clinical depression, wouldn't you expect everyone who failed the test to have a depression? . . . Did everyone who failed get depressed enough to require treatment?
>
> **Client:** No, but it depends on how important the test was to the person.
>
> **Beck:** Right, and who decides the importance?
>
> **Client:** I do.
>
> **Beck:** And so, what we have to examine is your way of viewing the test (or the way that you think about the test) and how it affects your chances of getting into law school. Do you agree?
>
> **Client:** Right.
>
> **Beck:** Do you agree that the way you interpret the results of the test will affect you? You might feel depressed, you might have trouble sleeping, not feel like eating, and you might even wonder if you should drop out of the course.
>
> **Client:** I have been thinking that I wasn't going to make it. Yes, I agree.
>
> **Beck:** Now what did failing mean?

Client: *(tearful)* That I couldn't get into law school.

Beck: And what does that mean to you?

Client: That I'm just not smart enough.

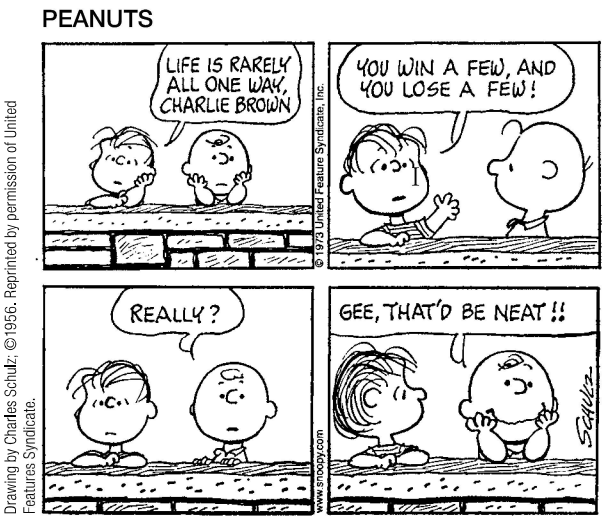
Beck: Anything else?

Client: That I can never be happy.

Beck: And how do these thoughts make you feel?

Client: Very unhappy.

Beck: So it is the meaning of failing a test that makes you very unhappy. In fact, believing that you can never be happy is a powerful factor in producing unhappiness. So, you get yourself into a trap—by definition, failure to get into law school equals "I can never be happy."



We often think in words. Therefore, getting people to change what they say to themselves is an effective way to change their thinking. Perhaps you can identify with the anxious students who, before a test, make matters worse with self-defeating thoughts: "This test's probably going to be impossible. All these other students seem so relaxed and confident. wish I were better prepared. Anyhow, I'm so nervous I'll forget everything." To change such negative self-talk, Donald Meichenbaum (1977, 1985) offered *stress inoculation training:* teaching people to restructure their thinking in stressful situations. Sometimes it may be enough simply to say more positive things to oneself: "Relax. The test may be hard, but it will be hard for everyone else, too. I studied harder than most people. Besides, I don't need a perfect score to get a good grade in this class." After being trained to dispute their negative thoughts, depression-prone children, teens, and college students exhibit a greatly reduced rate of future depression (Seligman, 2002; Seligman et al., 2009). To a large extent, it *is* the thought that counts. **TABLE 71.1** provides a sampling of techniques commonly used in cognitive therapy.

Table 71.1 Selected Cognitive Therapy Techniques

Aim of Technique	Technique	Therapists' Directives
Reveal beliefs	Question your interpretations	Explore your beliefs, revealing faulty assumptions such as "I must be liked by everyone."
	Rank thoughts and emotions	Gain perspective by ranking your thoughts and emotions from mildly to extremely upsetting.
Test beliefs	Examine consequences	Explore difficult situations, assessing possible consequences and challenging faulty reasoning.
	Decatastrophize thinking	Work through the actual worst-case consequences of the situation you face (it is often not as bad as imagined). Then determine how to cope with the real situation you face.
Change beliefs	Take appropriate responsibility	Challenge total self-blame and negative thinking, noting aspects for which you may be truly responsible, as well as aspects that aren't your responsibility.
	Resist extremes	Develop new ways of thinking and feeling to replace maladaptive habits. For example, change from thinking "I am a total failure" to "I got a failing grade on that paper, and I can make these changes to succeed next time."

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT), a widely practiced integrative therapy, aims not only to alter the way people think (cognitive therapy), but also to alter the way they act (behavior therapy). It seeks to make people aware of their irrational negative thinking, to replace it with new ways of thinking, *and to practice* the more positive approach in everyday settings. Behavioral change is typically addressed first, followed by sessions on cognitive change; the therapy concludes with a focus on maintaining both and preventing relapses.

"The trouble with most therapy is that it helps you to feel better. But you don't get better. You have to back it up with action, action, action." -Therapist Albert Ellis (1913–2007)

Anxiety and mood disorders share a common problem: emotion regulation (Aldao & Nolen-Hoeksema, 2010). An effective CBT program for these emotional disorders trains people both to replace their catastrophizing thinking with more realistic appraisals, and, as homework, to practice behaviors that are incompatible with their problem (Kazantzis et al., 2010a,b; Moses & Barlow, 2006). A person might, for example, keep a log of daily situations associated with negative and positive emotions, and engage more in activities that lead them to feeling good. Or those who fear social situations might be assigned to practice approaching people.

CBT may also be useful with obsessive-compulsive disorder. In one study, people learned to prevent their compulsive behaviors by relabeling their obsessive thoughts (Schwartz et al., 1996). Feeling the urge to wash their hands again, they would tell themselves, "I'm having a compulsive urge," and attribute it to their brain's abnormal activity, as previously viewed in their PET scans. Instead of giving in to the urge, they would then spend 15 minutes in an enjoyable, alternative behavior, such as practicing an instrument, taking a walk, or gardening. This helped "unstick" the brain by shifting attention and engaging other brain areas. For two or three months, the weekly therapy sessions continued, with relabeling and refocusing practice at home. By the study's end, most participants' symptoms had diminished and their PET scans revealed normalized brain activity. Many other studies confirm CBT's effectiveness for those with anxiety, depression, or anorexia nervosa (Covin et al., 2008; Mitte, 2005; Norton & Price, 2007). Studies have also found that cognitive-behavioral skills can be effectively taught and therapy conducted over the Internet (Barak et al., 2008; Kessler et al., 2009; Marks & Cavanaugh, 2009; Stross, 2011).

cognitive-behavioral therapy (CBT) a popular integrative therapy that combines cognitive therapy (changing self-defeating thinking) with behavior therapy (changing behavior).

group therapy therapy conducted with groups rather than individuals, permitting therapeutic benefits from group interaction.

Group and Family Therapies

71-4 What are the aims and benefits of group and family therapy?

Group Therapy

Except for traditional psychoanalysis, most therapies may also occur in small groups. **Group therapy** does not provide the same degree of therapist involvement with each client. However, it offers benefits:

- *It saves therapists' time and clients' money,* often with no less effectiveness than individual therapy (Fuhriman & Burlingame, 1994).
- *It offers a social laboratory for exploring social behaviors and developing social skills.* Therapists frequently suggest group therapy for people experiencing frequent conflicts or whose behavior distresses others. For up to 90 minutes weekly, the therapist guides people's interactions as they discuss issues and try out new behaviors.

Photograph Courtesy of Muse Entertainment Enterprises Inc.

Group Therapy ABC Family's and *Seventeen Magazine's* 2011 film *Cyberbully* realistically portrayed main characters attending group therapy, where they found they were not alone in their troublesome feelings.

- *It enables people to see that others share their problems.* It can be a relief to discover that you are not alone—to learn that others, despite their composure, experience some of the same troublesome feelings and behaviors.
- *It provides feedback as clients try out new ways of behaving.* Hearing that you look poised, even though you feel anxious and self-conscious, can be very reassuring.

Family Therapy

One special type of group interaction, **family therapy,** assumes that no person is an island: We live and grow in relation to others, especially our families. We struggle to differentiate ourselves from our families, but we also need to connect with them emotionally. Some of our problem behaviors arise from the tension between these two tendencies, which can create family stress.

Unlike most psychotherapy, which focuses on what happens inside the person's own skin, family therapists work with multiple family members to heal relationships and to mobilize family resources. They tend to view the family as a system in which each person's actions trigger reactions from others, and they help family members discover their role within their family's social system. A child's rebellion, for example, affects and is affected by other family tensions. Therapists also attempt—usually with some success, research suggests—to open up communication within the family or to help family members discover new ways of preventing or resolving conflicts (Hazelrigg et al., 1987; Shadish et al., 1993).

Self-Help Groups

Many people also participate in self-help and support groups (Yalom, 1985). One analysis of online support groups and more than 14,000 self-help groups reported that most support groups focus on stigmatized or hard-to-discuss illnesses (Davison et al., 2000). AIDS patients, for example, are 250 times more likely than hypertension patients to be in support groups. Those struggling with anorexia and alcohol use disorder often join groups; those with migraines and ulcers usually do not. People with hearing loss have national organizations with local chapters; people with vision loss more often cope on their own.

The grandparent of support groups, Alcoholics Anonymous (AA), reports having more than 2 million members in 114,000 groups worldwide. Its famous 12-step program, emulated by many other self-help groups, asks members to admit their powerlessness, to seek help from a higher power and from one another, and (the twelfth step) to take the message to others in need of it. In one eight-year, $27 million investigation, AA participants reduced their drinking sharply, although so did those assigned to cognitive-behavioral therapy or to "motivational therapy" (Project Match, 1997). Other studies have similarly found that 12-step programs such as AA have helped reduce alcohol use disorder comparably with other treatment interventions (Ferri et al., 2006; Moos & Moos, 2005). The more meetings members attend, the greater their alcohol abstinence (Moos & Moos, 2006). In one study of 2300 veterans who sought treatment for alcohol use disorder, a high level of AA involvement was followed by diminished alcohol problems (McKellar et al., 2003).

In an individualistic age, with more and more people living alone or feeling isolated, the popularity of support groups—for the addicted, the bereaved, the divorced, or simply those seeking fellowship and growth—seems to reflect a longing for community and connectedness. More than 100 million Americans belong to small religious, interest, or self-help groups that meet regularly—and 9 in 10 report that group members "support each other emotionally" (Gallup, 1994).

* * *

For a synopsis of the modern forms of psychotherapy we've been discussing, see **TABLE 71.2.**

FYI

With more than 2 million members worldwide, AA is said to be "the largest organization on Earth that nobody wanted to join" (Finlay, 2000).

family therapy therapy that treats the family as a system. Views an individual's unwanted behaviors as influenced by, or directed at, other family members.

Table 71.2 Comparing Modern Psychotherapies

Therapy	Presumed Problem	Therapy Aim	Therapy Technique
Psychodynamic	Unconscious conflicts from childhood experiences	Reduce anxiety through self-insight.	Interpret patients' memories and feelings.
Client-centered	Barriers to self-understanding and self-acceptance	Enable growth via unconditional positive regard, genuineness, and empathy.	Listen actively and reflect clients' feelings.
Behavior	Dysfunctional behaviors	Relearn adaptive behaviors; extinguish problem ones.	Use classical conditioning (via exposure or aversion therapy) or operant conditioning (as in token economies).
Cognitive	Negative, self-defeating thinking	Promote healthier thinking and self-talk.	Train people to dispute negative thoughts and attributions.
Cognitive-behavioral	Self-harmful thoughts and behaviors	Promote healthier thinking and adaptive behaviors.	Train people to counter self-harmful thoughts and to act out their new ways of thinking.
Group and family	Stressful relationships	Heal relationships.	Develop an understanding of family and other social systems, explore roles, and improve communication.

Before You Move On

▶ ASK YOURSELF

Critics say that behavior modification techniques, such as those used in token economies, are inhumane. Do you agree or disagree? Why?

▶ TEST YOURSELF

What is the major distinction between the underlying assumptions in insight therapies and in behavior therapies?

Answers to the Test Yourself questions can be found in Appendix E at the end of the book.

Module 71 Review

71-1 How does the basic assumption of behavior therapy differ from those of psychodynamic and humanistic therapies? What techniques are used in exposure therapies and aversive conditioning?

- *Behavior therapies* are not insight therapies. Their goal is to apply learning principles to modify problem behaviors.
- Classical conditioning techniques, including *exposure therapies* (such as *systematic desensitization* or *virtual reality exposure therapy*) and *aversive conditioning,* attempt to change behaviors through *counterconditioning*—evoking new responses to old stimuli that trigger unwanted behaviors.

71-2 What is the main premise of therapy based on operant conditioning principles, and what are the views of its proponents and critics?

- Therapy based on operant conditioning principles uses behavior modification techniques to change unwanted behaviors through positively reinforcing desired behaviors and ignoring or punishing undesirable behaviors.
- Critics maintain that (1) techniques such as those used in *token economies* may produce behavior changes that disappear when rewards end, and (2) deciding which behaviors should change is authoritarian and unethical.
- Proponents argue that treatment with positive rewards is more humane than punishing people or institutionalizing them for undesired behaviors.

71-3 What are the goals and techniques of cognitive therapy and of cognitive-behavioral therapy?

- The *cognitive therapies,* such as Aaron Beck's cognitive therapy for depression, assume that our thinking influences our feelings, and that the therapist's role is to change clients' self-defeating thinking by training them to view themselves in more positive ways.
- *Rational-emotive behavior therapy (REBT)* is a confrontational cognitive therapy that actively challenges irrational beliefs.
- The widely researched and practiced *cognitive-behavioral therapy (CBT)* combines cognitive therapy and behavior therapy by helping clients regularly act out their new ways of thinking and talking in their everyday life.

71-4 What are the aims and benefits of group and family therapy?

- *Group therapy* sessions can help more people and costs less per person than individual therapy would. Clients may benefit from exploring feelings and developing social skills in a group situation, from learning that others have similar problems, and from getting feedback on new ways of behaving.
- *Family therapy* views a family as an interactive system and attempts to help members discover the roles they play and to learn to communicate more openly and directly.

Multiple-Choice Questions

1. Dr. Welle tries to help her clients by teaching them to modify the things they do when under stress or experiencing symptoms. This means that Dr. Welle engages in _____ therapy.

a. behavior
b. cognitive
c. group
d. rational-emotive behavior
e. client-centered

2. Mary Cover Jones helped a little boy named Peter overcome his fear of rabbits by gradually moving a rabbit closer to him each day while he was eating his snack. This was one of the first applications of

a. group therapy.
b. virtual reality exposure therapy.
c. aversive therapy.
d. exposure therapy.
e. cognitive therapy.

3. On which of the following are token economies based?

a. Classical conditioning
b. Operant conditioning
c. Group therapy
d. Cognitive therapy
e. Cognitive-behavioral therapy

4. Which of the following is considered a benefit of group therapy?

a. It is the most effective therapy for children.
b. It is particularly effective in the treatment of antisocial personality disorder.
c. It is particularly effective in the treatment of schizophrenia.
d. It is the only setting proven effective for virtual reality exposure therapy.
e. It saves time and money when compared with other forms of therapy.

Practice FRQs

1. Name and describe two specific types of group therapy.

Answer

1 point: Family therapy is a means of treating an entire family as an interdependent system.

1 point: Self-help groups, such as Alcoholics Anonymous (AA), are groups of individuals who share a similar problem working together to overcome that problem.

2. Explain what systematic desensitization is, then describe the two major components of the therapy.

(3 points)