Table 15.3 One-Year Prevalence Rates of Mental Illness in Older and Younger Generations as Estimated in the Epidemiological Catchment Area Data

	One-Year Prevalence Rate (%)	
Disorder	**Age 18–54**	**Age 55+**
Any anxiety disorder	13.1	11.4
Simple phobia	8.3	7.3
Social phobia	2.0	1.0
Agoraphobia	4.9	4.1
Panic disorder	1.6	0.5
Obsessive-compulsive disorder	2.4	1.5
Any mood disorder	7.1	4.4
Major depressive disorder	5.3	3.7
Dysthymia	1.6	1.6
Bipolar I	1.1	0.2
Bipolar II	0.6	0.1
Schizophrenia	1.3	0.6
Antisocial personality disorder	2.1	0.0
Anorexia nervosa	0.1	0.0

Source: U.S. Department of Health and Human Services (1999).

ter, other than to note that treatments for older and younger people appear comparable (Jeste et al., 2003).] Prevalence rates for alcohol abuse or dependence are less than 2 percent in late life (Helzer, Burnam, & McEvoy, 1991). In one major NIMH survey (Regier et al., 1988), none of those aged 65 and older met criteria for a drug abuse or dependency disorder. These rates of substance abuse and dependence are much lower than the rates that have been determined for the general adult population (p. 279). Even rates of depression and anxiety appear lower than in younger populations. In sum, most people 65 years of age and older are free from serious psychopathology. Nonetheless, 10 to 20 percent do have psychological problems severe enough to warrant professional attention (Gatz et al., 1996).

Why are rates of psychopathology so low in late life? There are several completely different answers to these questions. Some have advised caution in interpreting such data, as a set of methodological issues must be considered. It also appears that there may be some processes related to aging that promote better mental health.

Methodologically, older adults may be more uncomfortable acknowledging and discussing mental health problems compared to younger people. Similarly, older people might feel embarrassed about describing drug use.

In addition to reporting bias, there are potential cohort effects. That is, the next generation of people to become old may manifest more depression, anxiety, and substance abuse than people who are already older (Zarit & Zarit, 1998).

Beyond these explanations, people with mental illness are at risk for dying earlier—before age 65—for several different reasons. Among heavy drinkers, the peak years for death from cirrhosis are between 55 and 64 years of age, and cardiovascular disease is also common (Shaper, 1990). Cardiovascular disease is also more common among people with a history of anxiety disorders, depressive disorders, and bipolar disorder (Kubzanski et al., 2007). Even milder psychological disorders compromise immune function, and as people age, they become particularly sensitive to these immune effects (Kiecolt-Glaser & Glaser, 2001). This may lead to worse outcomes for many medical conditions that are more common as people age. Psychological disorders are associated with increased mortality (Angst et al., 2002; Enger et al., 2004; King, 2005). For example, Frojdh and colleagues (2003) conducted surveys with over 1,200 elderly people living in Sweden. Compared to those with low scores, those who obtained high scores on a self-report measure of depression were 2.5 times as likely to die within the next six years. Because people with mental illness may die earlier, research studies on aging may suffer from the issue of selective mortality.

These three methodological issues—response biases, cohort effects, and selective mortality—could help explain the low prevalence of psychological disorders in late life. Most researchers, though, believe that aging is also genuinely related to better mental health. Above, we described findings that emotional coping improves as people age. This should translate into a decrease in psychological disorders. Some longitudinal studies suggest that many people who experience psychopathology early in life seem to grow out of those symptoms. For example, longitudinal studies indicate that heavy drinkers tend to drink less as they enter late life (Fillmore, 1987). Findings like these suggest that enhanced coping abilities developed across the life course may help protect people from mental illness during late life.

In sum, studies suggest lower rates of mental illness among the elderly. Although some methodological issues (low levels of disclosure, cohort effects, and selective mortality) might explain part of this effect, it is also possible that some people become more psychologically healthy as they age.

Beyond examining the prevalence rates of disorder, it is important to consider the incidence rates, or how many people are experiencing the onset of a new disorder. Most people who have an episode of a psychological disorder late in life are experiencing a recurrence of a disorder that started earlier in life, rather than an initial onset. For example, 97 percent of older adults with generalized anxiety disorder reported that their anxiety symptoms began before the age of 65 (Alwahhabi, 2003), and 94 percent of older adults with major depressive disorder had experienced depressive episodes earlier in life (Norton et al., 2006). Late onset is also extremely rare for schizophrenia (Karon & VandenBos, 1998). In contrast, late-onset alcohol dependence is more common among older adults with drinking problems (Liberto, Oslin, & Ruskin, 1996).

Medical Issues in Diagnosing Psychological Disorders

DSM criteria specify that a psychological disorder should not be diagnosed if the symptoms can be accounted for by a medical condition or medication side effects. Because medical conditions are more common in the elderly, it is particularly important to rule out such explanations. Medical problems such as thyroid problems, Addison's disease, Cushing's disease, Parkinson's disease, Alzheimer's disease, hypoglycemia, anemia, and vitamin deficiencies can produce symptoms that mimic schizophrenia, depression, or anxiety (Marengo & Westermeyer, 1996). Angina, congestive heart failure, and excessive caffeine consumption may all cause a faster heart rate, which can be mistaken as a symptom of anxiety (Fisher & Noll, 1996). Age-related deterioration in the vestibular system (inner-ear control of one's sense of balance) can account for panic symptoms such as severe dizziness (Raj, Corvea, & Dagon, 1993). Antihypertensive medication, hormones, corticosteroids, and antiparkinsonism medications may contribute to depression or anxiety (Spar & LaRue, 1990).

Although depression is less common among older adults than younger ones, it accounts for a very large proportion of the psychiatric hospital admissions among the aged. (David Young-Wolff/PhotoEdit.)

Major Depressive Disorder

The epidemiology of depression in late life shares many parallels with patterns observed earlier in life. For example, during late life, depression is more likely to occur in women than men, and depressive episodes tend to co-occur with anxiety and alcohol abuse (Gallo & Lebowitz, 1999). Researchers initially believed that symptoms of depression differed in late life, but researchers have identified only one consistent difference—cognitive symptoms (such as memory deficits and confusion) appear more pronounced when depression emerges in late life compared to earlier adulthood, as discussed next.

Depression versus Dementia Depression is likely to produce more cognitive impairment in the elderly than it does in younger people (Lockwood et al., 2000). The frequent presence of cognitive symptoms in late-life depression can make it hard to differentiate whether memory problems are due to dementia or to depression. Indeed, depression in older adults is often misdiagnosed as dementia because of the severe cognitive impairment. No single neuropsychological test can clearly differentiate people with depression from those with dementia, although researchers are working hard to develop a battery of specific memory tests that would help make this distinction (Swainson et al., 2001). When depressive symptoms are present, a good course of action is to treat them and hope that cognitive symptoms are improved in the process. Although treating depression is likely to bring some relief from cognitive symptoms, many elderly people who show cog-

nitive deficits during their depressive episodes will continue to experience at least mild cognitive problems after they recover from the depressive symptoms (Bhalla et al., 2006).

Of course, people can have both dementia and depression. Cognitive difficulties in late life do predict increases in depression over time (Vinkers et al., 2004). And the opposite direction of effects seems to occur as well: a lifetime history of depression predicts more decline in cognitive functioning (Ganguli et al., 2006); a twofold increase in risk for Alzheimer's disease (Ownby et al., 2006); and, among those who develop Alzheimer's disease, a faster progression of the illness (Rapp et al., 2006).

Etiology of Depression in Older Adults Many of the causes of depression in older adults parallel those seen among younger adults. On the other hand, some new problems emerge during late life that can trigger depression.

A body of evidence has emerged about people who develop a first episode of depression after age 65. These late-onset first episodes seem particularly tied to vascular disease. For example, more than 20 percent of people develop a depressive episode in the 18 months after a myocardial infarction (Frasure-Smith, Lesperance, & Talajic, 1995). Moreover, a meta-analysis of 98 studies indicates that when the brains of people with late-onset depression are imaged, small white spots, called white matter hyperintensities (WMH), are often present (Herrmann, Le Masurier, & Ebmeier, 2008). WMH are more common as people age and are associated with cardiovascular risk factors, but they appear to be about twice as common among people with late-onset depression as they are in age-matched persons who do not experience depression. Taken together, these findings suggest that strokes and other vascular disease could explain the development of some late-onset depressions. The opposite direction of effects also has been shown. That is, increasing evidence suggests that depression can also contribute to cardiovascular disease, a topic we cover in Focus on Discovery 15.2.

FOCUS ON DISCOVERY 15.2

Depression and Cardiovascular Disease

It is now well established that depression predicts a worse outcome for people with cardiovascular disease. Indeed, in one meta-analysis, authors were able to compile the findings of 22 prospective studies that controlled for baseline medical and cardiovascular factors. Across those studies, depression was found to be related to a 90 percent increase in the risk of onset of cardiovascular disease and a 60 percent increase in the severity of cardiovascular disease over time (Nicholson, Kuper, & Hemingway, 2006). A separate meta-analysis shows that depression is also related to increased risk of death from cardiovascular disease, even after controlling for baseline cardiovascular health (Barth, Schumacher, & Herrmann-Lingen, 2004).

Given these disturbing findings, a high priority has been placed on whether these depressions are relieved by standard treatments. Several major studies have been conducted to examine this question. For example, in one study, more than 2,400 people who had just experienced a myocardial infarction (MI) and had at least mild symptoms of depression were randomly assigned to receive cognitive behavior therapy (CBT) or standard medical care. If people receiving CBT continued to show high levels of depression after five sessions, Sertraline was prescribed as well. Active intervention did lead to significant reductions in depression compared to placebo treatment (Berkman et al., 2003). In contrast to these promising results for CBT, interpersonal psychotherapy does not appear to significantly reduce depression in this population (Lesperance et al., 2007).

Researchers have also examined how well antidepressants work within this population. Tricyclic antidepressants are not recommended, because they have been found to be associated with twice the risk of subsequent MI as compared to placebos in this population (Cohen, Gibson & Alderman, 2000). Better evidence has emerged for selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac), among people who are depressed after an MI. For example, in one study, 369 people were randomly assigned to receive Sertraline (an SSRI) or a placebo for 24 weeks. Sertraline was effective—and particularly effective for the people with severe and recurrent depression (Glassman et al., 2002).

While it is clear that depression can be treated among people who have had an MI, treatment has not been found to reduce the risk of death from cardiovascular disease. More specifically, many of the treatment studies have documented slightly lower rates of death in the treatment group than in the control group, but the number of deaths is small enough that such findings do not achieve statistical significance (Glassman, 2005). Carney and his colleagues reasoned that it isn't whether or not a person receives treatment that should matter, but rather, whether or not treatment worked. In a more careful analysis of people prescribed antidepressants after an MI, actual improvement in depression predicted greater likelihood of survival (Carney et al., 2004). This would suggest that it may be important to offer aggressive treatment, to ensure full relief from depression.

A major goal, then, is to help medical teams to routinely screen for depression and provide treatment. Many physicians are likely to dismiss symptoms of depression in a patient who has just had a heart attack, assuming that people might be understandably distressed by their recent change in health. However, depression relief may be an important component of medical recovery.

Beyond the specific ties to cardiovascular disease, poor physical health is a major risk factor for depression among older adults. Medical illness and physical disabilities (such as trouble walking) are major predictors of the onset of depressive symptoms in late life (Schoevers et al., 2006). As we grow older, we are more likely to experience a number of life events that would be expected to cause depression, such as the death of a spouse, social isolation, and retirement. Rates of depression do increase markedly in the year after people become widowed (Bruce, 2002). On the other hand, the number of people in a person's network (social isolation) is not as strongly linked to depression in late life as it is in middle age (Bruce et al., 2002), perhaps because older people place less emphasis on casual social contacts than younger people do (see the earlier discussion of social selectivity in older adults). Furthermore, most people do not become depressed after retirement. Any ill effects of retirement may have more to do with the poor health and low incomes of some retirees and less with retirement per se (Pahkala, 1990). Successful adjustment to retirement is tied to positive marital relationships, high education, high job prestige before retirement, and high self-efficacy and self-esteem (Kim & Moen, 2001). For many older adults, retirement ushers in a satisfying period of life (Wolfe, Morrow, & Frederickson, 1996). We would do well to assume that adaptation rather than depression is the common reaction to loss and stress in late life.

Treatment of Depression Many primary care physicians do not diagnose, and therefore do not treat, depression (Wolfe et al., 1996). In one study of 599 people who were at least 85 years of age, only 25 percent of people who met criteria for major depressive disorder were diagnosed with such by their primary care doctor, and very few received appropriate treatment (Stek et al., 2004).

At least 20 high-quality studies have been conducted to examine psychotherapy for late-life depression (Scogin et al., 2005). As with younger adults, research supports the use of cognitive and behavioral approaches (Scogin et al., 2005). Several of the psychotherapy findings, though, contrast with those observed in younger adults. Interpersonal psychotherapy does not appear to be more effective than a placebo in preventing relapse among older adults with depression (Reynolds et al., 2006). Other treatments that have received little attention for depression occurring earlier in life appear helpful for late-life depression. These include short-term psychodynamic therapy (Gallagher & Thompson, 1983) as well as reminiscence therapy, in which people review significant positive and negative events in their life histories to gain perspective (Scogin et al., 2005).

At least 17 studies now indicate that antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), are more effective than placebos are for treatment of late-life depression (Roose & Schatzberg, 2005). About 60 percent of elderly people with depression respond to antidepressant treatments as compared to about 40 percent of patients who respond to placebo (Delano-Wood & Abeles, 2005). Cognitive behavioral therapy provides additional relief when added to antidepressant medication (Unutzer et al., 2002).

Despite the encouraging findings for antidepressant medications, either alone or in combination with psychological treatment, some caution is merited. Older adults are likely to be highly sensitive to the side effects of antidepressant drugs, such as postural hypotension (a fall in blood pressure when standing up), which causes some people to become dizzy when they stand up and then to fall. (Falls in older adults are far more serious than they are for younger people. Broken bones take much longer to heal, and certain head injuries can be fatal.) Moreover, older people are at high risk for toxic reactions to medications of all kinds. Side effects of antidepressants may also be problematic among older adults (Menting et al., 1996). In one clinical trial, 76 percent of elderly people taking SSRIs experienced at least some side effects, and 25 percent discontinued medications because of side effects. Side effects and drug discontinuation rates are worse for tricyclic antidepressants than for SSRIs among the elderly (Mottram, Wilson, & Strobl, 2006). Although not all studies have found such high side effect rates, the lower tolerability of antidepressants among the elderly suggests that nonpharmacological approaches are particularly important (Scoggin & McElerath, 1994). Indeed, Landreville and colleagues (2001) found that elderly people with depression reported that they would rather receive cognitive therapy than antidepressant medications.

Some psychiatrists recommend electroconvulsive therapy (p. 241), particularly for elderly people who had an earlier favorable response to it (Sackeim, 2004). ECT does involve significant side effects, though, including cardiovascular risks that may be of particular concern among the elderly (Delano-Wood & Abeles, 2005). Cognitive side effects also appear more severe among elderly compared to younger patients (Sackeim et al., 2007).

One innovative program addressed depression among elderly people with chronic medical illnesses. Although chronic medical illnesses increase risk for depression, problems with mobility can interfere with attending therapy sessions. Ciechanowski and colleagues (2004), then, looked at how therapy would work if it were offered in the home. The treatment they offered had a great deal in common with psychological treatments covered in Chapter 8; it included problem solving for improving life situations, increasing behavioral activation, and other standard techniques. If warranted, recommendations were made to primary care providers for antidepressant medications. In this way, the study was not designed to look at psychological treatment so much as to provide some form of depression treatment for this highly vulnerable population. People were randomly assigned to receive either depression treatment or treatment as usual (standard medical care). Findings of this study offer good news and bad news. On the good side, depression treatment was significantly more likely to produce remission (33 percent) than treatment as usual (12 percent). On the downside, even with depression treatment, two-thirds of people continued to experience depressive symptoms, and treatment also did not improve quality of life. The findings suggest that depression treatment helps but also that it is hard to restore all aspects of life when older people face such severe medical conditions.

Suicide The risk factors for suicide in the elderly are parallel with those in younger people (see Chapter 8). For example, in older and younger people, depression is the major risk factor. Beyond depression, it is worth noting that physical illness, loss of loved ones, and dire financial circumstances, problems that are widespread among older adults, are important risk factors for suicide.

Regardless of the reasons, the elevated suicide rates for people over age 65 are a concern: older adults are three times more likely to kill themselves than younger adults are (McIntosh, 1995). The suicide rate for men increases in a linear fashion with age from adolescence onward, whereas the rate for women peaks in their fifties and then slowly declines across the rest of the life span (McIntosh, 1995). Older Caucasian men are more likely to commit suicide than are members of any other group; the peak ages for committing suicide in this group are from 80 to 84 (Conwell, 2001). Although African American men are less likely to die from suicide than Caucasian men are, the rate of suicide increases with age among African American men (Alston, Rankin, & Harris, 1995).

Older persons are less likely to communicate their intentions to commit suicide and more likely to use lethal methods than are younger people (Conwell, 2001). Once people are past age 65, their attempts rarely fail (Butler, Lewis, & Sunderland, 1998). Furthermore, the statistics are probably underestimates; older adults have many opportunities to neglect their diet or medications, thus killing themselves in a more passive fashion.

One treatment program to reduce depression and suicidality among the elderly draws on the finding that elderly people are more likely to visit primary care doctors than to see specialty mental health providers. Bruce and colleagues (2004) screened for depression among people over the age of 60 who were seeking medical care. People with symptoms were offered an antidepressant medication, and if they did not want medication, they were offered a chance to receive psychological treatment. Interestingly, although the people had not been seeking depression treatment, about 90 percent of them accepted either medication or psychological treatment when they were offered. Compared to people who received typical medical care, those who received either medication or psychological treatment obtained faster relief from their depression and from suicidal ideation, differences that were still observable at a one year follow-up.

Anxiety Disorders

In general, symptoms of anxiety disorders do not differ as people enter late life (Gretarsdortir et al., 2004). GAD is the most common anxiety disorder among the elderly (Alwahhabi, 2003). Posttraumatic stress disorder (PTSD) is seen among some older war veterans (Cook, 2001) and has been observed among older people after traumatic health crises (Scogin, 1998). One study found that even 50 years after the event, many veterans are still affected by their war experiences (Hunt & Robbins, 2001).

Beyond ruling out medical explanations, causes of anxiety disorders are often related to the circumstances of getting older (Fisher & Noll, 1996)—threats of social isolation, poverty,

As with younger adults, anxiety disorders are more prevalent than depression. Worries about illnesses and becoming incapacitated may be a focus of concerns. (Zac Macaulay/The Image Bank/Getty Images.)

and medical difficulties become more prominent as people age. In addition to aging-relevant causes, anxiety in late life appears related to some of the same risk factors that are known to increase risk of anxiety disorders earlier in life, such as neuroticism (Schuurmans et al., 2005).

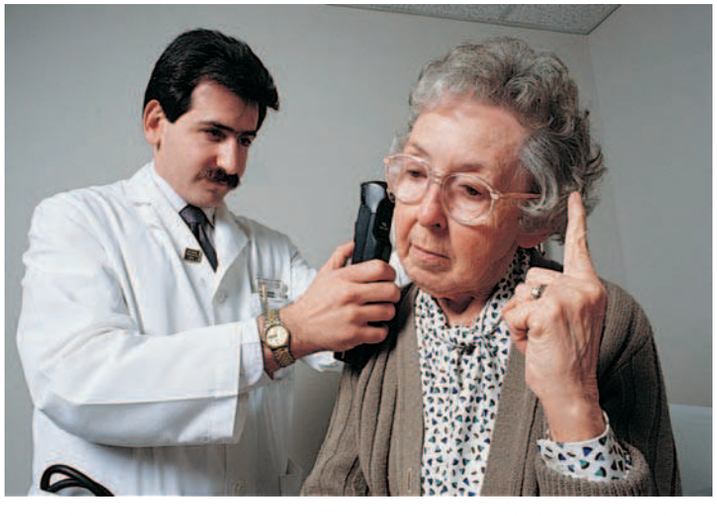
Anxiety problems in older adults seem to respond to the same types of psychological treatments found useful with younger adults (see Chapter 5), but less controlled research is available. For example, cognitive behavioral treatment has been found to be fairly helpful in reducing symptoms of anxiety (Ayers et al., 2007).

Short-acting benzodiazepines are the most widely used treatment for anxiety disorders in the elderly (Alwahhabi, 2003). Unfortunately, older adults are particularly sensitive to side effects from this class of medications—longitudinal research has shown that benzodiazepine use in older adults is predictive of increased morbidity, cognitive decline, and urinary incontinence (Alwahhabi, 2003). Indeed, given the concerns about how dangerous these medications can be for older adults, the federal government has now instituted guidelines that long-term care facilities should limit the use of short-acting benzodiazepines to less than 10 continuous days and the use of longer-acting benzodiazepines to less than four months. Despite these guidelines, more than 20 percent of nursing home residents are prescribed benzodiazepines, and eight percent use them for more than four months (Svarstad & Mount, 2001). A central goal, then, is to identify medications with fewer side effects. Busiperone (BusPar), which has fewer side effects, has been shown to be effective in one study of GAD. Surprisingly, researchers know little about antidepressant medications for treatment of anxiety in older adults, despite their efficacy in younger populations.

Delusional (Paranoid) Disorders

Symptoms of paranoia, such as Jeanine's fears in the upcoming clinical case that her husband and her neighbors were trying to hurt her, are found in many older people with psychiatric disorders. For example, in a study of people age 85 and older, psychiatric interviews with family members and key informants suggested that 6.9 percent of people had experienced at least mild paranoid symptoms in the past year (Ostling & Skoog, 2002). In evaluating whether such symptoms merit diagnosis, though, clinicians must be sensitive to the fact that older people are often mistreated. Others may talk about them behind their backs or even to their faces, and people may take advantage of older adults in many ways. That is, complaints from an older person concerning persecution may be justified.

Although paranoia in older people may be the continuation of a disorder that began earlier in life, the most common causes of paranoia in late life are delirium and dementia (Livingston et al., 2001). Paranoid ideation also has been linked to loss of hearing or sight (Ostling & Skoog, 2002). An older person who is having trouble hearing may believe that other people are whispering about him or her. Beyond cognitive and sensory declines, increases in social isolation can trigger paranoid symptoms (Gurland, 1991). This isolation limits the person's opportunities to check his or her suspicions about the world, making it easier for delusions to take hold. A good evaluation, then, will incorporate medical, cognitive, sensory, and social assessments.



Loss of hearing is common in the elderly and can create the sense that others are whispering behind their back. (J. Griffin/The Image Works.)

If paranoid symptoms are secondary to delirium or sensory impairment, treatment should address these issues. Otherwise, the treatment of paranoia is much the same for older adults as for younger adults. Although controlled data on the treatment of paranoia in older adults are lacking, supportive approaches to establish rapport, complemented by cognitive therapy, are recommended. Studies indicate that delusions in older people can be treated with some success with antipsychotic medications (Schneider, 1996), although people who are experiencing paranoia are generally suspicious of the motives of those who give them drugs. Toxicity from medications must also be considered, given the particular sensitivity of older people to drugs.

Clinical Case: Jeanine

Jeanine was a 66-year-old married woman who reluctantly agreed to a clinical evaluation. She [had] a six-week history of bizarre delusions and hallucinations of her husband spraying the house with a fluid that smelled like "burned food." She complained that he sprayed the substance everywhere around the house, including draperies and furniture, although she had never seen him do it. She could smell the substance almost constantly, and she said that it affected her head, chest, and rectum. She also complained that someone in the neighborhood had been throwing bricks and rocks at her house. In addition, she suspected her husband of having affairs with other women, whose footprints she claimed to have seen near home.

During the interview, Jeanine was sullen toward the interviewer. She looked very sad at times and would occasionally wipe away a tear, but her predominant affect was extreme hostility about her husband's alleged behavior (Varner & Gaitz, 1982, p. 108).

Substance Abuse and Dependence

Although few people meet diagnostic criteria for alcohol or substance abuse, a fair number of people drink heavily during late life (Molgaard et al., 1990). It is important, then, to consider that the physiological consequences of alcohol become more intense as people age. For example, tolerance for alcohol diminishes with age, in part because the ratio of body water to body mass decreases with time, resulting in higher blood alcohol concentration per unit of alcohol imbibed (Morse, 1988). In addition, older people metabolize alcohol more slowly. Thus, the drug may cause greater changes in brain chemistry and may more readily bring on toxic effects, such as delirium and memory problems, in older people (Brandt et al., 1983).

Because older adults tend not to go to work regularly and may not even be seen in public for days or weeks at a time, consequences of drugs may continue for a long time without being noticed. Compounding these issues, clinicians may be less likely to look for substance abuse in older people than in younger people and instead may attribute symptoms such as poor motor coordination and impaired memory to a medical problem or to late-life depression. Indeed, substance problems are often comorbid with major depression (Liberto et al., 1996). If substance abuse goes unrecognized, treatment will be severely compromised.

The misuse of prescription and over-the-counter medicines is a much greater problem than abuse of alcohol or illegal drugs in the elderly (LaRue, Dessonville, Jarvik et al., 1985). Elderly people have a higher rate of legal drug intake than any other group; although they constitute only 13 percent of the population, they consume about one-third of all prescribed medications (Weber, 1996). Older people also use more antianxiety medications than any other age group: rates of benzodiazepine use in older adults have been estimated at 14 to 37 percent (Wetherell, 1998). The use of benzodiazapines and sleep aids can create physical as well as psychological dependency. Many people may have trouble recognizing that the medications that were prescribed for them by a respected and trusted doctor may be addictive and problematic.

Check Your Knowledge 15.4

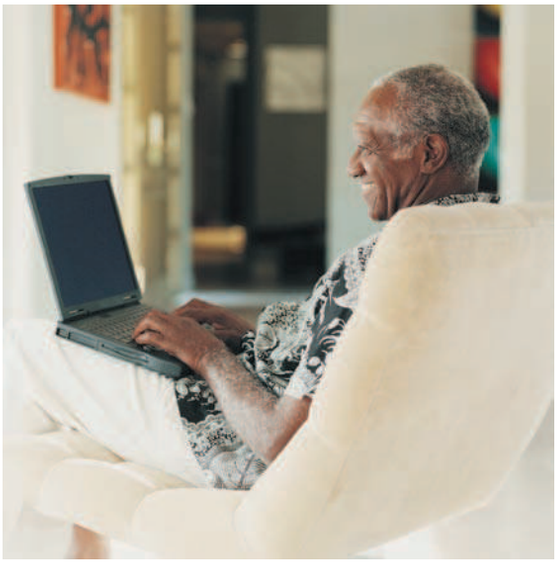
True or false?

1. Mental illnesses occur more often as people age.
2. Most mental illnesses among older adults are continuations of illnesses that they had earlier in life.
3. Elderly men are more likely to kill themselves than are younger men.

Adjusting Treatment with Older Adults

Several barriers may prevent older people from receiving adequate mental health care. First, older people may hold more negative beliefs about mental illness and treatment. Second, older people are less likely than younger adults to be assessed and referred for mental health care (Knight, 1996).

Even when an elderly person can access treatment, clinicians tend to expect less success in treating older people than in treating younger people (Knight, 1996). Yet, as described above, research shows that psychological treatments can be successful for older people. Indeed, with increasing years come increasing reflectiveness and a tendency to be philosophical about life (Neugarten, 1977), traits that bode well for psychotherapeutic interventions.



Being able to use a computer and access the Internet is one way older adults can increase their social connectedness. (Digital Vision/Getty Images.)

Although psychological treatment tends to be successful with the elderly, it may be important to adjust the process in several ways. Many of the emotional concerns of older adults may be realistic reactions to problems in aging, and pragmatic supports may be a better approach in those circumstances than attempts to help a person see the problem differently. For example, some clinicians focus on here-and-now practical problems in a more active and directive manner; they provide information, take the initiative in seeking out agencies for necessary services, and help clients through the maze of federal and local laws and offices that are in place to help them. Some treatments focus on helping the older person create a sense of meaning as he or she approaches the end of life.

It is also important to consider how cognitive characteristics of aging influence psychological treatment (Knight, 1996). For example, certain kinds of thinking simply take longer for many older people. Older people also tend to experience some diminution in the number of things that they can keep in mind at any one time. Explanations may have to be paced carefully. Researchers have developed accommodations, such as the use of more in-session summaries, to help compensate for the memory loss that some older clients experience.

Therapists, usually many years younger than these patients, can find that their interactions with patients touch on sensitive personal areas of their own, such as worries about their own aging process and mortality. As Knight, Kelly, and Gatz (1992) noted, working with older adults "will challenge therapists intellectually and emotionally to reach a maturity beyond their years" (p. 546).

Quick Summary

The prevalence of psychological disorders is lower among older adults than it is for any other age group. The psychological disorders that are present during late life usually represent a recurrence or continuation of symptoms that first emerged earlier in life. Some have argued that the low rates of mental illness could be an artifact of less disclosure among older people, could be a cohort effect, or could reflect selective mortality. Most researchers, though, believe that increased coping abilities might help explain the lower rates of disorder as people age. When psychological symptoms are present in the elderly, it is important to screen for medical causes.

Certain issues should be considered in thinking about specific psychological disorders in late life. For example, cognitive symptoms may be a prominent symptom of depression during late life, so that differential diagnosis with dementia is important. Late-life depression may also be related to cardiovascular conditions. Aggressive depression treatment is particularly important among people with a history of myocardial infarction. Although the base rates of depression are low, suicide rates are high among older men, in part because suicide attempts made by older people are likely to be lethal. Aside from cognitive disorders, anxiety disorders are the most common mental health problem faced in late life and may often be tied to the stresses involved in aging. Unfortunately, benzodiazepines are widely prescribed for the elderly despite clear evidence for dangerous side effects. Symptoms of paranoia become more common as people age and may be triggered by sensory loss, dementia, or social isolation. Alcohol and substance abuse are rare, but inappropriate use of prescription or over-the-counter medications is a concern. Treatment for most conditions parallels the treatment used with younger adults, but some innovations have been made, such as providing more in-session summaries and offering treatment in the home or through primary care. Contrary to stereotypes, older people tend to benefit a great deal from psychological treatments.

Living Situations: Community Living, Nursing Homes, and Other Alternatives

At any given time, 95 percent of older persons reside in the community. Many of these people are frail and have an urgent need for help with daily living arrangements (Meeks & Murrell, 1997). Some communities and for-profit agencies are organized to provide services such as the following:

- Daily phone calls to older persons living alone to check that they are all right
- Home services that deliver hot meals
- Volunteers who cook meals, do household chores, and do minor repairs
- Home visits by health professionals
- Adult day services that provide health and social services in a group setting
- Senior centers, which serve hot lunches, help with state and federal forms, and also provide opportunities for socializing.

Available services can be matched with the needs of the older person (Evashwick, 2001).

Because mental health and physical health problems are so interwoven, interdisciplinary collaboration is critical with older clients. Focus on Discovery 15.3 describes the kind of interdisciplinary team effort that can serve the needs of older adults. A set of studies now clearly show that such community services as described above, coupled with careful coordination of services among health care providers, can enhance the quality of life as well as reduce hospitalization and institutionalization rates for older people (Johri, Beland, & Bergman, 2003).

FOCUS ON DISCOVERY 15.3

Interdisciplinary Teamwork in Health Care for the Elderly

The health problems of older adults—including psychological problems—are often more complex and chronic than are those of younger adults and of children (Birren & Schaie, 2001). Thus, the guiding principle that organizes the work of gerontological practitioners is interdisciplinary cooperation (Zeiss & Steffen, 1996). Professionals from several disciplines must work collaboratively to help older adults deal with psychological difficulties (Zeiss & Steffen, 1996). Figure 15.2 portrays how different professionals can work separately (the nonoverlapping areas) and collaboratively (the overlapping areas) to provide assessment and intervention. For example, although the medical doctor serves as the primary care physician, the cognitive screening (how well the person remembers and thinks about things) can be done by the psychologist.

Not all geriatric problems require interdisciplinary coordination, but as Zeiss and Steffen (1996) argue, even a seemingly straightforward health problem in an older adult can benefit from an interdisciplinary approach. They give an example of an 80-year-old woman with bronchitis. Can she be adequately treated by a physician alone? Maybe not. It may be essential to know that she is a caregiver for a husband with dementia, what other medications she is taking, what her immune status is, and other issues pertinent to her physical and emotional well-being. Social workers, psychologists, or other team members may be essential in planning not only acute treatment for her bronchitis but also backup care for her husband.

Coordination of care helps to prevent premature institutionalization among the elderly. Sadly, health care practices in the United States are behind those of other countries in developing "single point of entry" insurance systems, designed to facilitate coordinating health care needs across multiple agencies and providers (Johri et al., 2003).

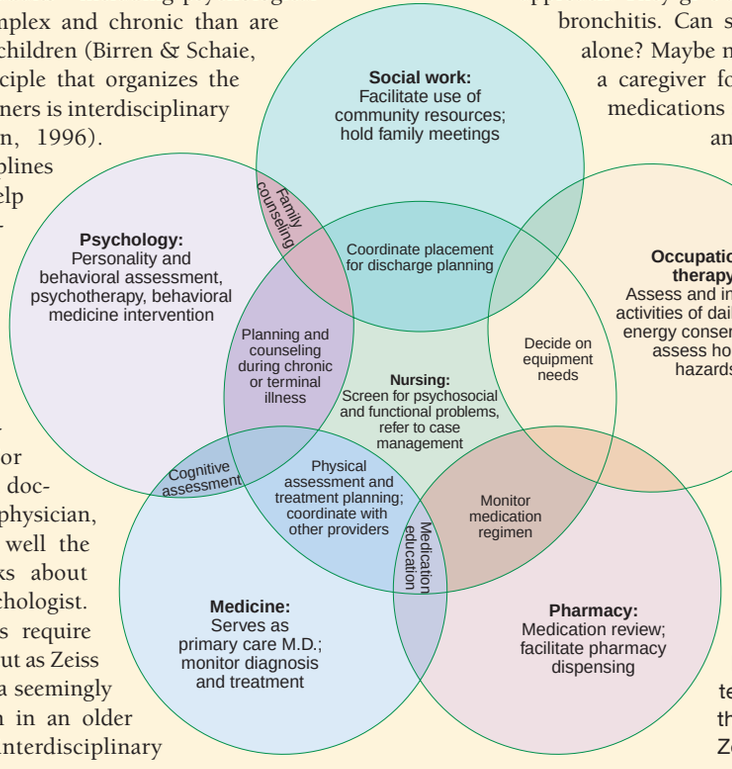


Figure 15.2 Geriatric interdisciplinary-team role map. Note both the separate and the overlapping areas of expertise. From Zeiss & Steffen (1996).

Mere availability of services is not enough. Services must be coordinated, and in most localities they are not. All too often an older person and his or her family are shuffled from one agency to another, getting lost in Kafkaesque bureaucracies. Even professionals who have experience with the system often have difficulty working through it to get needed services for their clients. Frustrating rules abound. In some states, for example, Medicare does not always pay for rehabilitation services, such as physical therapy, after a broken hip has healed. As a consequence, many older people do not regain as much function as they might; thus, they may experience additional physical and emotional deterioration, exacerbations that require more expensive services.

A growing number of older persons live with family members who help manage tasks of daily living. As changes in physical health or cognitive abilities become too daunting for community living, some people move to nursing homes, assisted living facilities, or retirement communities to receive more support. At any point in time, about 5 percent of elderly people live in long-term care facilities, but at least 40 percent of the elderly will spend some time in one of these facilities (Seperson et al., 2002).

Nursing Homes

The common myth about nursing homes is that families dump their older relatives into these institutions at the first sign of frailty. Rather, most families explore all their alternatives and exhaust their resources before they institutionalize an older relative. Thus, the decision to institutionalize comes as a last resort. For many families, the additional support and the relief from the difficulties of daily caretaking can actually improve the quality of relationships (Smith & Bengtson, 1979).

Nonetheless, nursing homes may have unintended negative consequences on some residents. Consider a classic study by Blenker (1967). Older adults who went to a family service center were randomly assigned to one of three treatments: intensive, intermediate, and minimal. Intensive treatment involved the services of a nurse and a social worker; intermediate treatment involved somewhat less professional attention; minimal treatment consisted of information and referral to community-based services. One might expect intensive treatment to have been the most effective, but after 6 months the death rate of members of the intensive-care group was four times that of people in the minimal-care group! The intermediate-care group was also better off than the intensive-care group; the death rate of its members was "only" twice that of the minimal-care group.

What happened? It turned out that the major factor was being placed in an institution such as a nursing home. A person was much more likely to be institutionalized if a nurse and social worker were intensively involved in planning his or her care, and the excessive death rates were found in people who were institutionalized. Since people had been assigned randomly to the three treatments, it is unlikely that the death rates were related to any pretreatment differences.

Among community-based services are day-care centers, where older people participate in various activities, such as exercise classes. (Corbis Images/SuperStock, Inc.)

What is it about some nursing homes that could contribute to decline? First, the stress of relocating to a new setting is believed to play a role in increased mortality (Schultz & Brenner, 1977). Beyond this, in many nursing homes, the nature of care discourages maintenance of whatever self-care skills and autonomous activities the resident may be capable of. Residents of nursing homes, even if they are able to do so, are often not permitted to cook, do their laundry, buy groceries, or tend the yard. Even more limiting, some facilities feed residents to speed mealtime, even when a resident is able to feed himself or herself. As residents lose their autonomy in these daily tasks, a sense of control is eroded.

In a nursing home, small ways of giving residents a sense of control may mean a lot. In one study, Rodin and Langer (1977) gave one group of residents a variety of decisions to make themselves, instead of the staff's making decisions for them; they were also given plants to take care of. A control group was told how eager the staff was to take care of them; the plants they were given were looked after by the staff. Members of the group given enhanced

responsibility—and presumably a sense of greater control—tested higher on measures of alertness, happiness, and well-being three weeks later and even 18 months later. More importantly, 18 months later only half as many members of the experimental group had died—7 of 47, compared with 13 of 44 for the control group. More recently, programs that give nursing home residents responsibility for plants and pets have been found to significantly diminish helplessness and boredom of the residents (Bergman-Evans, 2004).

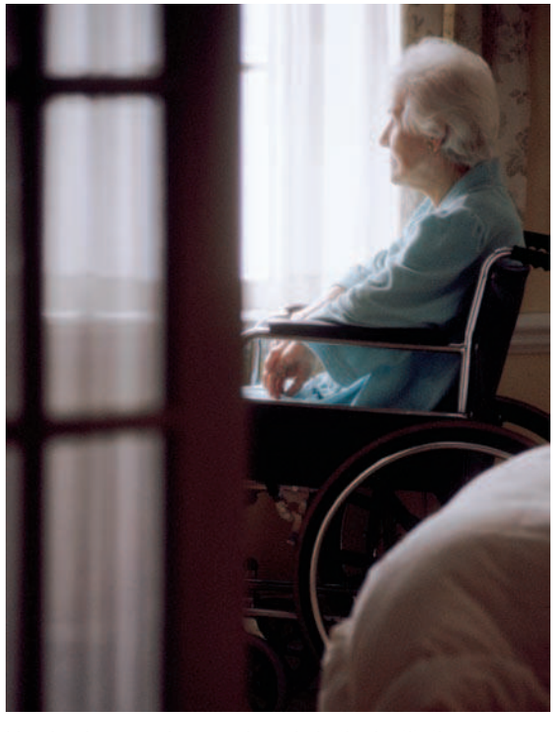
During the late 1980s a series of investigations into lax practices in nursing homes led to governmental reforms. Despite resulting improvements in most nursing homes, serious problems remain with many of them (Senate Special Committee on Aging, March 2002). For example, nursing assistants are often inadequately trained, overworked, and underpaid—and it is the nursing assistants, not the professional nursing staff or physicians, who have by far the most contact with nursing home residents. In one study, nursing assistants were found to have committed a set of harmful, even fatal, errors, such as failure to wash hands, to note dehydration, and to attend to bedsores (Pyle, 1999). There is little doubt that nursing homes still need reform.

National policy now mandates that people with primary mental illnesses should not be admitted to nursing homes. Despite that ruling, some people develop mental illnesses after admission, some people with mental illnesses were already living in nursing homes before the ruling, and others were admitted because diagnoses were not caught at admission. It has been estimated that 80 percent of people living in nursing homes have mental illness or dementia (Reichman et al., 1998), and 44 percent report significant symptoms of depression (Teresi et al., 2001).

Clearly, then, there is a need for mental health services in these settings. Beyond evidence that psychological disorders can be effectively treated, interventions such as behavior therapy have been found to be quite effective in reducing unwanted behaviors and improving overall functioning in nursing home residents with dementia. In fact, medication can often be significantly reduced once behavior therapy has been implemented (Mansdorf et al., 1999).

Many nursing homes do provide mental health care. Indeed, one-third of mental health and substance-abuse treatment costs for the elderly are provided to nursing homes (Harwood et al., 2003). Nonetheless, nursing homes vary substantially in their access to quality mental health care. Almost half of nursing home administrators report that they do not have access to adequate mental health consultation (Reichman et al., 1998). Many of the staff working in nursing homes are untrained in managing behaviorally disruptive residents. Instead, nursing homes often rely on an off-site mental health provider who meets with a client and provides written recommendations for staff members to follow. One study of 523 nursing homes found that less than a third of written recommendations for mental health care were implemented by staff (Snowden & Roy-Byrne, 1998). These gaps in service are particularly sad, given that mental health interventions are shown to be helpful in late life.

In an attempt to improve the quality of care, the federal government now mandates that the care provided to each client in a nursing home be evaluated using quality control indices at admission and annually. Many of these indices are designed to assess whether procedures are in place to address depression, memory problems, and other psychological conditions. Average indices for each facility are included in a national database in order to allow researchers, reviewers, and policy makers to make data-guided decisions (*http://www.cms.hhs.gov/NursingHomeQualityInits*).



Nursing homes play a major role in the institutional care of the aged. They have often been criticized for the poor care they provide as well as the lack of stimulation in the environment. (Jose Luis Pelaez/Corbis Stock Market.)

Alternative Living Settings

Assisted living has become a popular alternative to nursing homes for many older adults who require some assistance with daily activities (AARP, 1999). In contrast to nursing homes, assisted-living facilities resemble hotels with separate suites for the residents as well as dining rooms and on-site amenities such as beauty and barber shops. The philosophy of assisted living stresses autonomy, dignity, and privacy (AARP, 1999). Assisted living may sometimes go by other names, such as group homes or board-and-care. Many such residences are quite luxurious, with attentive staff, nursing and medical assistance readily available, daily activities such

CCRCs often provide extensive opportunities for social contact. (Keith Brofsky/PhotoDisc, Inc./Getty Images.)

as games and movies, and other services all designed to provide help for older adults too infirm to live on their own but not so infirm as to require a nursing home. Although assisted-living facilities can be costly, they are often more affordable than nursing homes.

In addition to assisted-living facilities and nursing homes, continuing care retirement communities (CCRCs) offer a continuum of care that enables residents to move from one housing option to another depending on their needs. These facilities combine independent living, assisted living, and nursing homes together on the same grounds. Residents may begin living in independent housing and move to other housing options as they require more assistance with their activities of daily living. The cost of living in these communities is quite high. Depending on the specific CCRC, residents may own or rent their apartment. Most CCRCs require their potential residents to pass a medical examination and demonstrate that they can still live relatively independently before they can join the community.

Check Your Knowledge 15.5

Answer the questions.

1. The most common living situation for people in late life is:
   - **a.** in the community
   - **b.** in a continuing care retirement community
   - **c.** in a nursing home
   - **d.** in a group home
2. National legislation focused on improving the quality of care in nursing homes has:
   - **a.** ignored mental health issues
   - **b.** broadly described the need for mental health care
   - **c.** provided specific guidelines about certain forms of mental health treatment
   - **d.** is nonexistent
3. National legislation concerning older people with current psychological disorders:
   - **a.** mandates that they should only be placed in nursing homes with good psychiatric coverage
   - **b.** mandates that they should not be placed in nursing homes
   - **c.** does not address proper placement of this population

Summary

Aging: Issues and Methods

- As life expectancy continues to improve, it will become even more important to learn about the disorders suffered by some older people and the most effective means of treating them.
- Several stereotypes about aging are false. Generally, people in late life report low levels of negative emotion, are not inappropriately concerned with their health, and are not lonely. Elderly couples report active sex lives as long as health problems do not interfere. On the other hand, poverty, stigma, and physical disease are common challenges for people as they age.
- In research studies, differences between a younger and an older group could reflect either cohort effects or effects of chronological age. Longitudinal studies are more helpful for making this distinction than cross-sectional studies are.

Cognitive Disorders in Late Life

- Serious cognitive disorders affect a small minority of older people. Two principal disorders have been distinguished: dementia and delirium.
- In dementia, the person's intellectual functioning declines and memory, abstract thinking, and judgment deteriorate. As the dementia progresses, the person comes to seem like another person altogether and, in the end, may become oblivious to his or her surroundings. A variety of diseases can cause this deterioration. The most common is Alzheimer's disease. Genes play a major role in the etiology of Alzheimer's disease. A history of depression is a risk factor, and exercise and cognitive activity appear to be protective.
- Other forms of dementia include frontotemporal dementia, vascular dementia, dementia with Lewy bodies, and dementia due to other medical conditions.

- Dementia usually responds only minimally to medication treatment, but the person and the family affected by the disease can be counseled on how to make the remaining time manageable and even rewarding. Exercise programs for people with dementia may help improve cognitive functioning.
- In delirium, there is a sudden clouding of consciousness and other problems in thinking, feeling, and behaving: fragmented and undirected thought, incoherent speech, inability to sustain attention, hallucinations, illusions, disorientation, lethargy or hyperactivity, and mood swings. The condition is reversible, provided that the underlying cause is adequately treated. Causes include overmedication, infection of brain tissue, high fevers, malnutrition, dehydration, endocrine disorders, head trauma, cerebrovascular problems, and surgery.

Psychological Disorders in Late Life

- Data indicate that persons over age 65 have the lowest overall rates of psychiatric disorders of all age groups. When older people experience psychological disorders, the symptoms are often a recurrence of a disorder that first emerged earlier in life.
- In older adults, depression tends to be accompanied by more cognitive impairment. When the onset of a first episode of depression occurs after age 65, cardiovascular disease is often a cause. Depression is also predictive of worse outcomes of cardiovascular diseases.
- Suicide attempts of older people are more likely to result in death than those of younger people, and the group with the highest rate of suicide is elderly Caucasian men.
- Anxiety disorders are more prevalent than depression among older adults.
- Delusional (paranoid) disorder may also be seen in older people. Sometimes onset occurs in the context of brain disorders, sensory losses, or increasing social isolation.
- Medication treatments for psychological disorders are similar in effectiveness during adulthood and late life, but they must be used with caution because the elderly are more sensitive to side effects and toxicity.

Adjusting Treatment with Older Adults

- Many of the treatments shown to help most psychological disorders in adulthood appear to be helpful for late-life disorders. For example, cognitive behavioral psychotherapy is effective for depression and for anxiety.
- Psychological treatments may need to be tailored to the needs of older people. Clinicians should sometimes be active and directive, providing information and seeking out the agencies that give the social services needed by their clients.

Living Situations: Community Living, Nursing Homes, and Other Alternatives

- Most older persons reside in the community.
- Nursing homes sometimes do little to encourage residents to maintain whatever capacities they have. Both physical and mental deterioration may occur. Serious neglect can be found in some nursing homes, and access to mental health care is limited. Several efforts have been made to correct these deficiencies.
- An increasingly popular alternative is assisted-living facilities.

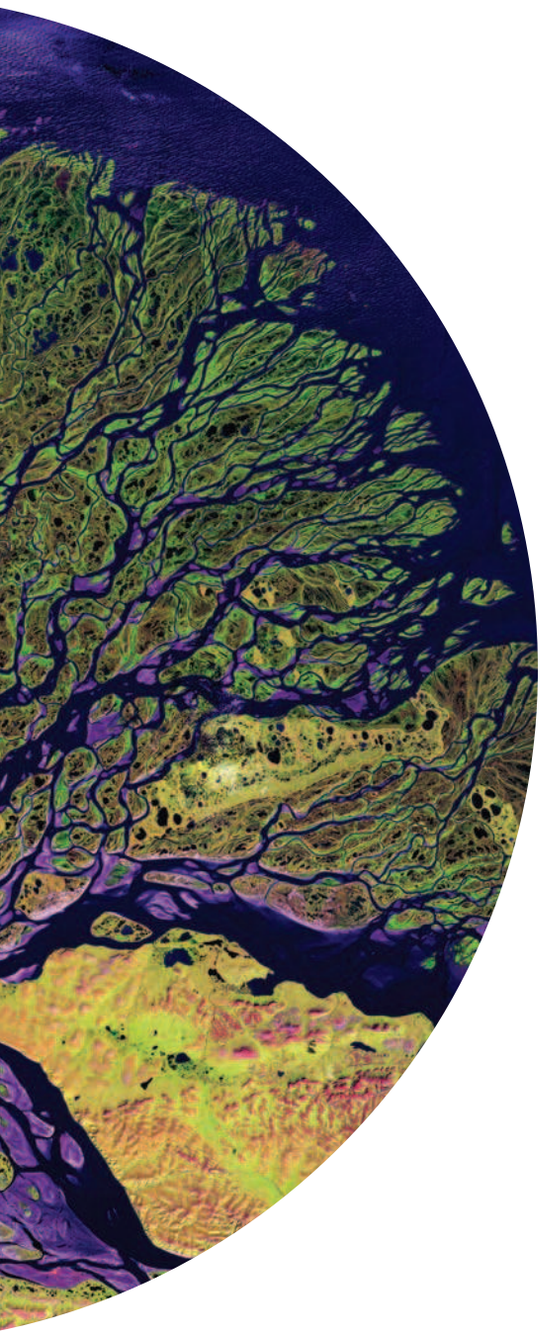
Answers to Check Your Knowledge Questions

15.1 1. F; 2. F; 3. F; 4. F
15.2 1. a; 2. b; 3. d; 4. a; 5. b
15.3 1. b; 2. c; 3. d
15.4 1. F; 2. T; 3. T
15.5 1. a; 2. c; 3. b

Key Terms

age effects
Alzheimer's disease
cohort effects
delirium
dementia
dementia with Lewy bodies (DLB)
disorientation
frontotemporal dementia (FTD)
neurofibrillary tangles
plaques
selective mortality
social selectivity
time-of-measurement effects

16 Psychological Treatment



LEARNING GOALS

1. Be able to describe the major forms of psychological treatments.
2. Be able to explain standards and issues for psychotherapy outcome research and the major research findings.
3. Be able to discuss different approaches for adapting psychotherapies for people from diverse ethnic and cultural backgrounds.
4. Be able to understand the basic goals of psychotherapy process research and some of the factors that predict better treatment outcome within different forms of therapy.
5. Be able to discuss the goals of community psychology and political trends in that field.

IN CHAPTERS 1 AND 2 we described the major approaches to psychological therapeutic intervention, and in Chapters 5 through 15 we reviewed how these approaches work for specific disorders. We now discuss some broader issues in psychological treatment. First, we review some of the major forms of therapy. Although cognitive behavioral therapies have received a lot of attention in previous chapters, here we also cover psychodynamic therapies, experiential therapies, couples therapies, and family therapies. Our goal is to provide a richer description of the philosophy behind these treatments as well as specific intervention strategies. To illustrate some of the treatments, we will include brief case studies. After describing the different forms of therapy, we provide an overview of treatment outcome research, which strives to address whether a given treatment works. We describe standards to evaluate treatment outcome studies as well as issues in applying those standards. With the standards in mind, we discuss the findings for the different types of therapy. A major concern is that most treatment outcome research has not addressed whether these treatments work well for diverse populations. We describe the small literature regarding ethnicity and treatment outcome. Then we discuss different approaches to enhancing the validity of therapy for people from different ethnic and cultural backgrounds. After providing an overview of the treatment outcome research, we consider psychotherapy process research, which attempts to understand the mechanisms involved in effective treatment. We close with a discussion of community psychology, a field that focuses on making interventions available on a broad social scale rather than with one person at a time.

Specific Treatment Approaches

We begin with an overview of several specific therapeutic approaches. For each therapy, we consider some issues in how to apply techniques and to refine the treatments.

Psychodynamic Treatment

As we noted in Chapter 1, psychoanalysis was originally developed by Freud and his colleagues. They proposed that symptoms were caused by unconscious conflicts and so developed a set of strategies to help clients gain insight into these underlying conflicts. The approach evolved over time, and today most people use psychodynamic therapies that tend to be briefer and more active. Psychoanalytic and psychodynamic treatments, though, both emphasize the importance of early parental relations and unconscious motivations in the genesis of symptoms. Both treatments, then, involve helping the client develop insight.

In psychoanalytic and psychodynamic treatments, the goal of the therapist is to understand the person's early-childhood experiences, the nature of their key relationships, and the patterns in their current relationships. The therapist is listening for core emotional and relationship themes that surface again and again. One way for the therapist to understand core themes is to watch the way that the client begins to relate to the therapist. Some clients express helpless bewilderment, perhaps a clue to underlying conflicts between helplessness and autonomy. Others develop fears that the therapist is secretly annoyed at them, perhaps providing a clue that the client has internalized an idea of relationships as overly punitive. To help the client gain insight, a core aspect of these interventions is interpretation, in which the therapist points out patterns in relationships and emotions that a client may not have realized. Insight is conceptualized as a process in which the client develops a new understanding and, with this understanding, experiences a cathartic release of emotions.

It has been assumed that psychoanalytic therapists would be more passive than psychodynamic therapists. The classic image of a psychoanalytic therapist is of a person who sits behind the client, providing a tabula rasa, or blank slate, as the client free-associates. In a report of a large psychoanalytic psychotherapy project, Wallerstein (1989) reported that in actual practice psychodynamic and psychoanalytic therapists appeared pretty similar; both were fairly active and engaged.

As we discuss treatment outcome research later, it is worth noting that the core goal of psychodynamic treatment is to improve insight and self-understanding. Symptom reduction is expected to happen as a consequence of this improved awareness, but it is not the central concern. Because of this, treatment outcome studies have been accused of focusing on the wrong goal due to their almost exclusive focus on symptom reduction as the measure of success.

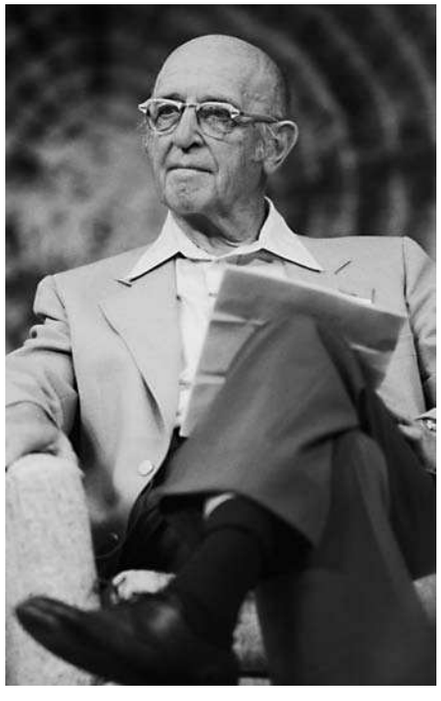
Experiential Therapies

Experiential therapies were first developed in the mid-twentieth century and have continued to evolve since that time. Experiential approaches all share a belief that humans are innately good. In this way, experiential therapies differ from the psychodynamic focus on the unconscious as a caldron of powerfully negative impulses and motivations that must be managed. Experiential therapists emphasize the creative and expressive aspects of people, rather than the problematic and symptomatic features on which psychoanalysts often seem to concentrate. In experiential therapies, the therapist aims to promote growth by helping clients to understand and value their internal emotions and needs. The goal of the therapist is to provide a safe relationship so that clients can explore their emotions (Elliot, Greenberg & Lietaer, 2004). To do so, the therapist uses **empathy**, the accurate awareness of the client's emotions. Because we have not reviewed these in much detail elsewhere in the book, we describe three of these approaches here: client-centered therapy, Gestalt therapy, and emotion-focused therapy.

Client-Centered Therapy

The American psychologist Carl Rogers (1902–1987) developed **client-centered therapy** based on a humanistic perspective. Humanism holds that if unfettered by groundless fears and societal restrictions, human beings will develop normally, even exceptionally, much as a healthy plant will naturally develop from a seed if given enough light, air, and water without harmful or limiting conditions. Rogers (1951, 1961) developed a therapy that included the following assumptions:

1. People can be understood only from the vantage point of their own perceptions and feelings.
2. Humans are innately good, effective, and self-directed. Humans share an innate tendency for **self-actualization,** or the potential to fulfill one's potential.
3. People's innate goodness and effectiveness is thwarted by too many internalized demands and preferences from others and from society.



Carl Rogers, who developed client-centered therapy, proposed that the key ingredient in therapy is the attitude and style of the therapist rather than specific techniques. (Roger Ressmeyer/Corbis Images.)

In the empty-chair technique, the client projects a person, object, or situation onto an empty chair and then talks to it. (Copyright John Wiley & Sons, Inc.)

The therapeutic goals include helping people listen to their own internal feelings and needs rather than responding to externally imposed demands. The therapist's job is to create a therapeutic relationship that fosters a return to the client's basic nature. The therapist promotes growth by totally accepting the person for who he or she is and by providing what Rogers called **unconditional positive regard**. Other people set what Rogers called "conditions of worth"—"I will love you if." In contrast, the client-centered therapist values clients as they are—with unconditional positive regard—even if the therapist does not approve of their behavior. The therapist must deeply care for and respect a client for the simple reason that he or she is another human being struggling to live and grow.

Gestalt Therapy A central goal of **Gestalt therapy**, derived from the work of Freidrich (Fritz) S. Perls (1893–1970), is to help clients to be aware of how they block themselves from experiencing their emotions and satisfying their needs. Gestalt therapists focus on what a client is doing here and now in the session, without delving into the past. The therapist attempts to help clients become more aware of and more expressive of their feelings and needs.

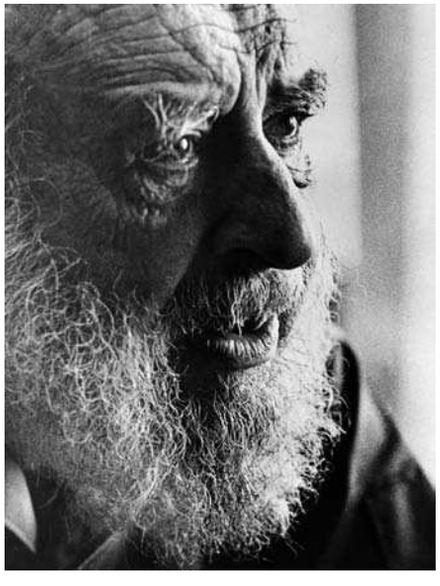
Compared to client-centered therapies, Gestalt therapy is noted for its emphasis on techniques. Here is a small sample of Gestalt techniques.

- *Language.* To help clients take responsibility for their lives, the therapist instructs them to change "it" language into "I" language.

  Therapist: What do you hear in your voice?
  Patient: My voice sounds like it is crying.
  Therapist: Can you take responsibility for that by saying, I am crying?
  (Levitsky & Perls, 1970, p. 142)

  This simple change in language reduces the client's sense of being alienated from aspects of his or her being.

- *The empty chair.* In the empty-chair technique, a client projects a feeling, person, object, or situation and then talks to the projection. For example, if a client is crying about childhood abuse, the Gestalt therapist might ask the client to pretend that the abuser is in an empty chair opposite the client and to speak to the abuser. This tactic increases the client's awareness of his or her feelings. A variation of the empty chair is the two-chair technique—the client moves to the chair that he or she has been talking to and responds as if he or she were the projected person or feeling.



Freidrich (Fritz) Perls, the colorful founder of Gestalt therapy. (Courtesy Harriet F. Schenker, Gestalt Institute of Cleveland.)

- *Attention to nonverbal and paralinguistic cues.* Therapists are trained to pay attention to nonverbal and paralinguistic cues given by the client, including body movements, facial expressions, gestures, and tone of voice. Often without realizing it, people use nonverbal or paralinguistic cues to negate their words with their hands or their eyes. Perls placed emphasis on observing these cues to determine what clients might really be feeling. "What we say is mostly lies or bullshit. But the voice is there, the gesture, the posture, the facial expression" (Perls, 1969, p. 54).

Gestalt therapy forcefully conveys the message that a person can make the existential choice to be different at any time and that the therapist will not tolerate stagnation. Undoubtedly this optimistic view helps many people change.

Emotion-Focused Therapy Greenberg (2002) developed *emotion-focused therapy,* which incorporates elements of client-centered therapy and Gestalt techniques. Within this approach, the therapist focuses on the idea that some emotions are adaptive, in that they are accurate responses to a given situation, whereas others are maladaptive—responses that are biased by previous experiences. Maladaptive emotions are based on an underlying loneliness, abandonment, worthlessness, anger, or inadequacy. When these feelings surface repetitively, they damage a person's relationships and lifestyle. The goal, then, is for a client to become more aware of these maladaptive emotions, to understand the source of these feelings, and to learn skills to regulate emotions.

Clinical Case: An Example of Emotion-Focused Therapy

In emotion-focused therapy, the therapist will use a number of strategies to help clients develop a better understanding of their adaptive and maladaptive emotions. These include focusing on the present experience, as reflected nonverbally. By helping clients put their emotions into words, the therapist can begin to distinguish between healthy and unhealthy emotions as well as the needs that are driving those feelings.

In the session described below, the client began by describing the loneliness he had experienced in his previous marriage. He was harshly self-critical about the distance in the marriage (an unhealthy emotional pattern), and the therapist was helping him see this pattern. He began to talk about his amazement that his current girlfriend wanted closeness.

> *As my client talked about his girlfriend's active pursuit of him, he held his arms and hands straight out, gesturing that his response to her pursuit was to protectively hold her at bay. Paying attention to his hand movements, I asked him what it was like when he was approached by her. He said that he initially feels anxious when she approaches and that he internally pulls back. On further exploration of this feeling, I encouraged him first to own this possibly unhealthy fear rather than avoid or ignore it. He talked first about how unworthy he felt and then about how he was afraid to let anyone close for fear of being known and rejected again. This led back to his feelings of having been dropped by his ex-wife, not for another man but for her art. I shared with him that I could imagine how unimportant that must have left him feeling. His experience of feeling rejected was further evoked and intensified when I asked him to pretend his ex-wife was sitting in the chair across from him. I asked him to imagine telling her how unlovable this had made him feel. This helped him access his feeling of having been poorly treated by her. A feeling of anger emerged. He felt more empowered, because he was able to feel angry at the offense rather than rejected and sad. The session concluded with the client clearly describing his need to feel loved and to be self-affirming and his intention to continue to seek the closeness he wanted with his girlfriend.* (Greenberg, 2002, p. 104)

Behavioral Therapies

Exposure (see p. 45) is one of the best-established behavioral approaches. Beyond exposure, operant techniques, which involve manipulating rewards and punishment, have been found to be successful with a wide range of behavioral problems in both adults and children. Inroads in treating substance abuse have been made by reinforcing behavior that is incompatible with the use of a drug to deal with the stresses of everyday life (Higgins, Budney, & Sigmon, 2001). Linehan's dialectical behavior therapy (p. 377) also contains important operant elements for the management of suicidality. Another successful example of operant conditioning is **behavioral activation (BA) therapy** of depression (Jacobson, Martell, & Dimidjian, 2001, p. 239), which involves helping a person engage in tasks that provide an opportunity for positive reinforcement. See Focus on Discovery 16.1 for a discussion of self-control and operant contingencies.

Operant techniques such as systematically rewarding desirable behavior and extinguishing undesirable behavior have been particularly successful in the treatment of many childhood problems (Kazdin & Weisz, 1998). Consider how much of children's behavior is subject to the control of others-children tend to be supervised fairly continually by teachers at school and by parents at home. The behavior therapist can work with parents and teachers to change rewards and punishments for a child. A broad range of childhood problems are treated with through operant conditioning, including bed-wetting, thumb-sucking, nail-biting, aggression, tantrums, disruptive classroom behavior, poor school performance, extreme social withdrawal, mental retardation, and autistic disorder (Kazdin & Weisz, 1998).

Once contingencies shape a behavior, a key goal is to maintain the effects of treatment. If a therapist or a teacher has been providing reinforcement, one might not expect this person to keep providing reinforcement forever. This issue has been addressed in several ways. Because laboratory findings indicate that intermittent reinforcement—rewarding a response only a portion of the times it appears—makes new behavior more enduring, many operant programs move away from continuous schedules of reinforcement once desired behavior is occurring regularly.

Exposure treatment is one of the most well-supported approaches for anxiety disorders. (Michael Newman/PhotoEdit.)

FOCUS ON DISCOVERY 16.1

Self-Control—Outside a Behavioral Paradigm?

How do people change the way they think or behave? How do dieters resist a piece of chocolate cake, or alcoholics resist a drink, or angry people resist the urge to hurl a criticism at another person? Each of these impulses require people to control themselves, despite the conflicting possibility of reinforcement from taking another path. Self-control, then, involves consciously deciding to engage in a certain type of thought or behavior that requires some effort and is not explained by the immediate external contingencies. Most of us have decided to engage in some form of self-control.

Impulse control disorders, such as pathological gambling, may be related to poor self-control. (Doublas Kirkland/Corbis Images.)

Operant theory seems to assume that people passively respond to reinforcement and punishments in the environment. How can these models account for a person's ability to resist reinforcement in the hopes of improving life longer term?

Psychoanalytic writers posit that the ego controls the id's desire to indulge in immediate gratification. Behaviorists, especially Skinner (1953), objected to this explanation, as there is no way to observe the ego. Skinner argued that people engage in self-control by arranging the environment so that only certain controlling stimuli are present. A person wishing to lose weight rids the house of fattening foods and avoids standing by the food table at a party. Behavior remains a function of the surroundings, but the surroundings are controlled by the person. One way to control the environment is to promise oneself reinforcement after a goal is met (Bandura & Perloff, 1967). For example, one author of this book uses the strategy of promising herself a wonderful meal once she finishes a chapter. By setting up rewards for accomplishing a goal, self-control is promoted. Note that to account for self-control, behavior theorists incorporate cognition.

Muraven and Baumeister (2000) have described a model of self-control as an internal resource. They argue that we all have a certain amount of self-control and that some people tend to have more than others. Like a muscle, self-control can be strengthened but can also be exhausted. An interesting aspect of this model is the idea that there is a limit to how many self-regulatory goals a person can pursue at one time. For example, people trying to control their emotions after a major breakup (self-control over emotional expression) may find it harder to stick with their diet (self-control over their eating patterns). This model suggests that therapists should be careful not to assign their clients too many goals for self-improvement at once.

For example, if a teacher has succeeded in helping a disruptive child spend more time sitting by praising the child generously for each math problem finished while seated, the teacher will gradually reward the child for every other success, and ultimately only infrequently. Another strategy is to move from artificial reinforcers to those that occur naturally in the social environment. A token program might be maintained only long enough to encourage certain desired behavior, after which the person is weaned to naturally occurring reinforcers, such as praise from peers. If reinforcers are not likely to be available consistently in the natural environment, therapists sometimes manipulate surroundings to support behavioral changes. For example, in the treatment of children with autism, parents are taught how to provide reinforcement for good behavior (McEachin, Smith, & Lovaas, 1993). Hence, parent training often becomes an integral part of behavior therapy for children. Similarly, treatment for many anxiety disorders now includes partners and family members so that they can provide new reinforcement contingencies.

Cognitive Treatment

All cognitive approaches have one thing in common. They emphasize that how people construe themselves and the world is a major determinant of psychological disorders. By changing cognition, therapists hope that people can change their feelings, behaviors, and symptoms. In cognitive therapy, the therapist typically begins by helping clients become more aware of their maladaptive thoughts. People with depression may not realize how often they think

Clinical Case: An Example of Beck's Cognitive Therapy

The examples here illustrate ways of beginning to challenge a patient's negative cognitions.

Therapist: You said that you feel like a failure since Bill left you. How would you define "failure"?
Patient: Well, the marriage didn't work out.
Therapist: So, you believe that the marriage didn't work out because you, as a person, are a failure?
Patient: If I had been successful, then he would still be with me.
Therapist: So, would we conclude that we can say, "People whose marriages don't work out are failures"?
Patient: No, I guess I wouldn't go that far.
Therapist: Why not? Should we have one definition of failure for you and another for everyone else?

People who define "failure" as less than "extraordinarily successful" can see that their definitions are polarized in all-or-nothing terms—that is, "complete success" vs. "complete failure." A variation on this technique is to ask the patient how others would define "success" or "failure."

Therapist: You can see that your definition of failure is quite different from the way other people might see it. Few people would say that a person who is divorced is a failure. Let's focus on the positive end right now. How would most people define "success" in a person?
Patient: Well, they might say that someone has success when they accomplish some of their goals.
Therapist: OK. So, would we say that if someone accomplishes some goals they have success?
Patient: Right.
Therapist: Would we also say that people can have different degrees of success? Some people accomplish more goals than others?
Patient: That sounds right.
Therapist: So, if we applied this to you, would we say that you have accomplished some of your goals in life?
Patient: Yes, I did graduate from college and I have been working for the past six years. I've been busy raising Ted—he had some medical problems a couple of years ago, but I got the right doctors for him.
Therapist: So, would we call these some successful behaviors on your part?
Patient: Right. I've had some successes.
Therapist: Is there a contradiction, then, in your thinking—calling yourself a "failure" but saying that you have had several successes?
Patient: Yes, that doesn't make sense, does it? (quoted in Leahy, 2003, pp. 38-39).

self-critically, and those with anxiety disorders may not realize that they tend to be overly sensitive to possible threats in the world. The therapist begins by tracking the daily thoughts a person experiences but then moves to understanding more about core cognitive biases and schemata that might shape those daily negative thoughts. Although many would imagine that cognitive therapy might be dry and unemotional, some cognitions are affect-laden, sometimes referred to as "hot cognitions." Beck argued that "emotions are the royal road to cognition." That is, during highly distressed states, clients may have access to their most negative thoughts.

The roots of cognitive therapy included Beck's cognitive therapy and Ellis's **rational-emotive behavior therapy (REBT)**. There have also been many recent innovations in cognitive behavior therapy (CBT). These treatments include dialectical behavior therapy (see Chapter 12), mindfulness-based cognitive therapy (see Chapter 8), and acceptance and commitment therapy. The newer treatments differ from traditional CBT by incorporating a focus on spirituality, values, emotion, and acceptance (Hayes et al., 2004). One theme that emerges across these manuals is acceptance (see Focus on Discovery 16.2). Another theme involves strategies to minimize emotional avoidance. For example, in acceptance and commitment therapy (Hayes, 2005), a person might be taught that much of the destructive power of emotions lies in the way we respond to them cognitively and behaviorally. An overarching goal of these therapies is to help a person learn to be more aware of emotions but to avoid immediate, impulsive reactions to that emotion. In the case of mindfulness-based cognitive therapy, this is facilitated through the use of meditation (Segal, Williams, & Teasdale, 2003). Overall a rich array of cognitive behavioral approaches have been developed.

Couples Therapy

Conflict is inevitable in any long-term partner relationship, whether the two people are married or not, or of the opposite sex or not. About 50 percent of marriages in the United States end in divorce, and most of these divorces happen within the first seven years of marriage (Snyder,

FOCUS ON DISCOVERY 16.2

Acceptance in Couples Therapy

The notion of acceptance in therapy dates back at least to Sigmund Freud. As Christensen and Jacobson (2000) indicate, the use of interpretation in psychoanalytic couples therapy (e.g., Scharff, 1995) can help partners understand that displeasing behaviors stem from childhood wounds, thereby fostering greater acceptance. But the concept assumes greater primacy in the work of Carl Rogers, whose client-centered therapy rested on the belief that "conditions of worth" should not be set for others. Rather, we should try to accept clients as worthy people deserving of respect regardless of their behavior at any point in time. Albert Ellis's rational-emotive behavioral therapy also emphasized acceptance by encouraging people to renounce many of the demands they impose on themselves and on others. As described on p. 378, Linehan's dialectical behavior therapy (1993) emphasizes the importance of the therapist providing genuine caring and acceptance for the client with borderline personality disorder.

Drawing on earlier work, Neil Jacobson and Andrew Christensen (1996) developed integrative behavioral couples therapy (IBCT). The goal of this therapy is to uncover the major variables driving the couple's distress rather than to create superficial behavioral changes. For example, whereas traditional behavior therapists might focus on discrete observable behavior, such as lack of sex or frequent arguments, integrative therapists might focus on a partner's feeling that he or she is not loved by the other partner. Jacobson and Christensen argue that traditional behavioral couples therapists have overlooked the importance of accepting a partner while at the same time hoping for and encouraging change. To address this, IBCT supplements traditional behavioral therapy techniques with a focus on acceptance. This shift in therapeutic attention provides one example of recent versions of cognitive behavioral therapies being enriched by attention to broader goals.

IBCT includes a set of techniques to promote acceptance. One technique, known as "unified detachment," is used to help partners gain a degree of emotional distance from their problems (Cordova, Jacobson, & Christensen, 1998). Usually, couples in conflict are stuck blaming and criticizing each other. In unified detachment, couples are taught to focus on describing what happens in their interaction as objectively as possible, without trying to evaluate who is at fault or who caused a fight. They are taught to understand processes that can intensify conflicts, such as escalation (increasing tension as couples expand the focus of a conflict), polarization (increasing stalemate as people try to defend their positions), and alienation (increasing loneliness as conflict continues). Responses differ once an argument becomes heated—some people tend to accuse, others avoid conflict, and some do both. Couples are taught to take a step back, carefully observe their interactions, and label the processes that influence their conflict.

Beyond gaining perspective on conflicts, couples are even encouraged to embrace the differences that have become a source of conflict (Jacobson, 1992). "What one partner sees as the other partner's 'uptightness' might be the 'stability' that first attracted him/her. Or alternatively, what one partner sees as the other's 'flakiness' or 'irresponsibility' might be the 'free-spiritedness' or 'rebelliousness' that so attracted him or her in the beginning of their relationship. The therapist must help the partners notice the positive aspects of what they have come to see as purely negative behavior. And often this behavior is in some way related to a quality one partner once found attractive about the other" (Wheeler, Christensen, & Jacobson, 2001, p. 617). In every relationship, there are differences that are impossible to change; rather than futile attempts to remake a person, the idea is to appreciate differences.

Is acceptance tantamount to resignation, to accepting a status quo that keeps one or both partners in a destructive relationship, one that perhaps demeans one partner to satisfy the selfish demands of the other? Jacobson and Christensen argue that acceptance is actually affirmative. By truly understanding and appreciating differences, it is hoped that couples achieve a more fundamental closeness. And some behavioral changes that were formerly unreachable in behavioral couples therapy with direct attempts at change might actually be facilitated by embedding such efforts within a context of acceptance.

Castellani, & Whisman, 2006). People in a distressed marriage are two to three times as likely to experience a psychological disorder (Whisman & Uebelacker, 2006). In some couples, distress may be a consequence of the psychological disorder, but it is also clear that distress can trigger many psychological disorders. Couples therapy is often used in the treatment of psychological disorders, particularly when they occur in the context of major relationship distress. We describe a few of the predictors of relationship distress and then discuss several forms of couples therapy.

Understanding relationships is complex, but several patterns have been shown to predict distress over time. Some couples adopt the strategy of avoiding disagreements and conflicts. For couples who believe in the fairy-tale ending, "And they lived happily ever after," signs of conflict are threatening and must be ignored. Such patterns may keep the peace for a short time, but dissatisfaction takes a toll over time. Because the partners do not quarrel, they may appear to be a perfect couple to observers, but the lack of open communication produces emotional distance. Whereas disagreement among couples may be related to unhappiness in the short term, expression of differences predicts more satisfaction over time (Gottman & Krokoff, 1989).

One particularly destructive interaction pattern is known as the *demand–withdraw cycle*. In this pattern, one partner attempts to discuss a problem and the other withdraws from such efforts. This withdrawal generates more demands from the first spouse, who tries harder and

harder to engage the other, only to be met with more avoidance. And so the cycle escalates. Christensen and Heavey (1990) suggest that there are sex differences in this pattern; women tend to assume the demanding role, whereas men usually withdraw. This process can reverse when the husband initiates discussion of his concerns (which men tend to do less often)—then, sometimes, the wife withdraws (Klinetob & Smith, 1996). In a subtler version of withdrawal, called "stonewalling," one person becomes very quiet. Although it can look like the person is uncaring, psychophysiological studies suggest that people who are stonewalling show incredibly high arousal (Gottman, 1994). Beyond the cycle of cricitism and withdrawal just described, couples who are defensive with each other or express contempt toward each other are at high risk for marital dissatisfaction and divorce (Gottman, 1994).

In couples therapies, the therapist works with both partners together to reduce relationship distress. Most couples treatments focus on improving communication, problem solving, satisfaction, trust, and positive feelings. To enhance communication, each partner is trained to listen empathically to the other and to state clearly to the partner what he or she understands is being said and what feelings underlie those remarks.

When a problem involves a couple, treatment is most effective if the couple is seen together. (Gary Corner/Alamy.)

Despite the common ground, there are also major differences across forms of couples therapy. Therapists choose techniques to match their theoretical orientation. A psychoanalytically oriented couples therapist will attend to possible unconscious factors in each person's behavior toward the other, whereas a behavioral couples therapist will focus on maladaptive behavioral patterns that are being unwittingly reinforced in the relationship. Behavioral couples therapists often assign homework, such as asking couples to practice active listening skills for half an hour after dinner or to schedule a romantic activity. Table 16.1 outlines the major goals in different forms of couples therapies. See Focus on Discovery 16.2, for one example of a way that behavioral couples therapy has been expanded to include new ideas and procedures.

Family Therapy

Family therapy is based on the idea that the problems of the family influence each member and that the problems of each member influence the family. As such, family therapy is used to address specific symptoms of a given family member, particularly for the treatment of childhood problems.

Over time, family therapy approaches have evolved to include a broader array of strategies (Sexton, Alexander, & Mease, 2004), often carefully integrated into the school and community (Liddle, 1999). Some family therapists focus on roles within the family, asking questions about whether parents assume an appropriate level of responsibility. Sometimes family therapists attend

Table 16.1 Goals in Different Forms of Couples Therapy

Type of Couples Therapy	Chief Goal
Psychodynamic insight-oriented couples therapy	To help clients understand the interpersonal dynamics and needs that each partner brings to the relationship and how these influence their emotional reactions (Snyder, Wills, & Grady-Fletcher, 1991).
Behavioral couples therapy	To increase the rate of pleasant interactions and decrease the rate of unpleasant interactions (Wood & Jacobson, 1985).
Cognitive behavioral couples therapy	To supplement the behavioral approach with procedures designed make less negative interpretations of each others' actions (Wheeler, Christenson, & Jacobson, 2001).
Integrative behavioral couples therapy	To supplement the behavioral approach with procedures designed to foster acceptance of the partner (Christensen, Jacobson, & Babcock, 1995).
Emotionally focused therapy	To improve emotional engagement and responsiveness to each other's needs; to address "innate adaptive needs for protection, security, and connectedness with significant others" (Johnson & Greenberg, 1995, p. 124).

Clinical Case: Clare

Clare, a 17-year-old female who lived with her parents and her 15-year-old brother, was referred for family-focused treatment (FFT) of bipolar disorder as an adjunct to medication treatment. She had received a diagnosis of bipolar I disorder in early adolescence and was treated with lithium carbonate and quetiapine but had never fully responded to medications.

During an individual assessment session, Clare explained that she thought about suicide almost daily and had made two prior attempts, both by overdosing on her parents' medications. Clare had kept both attempts secret from her parents. Ethically, clinicians need to take steps to keep a client safe, and in this case, one measure would be to let Clare's parents know about her suicidality. The clinician explained this to Clare.

The first goal in family-focused treatment is to provide psychoeducation about bipolar disorder. As the symptoms of bipolar disorder were being reviewed, the clinician asked Clare to discuss her suicide attempts with her parents. When Clare did so, her parents were surprised. Her father, who had experienced his own father's suicide, was particularly concerned.

After psychoeducation, a goal in FFT is to choose one problem for the family to address and to help them learn new problem-solving skills in the process. In this family, the focus of problem solving was how to keep Clare safe from her suicidal impulses. To begin problem solving, the therapist works with the family to define the problem and its context. The therapist asked the family to discuss situations that seemed to place Clare at most risk for suicide. The family was able to pinpoint that both previous attempts had followed interpersonal losses.

The next phase of problem solving is to generate potential solutions. To help with this process, the clinician framed questions in the problem-solving process for the family, including whether Clare could share her suicidal thoughts with her parents, how to establish whether she was safe, what responses would be helpful from them, and what other protective actions should be taken. Using this structure, the family was able to agree on the plan that Clare would phone or page her parents when she was feeling self-destructive. Clare and her parents generated a plan in which her parents would help Clare engage in positive and calming activities until her suicidal thoughts were less intrusive. Clare and her parents reported feeling closer and more optimistic.

The therapist then began to conduct the next phase of therapy, which focused directly on symptom management. This phase consisted of training Clare to monitor her moods, to identify triggers for mood changes, and to help her cope with those triggers.

As is typical in FFT, the clinician introduced the communication enhancement module during session eight. A goal of this module is to role-play new communication skills. Family members practice skills such as "active listening" by paraphrasing and labeling the others' statements and by asking clarifying questions. At first, Clare and her brother protested against the role-play exercises.

Clare experienced another loss during this period, in that her one and only close long-term friend announced that she was going to be moving out of state. Clare took an overdose of Tylenol as a suicide attempt. Afterward, she became afraid, induced vomiting, and later told her parents about the attempt.

The next session focused on the suicide attempt. Her parents, particularly her father, were hurt and angry. Clare reacted angrily and defensively. The therapist asked the family to practice active listening skills regarding Clare's suicidality. Clare explained that she had acted without even thinking about the family agreement because she had been so distressed about the idea of losing her friend. Clare's parents were able to validate her feelings using active listening skills. The therapist reminded the parents that suicidal actions are common in bipolar disorder and noted that Clare's ability to be honest about her suicide attempt was an indicator of better family connectedness. The therapist also recommended that Clare see her psychiatrist, who increased her dosage of lithium.

By the end of treatment after nine months, Clare had not made any more suicide attempts, had become more willing to take her medications, and felt closer to her parents. Like many people with bipolar disorder, though, she remained mildly depressed. Clare and her family continued to see the therapist once every three months for ongoing support. [Adapted from Miklowitz and Taylor (2005) with permission of the author.]

to whether a given person in the family has been "scapegoated," or unfairly blamed for a broader issue in the family. Many family therapists teach strategies to help families communicate and problem-solve more effectively.

Family therapy is often tailored to the specific disorder. In family approaches for conduct disorder, the therapist may focus on improving parental monitoring and discipline. For adolescents with other externalizing problems, the goal of family therapy may be to improve communication, to change roles, or to address a range of family problems. With disorders like schizophrenia and bipolar disorder, family therapy often includes psychoeducation as a supplement for the medication treatment provided to the individual. Psychoeducation focuses on improving understanding of the disorder, reducing expressed family criticism and hostility, and helping families learn skills for managing symptom (Miklowitz et al., 2003; see the clinical case of Clare). For people with substance-abuse problems, family therapy has been used to help clients recognize the need for treatment. In sum, the goals and strategies of family therapy will be adjusted to meet the needs of different clients.

Quick Summary

Psychoanalytic and psychodynamic treatments focus on how early childhood relationships shape interpersonal and emotional concerns in current life. Therapists uses transference, or the client's ways of responding to the therapist, as a way of understanding the themes in a client's relationships. They use interpretation to increase the client's insight into unconscious conflicts.

Experiential therapies emphasize the goodness of humans. Humanistic therapy focuses on providing the client with unconditional positive regard as a way to promote growth. Gestalt therapy provides a number of techniques to enhance emotional awareness. Emotion-focused therapy aims to help clients become more aware of their feelings and to differentiate adaptive emotions (based on the current context) from maladaptive emotions (held over from previous life experiences).

The most-researched form of behavioral therapy is exposure treatment, used in the treatment of anxiety disorders. Operant conditioning is used to treat many other disorders. In operant approaches, attention must be given to how to sustain the effects of treatment once therapy ends.

There are several forms of cognitive therapy. Beck's cognitive therapy of depression focuses on overly negative cognitions about the self and the world. Several new cognitive behavioral treatments have been developed in the past few years that focus on fostering acceptance, diminishing emotional avoidance, and other broader goals in managing thoughts and emotions.

Behavioral couples therapy focuses on communication and problem solving. Integrative behavioral couples therapy supplements this approach with techniques to bolster acceptance of differences. Emotionally focused couples therapy places an emphasis on developing strategies for enhancing closeness. Insight-oriented couples therapy helps each partner consider the childhood experiences that might drive behavior in their relationship. Family therapy can include psychoeducation about symptoms, communication training, and problem solving.

Check Your Knowledge 16.1 (Answers are at the end of the chapter.)

Choose the answer that best fits the statement.

1. All forms of psychoanalytic therapy are long.
2. The form of therapy that is most associated with the idea that humans naturally develop toward being positive and good is:
   - **a.** Psychodynamic therapy
   - **b.** Humanistic therapy
   - **c.** Behavioral therapy
   - **d.** Individualistic therapy

Treatment Outcome Research

Researchers have been studying treatment outcomes, or how well different therapies work, for decades. **Outcome research** is designed to address a simple question: does therapy work? The clear answer is yes. Hundreds of studies have examined whether people who receive psychotherapy fare better than those who do not. In meta-analyses of more than 300 studies, researchers have found that there is a moderately positive effect of treatment. About 75 percent of people who enter treatment achieve at least some improvement (Lambert & Ogles, 2004). As shown in Figure 16.1, these effects appear to be more powerful than the passage of time or support from friends and family. Eysenck (1952) had earlier questioned the effectiveness of most kinds of insight-oriented psychotherapy, finding that treated clients' rates of improvement were no better than the spontaneous remission rate. Eysenck's criticisms were compellingly rebutted by a number of scholars (e.g., Bergin, 1971) and continue to be rebutted by the accumulation of studies showing that therapy does work. On the other hand, it is also clear that therapy does not always work. About 30 percent of people do not improve in therapy (see Figure 16.1).

Because there are hundreds and hundreds of studies on psychotherapy, there is a need for people to systematically cull through the articles and identify the treatments that have strong support. In 1995, a

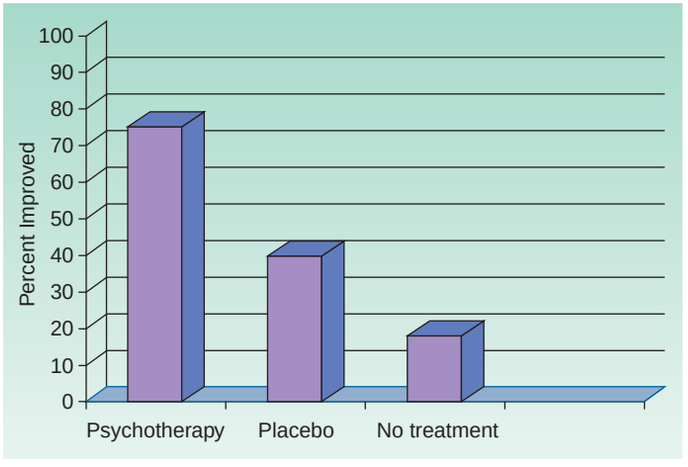


Figure 16.1 Summary of percent of people who achieve improvement across outcome for psychotherapy, placebo, and no treatment across studies. [Drawn from Lambert (2004). Psychotherapeutically-speaking—updates from the Division of Psychotherapy (29). With permission of the author and of APA.]

Table 16.2 Examples of Empirically Supported Treatments for Adult Disorders

Depression
Cognitive therapy
Behavior therapy
Interpersonal psychotherapy

Generalized anxiety disorder
Cognitive therapy
Applied relaxation

Social phobia
Exposure
Cognitive behavioral group therapy
Systematic desensitization

Simple phobia
Exposure
Guided mastery
Systematic desensitization

Obsessive-compulsive disorder
Exposure and response prevention
Cognitive therapy

Agoraphobia
Exposure
Cognitive behavior therapy

Panic
Cognitive therapy
Exposure
Applied relaxation

PTSD
Exposure
Eye movement desensitization and reprocessing (although see p. 150)

Schizophrenia
Social skills training
Behavioral family therapy
Supported employment programs

Alcohol abuse and dependence
Community reinforcement approach

Relationship distress
Behavioral couples therapy
Emotion-focused therapy
Insight-oriented couples therapy

Sexual dysfunctions
Partner assisted sexual skills training

Bulimia
Cognitive behavior therapy
Interpersonal psychotherapy

Borderline personality disorder
Dialectical behavior therapy

Drawn from Chambless et al. (1998) and the Dissemination Subcommittee of the Committee on Science and Practice (2008) Available at *http://www.apa.org/divisions/div12/journals.html#Anchor-EMPIRICALLY-49575.*

task force for the American Psychological Association defined standards for research on psychotherapy and then published a report on the therapies that had received empirical support (Task Force on Promotion and Dissemination of Psychological Treatments, 1995). The report was updated in 2008 (see Table 16.2). The goal was to help clinicians draw more easily on this rapidly growing literature about **empirically supported treatments (ESTs)** to provide consumers with the best available treatments. These summaries also might help defend the role of psychotherapy with managed care agencies and insurance companies, who have increasingly demanded research evidence before they are willing to pay for treatments.

What are the standards for treatment **outcome research** to be seen as valid? Several different working groups have come up with slightly different answers to this question. At a minimum, most researchers agree that a treatment study should include the following criteria:

- A clear definition of the sample being studied, such as a description of diagnoses
- A clear description of the treatment being offered, as in a treatment manual (described below)
- Reliable and valid outcome measures
- Inclusion of a control or comparison treatment condition
- Random assignment of clients to treatment or comparison conditions
- A large enough sample for statistical tests

Studies in which clients are randomly assigned to receive active treatment or a comparison (either no treatment, a placebo, or another treatment) are called **randomized controlled trials (RCTs)**. These studies can be considered an experiment, in which the independent variable is the treatment and the dependent variable is the clients' outcome.

Many different types of control groups can be included in psychotherapy research. Although some people argue that the inclusion of a control group may be unethical (Wolitzky, 1995), it is difficult to make a compelling case for any treatment when treatment outcome studies do not include a control group of some form. A no-treatment control group allows researchers to test whether the

mere passage of time helps as much as treatment does. A stricter test compares the treatment group to an attention-control group in which clients see a therapist regularly for support and encouragement (the "attention" component), but they do not receive what is considered to be the "active ingredient" in the kind of therapy being tested (e.g., exposure to a feared situation in a behavioral treatment of a phobia). The strictest type of design includes an active-treatment control group, in which researchers compare the new treatment against a well-tested treatment. This type of design allows researchers to make comparative statements about two treatments.

Issues in Treatment Outcome Research

As shown by the complexities in choosing a control group, designing treatment trials is difficult. Some aspects of the APA task force recommendations have been hotly debated. For example, failure for a treatment to appear on the APA task force list of empirically supported treatments (Table 16.2) could simply reflect a lack of careful studies. As you can see, most of the treatments listed are cognitive behavioral. Although we will discuss research supporting many other treatments in this chapter, cognitive behavioral treatments are featured in the APA list because the studies for these treatments have met the strict APA criteria. We turn toward four other issues that are a subject of debate: the need to track which treatments are harmful, the use of treatment manuals, the nature of samples within treatment studies, and the generalizability of findings to the real world.

Can Therapy be Harmful? The APA guidelines have been criticized because they do not consider whether treatments have been harmful. Despite the substantial evidence that therapies, on average, tend to be helpful, this does not mean that they help everyone. Indeed, a small number of people may be in worse shape after therapy. Estimating how often therapy is harmful is not easy. Up to 10 percent of people are more symptomatic after therapy than they were before therapy began (Lilienfeld, 2007). Does this mean that therapy harmed them? Maybe not. Without a careful control group, it is hard to know whether symptoms would have worsened even without therapy. Unfortunately, few researchers report the percentage of people who worsened in the different branches of RCTs.

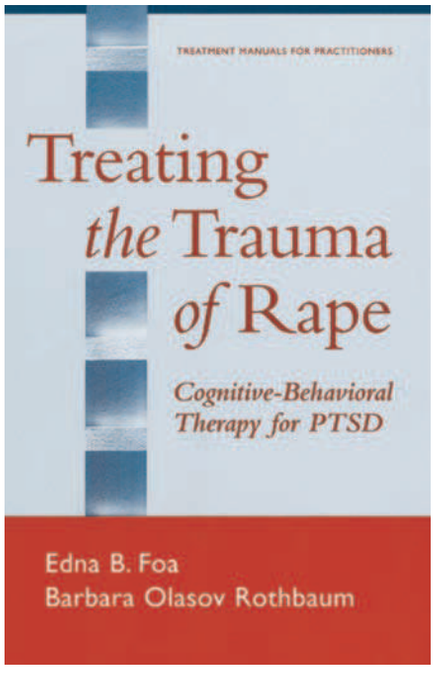
Nonetheless, it is important to be aware that several treatments have been found to be harmful to some people. That is, evidence that these treatments can be harmful for some people has emerged from multiple studies or from case reports of sudden deteriorations as treatment was implemented. See Table 16.3 for a summary of

Troubled people may talk about their problems with friends or seek professional therapy. Treatment is typically sought by those for whom the advice and support of family or friends have not provided relief. (Top: Rhoda Sidney/PhotoEdit; bottom: Esbin-Anderson/The Image Works.)

Table 16.3 Treatments Found to be Harmful in Multiple Studies or Case Reports

Treatment	Negative Effects
Critical incident stress debriefing	Heightened risk for posttraumatic symptoms
Scared Straight	Exacerbation of conduct problems
Facilitated communication	False accusations of child abuse against family members
Attachment therapies (e.g., rebirthing)	Death and serious injury to children
Recovered-memory techniques	Production of false memories of trauma
Dissociative identity disorder-oriented therapy	Induction of "alter" personalities
Grief counseling for people with normal bereavement reactions	Increases in depressive symptoms
Expressive-experiential therapies	Exacerbation of painful emotions
Boot-camp interventions for conduct disorder	Exacerbation of conduct problems
DARE programs	Increased intake of alcohol and cigarettes

Drawn from Lilienfeld (2007).



A treatment manual provides specific procedures for a therapist to use in working with a client. Although they are increasingly standard in research trials, many therapists still say they don't use them. From Edna B. Foa and Barbara Olasov Rothbaum, *Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD*. Represented with permission of Guilford Publications.

treatments that have been found to be harmful. Just as there is debate about the APA task force recommendations, there is debate about the list provided in Table 16.3. For example, although some studies found that group interventions for conduct disorder were associated with negative outcomes (presumably because peers teach each other bad behaviors), one review found little evidence to support the harmful effects of such interventions (Weiss et al., 2005). We should note that harmful effects of treatment are not exclusive to therapy; the FDA has issued warnings that antidepressants and antiseizure medications can increase the risk of suicidality and that antipsychotic medications can increase the risk of death among the elderly.

The Use of Treatment Manuals Treatment manuals are detailed books on how to conduct a particular psychological treatment—they provide specific procedures for the therapist to follow at each stage of treatment. The use of manuals has been a major advance in psychotherapy research (e.g., Nathan & Gorman, 2002) and is required to receive grant funding for treatment outcome research. Without a manual, it is hard to know what therapists actually do, because a therapist's descriptions of a session or allegiance to an orientation might not capture what really happens (London, 1964). With manuals, someone reading a psychotherapy study can have an idea of what happened in therapy sessions.

The purpose of using treatment manuals is to help therapists to be more similar in what they do. That is, the goal is to minimize differences across therapists. However, therapists vary even in RCTs. For example, in the well-known NIMH Treatment of Depression Collaborative Research Program, therapists differed in how well they implemented the manuals. Some therapists were more successful than others using the same manual (Blatt et al., 1996). Research suggests that sometimes these differences between therapists can be greater than the differences between treatments (Beutler, 1997). Maintaining precision in delivering therapy is a challenge—almost no other experiments in science attempt to control the independent variable (in this case, the intervention condition) for months (Westen, Novotny, & Thompson-Brenner, 2004).

Although manuals help us to know what the therapists in a study actually did, some have argued that manuals might be too limiting for a good therapist (Beutler, 1999; Goldfried & Davison, 1994). Outside of RCTs, therapists tend to tailor treatment to the client (Haaga & Stiles, 2000) so that they are more responsive to a client's needs. In contrast, the very essence of treatment manuals is to minimize the tailoring of intervention to individual clients. The problem is that if a therapist adheres too rigidly to a treatment manual, the client can feel that his or her particular concerns are not being addressed (Henry et al., 1993).

Some of this debate about manuals could be resolved by research to compare results when therapists either do or do not use manuals. Some studies have suggested that manuals do not make a major difference in outcomes (Beutler et al., 2004). But the clear guidelines provided by manuals seem to help novice therapists more than experienced therapists (Multon, Kivlighan, & Gold, 1996). Further, in one meta-analysis of brief psychodynamic treatment studies, those that involved treatment manuals achieved greater gains than those with no treatment manuals (Anderson & Lambert, 1995). The challenge, then, might be to provide manuals that give therapists a clear road map but do not constrain experienced therapists to the point where their flexibility is diminished. One way to do this is to provide manuals that give therapists lots of freedom—for example, promoting the goal of exposure treatment for anxiety disorders but also giving a menu of options of how to conduct exposure (Kendall & Beidas, 2007).

Defining a Sample Randomized controlled trials (RCTs) typically focus on treating people who have a certain DSM diagnosis. For example, many major studies have recruited people who met DSM criteria for major depressive disorder. But depressions are not all caused by the same factors (e.g., negative cognitive styles). Some have argued that we should be designing studies focused on people with similar psychological profiles (Persons, 1991). For example, clients with negative cognitive styles can be assigned to cognitive therapy, whereas those with significant family distress can be assigned to family therapy (Beevers & Miller, 2005). Beutler and colleagues (2003) have conducted research to demonstrate the effective-

ness of matching clients to treatment based on their coping styles. Hence, some have argued that it would be better to choose a treatment based on a person's profile of risk factors for psychopathology rather than on their diagnosis.

Beyond concerns about the best basis for defining a sample, there are concerns about the number of people who are excluded in treatment research. In a typical RCT, researchers might include people who meet diagnostic criteria for a given disorder but exclude those who have more than one disorder, acute suicidality (for ethical reasons), or other characteristics. Some participants might not be willing to take part in a study in which they might be assigned to an ineffective treatment (the control condition). As it turns out, researchers exclude almost as many people as they recruit into these studies (Westen et al., 2004). This situation creates problems with generalizing from controlled studies to the actual practice of psychotherapy in the real world, a topic we consider next.

Treating Disorders in the Real World Controlled RCTs, typically conducted in academic research settings, are designed to determine the **efficacy** of a treatment, that is, whether a treatment works under the purest of conditions. Because of the kinds of concerns just raised, academic research might not inform us about how these treatments work with broader samples in the hands of nonacademic therapists. We need to determine not just the efficacy of a treatment but also its **effectiveness**, that is, how well the treatment works in the real world. Studies of effectiveness might do the following:

- Include people with a broader range of problems (such as comorbid conditions)
- Provide less intensive supervision of therapists
- Examine a broader range of outcomes, such as whether clients believe they were helped and feel satisfied with their lives at the end of treatment
- Rely on briefer assessments

As you might expect, when clients have more serious diagnostic complications and providers have less support, even medications tend to look less powerful than they do in careful efficacy studies (Rush et al., 2006). Effectiveness research can focus on how to foster better treatment in the community. For example, one study examined whether medication treatment of depression in the community was improved by providing psychiatrists with easily navigated hand-held computers programmed to provide quick feedback and assistance regarding treatment decisions (Trivedi et al., 2004). If it is hard to foster good medication treatment, one can imagine that interventions as complicated as a 16-session course of psychotherapy will be challenged by real-world hurdles, too. Even though such studies may incorporate less experimental control, they are fundamentally important in evaluating how well these treatment approaches will work in the real world. Beyond some important surveys of how people see the therapy they have received (see *Consumer Reports*, 1995), effectiveness studies do provide support for cognitive behavioral treatments of anxiety (e.g., Wade, Treat, & Stuart, 1998) and depression (e.g., Persons, Bostrom, & Bertagnolli, 1999). Effectiveness studies also provide support for offering psychotherapy as a supplement to medication for bipolar disorder (Miklowitz et al., 2007).

Even with increasing evidence that these treatments work in the real world, there is a big gap between what happens in research centers and the real world (see Focus on Discovery 16.3 for a discussion of how economic issues shape treatment in the real world). Even though more than 145 treatment manuals have been recognized as empirically supported (Chambless & Ollendick, 2001), therapists in the community seem relatively unaware of these manuals. For example, Addis and Krasnow (2000) reported that 23 percent of therapists surveyed said they had not heard of treatment manuals, and another 38 percent reported that they had heard of them but did not know what they were. Hopefully, more clinicians have heard about these treatment manuals since the survey was done, but clearly this demonstrates a need to work harder on getting research findings into the hands of therapists and consumers! One way to do this has been to recommend that graduate students in psychology be taught empirically supported treatments (Crits-Christoph et al., 1995).

FOCUS ON DISCOVERY 16.3

Stepped Care: An Economic Approach to Treatment Decisions

Partly in response to managed care, a strategy from medicine called **stepped care** is becoming more widely used in psychology and psychiatry (Haaga, 2000). Stepped care refers to the practice of beginning treatment efforts with the least expensive intervention possible and moving on to more expensive interventions only if necessary (see Figure 16.2). For example, a client with mild depression might be offered a self-help book that has been shown to be helpful in reducing symptoms (McKendree-Smith, Floyd, & Scogin, 2003). After a month, people who do not gain symptom relief would be offered psychotherapy or antidepressant medication.

There is growing evidence that pretty minimal levels of intervention can be helpful for many people, and some people may actually prefer to receive help in the privacy of their home. Computerized cognitive behavioral interventions have been developed for anxiety and depression. One meta-analysis of 12 randomized controlled trials showed an interesting pattern of findings (Spek et al., 2007). First, these programs have yielded only small effects on depression. Second, Internet programs have been moderately helpful for the relief of anxiety symptoms. Third, effects are much more substantial when the Internet program is supplemented with some form of therapist contact. Beyond the growing literature on computer-based intervention materials, brief written materials appear to be extremely helpful for many people who want to gain better control over drinking habits (Apodaca & Miller, 2003).

There are risks associated with low-intensity treatments. If the initial intervention does not help, the client may lose heart and drop out of treatment altogether. Consider one example of stepped care. In a study of weight loss, researchers initially assigned 26 clients to receive basic education about how to lose weight. Only 4 of the 26 clients, though, were able to reach their desired weight (Black & Threlfall, 1986). Bibliotherapy was added, and the remaining 22 clients reached their desired weight. In this type of circumstance, it would make sense to start with the more powerful intervention to avoid the demoralization that can arise when initial treatment efforts fail (Wilson, Vitousek, & Loeb, 2000). Effective stepped care programs will depend on using minimal treatments that have strong research backing (Rosen, 2004). Planning stepped care interventions requires a delicate juggling act to consider economics, illness severity, and the relative efficacy of different approaches.

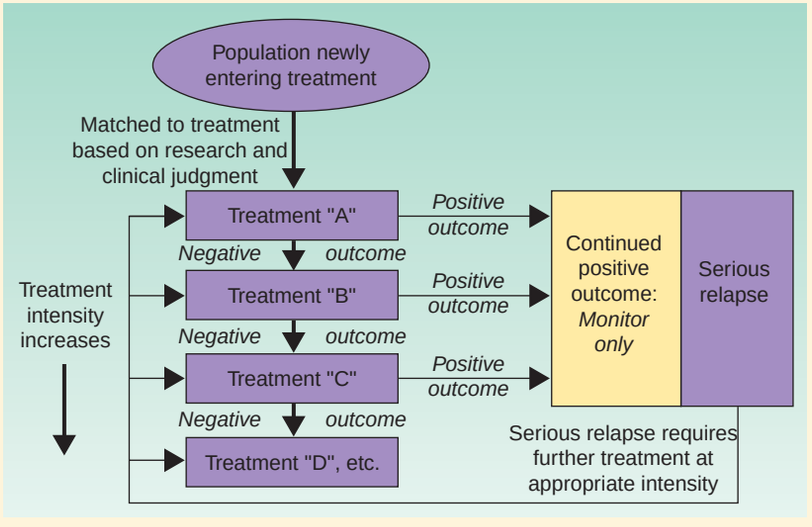


Figure 16.2 Stepped care involves starting with the least expensive intervention and moving on to more expensive interventions only if needed. From Sobell, M. B., & Sobell, L. C. (2000). Stepped Care as a Heuristic Approach to the Treatment of Alcohol Problems. *Journal of Consulting and Clinical Psychology, 68,* 573–579. Adapted with permission from *Addictive Behaviors across the Lifespan: Prevention, Treatment, and Policy Issues* (p. 150), by J. S. Baier, G. A. Marlatt, & R. J. McMahon (Eds.), 1993, Beverly Hills, CA: Sage.

Check Your Knowledge 16.2

Circle all that apply for the following questions.

1. Which of the following are the elements of an RCT by definition?
   - **a.** randomization
   - **b.** a comparison condition
   - **c.** medications
   - **d.** double-blind procedures
2. Which of these are common problems in treatment outcome studies?
   - **a.** nonrepresentative samples
   - **b.** no way to measure improvement
   - **c.** variability across therapists
   - **d.** treatment manuals constrain therapists
   - **e.** lack of generalizability to the real world
   - **f.** lack of clarity about treatment goals
3. The goal of effectiveness studies is to determine whether a treatment works
   - **a.** under the best possible conditions
   - **b.** under real-world conditions

The Evidence from Randomized Controlled Trials

We've described a set of issues in conducting and evaluating treatment outcome studies. But hundreds and hundreds of studies have been conducted to test different forms of psychotherapy, and at this point, a large literature has been amassed to support the helpfulness of therapy. We turn now to a discussion of the findings in regard to the different therapies we have described above.

Traditional Psychoanalytic Treatment There are only four outcome studies of long-term psychoanalytic treatment (Bachrach et al., 1991). Major reviews of research on classical psychoanalysis suggest the following conclusions (Henry et al., 1994; Luborsky & Spence, 1978):

- Clients with severe psychopathology (e.g., schizophrenia) do not do as well as those with anxiety disorders. This is understandable in view of Freud's emphasis on less severe disorders.
- People with more education tend to do better in psychoanalysis than those with less education.
- Poor outcomes are more likely when a therapist makes frequent interpretations of transference reactions—for example, indicating to a male client that his behavior toward the therapist seems to reflect unresolved conflicts with his mother.

Each of the available studies of long-term psychoanalysis, though, has methodological problems, the most limiting of which is the lack of a control group. Because of this, we do not know whether psychoanalysis achieves more than the passage of time or the support of close others. This is not to say that psychoanalysis does no good, only that clear evidence is lacking as to its specific efficacy.

Perhaps the most ambitious attempt to evaluate the efficacy of psychoanalysis was the Menninger Foundation Psychotherapy Research Project, which began in the mid-1960s. In this study, 42 clients—mostly Caucasian clients with anxiety, depression, or both—were seen in either psychoanalysis or short-term psychodynamic psychotherapy. In both groups about 60 percent of the clients improved. There were no significant differences between the two groups either immediately after treatment or at follow-up 2 to 3 years later (Wallerstein, 1986, 1989).

Brief Psychodynamic Treatments The picture emerging from outcome studies on brief psychodynamic treatment is inconsistent but generally positive. A meta-analysis of more than 25 studies suggested that brief psychodynamic therapy achieved moderately positive outcomes compared to no treatment (Anderson & Lambert, 1995). As reviewed by Goldfried, Greenberg, and Marmar (1990), brief psychodynamic therapy has been found to be helpful in treating bereavement (Marmar & Horowitz, 1988), job-related distress and anxiety disorders (Koss & Shiang, 1994), posttraumatic stress disorder (Horowitz, 1988) and psychopathy (Salekin, 2002).

Although psychodynamic treatment has received support, there are three important caveats:

- Psychodynamic treatment offers an advantage compared to control conditions only when treatment lasts more than 20 sessions; effects of briefer psychodynamic treatment (less than 20 sessions) appear comparable to control conditions (Abbass et al., 2008).
- Psychodynamic treatments have not been found to be more helpful than general treatment as offered in the community (Abbass et al., 2008).
- Brief psychodynamic therapies are likely to fare best when therapists use a manual and receive specific training in these approaches (Anderson & Lambert, 1995).

Taken together, these findings suggest that psychodynamic treatments can be helpful but also that there is more research needed.

Experiential Therapies More than 100 treatment outcome studies have been conducted on experiential approaches (Elliot et al., 2004). Compared to wait-list and no-treatment controls, these treatments tend to have a positive effect. It does appear that experiential therapies, like most psychotherapies, are more likely to relieve symptoms of less severe problems, like anxiety and depression, than more severe problems, like schizophrenia. Of the different experiential treatments, emotion-focused therapy, developed by Greenberg and colleagues (2002), appears to have the strongest results. Of concern, two studies have suggested that Gestalt therapy

and related approaches that emphasize expressing feelings (without much help in understanding those feelings and dealing with them constructively) lead to deterioration in about 15 percent of people (Beutler et al., 1984; Mohr et al., 1990).

Cognitive Behavior Therapy Treatment outcome research supports the use of exposure to treat a wide variety of anxiety disorders, including simple phobias, posttraumatic stress disorder, obsessive-compulsive disorder, panic disorder, and agoraphobia (Chambless & Ollendick, 2001). Although most of the research has been done with adults, children also benefit from exposure treatment (Kazdin & Weisz, 1998). Exposure consistently performs better than other treatment approaches for anxiety disorders (Emmelkamp, 2004).

Beck's cognitive therapy (CBT) has received more intensive study than other forms of CBT (Hollon, Haman, & Brown, 2002). Beck's therapy achieves greater short-term improvement than wait-list controls, noncognitive behavioral treatments, and a heterogeneous group of other psychotherapies (Dobson, 1989). Beck's CBT also has proven efficacy in treating depression in children (Stark et al., 1998) as well as adolescents (Brent et al., 1997).

Other forms of CBT have received empirical support as well. A range of studies have shown positive effects of rational emotive behavior therapy for both adults and children (Chambless & Ollendick, 2001; Kendall et al., 1995). Marlatt's relapse prevention treatment has been shown to work better than attention-control or no-treatment conditions in a series of randomized controlled trials for substance abuse and appears to have particular promise when researchers study clients over longer follow-up periods (Witkiewitz & Marlatt, 2004). In a review of 16 meta-analyses, CBT was noted to be a well-supported intervention for schizophrenia, anxiety disorders, bulimia nervosa, and pain disorders, and to show small effects for sexual offenders (Butler et al., 2006).

There are relatively few treatment outcome studies available regarding the new approaches to CBT that focus on acceptance and emotional avoidance. The available studies have been criticized methodologically (Öt, 2008), but the early evidence is also promising. Preliminary evidence suggests that these types of approaches are helpful for problems that are quite difficult to address, such as borderline personality disorder, recurrent major depression, severe couples distress, and opiate addiction (Hayes et al., 2004). It is also worth noting that these approaches have become extremely popular with therapists—so popular that some have cautioned that we need to hold back against adopting them until more data can be accrued (Corrigan, 2001). Indeed, Teasdale (2004), one of the developers of mindfulness-based cognitive therapy, has argued for the need to proceed cautiously, with a strong sense of theory and a good knowledge of which conditions these treatments have been shown to help.

One of the positive aspects of cognitive therapy is that people may learn skills that help them even after they stop seeing a therapist. For example, CBT appears to help prevent future episodes of depression (Bockting et al., 2005). Given that as many as 50 percent of people with a first episode of depression will experience a second episode (APA, 2000), this is an important issue and suggests that CT has an important advantage compared to medication treatment (Vittengl et al., 2007). In one study of CBT for drug abuse, researchers found that clients who received CBT actually improved further after treatment stopped (Carroll, Rounsaville, Nich, et al., 1994). The investigators speculated that CBT had taught clients coping skills that they were able to implement after therapy ended.

One final issue is worth noting about cognitive therapy. Somewhat surprisingly, therapist experience doesn't seem to matter much in predicting outcomes of many treatments. Cognitive therapy, though, may be harder to implement than other types of therapy are. Research shows that therapist experience is related to better outcomes in cognitive therapy of major depressive disorder (DeRubeis et al., 2005) and panic disorder (Huppert et al., 2001).

Couples Therapy A meta-analysis of more than 163 studies suggests that couples therapies work. About 80 percent of couples who receive couples therapy report being more satisfied than those who received no treatment (Shadish & Baldwin, 2003). Couples therapy is also more successful than individual therapy is for reducing couples' distress (Baucom et al., 1998; Sexton et al., 2004). When individual therapy is used to treat couples problems, about 10 percent get worse. Brief premarital training in communication skills can improve future relationship satisfaction and divorce rates compared with no intervention (Markman et al., 1989).

By far, behavioral couples therapy has received more attention than other forms of therapy. At least 30 RCTs of behavioral couples therapy have been conducted, and only 4 RCTs of emotion-focused couples therapy have been conducted. Behavioral couples therapy clearly reduces relationship distress compared to no-treatment and placebo-controlled treatments, and many of the gains last a year after therapy ends (Baucom et al., 1998; Sexton et al., 2004). Adding a cognitive component to behavioral couples therapy does not appear to add to the positive outcomes (Montag & Wilson, 1992).

Even though behavioral couples therapy has achieved support across a range of studies, the outcomes of behavioral couples therapy research are not as good as one might hope (Jacobson et al., 1984). Across all studies, no more than half the treated couples are happily married at the end of treatment (even if they had improved some during treatment). Interestingly, three therapies that include an emotionally relevant component have achieved positive results compared to behavioral couples therapy, including emotionally focused therapy (Johnson & Greenberg, 1995), psychodynamic insight-oriented therapy (Snyder, Wills, & Grady-Fletcher, 1991), and integrative couples behavior therapy (Christensen et al., 2006). Insight-oriented therapy was even found to be superior to behavioral couples therapy over a four-year follow-up in terms of divorce rates and marital satisfaction (Snyder et al., 1991).

Some research has focused on couples therapy as a way to address symptoms in one of the partners. For example, couples therapy has been found to be helpful in the treatment of sexual disorders, alcohol abuse (Sexton et al., 2004), and depression (O'Leary & Beach, 1990). Hence, psychological disorders that occur in the context of relationship problems may respond well to couples therapy.

Family Therapy Family therapy has been found to have efficacy in reducing symptoms of a broad range of disorders, including agoraphobia, substance abuse, schizophrenia, and bipolar disorder (Lebow & Gurman, 1995). Family interventions for schizophrenia lead to substantially lower relapse rates, even two years after treatment (McFarlane et al., 2003).

Choosing between Therapies The evidence above suggests that many different forms of therapy are helpful. Is there enough evidence to help consumers know whether one treatment is better than another? There is more debate about this issue of how different treatments compare than we can cover well here.

In one review, the authors concluded that brief psychodynamic treatment achieved comparable results to other kinds of therapies (Anderson & Lambert, 1995). Similarly, one study found that brief psychodynamic therapy was as helpful as cognitive therapy for certain personality disorders (Svartberg, Stiles, & Seltzer, 2004). There is a fair amount of controversy about these comparisons between treatments, though (see Lamberg & Ogles, 2004, for a discussion of how different reviewers find different patterns). Some of this debate may concern which studies and treatments should be included in a review. For example interpersonal psychotherapy, a well-validated treatment for depression (see p. 237), builds on the psychodynamic emphasis on relationships, but it does not focus on the therapeutic relationship or a person's history. Should this be included in reviews of psychodynamic therapy? Reviewers differ on decisions such as this. As a result, some reviews find a small advantage for cognitive behavioral therapies, whereas others do not.

Researchers have also compared experiential therapies, particularly emotion-focused therapy, with cognitive behavioral treatment. One comprehensive review suggests that if there is an advantage to CBT, it is probably fairly small (Elliot et al., 2004).

CBT does appear to fare better than other psychological treatments for anxiety disorders. Overall, however, the dominance of CBT approaches in Table 16.2 reflects that there are more carefully controlled trials available of CBT than of experiential therapies.

For the treatment of depression, eight studies have compared couples treatment and individual treatment. It turns out that both have similar effects in relieving depression, and couples therapy is more helpful in relieving relationship problems (Barbato & D'Avanzo, 2008). Similarly, family therapy has been found to be as helpful as interpersonal or cognitive therapy offered as a supplement to medications in bipolar disorder (Miklowitz et al., 2007).

Finally, a good deal of research has examined whether cognitive therapy offers an advantage compared to more strict behavioral interventions. Much of this work has been focused on

anxiety disorders. In many forms of anxiety disorders, cognitive therapy does not yield better outcomes than exposure treatment alone (see Chapter 5 for more detail). Similarly, two major studies suggest that the behavioral activation component of depression treatment may be as helpful as a more complex therapy that combines behavioral activation with cognitive components (Dimidjian et al., 2006; Jacobson et al., 1996).

The Importance of Culture and Ethnicity in Psychological Treatment

Above, we described concerns about who is recruited into treatment studies. As it turns out, one of the major gaps in treatment outcome studies has been the exclusion of people from diverse cultural and ethnic backgrounds. Most studies enroll predominantly white, non-Latino clients, so samples are often not diverse enough to examine how treatment effects vary for differing groups of people. But there are many reasons to suspect that these treatments may not meet the needs of minority group members. For example, people from minority groups are much less likely to receive treatment for mental health conditions [U.S. Department of Health and Human Services (USDHHS), 2002]. As shown in Table 16.4, there are also dramatic differences in rates of treatment seeking by country among people with psychological disorders (Wang, Simon et al., 2007).

We believe it is important to consider some of the issues that may limit how well therapies work for people from different backgrounds. We do want to raise one caveat. Our discussion of ethnic and cultural factors in intervention runs the risk of stereotyping because we are going to review generalizations about the way a group of people react to psychological assistance. People from minority groups can differ as much from each other as their racial or ethnic group differs from another racial or ethnic group. It is important to consider the degree to which the person is *assimilated* into the majority culture and holds the same values as the majority culture (Sue & Sue, 2008). Nonetheless, a consideration of group characteristics is important and is part of a specialty called ethnic-minority mental health.

It is usually assumed that clients do better with therapists who are similar to them in cultural and ethnic background. Indeed, many minority clients report that they would prefer to

Table 16.4 Percent of People Diagnosed with a Psychological Disorder (*N*=5,630) Who Sought Treatment by Severity of the Disorder and Country

	Severe	Moderate	Mild
Nigeria	21.3	13.8	10.0
China	11.0	23.5	1.7
Colombia	27.8	10.3	7.8
South Africa	26.2	26.6	23.1
Ukraine	25.7	21.2	7.6
Lebanon	20.1	11.6	4.0
Mexico	25.8	17.9	11.9
Belgium	60.9	36.5	13.9
France	48.0	29.4	21.1
Israel	53.1	32.3	14.4
Germany	40.0	23.9	20.3
Italy	51.0	25.9	17.3
Japan	24.2	24.2	12.8
Netherlands	50.4	31.3	16.1
New Zeeland	56.6	39.8	22.2
Spain	58.7	37.4	17.3
United States	59.7	39.9	26.2

Drawn from a World Health Organization study reported by Wang, Aguilar-Gaxiola et al. (2007).

see someone from a similar background (Lopez, Lopez, & Fong, 1991). Such preferences may be particularly strong when individuals maintain a strong identification with their ethnic group (Ponce & Atkinson, 1989). Many clients believe that therapists of similar background, perhaps even of the same gender, will understand their life circumstances more quickly. Despite this assumption, it has *not* been demonstrated that better outcomes are achieved when client and therapist are similar in race or ethnicity (Beutler, Machado, & Neufeldt, 1994), nor that clients are more likely to continue treatment when there is a match (Maramba & Nagayama-Hall, 2002). **Cultural competence** may matter more than ethnic matching. A therapist who is not a member of the same racial or ethnic group as the client might still understand the client and create a good therapeutic relationship if he or she is familiar with the client's culture (USDHHS, 2002). We provide a brief glimpse of the kinds of knowledge related to cultural competence in Focus on Discovery 16.4.

Although many minority clients report that they would like to see a minority therapist, cultural sensitivity appears to be more important to outcome than a match of ethnicity between the client and therapist. (Lew Merrim/Photo Researchers, Inc.)

Here, we highlight work by a few researchers who have begun to provide data on whether currently available treatments work well when offered to people from different backgrounds. Then we turn to new treatments that have been developed to draw on the strengths of people from different backgrounds.

Overall, there are far too few studies on whether treatments are valid for any specific minority group (Chambless & Ollendick, 2001). Nonetheless, several studies have tested whether standard empirically validated treatments work well for culturally diverse populations. For example a group version of interpersonal psychotherapy for depression was found to be efficacious for people living in Ugandan villages (Bolton et al., 2003). Several studies support the efficacy of CBT for anxiety disorders among African American clients (Miranda et al., 2005). Two studies have found comparable efficacy for CBT of childhood anxiety disorders across ethnicities, and findings of several studies indicate that the effects of treatments for childhood disruptive disorders, including CBT and family therapy, do not differ by ethnicity (Miranda et al., 2005).

Even though there is a small amount of evidence that established treatments are helpful for minority populations, many theorists argue that treatments should be adapted to be more culturally sensitive. As outlined by Duran and colleagues (2004), established treatments may need to be modified to change the role of the therapist, the types of intervention strategies used, the content of the intervention, and how to present certain content. For example, in refining an established treatment manual for stress management in an HIV-positive population, changes were made to the ways that assertiveness training was covered, new content was introduced on coping strategies and spirituality, and an array of other changes were made based on feedback from therapists and clients. Early results suggest that these efforts were a good idea; in a small group of HIV-positive Latino men, culturally sensitive treatment was found to produce significantly larger changes in depression, functioning, denial, and even HIV symptoms compared to a no-treatment control.

Amy Weisman's research focuses on how to modify family treatment for schizophrenia to draw on strengths of Latino families. (Courtesy of Amy Weisman, University of Miami.)

One approach to developing culturally sensitive interventions is to draw on strengths that might be promoted by a given culture. For example, Latino culture emphasizes family values and spirituality. Weisman (2005) modified traditional family therapy for schizophrenia to build on these values, with a more explicit focus on spirituality and family coping. Another team modified cognitive behavioral therapy and interpersonal psychotherapy for depression to incorporate family values. Puerto Rican adolescents who received culturally sensitive CBT demonstrated significantly more decrease in depressive symptoms than did those who received IPT or a control condition (Rosello, Bernal, & Rivera-Medina, 1998). Hence, early data suggests that tailoring interventions to culturally relevant strengths can bolster applicability.

Another example of innovative approaches is illustrated by the work of Ricardo Muñoz and colleagues, who have conducted research for years to examine how to treat depression among low-income, predominantly minority women in San Francisco. Their team first tailored cognitive behavioral therapy for depression so that it could be offered in a primary care group setting, such that it would be more widely accessible for people who might not seek out formal psychotherapy. Results of this intervention were successful (Muñoz et al., 1995). More recently, they modified the

FOCUS ON DISCOVERY 16.4

Cultural Competence

A good therapist takes the perspective of his or her client. This process can be more challenging when a therapist and a client are from different backgrounds. It is important for therapists to be aware of differences across ethnic groups in social experiences that may have shaped a client's life experiences, community values, implicit ideas about how to express emotions, and expectancies about therapy. Here, we give examples of how just a few of these issues may shape the therapeutic process.

African Americans

Racial stereotypes on the part of white therapists may be one barrier to African American clients receiving treatment. One experiment revealed that white therapists rated case study information about African American clients as reflecting more pathology than did African American therapists and also considered photographs of the clients less attractive (Atkinson et al., 1996).

Therapists need to accept that virtually all African Americans have encountered prejudice and racism, and many must wrestle with their rage at a majority culture that is sometimes insensitive to and unappreciative of the emotional consequences of growing up as a member of a feared, resented, and sometimes hated minority (USDHHS, 2002). And, like members of all the minority groups discussed in this section, many African Americans have been subjected to hate crimes. One survey of African American clients suggested that many felt that their therapists were insensitive to these issues (Thompson et al., 2004).

In evaluating differences in outcomes for African Americans, as with many ethnic minorities, it is important to consider that some effects are driven by poverty. For example, in a major study of treatment for attention-deficit/hyperactivity disorder, outcomes were worse for African American children than they were for white children; on the other hand, these differences were entirely explained by ethnic differences in poverty (MTA Cooperative Group, 1999b).

Latinos

The life experiences of Latino Americans vary a great deal depending on the region they originally came from—Mexico, Cuba, Puerto Rico, Central America, or South America. As is the case with other minority groups, generalizations are to be made with caution.

Therapy with most Latinos should appreciate that the culture may prohibit men from expressing weakness and fear. In addition, religion plays a very strong role in most Latin cultures and therefore needs to be considered in therapy with Latinos (USDHHS, 2002). Cognitive behavior therapy may be more acceptable than insight-oriented psychotherapy to some Latinos because it provides education, clear advice, and problem solving. This didactic and educational style of cognitive behavior therapy may demystify the process, thus reducing possible stigmatizing effects (Organista & Munoz, 1996). As with African Americans, though, many of the patterns described here apply more to lower-income people than higher-income people, regardless of race or ethnicity. This means that socioeconomic class has to be considered. There is no reason to assume that higher-income Latinos will find therapy less suitable than do Anglos.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders comprise more than three dozen distinct subgroups (e.g., Filipino, Chinese, Japanese, Vietnamese, Hawaiian, Samoan). They differ on dimensions such as how well they speak English, whether they came as refugees from war or terrorism in their homeland, and how much they identify with their native land (Sue & Sue, 2008). In

content of this intervention to be more specific to the concerns of African American women, including bolstering material to combat social isolation, to be sensitive to the high rates of trauma experienced in this population, to challenge myths of the superhuman African American woman, and to address family issues. African American women stated that they would rather receive the tailored intervention, and it produced a significantly larger reduction in depressive symptoms than a traditional CBT intervention (Kohn et al., 2002; Miranda et al., 2006).

Quick Summary

Treatment outcome research focuses on whether a given treatment works well. A number of groups have attempted to provide clear standards for psychotherapy research and to summarize the current state of knowledge about the validity of psychotherapy. With some minor variations in criteria, these groups have tended to emphasize the importance of clearly defining the sample and treatment regimen, random assignment to either the active treatment or a control comparison, and reliable and valid measures of outcome. These standards have provoked major debate. Treatment researchers and clinicians have raised concerns that evaluations of treatments should pay attention to the number of people who are harmed by treatments, that control groups may not always be ethical, that treatment manuals can be constraining, that diagnosis might not be the best way to choose a treatment, and that the samples in some treatment studies are not representative. One type of research focuses on the effectiveness of treatment, or the utility of a given treatment in the real world.

A large number of RCTs now support the efficacy of psychotherapy compared to wait-list controls or no treatment. More specifically, researchers have amassed evidence to support brief psychodynamic, experiential, cognitive behavioral, couples, and family therapies. Cognitive behavioral treatments have received more extensive study than any other form of psychotherapy. Generally differences between

general, these groups show a greater tendency than whites to be ashamed of emotional suffering and to be reluctant to seek out professional help.

The stereotype of Asian Americans as invariably being highly educated, earning good salaries, and being emotionally well adjusted is belied by the facts. The discrimination suffered in the United States and in many other countries is as severe as that endured by other minority groups (Sue & Sue, 2008). In the United States, for example, over 120,000 Japanese Americans—70,000 of them born in the United States (USDHHS, 2002)—were imprisoned in concentration camps and prisons for several years during World War II. More subtle discrimination remains in more recent times. Sue and Sue (2008) advise therapists to be sensitive to the personal losses that many Asian refugees have suffered. Given the importance of family ties, it is also important to be sensitive to the losses that family members may have endured.

Asian Americans in the United States are often caught between two cultures. One form of resolution is to identify vigorously with majority values and denigrate anything Asian, a kind of racial self-hate. Others, torn by conflicting loyalties, experience poorly expressed rage at a discriminatory Western culture. Acculturation, then, is important to consider.

Many cultural differences in values, particularly concerning relationships and emotional expression, have implications for how to conduct psychotherapy with Asian Americans and Pacific Islanders. Therapists should be aware that Asian Americans may initially describe stress in physical terms, such as headaches and fatigue, even though they are aware of emotional symptoms and will endorse those when asked directly (Chang et al., 2008). Generally, Asians respect structure and formality in interpersonal relationships more than Westerners, who can often favor informality. People from the Pacific Islands, however, may prefer friendliness and informality. For Asians, respect for authority may interfere with discussing differences openly. It may be more comfortable to agree with a therapist, even if that means that differences of opinion are so extreme as to keep the person from continuing in treatment. Asian Americans may also consider some areas off-limits for discussion with a therapist, for example, the nature of the marital relationship, especially sex. Finally, many Asian Americans prefer a structured approach to therapy over a reflective one (Iwamasa, 1993).

American Indians and Alaskan Natives

Like other minorities, American Indians and Alaskan Natives (sometimes referred to collectively as Native Americans or First Americans) are a highly heterogeneous group, with more than 500 tribes residing in the United States and many in Canada as well, speaking more than 200 languages, some of them as dissimilar to each other as English is to Chinese (Fleming, 1992).

American Indians and to a lesser but still significant extent Alaskan Natives have experienced severe institutional discrimination for over 300 years. They have been forbidden to speak their own language, driven from the land that their tribes had inhabited for hundreds of years, forbidden to engage in traditional native spiritual practices (in the case of American Indians), forced onto reservations in undesirable locations without regard for the special sanctity that land has for them, and subjected to other indignities. In recent years, however, their social and economic conditions have been improving, and tribes are achieving more control over their lives (USDHHS, 2002).

Because it is common for different family members to provide care for Native American children, the pattern of a child moving among different households is not necessarily a sign of trouble. A youngster's avoidance of eye contact is a traditional sign of respect but may be misconstrued by someone unfamiliar with the culture (Everett, Proctor, & Cartmell, 1989). As with members of other minority groups, conflicts about identification can be severe—young people can be torn between traditional values and those of the decidedly more privileged majority culture, which may underlie the high rates of truancy, substance abuse, and suicide among Native American young people (Red Horse, 1982). Drug abuse, especially alcoholism, is a widespread problem in some tribes and can lead to child abuse, particularly when there is family conflict. A value placed on cooperativeness rather than competitiveness can be misinterpreted by a culturally unaware therapist as lack of motivation. The importance of family may make it advisable to conduct treatment in the home and to engage family members in the process (Sue & Sue, 2008).

cognitive behavioral treatments and other forms of treatment are quite small, but cognitive behavior therapy for anxiety disorders appears to be more effective than other treatments.

Minority groups are less likely to receive psychotherapy for psychological concerns. Matching therapist and client ethnicity is not helpful for therapy outcomes; rather, enhancing the cultural competence of therapists is the goal. The few researchers who have tested treatment manuals developed for majority populations generally find such psychotherapies work with minority groups, although sometimes they observe less positive effect than seen in initial trials. Some researchers are working on ways to tailor treatment approaches to fit with culturally relevant values.

Check Your Knowledge 16.3

Answer the questions.

1. Which treatment has **not** been shown to have efficacy compared to treatment as provided in the community?
   - **a.** traditional psychoanalysis
   - **b.** short-term psychodynamic therapy
   - **c.** experiential therapy
   - **d.** behavior therapy
   - **e.** cognitive therapy
2. In the few available studies, cognitive behavioral treatments appear to offer more relief than experiential treatments for which disorders?
   - **a.** schizophrenia
   - **b.** depression
   - **c.** anxiety disorders
   - **d.** all psychological disorders
3. A couple comes for treatment of incessant conflicts. They are likely to show the strongest marital improvements if you offer them:
   - **a.** individual cognitive behavioral treatment for both partners
   - **b.** couples therapy

Psychotherapy Process Research

Treatment works for most people. But nonetheless, a careful review of the data suggests there is room for improvement—some people with serious mental illness don't seek treatment, others leave treatment early, still others don't find treatment helps them change, and for a very few, problems actually worsen during treatment. A growing number of theorists have suggested that one way to address these issues would be to draw from the best ideas in different treatment approaches (Castonguay et al., 2003). Treatments can be refined by studying what predicts good (or bad) outcomes. This is the goal of psychotherapy process research. Broadly, there are two types of **process research:**

- In the **common factors** approach, researchers try to understand the common ingredients that help all forms of therapy succeed (Goldfried, 2004).
- In research on *mechanisms of change*, researchers try to understand the unique processes involved when specific forms of therapy succeed. For example, does cognition have to change for cognitive therapy to work?

We cover these two different approaches next.

Common Factors Research

Well-documented common factors include a strong rationale for how treatment will work (which might bolster hope), therapist expectations for change, and a strong therapeutic relationship (Wampold, 2001). Bandura (1977) suggests that all therapeutic procedures work by giving the person a sense of mastery or *self-efficacy*. Here, we focus on a topic that has been studied in more than 1,000 studies using many different methods: the therapeutic relationship (Orlinsky, Ronnestad, & Willutzki, 2004).

Regardless of theoretical orientation, a good relationship between client and therapist is important. People are not likely to reveal deeply personal information if they do not trust their therapists. The heart of psychotherapy involves cooperation between a therapist and a client on making changes.

A strong relationship between therapist and client is widely regarded as essential for implementing treatment procedures. A great deal of research has focused on the therapeutic alliance. (Esbin-Andersonage/ Age Fotostock America, Inc.)

The term **therapeutic alliance** (also called the **working alliance**) describes the collaborative relationship between therapist and client, in which they share an affective bond and an ability to agree on treatment goals. In a meta-analysis of 79 studies, Martin, Garske, and Davis (2000) found that therapeutic alliance predicted a small but consistent amount of the variance in outcome across a broad range of psychological disorders, treatment approaches, and outcome measures. Overall, therapeutic alliance (measured with self-report scales given to the therapists or the client) accounted for at least 5 percent of the variability in outcome. This may seem like a really small piece of the pie! A few issues help put this in context. First, most therapists do establish good relationships with their clients—there may not be many terrible relationships being studied. Second, it is possible that other types of measures, like behaviorally based codes of actual interactions, would yield stronger effects. For example, across dozens of studies, clients' reports of empathy account for about 10 percent of the variance in outcome after treatment (Greenberg et al., 2001). Other variables that seem to be predictive include therapist friendliness and interpersonal flexibility (Beutler et al., 2004). Third, some data suggest that the quality of the therapeutic relationship influences variables that are not usually measured in these studies, such as whether a person leaves treatment (Horvath, 2001). Nonetheless, while it is clear that the therapeutic relationship is important, the research does not justify the assertion that the relationship alone produces change.

There are different views on how a good therapeutic alliance works (Henry et al., 1994). In client-centered therapy, a good relationship is assumed to be one of the critical ingredients for change (Elliott et al., 2004). In psychoanalysis, it might make interpretations more effective, thus having an indirect effect. Although the therapeutic relationship might not have received much direct attention in early cognitive manuals, it is central in some of the newer manuals, such as the manual for Linehan's dialectical behavior therapy. No matter how the alliance works, research suggests that a good relationship is important for any therapeutic approach (Martin et al., 2000).

Many researchers have focused on what fosters a strong therapeutic relationship. In most studies, the therapeutic alliance is measured after a couple sessions of treatment. Several studies sug-

gest that the therapeutic alliance is predicted by the degree of relief that patients are already getting from their symptoms (Crits-Cristoph, Gibbons, & Hearon, 2006). Nonetheless, even if you control for the early symptom relief, therapeutic alliance still predicts outcome (Klein et al., 2003).

Because therapeutic alliance matters, studies focus on how a therapist can promote a good relationship. Not surprisingly, these studies find that therapists who convey empathy and positive regard, who show their engagement in nonverbal behaviors (e.g., nodding their head, smiling, or leaning forward), and who are flexible but set consistent goals for treatment are able to promote stronger relationships (Ackerman & Hilsenroth, 2003). Beyond the therapists' behaviors, therapeutic relationships are also undoubtedly influenced by characteristics of the client as well as of the therapy.

Mechanisms of Change Research

Beyond the therapeutic relationship, researchers have focused on whether treatments actually change the mechanisms that each therapy is designed to target. For example, traditional behavioral couples therapy (BCT) focuses on communication training and integrative couples behavioral therapy (ICBT) focuses on acceptance. As one might expect, then, BCT produces more change in communication, and ICBT produces more change in acceptance (Doss et al., 2005).

A large body of research focuses on whether cognitive therapy works by changing negative cognitions. Many studies have found that clients who receive cognitive therapy become substantially less negative in their thinking (Jarrett et al., 2007). You might expect that this would answer the question of whether treatments actually change underlying mechanisms. But that is only part of the story. Some researchers have examined cognitive changes that occur during other forms of treatment. In one study, Jacobson and colleagues (1996) offered either traditional cognitive therapy or just one of the components of cognitive therapy—*behavioral activation*, which involves helping a person engage in more pleasant activities in the hopes that they will gain more positive reinforcement. During behavioral activation, the therapist does not talk about cognition. As it turns out, behavioral activation achieved similar results to cognitive therapy in terms of changes in cognitive variables among clients with depression. These results suggest that you can change cognition without offering cognitive therapy. Indeed, adding cognitive therapy to medication treatment does not influence the degree of change in negative cognitions; patients who receive medication treatment demonstrate just as much improvement in their negative cognitions as do those who receive cognitive therapy as well as medication treatment (Jarrett et al., 2007). The simplest way to understand this is that symptom relief (from many different treatments) helps people see the world and themselves less negatively. Indeed, careful analyses suggest that symptoms are driving the negative cognitions rather than that cognitions are driving symptoms (Jarrett et al., 2007).

These studies of cognitive therapy pose quite a challenge. As you can imagine, this is a major topic of research. Some researchers have suggested that maybe we need to be much more specific in how we think about what aspects of cognition need to change.

One example of this type of approach comes from work by David Clark (1994). Clark sees the driving force of panic disorder as cognitive misinterpretation of bodily sensations, such that a person believes that a small change in heart rate portends catastrophe. His treatment manual is designed to address this cognitive process, which is much more specific than general negative thoughts. In support of his proposed mechanism, clients who took part in treatment and yet retained cognitive misinterpretations of bodily sensations at the end of treatment were likely to relapse within a year.

One study has looked at very focused aspects of cognition in the context of therapy for depression. These authors reasoned that the key ingredient might not be whether a client's thoughts were negative at the end of therapy—most clients are pretty positive by the time depression is relieved. Rather, the authors argued that it might matter whether clients had the skills to ward off negative thoughts when they did occur. They had clients rate what they would do if they heard negative news about themselves (e.g., you aren't picked for a job), and they had observers rate how savvy clients seemed to be about using cognitive strategies during their therapy sessions. These two measures of the ability to challenge negative thinking predicted outcomes. That is, the ability to learn very specific skills to ward off negative thinking was associated with less risk of depression relapse (Strunk et al., 2007). These findings illustrate how sophisticated researchers will need to be to understand the mechanisms involved in therapeutic change.

It is hoped that by building our knowledge about the processes guiding therapeutic improvement, we can design better treatments. For example, Persons (2005) recommends conceptualizing the mechanisms that will be most important for a given person to obtain relief from symptoms and gathering data on whether treatment is working to change those processes. Similarly, Rosen and Davison (2003) have argued that we should be defining empirically supported principles of change rather than empirically supported treatments. That is, we should focus on the mechanisms that can successfully be changed in therapy and study when it would be most helpful to address those mechanisms. Many researchers have argued that we should be more focused on testing our ability to change these specific mechanisms than on comparing entire treatment packages.

Quick Summary

Process research focuses on understanding how therapy works. Common factors research attempts to find the predictors of good outcomes that work across different forms of therapy, including a strong therapeutic alliance. Other research is focused on mechanisms of change that might operate within specific forms of therapy. Some feel that process research may help us avoid a proliferation of treatment manuals, by encouraging us to go back to the basic elements of which strategies work for whom, at what time.

Check Your Knowledge 16.4

Fill in the blanks.

1. Treatment outcome studies test _____.
2. Process research focuses on _____.

True or False?

3. True or False? Cognitive therapy is the only treatment that changes negative cognitive styles.

Community Psychology and Prevention Science

Community psychology aims to change large systems to help groups of people rather than individuals. Community psychologists are invested in reaching out to large populations to prevent the onset or recurrence of physical or mental disorders. Community psychology gained popularity in the 1960s, during a period of tremendous social activism. Cities and college campuses erupted in riots, and many ethnic-minority groups demonstrated against racism and political repression. This social upheaval encouraged looking at social institutions for causes of individual suffering. Against this backdrop, mental health professionals began to shift from a focus on individual-level risk factors to a focus on large-scale social problems, such as poverty, overcrowding, violence, racism, poor education, segregation, and the alienation felt in large cities. Community psychology's emphasis on prevention became especially important in the United States, where a large gap had developed between the need for mental health care and the availability of services (Weissberg, Caplan, & Sivo, 1989).

These large-scale issues in understanding mental health have not gone away. We have described the prevalence of rape, child abuse, and homelessness in other chapters—ongoing problems of this magnitude call for interventions at a system level. Beyond evidence for social pressures on mental health, the high prevalence rates of depression, anxiety, and substance-abuse disorders demand approaches to identification and prevention that will reach a lot of people.

Researchers working from the perspective of community psychology have developed a number of techniques to evaluate the prevalence of risk factors using epidemiological studies, to reduce environmental risk factors, and to strengthen protective factors. Researchers may gather data using epidemiological research and then use that data to develop interventions, such as mass media

campaigns, instructional programs in schools, or other techniques to reach a large number of people. These strategies have been called prevention science (Heller, Wyman, & Allen, 2000).

Many prevention science projects have worked well (Heller et al., 2000). Massive studies have been conducted to understand the epidemiology of risk factors in the general U.S. population (Kessler, Berglund, et al., 2005). Large-scale programs, such as National Depression Awareness Day, are implemented across the United States to enhance the detection of depression and other disorders. Jose Szapocznik has earned awards for his work on how community and school systems influence family and child mental health (APA, 2002), and the former president of the APA, Martin Seligman (1998), has conducted studies of how to prevent depression by teaching positive thinking skills to school children. Large-scale studies have considered how well medications and therapy can be implemented in community clinics, and a set of researchers are trying to develop therapies that can be efficiently offered over the web. We have previously described many other successful community psychology programs, including interventions to address depression when people seek primary care (p. 245) or through workplace interventions (p. 237), and suicide prevention centers with telephone hotlines (p. 251).

The success of these programs, coupled with the vast numbers of people affected by mental health problems, indicate that there is an ongoing need for this type of science. That is, there is a need for people who specialize in understanding how broad social systems influence mental health, how to develop effective prevention programs, how to develop national policies that will diminish stigma, and how to increase the accessibility and sensitivity of services for the needs of a diverse population.

Summary

Specific Treatment Approaches:

- Psychodynamic treatments focus on unconscious conflicts and childhood experiences that shape emotions and relationships in a person's current life.
- Experiential psychotherapies emphasize freedom to choose, personal growth, personal responsibility, and emotional awareness. Variants of these approaches include Rogers's client-centered therapy, Gestalt therapy, and emotion-focused therapy.
- Behavioral treatments include exposure treatment and treatments based on operant principles. Cognitive therapies vary in the targets of their work, but a core goal is often to challenge underlying negative schemata. Cognitive behavioral treatments have evolved over the past 10 years to incorporate themes like acceptance, emotional avoidance, spirituality and meaning.
- Couples therapy helps distressed couples resolve the inevitable conflicts in any ongoing relationship of two adults living together. Many different forms of couples therapy have been developed, including behavioral couples therapy, integrative behavioral couples therapy, emotionally focused couples therapy, and insight-oriented couples therapy.
- Family therapy includes many different techniques to address different family and individual concerns.

Challenges in Evaluating Treatment Outcomes

- Research on the effectiveness of various forms of psychological treatments has been conducted for many decades. Overall, this research suggests that about 75 percent of people gain some improvement from therapy. Therapy also seems to be more helpful than a placebo or the passage of time.
- Efforts have been made to define standards for research on psychotherapy trials and to summarize current knowledge on which psychological treatments work. These standards typically include the need to randomly assign participants to treatment or a control, to use a treatment manual, to define the treated sample carefully, and to use reliable and valid outcome measures. It is hoped that these efforts will help disseminate the best available therapeutic practices to clinicians and their clients as well as provide insurance companies with the data to support the use of psychotherapy.
- Controversy exists about research standards: most standards do not consider the proportion of patients who are harmed by a treatment, a large proportion of clients are excluded or will not take part in clinical trials, cultural diversity is lacking in most trials, many treatment approaches remain untested, and treatment manuals could constrain a talented therapist. A broader concern is that a huge gap exists between what happens in the research world and the real world. Efficacy research focuses on how well therapies work in carefully controlled experiments, whereas effectiveness research focuses on how well therapies work in the real world.

Specific Treatment Approaches: Treatment Outcome Research

- Treatment outcome research supports the efficacy of psychodynamic, experiential, cognitive behavioral, couples, and family therapy approaches compared to no treatment. Differences in how well these active forms of psychotherapy perform are quite small, but behavioral approaches offer a clear advantage for the treatment of anxiety disorders.
- Couples therapy offers an advantage compared to individual therapy in reducing couples' distress. Promising evidence exists for integrative behavioral couples therapy, emotion-focused couples therapy, and insight-oriented couples therapy as compared to standard behavioral couples therapy.

- Family therapy has been shown to be successful in the treatment of externalizing disorders among children and adolescents, in helping people with substance abuse accept the need for treatment, and in reducing relapse among adults with schizophrenia and bipolar disorder.

The Importance of Culture and Ethnicity in Psychological Treatment

- Clinicians offering treatment to minority clients must be sensitive to the cultural values and events that shape the way people may approach relationships, therapy, and emotional expression. Little empirical research is available on how psychotherapies work for people from diverse backgrounds, but minority status is associated with less use of therapy. Researchers have developed modifications of some treatments to be more culturally sensitive.

Psychotherapy Process Research

- Common factors research identifies variables that predict outcomes across a broad range of therapies, such as the quality of the therapeutic alliance.
- Process researchers also examine mechanisms of change. For example, researchers conduct studies on whether it is necessary to change cognition in order for cognitive therapy to work.

Community Psychology and Prevention Science

- Community psychology aims to understand and prevent disorder on a large scale.

Answers to Check Your Knowledge Questions

16.1. 1. f; 2. b
16.2. 1. a, b; 2. a, c, d, e; 3. b
16.3. 1. a; 2. c; 3. b
16.4. 1. Whether a given treatment works; 2. How a treatment works; 3. F

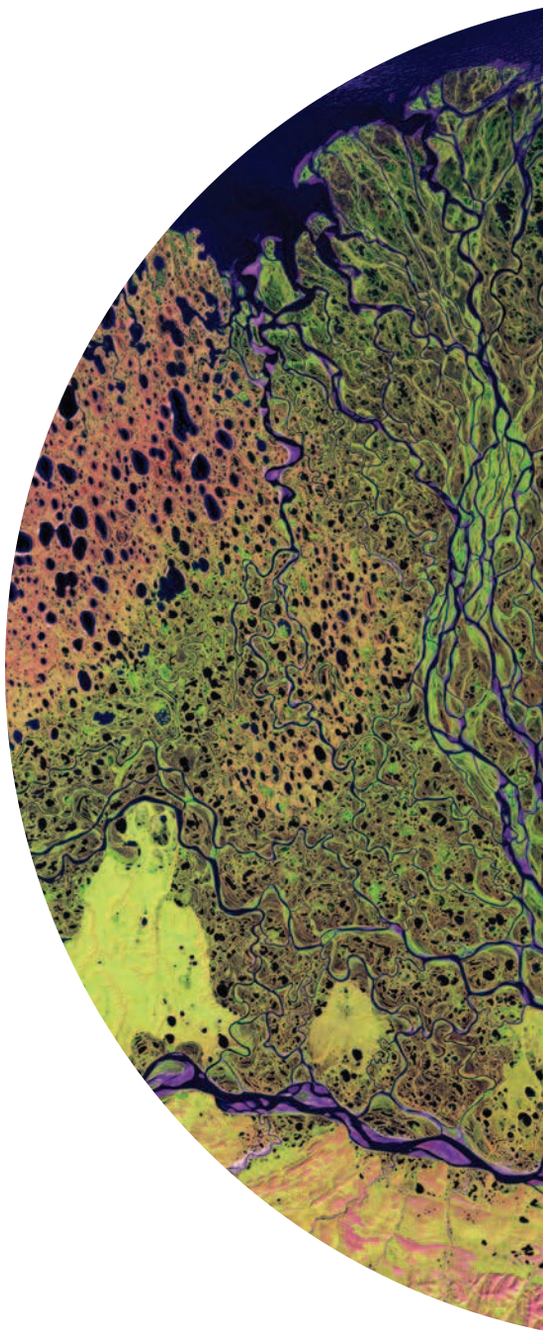
Key Terms

behavioral activation (BA) therapy
client-centered therapy
common factors
cultural competence
effectiveness
efficacy
emotion-focused therapy
empathy
empirically supported treatments (ESTs)
Gestalt therapy
outcome research
process research
randomized controlled trials (RCTs)
self-actualization
stepped care
therapeutic (working) alliance
unconditional positive regard

17 Legal and Ethical Issues

LEARNING GOALS

1. Be able to differentiate the legal concepts of insanity and the various standards for the insanity defense.
2. Be able to describe the issues surrounding competency to stand trial.
3. Be able to delineate the conditions under which a person can be committed to a hospital under civil law.
4. Be able to discuss the difficulties associated with predicting dangerousness and the issues surrounding the rights to receive and refuse treatment.
5. Be able to describe the ethics surrounding psychological research and therapy.



Amendment I *Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.*

Amendment IV *The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated. . . .*

Amendment V *No person . . . shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law. . . .*

Amendment VI *In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial . . . to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defense.*

Amendment VIII *Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.*

Amendment XIII *. . . Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction. . . .*

Amendment XIV *. . . No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.*

Amendment XV *. . . The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.*

THESE ELOQUENT STATEMENTS DESCRIBE and protect some of the rights of U.S. citizens and others residing in the United States. Against what are these rights being protected? Be mindful of the circumstances under which most of these statements were issued. After the Constitutional Convention had delineated the powers of government in 1787, the first Congress saw fit in 1789 to amend what had been framed and to set specific limits on the federal

Clinical Case: David

David had been hearing voices for several days. Unable to drown them out with music or talking, he became more and more troubled. The voices were telling him that he was the one chosen by God to rid the world of evil. David went to the emergency room of the local hospital seeking relief. Instead of being admitted, David was given a prescription for Haldol and sent on his way. Two days later, David took a loaded gun into the busy train station and began shooting. He killed two people and injured four others. When he was arrested, David told the police he was answering to God. His speaking was disorganized and hard to follow, and he expressed a number of paranoid beliefs.

David was found competent to stand trial because he understood that he was charged with murder and he was able to help his attorney with his defense. At trial, David entered a plea of "not guilty by reason of insanity" (NGRI). His defense lawyer arranged for David to be evaluated by a psychologist. The psychologist concluded that David had schizophrenia, paranoid type, and that at the time of the crime he was unable to discern right from wrong (he thought his behavior was the right thing to do since God was directing him) and unable to conform his behavior to the requirements of the law. The prosecution did not dispute these findings, and the case was settled before going to trial. David was committed to the local forensic hospital for an indeterminate period of time. He was to remain there until he was no longer dangerous and mentally ill. Periodic evaluations would be conducted to see if David could be transferred to a less secure hospital.

After seven years in the hospital, David had done very well. He took his prescribed medication (Zyprexa), was never in a physical altercation with other patients, participated in individual and group therapy, worked in the hospital machine shop, and served as a team leader for the unit he was living in. David felt horribly remorseful for the crimes he had committed, and he recognized that he had schizophrenia that would require treatment for the rest of his life. The treatment team on the unit all agreed that David was no longer dangerous and that his schizophrenia was under control with the medication. They recommended that he be transferred to a less secure psychiatric hospital. David's attorney presented the case before a judge in the courtroom that was part of the hospital. The attorneys for the state objected to David's release, arguing that David could stop taking his medications and become violent again. The judge agreed that release was premature at this time and ordered that David remain in the forensic hospital for another year before being evaluated again.

government. This was accomplished with what came to be called the Bill of Rights, which are the first 10 amendments to the Constitution. Amendments beyond the original 10 have been added since that time. The philosophical ideal of the U.S. government is to allow citizens the maximum degree of liberty consistent with preserving order in the community at large.

We open our final chapter in this way because the legal and mental health systems collaborate continually, although often subtly, to deny a substantial proportion of the U.S. population their basic civil rights. With the best of intentions, judges, governing boards of hospitals, legal associations, and professional mental health groups have worked over the years to protect society at large from the actions of people regarded as mentally ill and considered dangerous to themselves or to others. But in so doing they have denied many thousands of people their basic civil rights.

People with mental illness who have broken the law or who are alleged to have done so are subject to **criminal commitment**, a procedure that confines a person in a mental hospital either for determination of competency to stand trial or after acquittal by reason of insanity. **Civil commitment** is a set of procedures by which a person who is deemed mentally ill and dangerous but who has not broken a law can be deprived of liberty and placed in a psychiatric hospital. In this chapter we look at these legal procedures in depth. Then we turn to an examination of some important ethical issues as they relate to therapy and research.

Criminal Commitment

We examine first the role of psychiatry and psychology in the criminal justice system. Almost as early as the concept of mens rea, or "guilty mind," and the rule "No crime without an evil intent" had begun to be accepted in English common law, the concept of *insanity* was taken into consideration. Broadly speaking, insanity refers to a disordered mind, and a disordered mind may be regarded as unable to formulate and carry out a criminal purpose (Morse, 1992). In other words, a disordered mind cannot be a guilty mind, and only a guilty mind can engender culpable actions.

It is important to note that insanity is a legal concept, not a psychological one. As such, its definition comes from court proceedings. In today's courts, judges and lawyers call on psychiatrists and clinical psychologists for assistance in dealing with criminal acts thought to result from the accused person's disordered mental state. Although the insanity defense was developed to protect people's rights, in practice, the insanity defense often results in a greater denial of liberties than they would otherwise experience.

The Insanity Defense

The **insanity defense** is the legal argument that a defendant should not be held responsible for an illegal act if it is attributable to mental illness or mental retardation that interferes with rationality or that results from some other excusing circumstance, such as not knowing right from wrong. A staggering amount of material has been written on the insanity defense, even though it is pleaded in less than 1 percent of all cases that reach trial and even when pleaded, it is rarely successful (Morse, 1982b; Steadman, 1979; Steadman et al., 1993).

Because an insanity defense is based on the accused's mental condition at the time the crime was committed, retrospective, often speculative, judgment on the part of attorneys, judges, jurors, and mental health professionals is required. And disagreement between defense and prosecution psychiatrists and psychologists is the rule.

Mental illness and crime do not go hand in hand. A person can be diagnosed as mentally ill and be held responsible for a crime. However, the most heinous or bizarre crime can be committed by someone who has no mental illness at all, despite our tendency to think someone must have been "crazy" to commit such a crime. Indeed, decades of social psychological research tell us that otherwise normal people can do horrendous, criminal acts under the right circumstances or contexts (Aronson, 2004).

The insanity pleas available in state and federal courts in the United States have been crafted from a series of legal definitions and precedents that we review below. Broadly, there are two different kinds of insanity pleas today. With the **not guilty by reason of insanity (NGRI)** plea, there is no dispute over whether the person actually committed the crime—both sides agree that the person did the crime. However, due to the person's insanity at the time of the crime, the defense attorney argues that the person should not be held responsible for the crime and should thus be acquitted of the crime. The successful NGRI plea indicates the person is not held responsible for the crime due to his or her mental illness. People acquitted with the NGRI plea are committed indefinitely to a forensic hospital. That is, they are only released from forensic hospitals if they are deemed no longer dangerous and no longer mentally ill (we discuss the difficulties in making these determinations below).

A forensic hospital looks very much like a regular hospital except that the perimeter of the grounds is secured with gates, barbed wires, or electric fences. Inside the hospital, doors to the different units may be locked, and bars may be placed on windows on the lower floors. Patients do not stay in jail cells, however. They stay in either individual or shared rooms. Security professionals are on hand to keep patients safe. They typically do not carry weapons of any sort, and they may be dressed in regular clothing rather than uniforms.

The second insanity plea is **guilty but mentally ill (GBMI)**. Initially adopted by Michigan in 1975, this plea allows an accused person to be found legally guilty of a crime—thus maximizing the chances of incarceration—but allows for psychiatric judgment on how to deal with the convicted person if he or she is considered to have been mentally ill when the act was committed. Thus, even a seriously ill person can be held morally and legally responsible for a crime but can then, in theory, be committed to a prison hospital or other suitable facility for psychiatric treatment rather than to a regular prison for punishment. In reality, however, people judged GBMI are usually put in the general prison population, where they may or may not receive treatment. As of 2004, at least ten states had adopted some or all of the GBMI provisions; four states have both NGRI and GBMI available. Table 17.1 compares these two insanity pleas. Three states—Idaho, Montana, and Utah—do not allow for any insanity defense.

We now turn to how these two pleas were developed by reviewing the legal precedents throughout history that set the stage for our current definitions of insanity.

Table 17.1 Comparing NGRI and GBMI

	NGRI	GBMI
Responsibility for crime	Not responsible	Responsible
Where committed	Forensic hospital	Prison
Given sentence?	No	Yes
When released	When no longer dangerous and mentally ill	End of sentence, but could then be committed civilly if dangerous and mentally ill
Treatment given?	Yes	Possibly

Landmark Cases and Laws Several court rulings and established principles bear on the problems of legal responsibility and mental illness. Table 17.2 summarizes these rulings and principles.

Irresistible Impulse The **irresistible impulse** concept was formulated in 1834 in a case in Ohio. According to this concept, if a pathological impulse or uncontrollable drive compelled the person to commit the criminal act, an insanity defense is legitimate. The irresistible-impulse test was confirmed in two subsequent court cases, *Parsons v. State* and *Davis v. United States.*[1]

The M'Naghten Rule The **M'Naghten rule** was formulated in the aftermath of a murder trial in England in 1843. The defendant, Daniel M'Naghten, had set out to kill the British prime minister, Sir Robert Peel, but had mistaken Peel's secretary for Peel. M'Naghten claimed that he had been instructed to kill Lord Peel by the "voice of God." The judges ruled that

> *to establish a defense of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was 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.*

As of 2004, this right–wrong test was the sole test in 20 states and in 4 others was applied in conjunction with irresistible impulse.

Table 17.2 Landmark Cases and Laws Regarding the Insanity Defense

Irresistible impulse (1834) M'Naghten rule (1843)	A pathological impulse or drive that the person could not control compelled that person to commit a criminal act. The person did not know the nature and quality of the criminal act in which he or she engaged, or, if the person did know it, the person did not know what he or she was doing was wrong.
American Law Institute guidelines (1962)	1. The person's criminal act is a result of "mental disease or defect" that results in the person's not appreciating the wrongfulness of the act or in the person's inability to behave according to the law (combination of M'Naghten rule and irresistible impulse). 2. "[T]he terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct" (American Law Institute, 1962).
Insanity Defense Reform Act (1984)	1. The person's criminal act is a result of severe mental illness or defect that prevents the person from understanding the nature of his or her crime. 2. The burden of proof is shifted from the prosecution to the defense. The defense has to prove that the person is insane. 3. If the person is judged to have recovered from mental illness, then instead of being released from the prison hospital, the person remains incarcerated for at least as long as he or she would have been imprisoned if convicted.
Guilty but mentally ill (1975)	The person can be found legally guilty of a crime—thus maximizing the chances of incarceration—and the person's mental illness plays a role in how he or she is dealt with. Thus, even a seriously ill person can be held morally and legally responsible but can then be committed to a prison hospital or other suitable facility for psychiatric treatment rather than to a regular prison for punishment.

[1]*Parsons v. State*, 2 So. 854, 866-67 (Ala. 1887); *Davis v. United States,* 165 U.S. 373, 378 (1897).

American Law Institute Guidelines In 1962 the American Law Institute (ALI) proposed its own guidelines, which were intended to be more specific and informative to lay jurors than were other tests. The **American Law Institute guidelines** state the following:

1. A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law.
2. As used in the article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct (American Law Institute, 1962, p. 66).

The first ALI guideline combines the M'Naghten rule and the concept of irresistible impulse. The phrase "substantial capacity" in the first guideline is designed to limit an insanity defense to those with the most serious mental disorders. The second guideline concerns those who are repeatedly in trouble with the law; repetitive criminal behavior and psychopathy are not evidence for insanity.

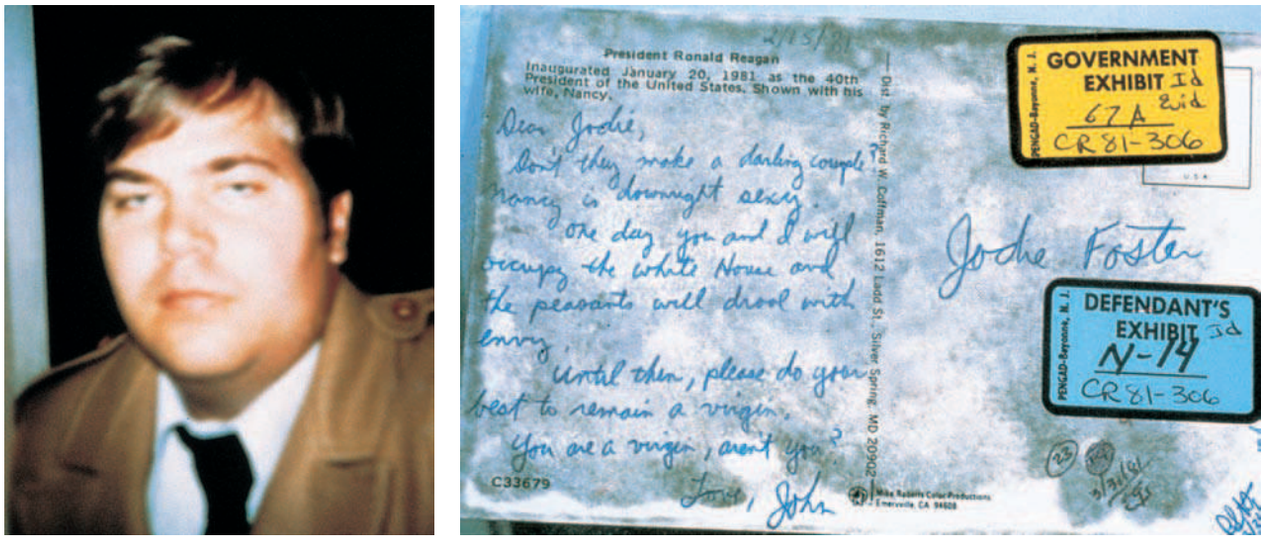
As of 2004, the ALI test was in use in 20 states. Until 1984, it was in use in all federal courts. In the 1980s a major effort began in the United States to clarify the legal defense of insanity at the federal level.

Insanity Defense Reform Act In a highly publicized trial in March 1981, John Hinckley Jr. received an NGRI verdict for his assassination attempt against President Ronald Reagan. After the NGRI verdict, the court received a flood of mal from citizens outraged that a would-be assassin of a U.S. president had not been held criminally responsible and had only been committed to an indefinite stay in a mental hospital until deemed mentally healthy enough for release. Their outrage reflects the public misperceptions about the insanity defense. The public often believes that a person is "getting away" with a crime when found NGRI and that he or she will be released from the hospital in short order. In reality, many people who are committed to a forensic hospital stay there longer than they would have stayed in prison had they been given a sentence (as vividly illustrated in the clinical case below of Michael Jones). With respect to John Hinckley, he has been committed to St. Elizabeth's Hospital, a public mental hospital in Washington, D.C., for over 25 years. Although he can be released whenever his mental health is deemed adequate, this has not yet happened. He has slowly won more freedoms: In 2003, a judge ruled that Hinckley could have six day-long unsupervised visits with his parents outside St. Elizabeth's hospital but only in the Washington, D.C., area. In 2005, a judge allowed Hinckley to have seven overnight visits with his parents at their home in Virginia. As of 2007, doctors need give four days advance notice to the Secret Service, instead of two weeks, when Hinckley visits his parents.

Because of the publicity surrounding the trial and the public outrage at the NGRI verdict, the insanity defense became a target of vigorous criticism from many quarters. As Judge Parker, who presided at the trial, put it: "For many, the [Hinckley] defense was a clear manifestation of the failure of our criminal justice system to punish people who have clearly violated the law" (quoted in Simon & Aaronson, 1988, p. vii).

As a consequence of political pressures to "get tough" on criminals, Congress enacted the Insanity Defense Reform Act in October 1984, addressing the insanity defense for the first time at the federal level. This new law, which has been adopted in all federal courts, contains several provisions designed to make it more difficult to plead NGRI.

- It eliminates the irresistible-impulse component of the ALI rules. This volitional and behavioral aspect of the ALI guidelines had been strongly criticized because one could regard any criminal act as arising from an inability to stay within the limits of the law.
- It changes the ALI's "lacks substantial capacity . . . to appreciate" to "unable to appreciate." This alteration in the cognitive component of the law is intended to tighten the grounds for an insanity defense by making more stringent the criterion for impaired judgment.
- The act also stipulates that the mental disease or defect must be "severe," the intent being to exclude insanity defenses on the basis of disorders such as antisocial personality disorder. Also abolished by the act were defenses relying on "diminished capacity" or "diminished



John Hinckley, President Reagan's assailant, wrote this letter to actress Jodie Foster expressing his dream of marrying her and becoming president. (R. Mims/Corbis Sygma.)

responsibility," based on such mitigating circumstances as extreme passion or "temporary insanity." Again, the purpose was to make it harder to mount an insanity defense.

- It shifts the burden of proof from the prosecution to the defense. Instead of the prosecution's having to prove that the person was sane beyond a reasonable doubt at the time of the crime (the most stringent criterion, consistent with the constitutional requirement that people are considered innocent until proved guilty), the defense must prove that the defendant was not sane and must do so with "clear and convincing evidence" (a less stringent but still demanding standard of proof). Table 17.3 shows the different standards of proof used in U.S. courts. The heavier burden now placed on the defense is, like the other provisions, designed to make it more difficult to relieve a defendant of moral and legal responsibility.[2]

Table 17.3 Standards of Proof

Standard	Certainty Needed to Convict (%)
Beyond a reasonable doubt	95
Clear and convincing evidence	75
Beyond a preponderance of the evidence	51

- Finally, the new act responds to what many felt was the most troublesome feature of the existing laws—that the person could be released from commitment after a shorter period of time than would be allowed under an ordinary sentence. According to this act, if the person is judged to have recovered from mental illness, then instead of being released from the prison hospital, he or she can be incarcerated up to the maximum time allowable for the crime.

Guilty but Mentally Ill Some states have created what seems to be a compromise verdict—guilty but mentally ill (GBMI). A GBMI verdict, as mentioned, allows the usual sentence to be imposed but also allows for the person to be treated for mental illness during incarceration, though treatment is not guaranteed. If the person is still considered to be dangerous or mentally ill after serving the imposed prison sentence, he or she may be committed to a mental hospital under civil law proceedings.

Critics of the GBMI verdict argue that it does not benefit criminal defendants with mental illness and does not result in appropriate treatment for those convicted (Woodmansee, 1996). A 1997 South Carolina Supreme Court case[3] found that South Carolina's GBMI statute did

[2]According to Simon and Aaronson (1988), this provision arose in large measure from the inability of the prosecution to prove John Hinckley's sanity when he shot Reagan and three others. Several members of the jury testified after the trial to a subcommittee of the Senate Judiciary Committee that the judge's instructions on the burden of proof played a role in their verdict of NGRI. Even before the act, almost half the states required that the defendant must prove insanity, but only one, Arizona, had the "clear and convincing" standard. A majority of the states now place the burden of proof on the defense, albeit with the least exacting of legal standards of proof, "by a preponderance of the evidence."

[3]*South Carolina v. Hornsby*, 484 S.E.2d 869 (S.C. Sup. Ct. 1997).

provide some benefit because it mandated that convicted people with mental illness receive mental health evaluations before being placed in the general prison population. Unfortunately, these assessments have not been shown to lead to better treatment. Other critics of the GBMI verdict note that the verdict is confusing and even deceiving to jurors. Jurors believe that GBMI is not as "tough" as a guilty verdict, but in reality people receving a GBMI verdict often receive harsher punishment (i.e., longer time incarcerated) than if they had been found guilty (Melville & Naimark, 2002).

One of the more famous cases involving the GBMI verdict was the 1992 conviction of Jeffrey Dahmer in Milwaukee, Wisconsin. He had been accused of and had admitted to butchering, cannibalizing, and having sex with the corpses of 15 boys and young men. Dahmer entered the insanity plea allowed in Wisconsin—guilty but mentally ill—and his sanity was the sole focus of an unusual trial that had jurors listening to conflicting testimony from mental health experts about the defendant's state of mind during the serial killings to which he had confessed. They had to decide whether he had had a mental disease that prevented him from knowing right from wrong or from being able to control his actions. Even though there was no disagreement that he was mentally ill, diagnosable as having some sort of paraphilia, Dahmer was deemed sane and therefore legally responsible for the grisly murders. The judge sentenced him to 15 consecutive life terms. Later, another inmate in prison killed him.

In the case of Michael Jones, the court considered whether someone who was found NGRI could be kept in a hospital longer than the person might have spent in prison had he or she been found guilty of the crime. Jones argued that he should be released; the Supreme Court disagreed. According to the court ruling, Jones could not be punished for the crime because his insanity left him legally blameless—this is the logic of the insanity defense. Jones would have been released from prison sooner had he pleaded guilty.

Jeffrey Dahmer, who admitted to butchering, cannibalizing, and having sex with the corpses of 15 boys and young men, was found guilty but mentally ill. (Reuters/Corbis Images.)

Clinical Case: Michael Jones

To illustrate the predicament that a person can get into by raising insanity as a condition for a criminal act, we consider a celebrated—some would call it infamous—Supreme Court case.[4]

Michael Jones was arrested, unarmed, on September 19, 1975, for attempting to steal a jacket from a department store in Washington, D.C. He was charged the next day with attempted petty larceny, a misdemeanor punishable by a maximum prison sentence of 1 year. The court ordered that he be committed to St. Elizabeth's Hospital for a determination of his competency to stand trial.

On March 2, 1976, almost six months after the alleged crime, a hospital psychologist reported to the court that Jones was competent to stand trial, although he had "schizophrenia, paranoid type." The psychologist also reported that the alleged crime resulted from Jones's condition, his paranoid schizophrenia. This comment is noteworthy because the psychologist was not asked to offer an opinion on Jones's state of mind during the crime, only on whether Jones was competent to stand trial. Jones then pleaded not guilty by reason of insanity. Ten days later, on March 12, the court found him NGRI and formally committed him to St. Elizabeth's Hospital for treatment of his mental disorder.

On May 25, 1976, a customary 50-day hearing was held to determine whether Jones should remain in the hospital any longer. A psychologist from the hospital testified that Jones still suffered from paranoid schizophrenia and was a danger to himself and to others. A second hearing was held on February 22, 1977, 17 months after Jones's commitment to St. Elizabeth's, for determination of competency. The defendant demanded release since he had already been hospitalized longer than the 1-year maximum sentence he would have served had he been found guilty of the theft of the jacket. The court denied the request and returned him to St. Elizabeth's.

In response to an appeal, the District of Columbia Court of Appeals agreed with the original court. Ultimately, in November 1982, more than seven years after his hospitalization, Jones's appeal to the Supreme Court was heard. On June 29, 1983, by a five-to-four decision, the Court affirmed the earlier decision: Jones was to remain at St. Elizabeth's. Jones was fully released from St. Elizabeth's in August 2004, 28 years after the crime!

The Court was also concerned about Jones's dangerousness. Jones argued in his petition to the Supreme Court that his theft of the jacket was not dangerous because it was not a violent crime. The Court stated, however, that for there to be violence in a criminal act, the act itself need not be dangerous. It cited a previous decision that a nonviolent theft of an article such as

[4] *Jones v. United States*, 463 U.S. 354 (1983).

a watch may frequently result in violence through the efforts of the criminal to escape, or of the victim to protect his or her property, or of the police to apprehend the fleeing thief.[5]

The dissenting justices of the Court commented that the longer someone such as Jones had to remain in the hospital, the harder it would be for him to demonstrate that he was no longer a dangerous person or mentally ill. Extended institutionalization would likely make it more difficult for him to afford medical experts other than those associated with the hospital and to behave like someone who was not mentally ill. Given that Jones remained in the hospital for 28 years, it would seem that the dissenting justices were correct.

Quick Summary

Insanity is a legal term, not a mental health term. Meeting the legal definition is not necessarily the same thing as having a diagnosable mental illness and vice versa. The insanity defense is the legal argument that a defendant should not be held responsible for an illegal act if it is attributable to mental illness that interferes with rationality or that results from some other excusing circumstance, such as not knowing right from wrong; the not guilty by reason of insanity (NGRI) plea signifies that an accused person should not be held responsible for the crime due to his or her mental illness. The guilty but mentally ill (GBMI) plea signifies that an accused person is legally guilty of a crime but can then, in theory, be committed to a prison hospital or other suitable facility for psychiatric treatment rather than to a regular prison for punishment.

The irresistible-impulse standard suggested that an impulse or drive that the person could not control compelled that person to commit the criminal act. The M'Naghten rule specified that a person could not distinguish right from wrong at the time of the crime because of the person's mental illness. The first part of the American Law Institute guidelines combines the M'Naghten rule and the concept of irresistible impulse. The second concerns those who are repeatedly in trouble with the law; they are not to be deemed mentally ill only because they keep committing crimes. The Insanity Defense Reform Act shifted the burden of proof from the prosecution to the defense, removed the irresistible impulse component, changed wording of substantial capacity, and specified that mental illness must be severe. The Jones case illustrates a number of the complexities associated with the insanity defense.

Check Your Knowledge 17.1 (Answers are at the end of the chapter.)

Match the statement with the correct insanity standard.

1. can't control behavior
2. found guilty
3. doesn't know right from wrong
4. affirmative defense

a. GBMI
b. NGRI
c. irrestible impulse
d. M'Naghten rule

Competency to Stand Trial

The insanity defense concerns the accused person's mental state at the time of the crime. An important consideration before deciding what kind of defense to adopt is whether the accused person is competent to stand trial at all. In the U.S. criminal justice system, **competency to stand trial** must be decided before it can be determined whether a persoon is responsible for the crime of which he or she is accused. It is possible for a person to be judged competent to stand trial and then be judged not guilty by reason of insanity.

The legal standard for being competent to stand trial has not changed since it was articulated by a 1960 U.S. Supreme Court decision:[6] "The test [is] whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and whether he has a rational as well as a factual understanding of the proceedings against him."

With the 1966 Supreme Court case *Pate v. Robinson*[7] as precedent, the defense attorney, prosecutor, or judge may raise the question of mental illness whenever there is reason to believe that

[5]*Overholser v. O'Beirne*, 302 F.2d 85, 861 (D.C. Cir. 1961).
[6]*Dusky v. United States*, 362 U.S. 402 (1960).
[7]*Pate v. Robinson*, 383 U.S. 375 (1966).

the accused person's mental condition might interfere with his or her upcoming trial. Another way to look at competency is that the courts do not want a person to be brought to trial **in absentia** ("not present"), which is a centuries-old principle of English common law that refers here to the person's mental state, not his or her physical presence. If, after examination, the person is deemed too mentally ill to participate meaningfully in a trial, the trial is delayed, and the accused person is placed in a hospital with the hope that means of restoring adequate mental functioning can be found.

If a court fails to order a hearing when there is evidence that raises a reasonable doubt about competency to stand trial, or if it convicts a legally incompetent defendant, there is a violation of due process.[8] Once competency is questioned, there must be a preponderance of evidence (see Table 17.3) showing that the defendant is competent to stand trial.[9] As just indicated, the test to be applied is whether the defendant is able to consult adequately with his or her lawyer and whether he or she can understand the proceedings.[10] The court has to consider evidence such as irrational behavior as well as any medical or psychological data that might bear on the defendant's competency.[11] However, analogous to the insanity defense, being deemed mentally ill does not necessarily mean that the person is incompetent to stand trial; a person with schizophrenia, for example, may still understand legal proceedings and be able to assist in his or her defense (Winick, 1997). In Focus on Discovery 17.1, we consider the case of Andrea Yates, who was found competent to stand trial despite clear agreement that she was mentally ill.

Being judged incompetent to stand trial can have severe consequences for the individual. Bail is automatically denied, even if it would be routinely granted had the question of incompetency not been raised. The person is usually kept in a hospital for the pretrial examination. During this period the accused person is supposed to receive treatment to render him or her competent to stand trial.[12] In the meantime, he or she may lose employment and undergo the trauma of being separated from family and friends and from familiar surroundings for months

Clinical Case: Yolanda

Yolanda, a 51-year-old African American woman, was arrested after taking a box of doughnuts from the local QuickMart. At the time of her arrest, she claimed she needed the doughnuts to feed the seven babies growing inside her. She said that Malcolm X was the father of her soon-to-be-born children and that she would soon assume the position of Queen of the New Cities. When asked what the New Cities were, she responded this was a new world order that would be in place following the alignment of the clouds with the planets Jupiter, Saturn, and Venus. Yolanda's public defender immediately realized that Yolanda was not ready for trial; she asked for a competency hearing and arranged for a psychologist to conduct an evaluation. Yolanda was diagnosed with schizophrenia, disorganized type, and her thought disturbance was found to be so profound that she was not able to understand that she had been charged with a crime. Furthermore, she was unable to help her attorney prepare a defense. Instead, Yolanda viewed her attorney as a threat to her unborn babies (she was not pregnant) and feared the attorney would keep her from assuming her rightful position as queen. At her competency hearing, the judge declared that Yolanda was not competent to stand trial and that she be committed to the local forensic hospital for a period of three months, after which another competency evaluation would be held.

At the hospital, Yolanda was prescribed Olanzapine, and her thinking became more coherent and organized after two months. One of the unit's psychologists worked with Yolanda, teaching her about the criminal justice system. She worked to help Yolanda understand what the charge of theft meant and what a defense attorney, prosecuting attorney, judge, and jury were. At the end of three months, a different psychologist evaluated Yolanda and recommended that she now be considered competent to stand trial. Yolanda's public defender came to the hospital and met with her to discuss the case. Yolanda was able to help her attorney by telling her about her past hospitalizations and treatment history for schizophrenia. Yolanda realized she was not pregnant but still held onto beliefs about the New Cities. Still, Yolanda understood that she had stolen the doughnuts and this was why she had to go to court. At her next competency hearing, Yolanda was deemed competent to stand trial. Two months later, she went to court again. This time, she entered a plea of NGRI. After a short trial, the judge accepted her NGRI plea and she returned to the forensic hospital. The treatment goals were now focused on helping Yolanda recover from schizophrenia, not on restoring her competency to stand trial.

[8]*United States v. White*, 887 F.2d 705 (6th Cir. 1989); *Wright v. Lockhart*, 914 F.2d 1093, cert. denied, 111 S.Ct. 1089 (1991).
[9]*United States v. Frank*, 956 F.2d 872, cert. denied, 113 S.Ct. 363 (1992); *United States v. Blohm*, 579 F.Supp. 495 (1983).
[10]*Frank*, 956 F.2d at 872; *Wright v. Lockhart*, 914 F.2d 1093 (8th Cir. 1990).
[11]*United States v. Hemsi*, 901 F.2d 293 (2d Cir. 1990); *Balfour v. Haws*, 892 F.2d 556 (7th Cir. 1989).
[12]*United States v. Sherman*, 912 F.2d 907 (7th Cir. 1990).

FOCUS ON DISCOVERY 17.1

Another Look at Insanity versus Mental Illness

On June 20, 2001, believing that her five children, ranging in age from six months to seven years, were condemned to eternal damnation, 37-year-old Andrea Yates, who lived with her husband and children in Houston, Texas, systematically drowned each child in a bathtub. As recounted on the CNN website:

> *. . . when the police reached [the] modest brick home on Beachcomber Lane in suburban Houston, they found Andrea drenched with bathwater, her flowery blouse and brown leather sandals soaking wet. She had turned on the bathroom faucet to fill the porcelain tub and moved aside the shaggy mat to give herself traction for kneeling on the floor. It took a bit of work for her to chase down the last of the children; toward the end, she had a scuffle in the family room, sliding around on wet tile. . . . She dripped watery footprints from the tub to her bedroom, where she straightened the blankets around the kids in their pajamas once she was done with them. She called 911 and then her husband. "It's time. I finally did it," she said before telling him to come home and hanging up.*

The nation was horrified by her actions, and in the months following the murders, information became known about Yates' frequent bouts of depression, especially after giving birth, as well as her several suicide attempts and hospitalizations for severe depression.

Eight months later her trial was held. The defense argued that she was mentally ill at the time of the murders—and for many periods of time preceding the events—and that also she have been unable to distinguish right from wrong when she put her children to death. The prosecution argued that she had known right from wrong and therefore should be found guilty. On two things the defense and the prosecution agreed: (1) she had murdered her children, and (2) she was mentally ill at the time of the murder. Where they disagreed was on the crucial question as to whether her mental illness entailed not being able to distinguish right or wrong, the familiar M'Naghten principle of criminal responsibility.

This trial shows the difficulty of making a successful insanity defense and is a vivid example of the critical difference between mental illness and insanity. No one disagreed that she was severely depressed, probably psychotic, when she killed her five small children. But, as we have seen, mental illness is not the same as legal insanity. Employing the right–wrong principle, the jury deliberated for only 3 hours and 40 minutes on March 12, 2002, and delivered a verdict of guilty. They had rejected the defense's contention that Ms. Yates could not distinguish right from wrong at the time of the crime. On March 15, the jury decided to spare her life and recommended to the presiding judge that she get life in prison, not being eligible for parole for 40 years.

The trial and the guilty verdict occasioned impassioned discussion in the media and among thousands of people. How could the jury not have considered her insane? If such a person is not insane, who could be judged to be so? Should the right–wrong M'Naghten principle be dropped from the laws of half the states in the United States? Didn't her phoning 911 to report what she had done prove that she knew she had done something very wrong? Didn't the careful and systematic way she killed her children reflect a mind that, despite her deep depression and delusional thinking, could formulate a complex plan and execute it successfully? Had she received proper treatment from psychiatrists, especially from the one who had recently taken her off the antidepressant medication that had been helping her and had sent her home without adequate follow-up?

Andrea Yates, who drowned her five children, pled NGRI. Although she was suffering from mental illness, her initial plea was unsuccessful because she was judged capable of knowing right from wrong. After the initial verdict was thrown out, her NGRI plea was successful in the second trial. (©AP/Wide World Photos.)

As it turns out, these questions were addressed in the Yates case after all. In January 2005, an appeals court overturned Yates's murder conviction because the jury had heard false testimony from one of the expert witnesses that may have unduly influenced their decision. The prosecution witness testified that Yates's behavior may have been influenced by an episode of the television show *Law and Order* that showed a woman with depression drowning her children, suggesting she knew right from wrong. However, there was no such episode on this television show, so Yates could not have been thus influenced. A new trial was conducted, and on July 26, 2006, after 3 days of deliberations, the new jury found Yates not guilty by reason of insanity. She was placed in a forensic hospital in Texas, and she will remain there until she is no longer considered dangerous.

or even years, perhaps making his or her emotional condition even worse and thus making it all the more difficult to show competency to stand trial. Until the 1970s, some people languished in prison hospitals for many years waiting to be found competent to stand trial.

A 1972 Supreme Court case, *Jackson v. Indiana*,[13] forced the states to a speedier determination of incompetency. The case concerned a deaf and mute man with mental retardation who

[13] *Jackson v. Indiana*, 406 U.S. 715 (1972).

was deemed not only incompetent to stand trial but unlikely ever to become competent. The Court ruled that the length of pretrial confinement must be limited to the time it takes to determine whether treatment during this detainment is likely to render the defendant competent to stand trial. If the defendant is unlikely ever to become competent, the state must, after this period, either institute civil commitment proceedings or release the defendant. Laws in most states define more precisely the minimal requirements for competency to stand trial, ending the latitude that has deprived thousands of people of their rights to due process (Fourteenth Amendment) and a speedy trial (Sixth Amendment). Defendants today cannot be committed for determination of competency for a period longer than the maximum possible sentence they face.[14]

Medication has had an impact on the competency issue. The concept of "synthetic sanity" (Schwitzgebel & Schwitzgebel, 1980) has been used to argue that if a drug, such as Thorazine, temporarily produces a bit of rationality in an otherwise incompetent defendant, the trial may proceed. The likelihood that the defendant will again become incompetent to stand trial if the drug is withdrawn does not disqualify the person from going to court.[15] However, the individual rights of the defendant are to be protected against forced medication, because there is no guarantee that such treatment would render the person competent to stand trial, and there is a chance that it might cause harm. A subsequent Supreme Court ruling[16] held that a criminal defendant generally cannot be forced to take medication in an effort to render him or her competent to stand trial. In general, the courts have responded to the existence of powerful psychoactive medications by requiring safeguards against their involuntary use to ensure that the defendant's civil rights are protected, even when a drug might restore legal competency to stand trial.[17]

In 2003, the Supreme Court ruled that forced medication to restore competency could be used only in very limited circumstances.[18] In this case, St. Louis dentist Charles Sell had been charged in 1997 with two different counts of fraud and with conspiring to kill a former employee and an FBI agent who arrested him. Sell was later diagnosed with delusional disorder and was found incompetent to stand trial. This was in essence a nonviolent crime, and the Supreme Court did not see that forced medication was justified in this case. The court ruled that forced medication could be used only if alternative treatments had failed; medication is likely to be effective; medication won't interfere with a person's right to defend him- or herself at trial, and there is an important government interest in trying the defendant for a serious crime.

If the defendant wishes, the effects of the medication must be explained to the jury, lest—if the defendant is pleading NGRI—the jury conclude from the defendant's relatively rational drug-produced demeanor that he or she could not have been insane at the time of the crime.[19] This requirement acknowledges that juries form their judgments of legal responsibility or insanity at least in part based on how the defendant appears during the trial. If the defendant appears healthy, the jury may be less likely to believe that the crime was an act of a disturbed mental state rather than of free will—even though an insanity defense has to do with the defendant's state of mind during the crime, not his or her psychological state during the trial.

Even if a person with a mental disorder is found competent to stand trial, that person may not be able to serve as his or her own defense attorney. A 2008 U.S. Supreme Court decision (*Indiana v. Edwards*) held that a judge may deny the right of self-reprensentation if it is clear that the defendant would not receive a fair trial. Focus on Discovery 17.2 discusses the unusual challenge posed by dissociative identity disorder in criminal commitments.

Insanity, Mental Retardation, and Capital Punishment

As we have just seen, an accused person's mental state can be taken into consideration to determine whether he or she is competent to stand trial and/or should be held legally responsible for a criminal act. On very rare occasions, the sanity or mental capacity of a person also becomes

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[14]*United States v. DeBellis*, 649 F.2d 1 (1st Cir. 1981); *State v. Moore*, 467 N.W. 2d 201 (Wis. Ct. App. 1991).
[15]*State v. Hampton*, 218 So.2d 311 (La. 1969); *State v. Stacy*, no. 446 (Crim. App., Knoxville, Tenn., August 4, 1977); *United States v. Hayes*, 589 F.2d 811 (1979).
[16]*Riggins v. Nevada*, 504 U.S. 127 (1992).
[17]*United States v. Waddell*, 687 F. Supp. 208 (1988).
[18]*Sell v. United States*, 539 U.S. 02-5664 (2003).
[19]*State v. Jojola*, 553 F.2d 1296 (N.M. Ct. App. 1976).

FOCUS ON DISCOVERY 17.2

Dissociative Identity Disorder and the Insanity Defense

Imagine that as you are having a cup of coffee one morning, you hear pounding at the front door. You hurry to answer and find two police officers staring grimly at you. One of them asks, "Are you Jane Smith?" "Yes," you reply. "Well, ma'am, you are under arrest for grand theft and for the murder of John Doe." The officer then reads you your Miranda rights against self-incrimination, handcuffs you, and takes you to the police station, where you are allowed to call your lawyer.

This would be a scary situation for anybody. What is particularly frightening and puzzling to you and your lawyer is that you have absolutely no recollection of having committed the crime that a detective later describes to you. You are horrified that you cannot account for the time period when the murder was committed—in fact, your memory is startlingly blank for that entire time. And, as if this were not bizarre enough, the detective then shows you a videotape in which you are clearly firing a gun at a bank teller during a holdup. "Is that you in the videotape?" asks the detective. You confer with your lawyer, saying that it certainly looks like you, including the clothes, but you are advised not to admit anything one way or the other.

Let's move forward in time now to your trial some months later. Witnesses have come forward and identified you beyond a reasonable doubt. There is no one you know who can testify that you were somewhere other than at the bank on the afternoon of the robbery and the murder. But did you murder the teller in the bank? You are able to assert honestly to yourself and to the jury that you did not. And yet even you have been persuaded that the person in the videotape is you—and that that person committed the robbery and the murder.

Because of the strange nature of the case, your lawyer arranged prior to the trial to have you interviewed by a psychiatrist and a clinical psychologist, both of them well-known experts in forensics. Through extensive questioning they have decided that you have dissociative identity disorder (DID, formerly called multiple personality disorder) and that the crimes were committed not by you, Jane Smith, but by your rather violent alter, Laura. Indeed, during one of the interviews, Laura emerged and boasted about the crime, even chuckling over the fact that you, Jane, would be imprisoned for it.

Can DID be an excusing condition for a criminal act? Should Jane Smith be held responsible for a crime committed by her alter, Laura?

In reviews of the DID literature and of its forensic implications, Elyn Saks (1997) of the University of Southern California Law Center argued that DID should be regarded as a special case in mental health law and that a new legal principle should be established. Her argument takes issue with legal practice that would hold a person with DID responsible for a crime as long as the personality acting at the time of the crime intended to commit it.

What is intriguing about Saks's argument is that she devotes a major portion of it to defining personhood. What is a person? Is a person the body we inhabit? Well, most of the time our sense of who we are as persons does not conflict with the bodies we have come to know as our own or rather, as us. But in DID there is a discrepancy. The body that committed the crimes at the bank was Jane Smith. But it was her alter, Laura, who committed the crimes. Saks argues that, peculiar as it may sound, the law should be interested in the body only as a container for the person. It is the person who may or may not be blameworthy, not the body. Nearly all the time they are one and the same, but in the case of DID they are not. In a sense, Laura committed the murder by using Jane's body.

Then is Jane blameworthy? The person Jane did not commit the crime; she did not even know about it. For the judge to sentence Jane—or, more specifically, the body in the courtroom who usually goes by that name—would be unjust, argues Saks, for Jane is descriptively innocent. To be sure, sending Jane to prison would punish Laura, for whenever Laura would emerge, she would find herself imprisoned. But what of Jane? Saks concludes that it is unjust to imprison Jane because she is not blameworthy. Rather, we must find her not guilty by reason of dissociative identity disorder and remand her for treatment of the disorder.

Dissociative identity disorder would not, however, be a justification for a verdict of NGRI if the alter that did not commit the crime was aware of the other alter's criminal intent and did not do anything to prevent the criminal act. Under these circumstances, argues Saks, the first alter would be complicit in the crime and would therefore be somewhat blameworthy. A comparison Saks draws is to Robert Louis Stevenson's fictional character of Dr. Jekyll and Mr. Hyde. Jekyll made the potion that caused the emergence of Mr. Hyde, his alter, with the foreknowledge that Hyde would do evil. So even though Jekyll was not present when Hyde was in charge, he would nonetheless be blameworthy because of his prior knowledge of what Hyde would do—not to mention that he, Jekyll, had concocted the potion that created his alter, Hyde.

Saks is optimistic about the effectiveness of therapy for DID and believes that people like Jane/Laura can be integrated into one personality and then released to rejoin society. Saks goes so far as to argue that people with DID who are judged dangerous but who have not committed a crime should be subject to civil commitment, even though this would be tantamount to preventive detention. In this way, she suggests, future crimes might be avoided.

Poster for the classic film about Jekyll and Hyde. (Jerry Ohlinger's Movie Material Store)

an issue after a conviction. The question is, should a person who is sentenced to be put to death (i.e., capital punishment) by the state have to be legally sane at the time of the execution? Furthermore, what if the person is deemed so mentally retarded as to not understand what is about to happen to him or her?

The question of insanity and capital punishment arose in April 1998 in California in the case of Horace Kelly, a 39-year-old man who had been found guilty of the rapes and murders of two women and the slaying of an 11-year-old boy in 1984. Although Kelly's mental state had not been an issue at the time of his trial, his lawyers argued—12 years later and just days before his scheduled execution by lethal injection—that his mental health had deteriorated during his imprisonment on death row to such an extent that one of his defense attorneys referred to him as a "walking vegetable." They made reference to a 1986 Supreme Court ruling[20] stating that it is a violation of the Eighth Amendment (which prohibits cruel and unusual punishment) for an insane individual to be executed.

Evidence of mental illness during Kelly's imprisonment included psychiatrists' reports of delusions, hallucinations, and inappropriate affect. He was also described by fellow inmates and by guards as hoarding his feces and smearing them on the walls of his prison cell. By 1995, after 10 years on death row, one court-appointed psychiatrist had concluded that Kelly was legally insane. On the other hand, another psychiatrist reported that when asked what being executed would mean for him, Kelly had given the rational reply that he would not be able to have a family; he was also able to name two of his victims and beat the psychiatrist had in several games of tic-tac-toe. A federal judge decided in June 1998 and the U.S. Supreme Court concurred in April 1999 to stay (delay) Kelly's execution and allow his lawyers to argue, among other things, that he should not be put to death because he was insane. After these arguments, Kelly's execution was permanently stayed.

In 2007, the U.S. Supreme Court overturned another death sentence in the case of Scott Panetti[21]. Panetti shot and killed his estranged wife's parents in 1992. He had been diagnosed with schiozophrenia and had been hospitalized numerous times prior to the murders. At his trial, Panetti served as his own attorney, dressed up as a cowboy (he had narrowly been deemed competent to stand trial). The court transcripts are filled with incoherent ramblings from him. For example, he tried to subpoena Jesus Christ. In his closing arguments, he said:

> *The ability to reason correctly. Common sense, the common sense, the horse sense. This is Texas and we're not talking loopholes and if we're talking—well, let's talk a lariat. Let's talk a catch rope . . .*

He was sentenced to death by a Texas court, and this sentence was upheld by an appeals court. The U.S. Supreme Court ruled, however, that Panetti could not understand why he was to be put to death given his mental state and returned the case for further evaluation of insanity by a lower court.

Eighteen of the 38 states that allow capital punishment already prohibit the execution of the people with mental retardation on Eighth Amendment grounds against cruel and unusual punishment. In 2002, the United States Supreme Court ruled in a six-to-three decision in the case of *Atkins v. Virginia* that capital punishment of those with mental retardation constitutes cruel and unusual punishment, which is prohibited by the Eighth Amendment. The Supreme Court left open the question of what constitutes mental retardation, however, leaving it up to the states to decide how to remain within the requirements of the Eighth Amendment. As illustrated in the case of Daryl Akins, the definitions of mental retardation can vary quite a bit from state to state.

If a person should not be executed due to insanity, what are the ethics of providing medications to improve a person's mental state? Increasing attention is being paid to this issue. In February 2002, for example, the Georgia Board of Pardons and Paroles threw out the death sentence of a convicted rapist and murderer on the grounds that he was delusional (note that he had not been found NGRI and that he had been on death row for nearly 16 years). What makes this case significant is that the person had been forced to take psychoactive medication that improved his mental condition enough to meet the federal standard that only a person who is legally sane can be executed (Weinstein, 2002).

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[20]*Ford v. Wainright*, 477 U.S. 399 (1986).

[21]*Panetti v. Quarterman*, 551 U. S. (2007)

Clinical Case: Daryl Atkins

Daryl Atkins was sentenced to death in Virginia for a kidnapping and murder he was convicted of in 1996. His IQ was rated at 59, which placed him in the range of the moderately retarded. His defense attorney argued that his intellectual limitations rendered capital punishment unconstitutional because he lacked understanding of the consequences of his actions and was therefore not as morally culpable for his acts as a person of normal intelligence.

Following the 2002 Supreme Court ruling (*Atkins v. Virginia*), the state of Virginia subsequently defined mental retardation as consisting of an IQ score of 70 or less along with difficulties in self-care and social interaction. In Virginia, a defendant must convince the jury of mental retardation using the standard "beyond a preponderance of the evidence" (see Table 17.3). Since 1998, Atkins had been given an IQ test at least four times. He scored below 70 on two testing occasions (scores of 59 and 67) and above 70 on two other testing occasions (scores of 74 and 76). In August 2005, a Virginia jury decided that Daryl Atkins did not meet Virginia's definition of mental retardation. Thus, even though the *Atkins* case effectively abolished the practice of executing people with mental retardation, Daryl Atkins could have been put to death in Virginia because the state jury's decision paved the way for the original death sentence to be carried out. However, in January 2008 a Virginia judge changed Atkins's death sentence to life imprisonment. The reason for this change was not due to any rethinking of Atkins's mental capacity. Rather, it was due to prosecutorial misconduct (improper witness coaching) that was revealed by one of the attorneys.

Check Your Knowledge 17.2

True or false?

1. The *Jackson* case established that people who will not be restored to competency should be found NGRI.
2. To be competent to stand trial, a person must be able to understand the charges and assist his or her attorney.
3. The Supreme Court ruled that executing prisoners with mental illness constitutes cruel and unusual punishment.

Civil Commitment

Historically, governments have had a duty to protect their citizens from harm. We take for granted the right and duty of government to set limits on our freedom for the sake of protecting us. Few drivers, for example, question the legitimacy of the state's imposing limits on them by providing traffic signals that often make them stop when they would rather go. Government has a long-established right as well as an obligation to protect us both from ourselves—the *parens patriae*, "power of the state"—and from others—the police power of the state. Civil commitment is one further exercise of these powers.

In virtually all states, a person can be committed to a psychiatric hospital against his or her will if a judgment is made that he or she is (1) mentally ill and (2) a danger to self—that is, the person is suicidal or unable to provide for the basic physical needs of food, clothing, and shelter—or to others (Perlin, 1994). At present, dangerousness to others is more often the principal criterion in court rulings that point to imminent dangerousness as (e.g., the person is right on the verge of committing a violent act).[22] In some states, a finding of imminent dangerousness must be evidenced by a recent overt act, attempt, or threat; however, there are some states that do not require an overt act [*In Re: Albright*, 836 P.2d 1 (Kan. App. 1992)]. Such commitment is supposed to last for only as long as the person remains dangerous.[23]

[22] *Suzuki v. Yuen*, 617 F.2d 173 (9th Cir. 1980).
[23] *United States v. DeBellis*, 649 F.2d 1 (1st Cir. 1981).

Specific commitment procedures generally fit into one of two categories, formal and informal. Formal (or judicial) commitment is by order of a court. It can be requested by any responsible citizen—usually the police, a relative, or a friend—seeks the commitment. If a judge believes that there is a good reason to pursue the matter, he or she will order a mental health examination. The person has the right to object to these attempts to "certify" him or her, and a court hearing can be scheduled to allow the person to present evidence against commitment.

Informal, emergency commitment of people with mental illness can be accomplished without initially involving the courts. For example, if a hospital administrative board believes that a voluntary patient requesting discharge is too mentally ill and dangerous to be released, it is able to detain the patient with a temporary, informal commitment order.

Any person acting in an out-of-control, dangerous fashion may be taken immediately to a psychiatric hospital by the police. Perhaps the most common informal commitment procedure is the 2PC, or two physicians' certificate. In most states, two physicians, not necessarily psychiatrists, can sign a certificate that allows a person to be incarcerated for some period of time, ranging from 24 hours to as long as 20 days. Detainment beyond this period requires formal judicial commitment.

Civil commitment affects far more people than criminal commitment. It is beyond the scope of this book to examine in detail the variety of state civil commitment laws and regulations; each state has its own, and they are in almost constant flux. Our aim is to present an overview that will provide a basic understanding of the issues and of current directions of change.

Preventive Detention and Problems in the Prediction of Dangerousness

The perception is widespread that people with mental illness account for a significant proportion of the violence that besets contemporary society, but this is not the case (Bonta, Law, & Hanson, 1998; Monahan, 1992). Only about 3 percent of the violence in the United States is clearly linked to mental illness (Swanson et al., 1990). Moreover, about 90 percent of people diagnosed with psychotic disorders (primarily schizophrenia) are not violent (Swanson et al., 1990). People with mental illness—even allowing for their relatively small numbers—do not account for a large proportion of violent offenses, especially when compared with people who abuse drugs or alcohol and people who are in their teens and twenties, are male, and are poor (Corrigan & Watson, 2005; Mulvey, 1994). The MacArthur Violence Risk Assessment Study, a large prospective study of violent behavior among persons recently discharged from psychiatric hospitals, found that people with mental illness who were not substance abusers were no more likely to engage in violence than are people without mental illness who were not substance abusers (Steadman et al., 1998). Also, when people with mental illness do act aggressively, it is usually against family members or friends, and the incidents tend to occur at home (Steadman et al., 1998). Additional findings from the MacArthur study indicated that people with delusions were not more violent than people without delusions, regardless of whether they had comorbid substance abuse (Appelbaum, Robbins, & Monahan, 2000). However, men with threat delusions were more likely to be violent than men without threat delusions or women with any type of delusion (Teasdale, Silver, & Monahan, 2006). Another analysis from the study found that people with mental illness reported more violent thoughts while in the

People with mental illness are not necessarily more likely to be violent than people without mental illness, contrary to the way movies often portray people with mental illness. (The Kobal Collection, Ltd.)

hospital compared to people not in the hospital (Grisso et al, 2000). However, these people were not necessarily more likely to actually be violent once they left the hospital. Actual violent behavior was found only among a subsample of people with mental illness (e.g., those with a diagnosis of substance abuse or those who had severe symptoms and persistent violent thoughts). By and large, then, the general public is seldom affected by violence from people with mental illness, even though certain people with mental illness can and will be violent.

The Prediction of Dangerousness Civil commitment is necessarily a form of preventive detention; the prediction is made that a person judged mentally ill may in the future behave in a dangerous manner and should therefore be detained. But the entire U.S. legal and constitutional system is organized to protect people from preventive detention. Thus, unless mental illness comes into the picture, a person can generally be imprisoned only after having been found guilty of committing a crime (or, if accused and not yet convicted, denied bail if the crime was especially heinous and if the person poses a risk of leaving the jurisdiction to avoid trial). Furthermore, ordinary prisoners are routinely released from prison even though statistics show that many will commit additional crimes.

But what if a person openly threatens to inflict harm on others, such as an individual who for an hour each day stands in the street and shouts threats to people in a nearby apartment house? Does the state have to wait until the person acts on the threats? Usually not. In such a case the civil commitment process can be brought into play if the person is deemed not only an imminent danger to others but also mentally ill (Perlin, 1994).

The likelihood of committing a dangerous act is central to civil commitment, but is dangerousness easily predicted? Early studies examining the accuracy of predictions that a person would commit a dangerous act found that mental health professionals were poor at making this judgment (e.g., Kozol, Boucher, & Garofalo, 1972; Monahan, 1973, 1976), but these studies had several methodological problems (Monahan, 1978).

Newer research suggests that greater accuracy can be achieved than previously assumed in predicting dangerousness in the longer term (Campbell, Stefan, & Loder, 1994; Monahan, 1984; Monahan & Steadman, 1994; Steadman et al., 1998). Violence prediction is most accurate under the following conditions:

- If a person has been repeatedly violent in the recent past, it is reasonable to predict that he or she will be violent in the near future unless there have been major changes in the person's attitudes or environment.
- If violence is in the person's distant past, and if it was a single but very serious act, and if that person has been incarcerated for a period of time, then violence can be expected on release if there is reason to believe that the person's predetention personality and physical abilities have not changed and if the person is going to return to the same environment in which he or she was previously violent.
- Even with no history of violence, violence can be predicted if the person is judged to be on the brink of a violent act, for example, if the person is pointing a loaded gun at an occupied building.

As noted earlier, the presence of substance abuse significantly raises the rate of violence, and this is true for people with and without other mental disorders (Gendreau, Little, & Goggin, 1996; Steadman et al., 1998).

Violence among people with mental illness is often associated with medication noncompliance (Monahan, 1992; Steadman et al., 1998). **Outpatient commitment** is one way of increasing medication compliance. It is an arrangement whereby a patient is allowed to leave the hospital but must live in a halfway house or other supervised setting and report to a mental health agency frequently. To the extent that outpatient commitment increases compliance with medication regimens and other mental health treatment—and evidence indicates that it does (Munetz et al., 1996)—we can expect violence to be reduced. Indeed, support services, such as halfway houses, can markedly reduce the chances that a person who might otherwise be prone to committing a violent act will actually commit one (Dvoskin &

Steadman, 1994). For a discussion of therapists' responsibilities to predict dangerousness, see Focus on Discovery 17.3.

Toward Greater Protection of Patients' Rights

The U.S. Constitution is a remarkable document. It lays down the basic duties of elected federal officials and guarantees a set of civil rights. But there is often some distance between the abstract delineation of a civil right and its day-to-day implementation. Moreover, judges must interpret the Constitution as it bears on specific contemporary problems. Since nowhere in this cornerstone of U.S. democracy is there specific mention of people with mental illness, lawyers and judges interpret various sections of the document to justify what they consider necessary in society's treatment of people whose mental health is in question.

Beginning in the 1970s, a number of court decisions were rendered to protect people from being involuntarily hospitalized unless absolutely necessary. For example, a 1976 federal court decision in Wisconsin, *Lessard v. Schmidt*,[24] gives a person threatened with civil commitment the right to timely written notice of the proceeding, opportunity for a hearing with counsel, the right to have the hearing decided by a jury, Fifth Amendment protection against self-incrimination, and other similar procedural safeguards already accorded defendants in criminal actions, including being present at any hearing to decide the need for commitment.[25] Such protections are to be provided even under emergency commitment conditions.[26] A 1979 Supreme Court decision, *Addington v. Texas*,[27] further provides that the state must produce clear and convincing evidence that a person is mentally ill and dangerous before he or she can be involuntarily committed to a psychiatric hospital. In 1980, the Ninth Circuit Court of Appeals ruled that this danger must be imminent.[28] Clearly, the intent is to restrict the state's power to curtail individual freedoms because of mental illness. Although protection of the rights of people with mental illness adds to the burden of both civil courts and state and county mental hospital staffs, it is a price a free society must pay. Being hospitalized against one's wishes is less likely today, in large part due to changes in health care that emphasize outpatient care over inpatient care. In fact, it is increasingly difficult to hospitalize a patient today who is in real need of at least a short hospital stay. However, many rights of people with mental illness are still curtailed. An analysis of mental health–related bills introduced in state legislatures in 2002 (Corrigan et al., 2005) found that 75 percent of these contracted liberties of people with mental illness (e.g., allowing involuntary medication) and 33 percent contracted privacy rights (e.g., sharing mental health records in the interest of public safety) (see also Focus on Discovery 1.1 in Chapter 1).

We turn now to a discussion of several issues and trends that revolve around the protections provided to those with mental disorders: the principle of the least restrictive alternative; the right to treatment; the right to refuse treatment; and, finally, the way in which these several themes conflict in efforts to provide humane mental health treatment while respecting individual rights. We will see that competing interests operate to create a complex and continually changing picture.

Least Restrictive Alternative As noted earlier, civil commitment rests on presumed dangerousness, a condition that may vary depending on the circumstances. A person may be deemed dangerous if living in an apartment by himself or herself, but not dangerous if living in a residential treatment home and taking prescribed medications every day under medical supervision. The **least restrictive alternative** to freedom is to be provided when treating people with mental disorders and protecting them from harming themselves and others. A number of court rulings require that only those people who cannot be adequately looked after in less restrictive settings be placed in hospitals.[29] In general terms, mental health professionals have to provide the treatment that restricts the patient's liberty to the least possible degree while remaining workable.[30] It is unconstitutional to

[24]*Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wisc. 1972), vacated and remanded on other grounds, 94 S.Ct. 713 (1974), reinstated in 413 F.Supp. 1318 (E.D. Wisc. 1976).
[25]*In Re: Lawaetz* 728 F.2d 225 (3d Cir. 1984).
[26]*Doremus v. Farrell*, 407 F.Supp. 509 (1975).
[27]*Addington v. Texas*, 441 U.S. 418 (1979).
[28]*Suzuki v. Yuen*, 617 F.2d at 173.
[29]*Lake v. Cameron*, 267 F. Supp 155 (D.C. Cir. 1967); *Lessard*, 349 F. Supp. at 1078.
[30]*In Re: Tarpley*, 556 N.E.2d, superseded by 581 N.E.2d 1251 (1991).

FOCUS ON DISCOVERY 17.3

The *Tarasoff* Case—The Duty to Warn and to Protect

The client's right to privileged communication—the legal right of a client to require that what goes on in therapy remain confidential—is an important protection, but it is not absolute. Society has long stipulated certain conditions in which confidentiality in a relationship should not be maintained because of the harm that can befall others. A famous California court ruling in 1974[a] described circumstances in which a therapist not only may but *must* breach the sanctity of a client's communication. First, we describe the facts of the case.

Clinical Case

In the fall of 1968, Prosenjit Poddar, a graduate student from India studying at the University of California at Berkeley, met Tatiana (Tanya) Tarasoff at a folk dancing class. They saw each other weekly during the fall, and on New Year's Eve she kissed him. Poddar interpreted this act as a sign of formal engagement (as it might have been in India, where he was a member of the Harijan, or "untouchable," caste). But Tanya told him that she was involved with other men and indicated that she did not wish to have an intimate relationship with him.

Poddar was depressed as a result of the rebuff, but he saw Tanya a few times during the spring (occasionally tape-recording their conversations in an effort to understand why she did not love him). Tanya left for Brazil in the summer, and Poddar, at the urging of a friend, went to the student health facility, where a psychiatrist referred him to a psychologist for psychotherapy. When Tanya returned in October 1969, Poddar discontinued therapy. Based in part on Poddar's stated intention to purchase a gun, the psychologist notified the campus police, both orally and in writing, that Poddar was dangerous and should be taken to a community mental health center for psychiatric commitment.

The campus police interviewed Poddar, who seemed rational and promised to stay away from Tanya. They released him and notified the health service. No further efforts at commitment were made because the supervising psychiatrist apparently decided that there was no need and, as a matter of confidentiality, requested that the letter to the police as well as certain therapy records be destroyed.

On October 27, Poddar went to Tanya's home armed with a pellet gun and a kitchen knife. She refused to speak to him. He shot her with the pellet gun. She ran from the house; he pursued, caught, and repeatedly and fatally stabbed her. Poddar was found guilty of voluntary manslaughter rather than first- or second-degree murder. The defense established with the aid of the expert testimony of three psychiatrists that Poddar's diminished mental capacity, paranoid schizophrenia, precluded the malice necessary for first- or second-degree murder. After his prison term, he returned to India, where, according to his own report, he is happily married (Schwitzgebel & Schwitzgebel, 1980, p. 205).

Under the privileged communication statute of California, the counseling center psychologist properly breached the confidentiality of the professional relationship and took steps to have Poddar civilly committed, for he judged Poddar to be an imminent danger. Poddar had stated that he intended to purchase a gun, and by his other words and actions he had convinced the therapist that he was desperate enough to harm Tarasoff. What the psychologist did not do, and what the court decided he should have done, was to warn the likely victim, Tanya Tarasoff, that her former friend had bought a gun and might use it against her. As stated by the California Supreme Court in *Tarasoff*: "Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victims of that danger." The *Tarasoff* ruling requires clinicians, in deciding when to violate confidentiality, to use the very imperfect skill of predicting dangerousness. Since the original ruling, it has been extended in several ways.

Extending Protection to Foreseeable Victims

A subsequent California court ruling[b] held by a bare majority that foreseeable victims include those in close relationship to the identifiable victim. In this instance, a mother was hurt by a shotgun fired by the dangerous patient, and her 7-year-old son was present when the shooting took place. The boy later sued the psychologists for damages brought on by emotional trauma. Since a young child is likely to be in the company of his or her mother, the court concluded in *Hedlund* that the *Tarasoff* ruling extended to the boy.

Extending Protection Further to Potential Victims

A 1983 decision of a federal circuit court in California[c] ruled that Veterans Administration psychiatrists should earlier have warned the murdered lover of an outpatient, Phillip Jablonski, that she was a foreseeable victim, even

[a] *Tarasoff v. Regents of the University of California,* 529 P.2d 553 (Cal. 1974), vacated, reheard in bank, and affirmed, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). The 1976 California Supreme Court ruling was by a four-to-three majority.
[b] *Hedlund v. Superior Court,* 34 Cal.3d 695 (1983).
[c] *Jablonski by Pahls v. United States,* 712 F.2d 391 (1983).

confine a person with mental illness who is nondangerous and who is capable of living on his or her own or with the help of willing and responsible family or friends.[31] Of course, this principle has meaning only if society provides suitable residences and treatments, which rarely happens.

Right to Treatment Another aspect of civil commitment that has come to the attention of the courts is the so-called right to treatment. If a person is deprived of liberty because he or she is mentally ill and is a danger to self or others, is the state not required to provide treatment to alleviate these problems? This important question has been the subject of several court cases.

[31] *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

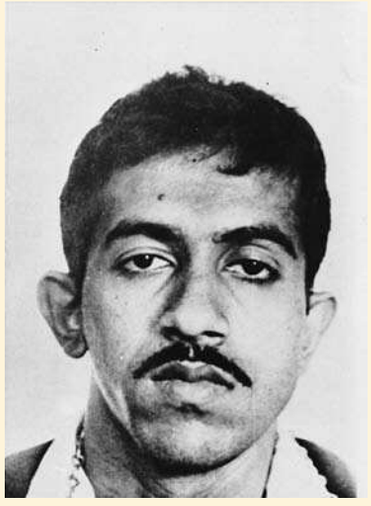
though the patient had never made an explicit threat against her to the therapists. The reasoning was that Jablonski, having previously raped and otherwise harmed his wife, would likely direct his continuing "violence . . . against women very close to him" (p. 392).

The court also found the hospital psychiatrists negligent in not obtaining Jablonski's earlier medical records. These records showed a history of harmful violent behavior, which, together with the threats his lover was complaining about, should have moved the hospital to institute emergency civil commitment. The court ruled that the failure to warn was a proximate or immediate cause of the woman's murder. Proper consideration of the medical records, said the judge, would have convinced the psychiatrists that Jablonski was a real danger to others and should be committed.

This broadening of the duty to warn and protect has placed mental health professionals in California in an even more difficult predicament, for the potentially violent patient need not even mention the specific person he or she may harm. It is up to the therapist to deduce who are possible victims, based on what he or she can learn of the patient's past and present circumstances.

Extending Protection to Potential Victims as Yet Unknown

Many courts have augmented the duty to warn and protect to foreseeable victims of child abuse and even to possible victims as yet unknown. In one such case,[d] a medical student underwent his own psychoanalysis as one of the requirements to become a psychoanalyst. During the therapy, he admitted that he was a pedophile. Later in his training, he saw a male child as a patient as part of his psychiatric residency and sexually assaulted the boy. The court decided that the training analyst, who was not only the student's therapist but also an instructor in the school, had reason to know that his patient-student "posed a specific threat to a specific group of persons, namely future minor patients, with whom [the student] would necessarily interact as part of his training" (p. 8). Even though the student did not have child patients at the time he revealed his pedophilia (and thus there were no specific people whom the instructor could warn and take steps to protect), the supervisor—as his instructor, not just his therapist—was judged to have sufficient control over the student's professional training and activities (specifically, the power to keep the student from pursuing his interests in working with children) for the *Tarasoff* ruling to be relevant.



Prosenjit Poddar was convicted of manslaughter in the death of Tatiana Tarasoff. The court ruled that his therapist, who had become convinced Poddar might harm Tarasoff, should have warned her of the impending danger. (©AP/Wide World Photos.)

Extending Protection Based on Families' Reports

In 2004, a California appeals court ruled that therapists have a duty to warn a possible victim if the threat is reported by a member of the patient's family.[e] In this case, a therapist learned about a threat not from his patient but from a family member of his patient. His patient revealed to his parents that he had thoughts of killing his ex-girlfriend's new boyfriend. The parents contacted the therapist about this threat. The therapist did not contact the new boyfriend, who was later killed by his patient. The parents of the boyfriend sued for wrongful death, saying the therapist should have warned their son. The court agreed and ruled that a close family member is in essence a part of the patient, and thus a therapist does have a duty to warn potential victims if notified by a close family member of a patient.

Extending Protection to Property

Tarasoff was further extended by a Vermont State Supreme Court ruling, *Peck v. Counseling Service of Addison County*,[f] which held that a mental health practitioner has a duty to warn a third party if there is a danger of damage to property. The case involved a 29-year-old male patient who, after a heated argument with his father, told his therapist that he wanted to get back at his father and indicated that he might do so by burning down his father's barn. He proceeded to do just that. No people or animals were harmed in the fire; the barn housed no animals and was located 130 feet away from the parents' home. The court's conclusion that the therapist had a duty to warn was based on reasoning that arson is a violent act and therefore a lethal threat to people who may be in the vicinity of the fire.

[d] *Almonte v. New York Medical College,* 851 F. Supp. 34, 40 (D. Conn. 1994) (denying motion for summary judgment).
[e] *Ewing v. Goldstein,* Cal. App. 4th B163112.2d. (2004).
[f] *Peck v. Counseling Service of Addison County,* 499 A.2d 422 (Vt. 1985).

The right to treatment was extended to all civilly committed patients in a landmark 1972 case, *Wyatt v. Stickney*.[32] In that case, an Alabama federal court ruled that treatment is the only justification for the civil commitment of people with mental illness to a state mental hospital. As stated by Judge Frank Johnson, "to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." People with mental illness who are hospitalized "have a constitutional right to receive such individual treatment as

[32] *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971), enforced in 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373, 379 (M.D. Ala. 1972), *aff'd sub nom Wyatt v. Anderholt*, 503 F.2d 1305 (5th Cir. 1974).

Civil commitment supposedly requires that the person be dangerous. But in actual practice, the decision to commit can be based on a judgment of severe disability, as in the case of some people who are homeless. (Corbis Images.)

will give each of them a realistic opportunity to be cured or to improve his or her mental condition." This ruling, upheld on appeal, is frequently cited as ensuring protection of people confined by civil commitment, at least to the extent that the state cannot simply put them away without meeting minimal standards of care. In fact, when people with mental retardation (as opposed to those judged to be mentally ill) are released from an institution, health officials are not relieved of their constitutional duty to provide reasonable care and safety as well as appropriate training.[33]

The *Wyatt* ruling was significant, because previously the courts had asserted that it was beyond their competence to pass judgment on the care given to people with mental illness, and they had assumed that mental health professionals possessed special and exclusive knowledge about psychopathology and its treatment. Repeated reports of abuses, however, gradually prodded the judicial system to rule on what went on within the walls of psychiatric hospitals. The *Wyatt* decision set forth very specific requirements for psychiatric hospitals—for example, dayrooms of at least 40 square feet, curtains or screens for privacy in multipatient bedrooms, and no physical restraints except in emergency situations. The ruling also specified how many mental health professionals ought to be in the hospital. When the *Wyatt* action was taken, Alabama state mental facilities averaged one physician per 2,000 patients, an extreme situation.[34] After *Wyatt*, there were to be at least two psychiatrists for every 250 patients. Similar protections have been extended to people with mental retardation.[35]

The *Wyatt* ruling appeared to have been weakened by a later Supreme Court decision, *Youngberg v. Romeo*,[36] regarding the treatment of a boy with mental retardation, Nicholas Romeo, who had been placed in physical restraints on occasion to keep him from hurting himself and others. While maintaining that people with mental illness have a right to reasonable care and safety, this 1982 decision deferred to the professional judgment of the mental health professionals responsible for the boy. However, the 1990 *Thomas S. v. Flaherty* decision held that professional judgment is not the final word when it comes to constitutional protections of people with mental retardation in public hospitals, a ruling more in line with *Wyatt*.

In a celebrated case, *O'Connor v. Donaldson*,[37] that eventually went to the Supreme Court in 1975, a civilly committed patient sued two state hospital doctors for his release and for monetary damages on the grounds that he had been kept against his will for 14 years without being treated and without being dangerous to himself or to others. In January 1957, at the age of 49, Kenneth Donaldson was committed to the Florida state hospital at Chattahoochee on petition of his father, who felt that his son was delusional. At a brief court hearing, a county judge found that Donaldson had paranoid schizophrenia and committed him for "care, maintenance, and treatment."

In 1971, Donaldson sued Dr. O'Connor, the hospital superintendent, and Dr. Gumanis, a hospital psychiatrist, for release. Evidence presented at the trial in a U.S. District Court in Florida indicated that the hospital staff could have released Donaldson at any time after they determined that he was not a dangerous person. Testimony made it clear that at no time during his hospitalization had Donaldson's conduct posed any real danger to others or to himself. Furthermore, just before his commitment in 1957 he had been earning a living and taking adequate care of himself (and immediately on discharge he secured a job in hotel administration). Nonetheless, O'Connor had repeatedly refused the patient's requests for release, feeling it was his duty to determine whether a committed patient could adapt successfully outside the hospital. His judgment was that Donaldson could not. In deciding the question of dangerousness on the basis of how well the patient could live outside the institution, O'Connor was applying a more restrictive standard than that required by most state laws.

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[33] *Thomas S. v. Flaherty*, 902 F.2d 250, cert. denied, 111 S.Ct. 373 (1990).

[34] The underlying assumption is that patients civilly committed to public mental hospitals will receive adequate care, but the evidence for this level of care is weak. Even though the extremely negligent conditions that the *Wyatt* decision remedied in Alabama are seldom found today, it is questionable, argued Morse (1982c), whether forced hospitalization benefits patients. At the very least, however, public mental hospitals can provide shelter, food, protection, and custodial care, which many deinstitutionalized patients lack.

[35] *Feagley v. Waddill*, 868 F.2d 1437 (5th Cir. 1989).

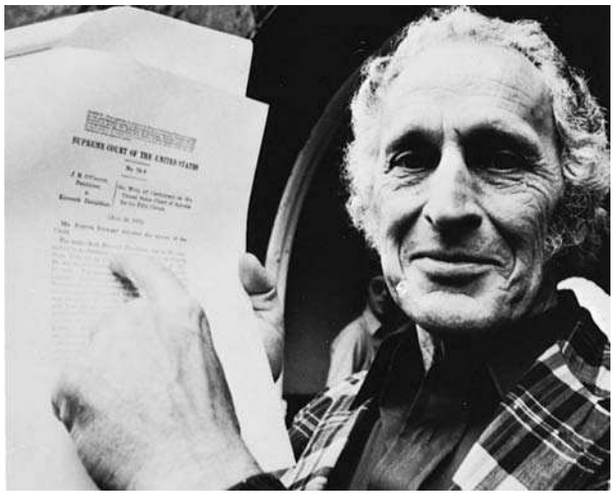
[36] *Youngberg v. Romeo*, 102 S.Ct. 2452 (1982).

[37] *O'Connor v. Donaldson*, 95 S.Ct. 2486 (1975).

The evidence indicated that Donaldson received only custodial care during his hospitalization. No treatment that could conceivably alleviate his assumed mental illness was undertaken. The therapy that O'Connor claimed Donaldson was undergoing consisted of being kept in a large room with 60 other patients. Donaldson had been denied privileges to stroll around the hospital grounds or even to discuss his case with Dr. O'Connor. O'Connor also regarded as delusional Donaldson's expressed desire to write a book about his hospital experiences (which Donaldson did after his release; the book sold well).

The Supreme Court ruled on June 26, 1975, that "a State cannot constitutionally confine . . . a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." In 1977, Donaldson settled for $20,000 from Dr. Gumanis and from the estate of Dr. O'Connor, who had died during the appeals process.

Because of this decision, a committed patient's status must be periodically reviewed, for the grounds on which a patient was committed cannot be assumed to continue in effect forever. This position seems straightforward enough, yet it may still be overlooked. For example, a 1986 court decision involved a woman with mental retardation who had spent her entire adult life in a state institution after having been committed at age 15; during her 20 years of confinement, she was never given a hearing to reconsider the grounds for the original commitment.[38]



Kenneth Donaldson, displaying a copy of the Supreme Court opinion stating that nondangerous people with mental illness cannot be confined against their will under civil commitment. (©AP/Wide World Photos.)

Right to Refuse Treatment Does a committed patient have the right to refuse treatment or a particular kind of treatment? The answer is yes, but with qualifications.

The right of committed patients to refuse medication is hotly debated. Psychiatrist E. Fuller Torrey (1996) asserts that because many people with mental illness have no insight into their condition, they believe they do not need any treatment and thus subject themselves and their loved ones to sometimes desperate and frightening situations by refusing medication or other modes of therapy, most of which involve hospitalization. Torrey's arguments plead for consideration of the costs of untreated mental illness.

On the other hand, there are many arguments against forcing a person to take medications. The side effects of most antipsychotic drugs are often aversive to the patient and are sometimes harmful and irreversible in the long run. As many as one-third of people with mental illness who take medications may not benefit from them.

Some court decisions illustrate the difficult issues that arise when the right to refuse treatment is debated. In a 1979 decision on some cases in which "unjustified polypharmacy" and "force or intimidation" had allegedly been applied without due consideration for the serious negative side effects of medications, the judge in a New Jersey federal district court concluded that medications can actually inhibit recovery and that, therefore, except in emergencies, even an involuntarily committed patient can refuse to take them, based on the rights of privacy (First Amendment) and due process (Fourteenth Amendment).[39] The judge ordered that advocates be available in each public hospital to help patients exercise the right to refuse treatment and that a listing of all the side effects of the medications that, might be given to the patients be posted in each hospital. In a reconsideration of this case, however, the judge stated that the opinion of the health professional must take precedence over the right to refuse treatment when patients are a danger to themselves or to others, in other words, in emergency situations.[40]

The question of the right to refuse medication continues to be the subject of lawsuits. Although there is inconsistency across jurisdictions and the forensic picture is always changing, there is a trend toward granting even involuntarily committed patients certain rights to refuse medication, based on the constitutional protections of freedom from physical invasion, freedom of thought, and the right to privacy.[41] In an extension of the least-restrictive-treatment principle, the court in *United States v. Charters* ruled that the government cannot force

[38]*Clark v. Cohen*, 794 F.2d 79, cert. denied, 479 U.S. 962 (1986).
[39]*Rennie v. Klein*, Civil Action No. 77-2624, Federal District Court of New Jersey, 14 September 1979.
[40]*Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983).
[41]*United States v. Charters*, 829 F.2d 479 (1987); *United States v. Watson*, 893 F.2d 970 (1990).

antipsychotic drugs on a person only on the supposition that at some future time he or she might become dangerous. The threat to the public safety has to be clear and imminent to justify the risks and restrictions that such medications pose, and it must be shown that less intrusive intervention will not likely reduce impending danger to others. In other words, forcible medication necessarily restricts liberty in addition to whatever physical risks it could bring; there has to be a very good reason to deprive a person of liberty and privacy via such intrusive measures. For example, a ruling in favor of forcible medication was made in a case of a person who had been threatening to assassinate the president of the United States. He posed a threat to his own safety, and he could be shown by clear and convincing evidence to be seriously mentally impaired.[42] Decisions of health professionals are nevertheless subject to judicial review.[43]

When someone already hospitalized is believed to be too psychotic to give informed consent about a treatment, mental health law sometimes invokes the doctrine of substituted judgment, the decision that the patient would have made if he or she had been able or competent to make a decision.[44] This principle creates as many problems as it solves. Deciding when a patient is competent to refuse treatment is one of the most controversial topics in the mental health law literature (e.g., Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1991; Winick, 1997).

To complicate matters even further, research findings indicate that many hospitalized patients, although showing impairment in their ability to think and make decisions, nonetheless demonstrate enough legally relevant abilities to be considered competent to participate in treatment decisions. Specifically, they have the ability to state a choice, to understand relevant information, to understand the nature of the situation they are in, and to think reasonably about the information pertaining to their treatment. For example, people diagnosed with schizophrenia that initially show major cognitive impairments that can interfere with their capacity to make treatment decisions for themselves usually improve enough after a few weeks of medication to be able to participate in decisions about their future therapy (Appelbaum & Grisso, 1995; Applebaum et al., 1999).

Rights to Treatment, to Refuse Treatment, and to Be Treated in the Least Restrictive Setting—Can They Be Reconciled? We have reviewed several legal principles that guide the courts and mental health professionals in meeting their constitutional obligations to civilly committed patients. Actions taken to implement one principle may conflict with another, however. The basic question is whether the right to be treated in the least restrictive fashion can be reconciled with both the right to treatment and the right to refuse treatment.

One approach to the conflict between right to treatment and right to refuse treatment is the so-called **advanced directive**, a legal document modeled after living wills. An advanced directive is composed by people who are legally competent and able to make decisions and specify how they want to be treated in the event that, sometime in the future, they need psychological or medical therapy but are mentally unfit to make decisions bearing on their therapy. The document may state what procedures the person consents to or refuses. Or the document may name another person to make such decisions. Many states now have laws that make such documents legally binding.

The use of advanced directives may enable people who are psychologically troubled but still competent to have more power over their future health care. But can such people really know what they will want or need if and when they become legally incompetent in the future? We can expect the debates on this issue of patient autonomy to continue.

Deinstitutionalization, Civil Liberties, and Mental Health

Court rulings such as *Wyatt v. Stickney* and *O'Connor v. Donaldson* put mental health professionals on notice to be careful about keeping people in psychiatric hospitals against their will and to attend more to the specific treatment needs of people with mental illness. Pressure was placed

[42] *Dautremont v. Broadlawns Hospital*, 827 F.2d 291 (8th Cir. 1987).
[43] *United States v. Charters*, 863 F.2d 302, cert. denied, 494 U.S. 1016 (1990).
[44] *Guardianship of Weedon*, 565 N.E. 2d 432, 409 Mass. 196 (1991).

on state governments to upgrade the quality of care in hospitals. In view of the abuses that have been documented in hospital care, these are surely encouraging changes. But the picture is not all that rosy. For judges to declare that patient care must meet certain minimal standards does not automatically translate into realization of that praiseworthy goal. Money is not in unlimited supply, and the care of people with mental illness has not been one of government's high priorities.

Beginning in the 1960s, many states embarked on a policy referred to as *deinstitutionalization*, discharging as many patients as possible from mental hospitals and discouraging admissions. Indeed, civil commitment is more difficult to achieve now than it was in the 1950s and 1960s, despite the fact that some people with mental illness need short stays in a hospital.

The population of state mental hospitals peaked in the 1950s at more than half a million patients. By 2000, these numbers had dropped to around 50,000. The number of hospitals continues to decline: there were 273 state mental hospitals in 1992 but only 195 in 2000 (Geller, 2006). The maxim is now "Treat them in the community," the assumption being that virtually anything is preferable to institutionalization.

Unfortunately, there are woefully inadequate resources for such treatment in the community. Some effective programs were described in Chapter 11, but these are very much the exception, not the rule. The state of affairs in cities is an unrelenting crisis for the hundreds of thousands of people with mental illness who have been released since the 1960s without adequate community services to help them. Many patients discharged from hospitals are eligible for benefits from the Veterans Administration and for Social Security Disability Insurance, but a large number are not receiving this assistance. Rates of homelessness have soard among the mentally ill, and homeless persons do not have fixed addresses and need help in establishing eligibility and residency for the purpose of receiving benefits. The state of homelessness undoubtedly exacerbates the emotional suffering of people with mental illness. People with mental illness are an especially defenseless segment of the homeless population.

Deinstitutionalization may be a misnomer. *Trans*institutionalization may be more apt, for declines in the census of psychiatric hospitals have occasioned increases in the presence of people with mental illness in nursing homes, the mental health departments of nonpsychiatric hospitals, and prisons (Cloud, 1999; Kiesler, 1991), and these settings are by and large not equipped to handle the particular needs of people with mental illness.

Indeed, jails and prisons have become the new "hospitals" for the people with mental illness in the twenty-first century. A study by the Justice Department found that 16.2 percent of the population in prison or jails is seriously mentally ill (BJS, 1999). The Los Angeles County Jail may now be the country's largest mental "hospital" facility, with 1,500 inmates believed to have a serious mental illness (CAPT, 2000). Have we come that far from the days of the abysmal institutions that we discussed in Chapter 1? Clearly, we need to do more.

> *It is deplorable and outrageous that this state's prisons appear to have become a repository for a great number of its mentally ill citizens. Persons who, with psychiatric care, could fit well into society, are instead locked away, to become wards of the state's penal system. Then, in a tragically ironic twist, they may be confined in conditions that nurture, rather than abate, their psychoses. Judge William Wayne Justice, Ruiz v. Johnson, 37 F. Supp.2d 855 (S.D. Texas, 1999).*

Police officers are now called on to do the work of mental health professionals. They are often the first to come in contact with a person with mental illness and can make decisions as to whether a person should be taken to a hospital or jail. In several cities, mental health professionals have teamed up with police officers to form mobile crisis units (Lamb, Weinberger, & DeCuir, 2002). These units consist of trained mental health professionals who work in conjunction with local police to find the best option for a person with mental illness in the community. Because police officers are increasingly called on to work with people with mental illness, communities are recognizing the need for the police to receive proper training. New laws passed in the past decade including America's Law Enforcement and Mental Health Project Act (2000) and the later extension of this, called the Mentally Ill Offender Treatment and Crime Reduction Act (2004), provide funding for such training. These laws

also provide funds to set up what are referred to as mental health courts in local communities. The idea is that people with mental illness who commit a crime may be better served by courts that can monitor treatment availability and adherence.

The approach of building partnerships between mental health professionals and law enforcement led to the creation of the Consensus Project (www.consensusproject.org). The Council of State Governments coordinated collaboration between criminal justice, mental health, and local and national lawmakers. A report entitled *Criminal Justice/Mental Health Consensus Project* was released in 2002, and it has been influential in increasing awareness of the large numbers of people with mental illness who are now housed in jails rather than in treatment facilities. The report outlines a number of policy ideas, all aimed at increasing cooperation between mental health and criminal justice and ultimately benefiting those with mental illness who are in the criminal justice system or who are at risk of becoming involved (e.g., sent to jail rather than treatment following a public outburst that reflects an exacerbation of illness).

Quick Summary

The legal standard for competency to stand trial requires that the accused understand the charges against him or her and be able to assist his or her attorney in the defense. Someone who is judged incompetent to stand trial receives treatment to restore competence and then returns to face the charges. The *Jackson* case specified that the pretrial period can be no longer than it takes to determine whether a person will ever become competent to stand trial. The use of medication to restore competency to stand trial can be used in limited circumstances.

The U.S. Supreme Court has ruled that it is unconstitutional (a violation of the Eighth Amendment, which prohibits cruel and unusual punishment) to execute people who are deemed legally insane or mentally retarded. Individual states can determine what constitutes mental retardation and insanity.

A person can be civilly committed to a hospital against his or her wishes if the person is mentally ill and a danger to self or others. Formal commitment requires a court order; informal commitment does not. People with mental illness who are not substance abusers are not necessarily more likely to engage in violence than are non–mentally ill people who are not substance abusers.

Early studies on the prediction of dangerousness had a number of flaws. Later research has shown that repeated acts of violence, a single serious violent act, being on the brink of violence, and medication noncompliance can maximize accuracy in predictions.

Court cases have tried to balance a person's rights with the rights of society to be protected. The least restrictive alternative to freedom is to be provided when treating people with mental disorders and protecting them from harming themselves and others. A series of court cases have generally supported the notion that those people committed to a hospital have the right to receive treatment. People with mental illness have the right to refuse treatment as well, except when doing so poses a danger to self or others.

The advanced directive is a legal document composed by people who are legally competent and able to make decisions and specify how they want to be treated in the event that, sometime in the future, they need psychological or medical therapy but are mentally unfit to make decisions bearing on their therapy.

Beginning in the 1960s, large numbers of patients were released from hospitals in what has been called deinstitutionalization. Unfortunately, there are not enough treatment options available in the community. Jails and prisons are now the new "hospitals" for people with mental illness. Police officers are called on to do the work once reserved for mental health professionals. Partnerships between police, courts, and community mental health providers are promising for helping people with mental illness.

Check Your Knowledge 17.3

True or false?

1. People with schizophrenia who have delusions are more likely to be violent than those without delusions.
2. Past violence is a predictor of future violence.
3. Court decisions have determined that hospitalized patients do not have a right to treatment unless they are dangerous.
4. People with mental illness can refuse treatment if they are found incompetent to stand trial after being charged with a nonviolent offense.

Ethical Dilemmas in Therapy and Research

The legal trends reviewed thus far in this chapter place limits on the activities of mental health professionals. These legal constraints are important, for laws are one of society's strongest means of encouraging all of us to behave in certain ways. Mental health professionals also have ethical constraints. Ethics statements are designed to provide an ideal, to review moral issues of right and wrong that may or may not be reflected in the law. All professional groups promulgate "should." These ethics guidelines describe what therapists and researchers should do with their patients, clients, and research participants. Courts have also ruled on some of these questions. Most of the time what we believe is unethical is also illegal, but sometimes existing laws are in conflict with our moral sense of right and wrong. The American Psychological Association publishes a *Code of Ethics* that includes the ethical standards that constrain research and practice in psychology (APA, 2002; http://www.apa.org/ethics). We examine now the ethics of making psychological inquiries and interventions into the lives of other human beings.

Ethical Restraints on Research

The training of scientists equips them to pose interesting questions, sometimes even important ones, and to design research that is as free as possible of confounds. They have no special qualifications, however, for deciding whether a particular line of research with people should be followed. Society needs knowledge, and a scientist has a right in a democracy to seek that knowledge. However, the ordinary citizens who participate in experiments must be protected from unnecessary harm, risk, humiliation, and invasion of privacy.

Perhaps the most reprehensible ethical insensitivity was evidenced in the brutal experiments conducted by German physicians on concentration camp prisoners during World War II. One experiment, for example, investigated how long people lived when their heads were bashed repeatedly with a heavy stick. Clearly, such actions violate our sense of decency and morality. The Nuremberg Trials, conducted by the Allies following the war, brought these and other barbarisms to light and meted out severe punishment (including the death penalty) to some of the soldiers, physicians, and Nazi officials who had engaged in or contributed to such actions, even when they claimed that they had merely been following orders.

It would be reassuring to be able to say that such gross violations of human decency take place only during incredible and cruel epochs such as the Third Reich, but unfortunately this is not the case. Spurred on by a blind enthusiasm for their work, researchers in the United States and other countries have sometimes dealt with human participants in reproachable ways.

For example, one experiment conducted after World War II compared penicillin with a placebo as a treatment to prevent rheumatic fever. Even though penicillin had already been acknowledged as the drug of choice for people with a streptococcal respiratory infection in order to protect them from later contracting rheumatic fever, placebos were administered to 109 service personnel without their knowledge or permission. More participants received penicillin than received the placebo, but three members of the control group contracted serious illnesses—two had rheumatic fever and one acute nephritis, a kidney disease. None of those who had received penicillin contracted such illnesses (Beecher, 1966).

Defendants at the Nuremberg trials. (Corbis-Bettmann.)

Half a century later, in January 1994, spurred on by Eileen Welsome, a journalist who won a Pulitzer Prize for her investigative reporting on the issue, the United States Energy Department began to publicize numerous experiments conducted in the 1950s through the 1970s that had exposed hundreds of people—usually without their informed consent or prior knowledge—to harmful doses of radiation. Particular concern was expressed because the overwhelming majority were people of low socioeconomic status, members of ethnic minorities, people with mental retardation, nursing

home patients, or prisoners. The scientists, for the most part supported in their research with federal funds, understood that the risks were great even though relatively little was known about the harmful effects of radiation at the time. Some of these experiments involved giving women in the third trimester of pregnancy a radioactive tonic to determine safe levels of exposure and irradiating the testicles of prisoners to find out the degree of radiation that service personnel could endure without negative effects on sperm production.

Responding to the many instances of harm inflicted on research participants, several international codes of ethics for the conduct of scientific research have been developed—the Nuremberg Code formulated in 1947 in the aftermath of the Nazi war-crime trials, the 1964 Declaration of Helsinki, and statements from the British Medical Research Council. In 1974, the U.S. Department of Health, Education, and Welfare began to issue guidelines and regulations governing scientific research that employs human and animal participants. In addition, a blue-ribbon panel, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, issued a report in 1978 that arose from hearings and inquiries into restrictions that the U.S. government might impose on research performed with patients in psychiatric hospitals, prisoners, and children. These various codes and principles are continually being reevaluated and revised as new challenges are posed to the research community.

For the past 40 years, the proposals of behavioral researchers, many of whom conduct experiments related to psychopathology and therapy, have been reviewed for safety and general ethical propriety by institutional review boards in hospitals, universities, and research institutes. Such committees—and this is significant—comprise not only behavioral scientists but also citizens from the community. They are able to block any research proposal or require questionable aspects to be modified if in their collective judgment the research would put participants at too great a risk. Such committees now also pass judgment on the scientific merits of proposals, the rationale being that it is not ethical to recruit participants for studies that will not yield valid data (Capron, 1999). In 2000, universities and other research institutions were required to begin certifying researchers on the basis of special coursework and examinations concerning research ethics. Researchers who receive funds from federal agencies, such as the National Institute of Mental Health, are also required to receive specialized training in research ethics.

Informed Consent

A core component of ethical research is **informed consent**. The investigator must provide enough information to enable people to decide whether they want to be in a study. Researchers must describe the study clearly, including any risks involved. Researchers should disclose even minor risks that could occur from a study, including emotional distress from answering personal questions or side effects from drugs. There must be no coercion in obtaining informed consent. Participants must understand that they have every right not to take part in the study or to withdraw from the study at any point, without any fear of penalty. For example, a psychologist might want to determine whether imagery helps students to associate one word with another. One group of students might be asked to associate pairs of words in their minds by generating a wacky image connecting the two, such as a cat riding on a bicycle. Current procedure allows prospective participants to decide that the experiment is likely to be boring and to decline to participate.

A central issue is that potential participants must be able to understand the study and associated risks. What if the prospective participant is a child with mental retardation, unable to understand fully what is being asked? In clinical settings, researchers must ascertain that patients are not having trouble understanding the study.

Irwin and colleagues (1985) found that although most people with mental illness said they understood the benefits and side effects of their drugs, only a quarter of them could actually demonstrate such understanding when queried specifically. The authors concluded that simply reading information to hospitalized patients—especially the more severely ill ones—is no guarantee that they fully comprehend; therefore, informed consent cannot be said to have been obtained. The report of the National Bioethics Advisory Commission pointed to many published experiments involving people with mental illness in which no effort was made to determine whether the research participants had the decision-making capacity to give informed consent

(Capron, 1999). Instead of simply allowing a guardian or family member to make the decision for the patient, the commission proposed that a health professional who has nothing to do with the particular study make a judgment on whether a given patient can give informed consent. The commission also recommended that if a guardian is allowed to give consent on behalf of a patient judged incompetent to do so, the guardian's own ability to give consent also be evaluated (Capron, 1999).

Still, as with the right to refuse treatment, there is recognition that being judged mentally ill does not necessarily mean being incapable of giving informed consent (Appelbaum & Gutheil, 1991). For example, although people with schizophrenia may do more poorly than people without schizophrenia on tests designed to assess decision-making skills, people with schizophrenia can give informed consent if a more detailed procedure describing a study is included—for example, one that describes what they will be asked to do and what they will see and explains that their participation is voluntary and that it in no way will impact their treatment (Carpenter et al., 2000; Wirshing et al., 1998).

The issue of informed consent is also of concern to researchers and clinicians who work with people with Alzheimer's disease. As with schizophrenia, having an Alzheimer's diagnosis does not necessarily mean a person cannot provide informed consent (Marson, Huthwaite, & Hupert, 2004). Measures have been developed to assess capacity for consent in this population, and this will continue to be an area of active research as the number of people over age 65 continues to increase (Marson, 2001).

These results point to the importance of examining each person individually for ability to give informed consent, rather than assuming that a person is unable to do so by virtue of being hospitalized for schizophrenia or Alzheimer's disease. Thus, having a mental disorder does not necessarily mean that a person cannot give informed consent.

Confidentiality and Privileged Communication

When people consult a psychiatrist or clinical psychologist, they are assured by professional ethics codes that what goes on in the session will remain confidential. **Confidentiality** means that nothing will be revealed to a third party except for other professionals and those intimately involved in the treatment, such as a nurse or medical secretary.

A **privileged communication** goes even further. It is communication between parties in a confidential relationship that is protected by law. The recipient of such a communication cannot legally be compelled to disclose it as a witness. The right of privileged communication is a major exception to the access courts have to evidence in judicial proceedings. Society believes that in the long term the interests of people are best served if communications to a spouse and to certain professionals remain off limits to the prying eyes and ears of the police, judges, and prosecutors. The privilege applies to such relationships as those between husband and wife, physician and patient, pastor and penitent, attorney and client, and psychologist and patient. The legal expression is that the patient or client "holds the privilege," which means that only he or she may release the other person to disclose confidential information in a legal proceeding.

There are important limits to a client's right of privileged communication, however. For example, this right is eliminated for any of the following reasons in some states:

- The client has accused the therapist of malpractice. In such a case, the therapist can divulge information about the therapy in order to defend himself or herself in any legal action initiated by the client.
- The client is less than 16 years old and the therapist has reason to believe that the child has been a victim of a crime such as child abuse. In fact, the psychologist is required to report to the police or to a child welfare agency within 36 hours any suspicion he or she has that the child client has been physically abused, including any suspicion of sexual molestation.
- The client initiated therapy in hopes of evading the law for having committed a crime or for planning to do so.
- The therapist judges that the client is a danger to self or others and disclosure of information is necessary to ward off such danger (recall Focus on Discovery 17.3 on *Tarasoff*).

Who Is the Client or Patient?

Is it always clear to the clinician who the client is? In private therapy, when an adult pays a clinician a fee for help with a personal problem that has nothing to do with the legal system, the consulting individual is clearly the client. But an individual may be seen by a clinician for an evaluation of his or her competency to stand trial, or the clinician may be hired by an individual's family to assist in civil commitment proceedings. Perhaps the clinician is employed by a state mental hospital as a regular staff member and sees a particular patient about problems in controlling aggressive impulses.

It should be clear, although it sometimes is not, that in these instances the clinician is serving more than one client. In addition to the patient, he or she serves the family or the state, and it is incumbent on the mental health professional to inform the patient that this is so. This dual allegiance does not necessarily indicate that the patient's own interests will be sacrificed, but it does mean that discussions will not inevitably remain secret and that the clinician may in the future act in a way that displeases or even seriously compromises the interests of the patient.

Quick Summary

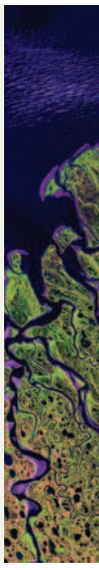
Ethical restraints on research are necessary to avoid the abuses that have occurred in the past. Since the Nuremberg Codes of 1947, a number of ethical codes regarding psychological research have been developed. Research must be approved for safety and ethics by an institutional review board. Universities and other research institutions, as well as federal grant-funding agencies, require that researchers receive specialized training and certification in research ethics, on the basis of special coursework and examinations, to make it less likely that research participants will be put at risk.

Special precautions must be taken to ensure that research participants with mental illness fully understand the risks and benefits of any research they are asked to participate in and that particular care be taken to make certain that they can decline or withdraw from research without feeling coerced. Informed consent procedures must include enough information about the research so that participants know about the risks and feel free to withdraw without penalty.

In therapy sessions, patients have the right to have what is discussed kept confidential (can't be disclosed to a third party), and this discussion is considered a privileged communication (information in confidential relationship protected by law). However, confidentiality and the privileged communication can be broken if an individual is a danger to self or others, is suing a therapist for malpractice, is a child under 16 who has been the victim of a crime or abuse, or is trying to evade the law for a crime committed or planned.

Summary

- Some civil liberties are rather routinely set aside when mental health professionals and the courts judge that mental illness has played a decisive role in determining an individual's behavior. This may occur through criminal or civil commitment.
- Criminal commitment sends a person to a hospital either before a trial for an alleged crime, because the person is deemed incompetent to stand trial, or after an acquittal by reason of insanity.
- A person who is considered mentally ill and dangerous to self and to others, although he or she has not broken a law, can be civilly committed to hospital or be allowed to live outside of a hospital but only under supervision and with restrictions placed on his or her activities.
- Several landmark cases and principles in law address the conditions under which a person who has committed a crime might be excused from legal responsibility for it—that is, not guilty by reason of insanity. These involve the presence of an irresistible impulse and the notion that some people may not be able to distinguish between right and wrong (the M'Naghten rule). The Insanity Defense Reform Act of 1984 made it harder for accused criminals to argue insanity as defense.
- Today, the defense of guilty but mentally ill is in use in a number of states.
- There is an important difference between mental illness and insanity. The latter is a legal concept. A person can be diagnosed as mentally ill and yet be deemed sane enough both to stand trial and to be found guilty of a crime.
- Court rulings have provided greater protection to all committed people with mental illness, particularly those under civil commitment. They have the right to written notification, to counsel, to a jury decision concerning their commitment, and to Fifth Amendment protection against self-incrimination; the right to the least restrictive treatment setting; the right to be treated; and, in most circumstances, the right to refuse treatment, particularly any procedure that entails considerable risk.
- Ethical issues concerning research include restraints on what kinds of research are allowable and the duty of scientists to obtain informed consent from prospective human participants.
- In the area of therapy, ethical issues concern the right of clients to confidentiality and the question of who is the client (e.g., an individual or the hospital that is paying the clinician).



Answers to Check Your Knowledge Questions

17.1 1. c; 2. a; 3. d; 4. b
17.2 1. F; 2. T; 3. T
17.3 1. F; 2. T; 3. F; 4. T

Key Terms

advanced directive
American Law institute guidelines
civil commitment
competency to stand trial
confidentiality
criminal commitment
guilty but mentally ill (GBMI)
in absentia
informed consent
insanity defense
irresistible impulse
least restrictive alternative
M'Naghten rule
not guilty by reason of insanity (NGRI)
outpatient commitment
privileged communication

Glossary

acute stress disorder. A short-lived anxiety reaction to a traumatic event; if it lasts more than a month, it is diagnosed as posttraumatic stress disorder.

addiction. See *substance dependence*.

adoptees method. Research method that studies children who were adopted and reared completely apart from their parents, thereby eliminating the influence of being raised by disordered parents.

advanced directive. Legal document in which an individual—before becoming incapable of making such decisions—prescribes and proscribes certain courses of action to be taken to preserve his or her health or terminate life support.

age effects. The consequences of being a given chronological age. Compare *cohort effects*.

agonist. A drug that stimulates receptors normally specific to a particular neurotransmitter.

agoraphobia. Literally, fear of the marketplace. Fear of being in crowded or open places. Anxiety about situations in which it would be embarrassing or difficult to escape if panic symptoms occurred; most commonly diagnosed in some individuals with panic disorder.

AIDS (acquired immunodeficiency syndrome). A fatal disease transmitted by transfer of the human immunodeficiency virus, usually during sexual relations or by using needles previously infected by an HIV-positive person; it compromises the immune system to such a degree that the person ultimately dies from one of any number of infections.

allele. Any of the various forms in which a particular gene is found.

allostatic load. The physiological burden of high levels of stress hormones such as cortisol; may lead to disease susceptibility because of altered immune system functioning.

alogia. A negative symptom in schizophrenia, marked by poverty of speech.

alternate-form reliability. See *reliability*.

altruistic suicide. As defined by Durkheim, self-annihilation that the person feels will serve a social purpose, such as the self-immolations practiced by Buddhist monks during the Vietnam War.

Alzheimer's disease. A dementia involving a progressive atrophy of cortical tissue and marked by memory impairment, intellectual deterioration, and, in more extreme cases, involuntary movements of limbs, occasional convulsions, and psychotic behavior. See also *plaques* and *neurofibrillary tangles*.

American Law Institute guidelines. Rules proposing that insanity is a legitimate defense plea if, during criminal conduct, an individual could not judge right from wrong or control his or her behavior as required by law. Repetitive criminal acts are disavowed as a sole criterion. Compare *M'Naghten rule* and *irresistible impulse*.

amphetamines. A group of stimulating drugs that produce heightened levels of energy and, in large doses, nervousness, sleeplessness, and paranoid delusions.

amygdala. A subcortical structure of the temporal lobe involved in attention to emotionally salient stimuli and memory of emotionally relevant events.

anal stage. In psychoanalytic theory, the second psychosexual stage, which occurs during the second year of life when the anus is considered the principal erogenous zone.

analogue experiment. An experimental study of a phenomenon different from but related to the actual interests of the investigator; for example, animal research used to study human disorders, or research on mild symptoms used as a bridge to clinical disorders.

analytical psychology. A variation of Freud's psychoanalysis introduced by Carl Jung, focusing less on biological drives and more on factors such as self-fulfillment, the collective unconscious, and religious symbolism.

anesthesia. An impairment or loss of sensation, usually of touch but sometimes of the other senses, that is often part of conversion disorder.

anger-in theory. The view that psychophysiological disorders, such as essential hypertension, arise from a person's not expressing anger or resentment.

angina pectoris. See *coronary heart disease*.

anhedonia. A negative symptom in schizophrenia or a symptom in depression in which the individual experiences a loss of interest and pleasure. See *anticipatory pleasure* and *consummatory pleasure*.

anomic suicide. As defined by Durkheim, self-annihilation triggered by a person's inability to cope with sudden and unfavorable change in a social situation.

anorexia nervosa. A disorder in which a person refuses to maintain normal weight, has an intense fear of becoming obese, and feels fat even when emaciated.

Antabuse. A drug that makes the drinking of alcohol produce nausea and other unpleasant effects; trade name for disulfiram.

antagonist. A drug that dampens the effect of a neurotransmitter on its receptors; for example, many dopamine antagonists block dopamine receptors.

anterior cingulate. In the subcortical region of the brain, the anterior portion of the cingulate gyrus, stretching about the corpus callosum.

anticipatory pleasure. Expected or anticipated pleasure for events, people, or activities in the future. See *consummatory pleasure*.

antidepressant. Any drug that alleviates depression; also widely used to treat anxiety disorders.

antipsychotic drugs. Psychoactive drugs, such as Thorazine, that reduce psychotic symptoms but have long-term side effects resembling symptoms of neurological diseases.

antisocial personality disorder. Personality disorder defined by the absence of concern for others' feelings or social norms, a pervasive pattern of rule breaking, and the presence of conduct disorder by age 15.

anxiety. An unpleasant feeling of fear and apprehension accompanied by increased physiological arousal; in learning theory, considered a drive that mediates between a threatening situation and avoidance behavior. Anxiety can be assessed by self-report, by measuring physiological arousal, and by observing overt behavior.

anxiety disorders. Disorders in which fear or tension is overriding and the primary disturbance; include phobic disorders, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, acute stress disorder, and posttraumatic stress disorder. These disorders form a major category in DSM-IV-TR.

Anxiety Sensitivity Index (ASI). A test that measures the extent to which people respond fearfully to their bodily sensations; predicts the degree to which unexplained physiological arousal leads to panic attacks.

anxiolytics. Minor tranquilizers or benzodiazepines used to treat anxiety disorders.

asociality. A negative symptom of schizophrenia marked by an inability to form close relationships and to feel intimacy.

Asperger's disorder. Pervasive developmental disorder believed to be a mild form of autism in which social relationships are poor and stereotyped behavior is intense and rigid, but language and intelligence are intact.

asthma. A disorder characterized by narrowing of the airways and increased secretion of mucus, often causing extremely labored and wheezy breathing.

asylums. Refuges established in western Europe in the fifteenth century to confine and provide for the mentally ill; forerunners of the mental hospital.

attachment theory. The type or style of an infant's attachment to his or her caregivers can set the stage for psychological health or problems later in development

attention-deficit/hyperactivity disorder (ADHD). A disorder in children marked by difficulties in focusing adaptively on the task at hand, inappropriate fidgeting and antisocial behavior, and excessive non-goal-directed behavior.

attribution. The explanation a person has for why an event or behavior has occurred.

attributional style. A person's relatively consistent approach to attribution; for example, the consistent attribution of negative life events to internal, stable, and global causes is thought to dispose to depression.

autistic disorder. Pervasive developmental disorder in which the child's world is one of profound aloneness: speech is often absent, and the child has an obsessive need for everything to remain the same.

autonomic nervous system (ANS). The division of the nervous system that regulates involuntary functions; innervates endocrine glands, smooth muscle, and heart muscle; and initiates the physiological changes that are part of the expression of emotion. See *sympathetic* and *parasympathetic nervous systems*; compare *somatic nervous system*.

aversive conditioning. Process believed to underlie the effectiveness of aversion therapy.

avoidant personality disorder. Personality disorder defined by aloofness and extreme sensitivity to potential rejection, despite an intense desire for affiliation and affection.

avolition. A negative symptom in schizophrenia in which the individual lacks interest and drive.

barbiturates. A class of addictive synthetic sedatives; in large doses, can cause death by almost completely relaxing the diaphragm.

behavior genetics. The study of individual differences in behavior that are attributable to differences in genetic makeup.

behavior therapy. A branch of psychotherapy conceived narrowly as the application of classical and operant conditioning to the alteration of clinical problems, but more broadly as applied experimental psychology in a clinical context.

behavioral activation (BA) therapy. Clinical approach to depression that seeks to increase participation in positively reinforcing activities.

behavioral assessment. A sampling of ongoing cognitions, feelings, and overt behavior in their situational context. Compare *projective test* and *personality inventory*.

behavioral inhibition. The tendency to exhibit anxiety or to freeze when facing threat. In infants, it manifests as a tendency to become agitated and cry when faced with novel stimuli and may be a heritable predisposition for the development of anxiety disorders.

behavioral couples therapy. Clinical approach to depression in which a couple works to improve communication and satisfaction; more likely to relieve relationship distress than individual cognitive therapy.

behavioral medicine. An interdisciplinary field concerned with integrating knowledge from medicine and behavioral science to understand health and illness and to prevent as well as treat psychophysiological disorders and other illnesses in which a person's psyche plays a role. See also *health psychology.*

behaviorism. The school of psychology originally associated with John B. Watson, who proposed that observable behavior, not consciousness, is the proper subject matter of psychology. Contemporary behaviorists do use mediational concepts, provided they are firmly anchored to observables.

benzodiazepines. Any of several drugs commonly used to treat anxiety, such as Valium and Xanax.

beta blockers. Any of numerous beta-adrenergic antagonists, competitive inhibitors of a class of receptors for the hormone adrenaline; are approved as cardiovascular drugs but often used to treat social phobia, despite a lack of demonstrated efficacy.

binge eating disorder. Categorized in DSM-IV-TR as a diagnosis in need of further study; includes recurrent episodes of unrestrained eating.

bipolar I disorder. A diagnosis defined on the basis of at least one lifetime episode of mania. Most people with this disorder also experience episodes of major depression.

bipolar II disorder. A form of bipolar disorder, diagnosed in those who have experienced at least one major depressive episode and at least one episode of hypomania.

blindsight. Conversion disorder wherein patients have suffered lesions in the visual cortex and report themselves blind but can perform well on some specific visual tests.

body dysmorphic disorder. A somatoform disorder marked by preoccupation with an imagined or exaggerated defect in appearance—for example, facial wrinkles or excess facial or body hair.

body mass index (BMI). Measure of body fat calculated by dividing weight in kilograms by height in meters squared; considered a more valid estimate of body fat than many others.

BOLD (blood oxygenation level dependent). The signal detected by functional MRI studies of the brain; measures blood flow and thus neural activity in particular regions.

borderline personality disorder. Personality disorder defined by impulsiveness and unpredictability, an uncertain self-image, intense and unstable social relationships, and extreme swings of mood.

brain stem. The part of the brain connecting the spinal cord with the cerebrum; contains the pons and medulla oblongata and functions as a neural relay station.

brief psychotic disorder. A disorder in which a person has a sudden onset of psychotic symptoms—incoherence, loose associations, delusions, hallucinations—immediately after a severely disturbing event; the symptoms last more than 1 day but no more than 1 month. Compare *schizophreniform disorder.*

brief therapy. Time-limited psychotherapy, usually ego-analytic in orientation and lasting no more than 25 sessions.

bulimia nervosa. A disorder characterized by episodic, uncontrollable eating binges followed by purging either by vomiting or by taking laxatives.

caffeine. Perhaps the world's most popular drug; a generalized stimulant of body systems, including the sympathetic nervous system. Though seldom viewed as a drug, caffeine is addictive, produces tolerance, and subjects habitual users to withdrawal.

cardiovascular disorders. Medical problems involving the heart and the blood circulation system, such as hypertension or coronary heart disease.

case study. The collection of historical or biographical information on a single individual, often including experiences in therapy.

catatonia. Constellation of schizophrenic symptoms including repetitive, peculiar, complex gestures, and, in some cases, an almost manic increase in overall activity level.

catatonic features. Immobility or excessive and peculiar physical movements characterizing a subtype of episodes of major depressive disorder or mania.

catatonic immobility. A fixity of posture, sometimes grotesque, maintained for long periods, with accompanying muscular rigidity, trancelike state of consciousness, and waxy flexibility.

catatonic schizophrenia. A subtype of schizophrenia whose primary symptoms alternate between stuporous immobility and excited agitation.

categorical classification. An approach to assessment in which a person is or is not a member of a discrete grouping. Compare *dimensional classification.*

cathartic method. A therapeutic procedure to relieve emotional suffering introduced by Breuer and developed further by Freud in the late nineteenth century, whereby a patient recalls and relives an earlier emotional catastrophe and reexperiences the tension and unhappiness.

central nervous system. The part of the nervous system that in vertebrates consists of the brain and spinal cord, to which all sensory impulses are transmitted and from which motor impulses pass out; supervises and coordinates the activities of the entire nervous system.

cerebellum. An area of the hindbrain concerned with balance, posture, and motor coordination.

cerebral cortex. The thin outer covering of each of the cerebral hemispheres; highly convoluted and composed of nerve cell bodies that constitute the gray matter of the brain.

cerebrum. The two-lobed structure extending from the brain stem and constituting the anterior (frontal) part of the brain; the largest and most recently developed portion of the brain, responsible for coordinating sensory and motor activities and performing higher cognitive processes.

childhood disintegrative disorder. Pervasive developmental disorder characterized by significant loss of social, play, language, and motor skills after the second year of life, with abnormalities in social interaction and communication similar to autism.

childhood sexual abuse (CSA). Sexual contact with a minor.

chromosomes. The threadlike bodies within the nucleus of the cell, composed primarily of DNA and bearing the genetic information of the organism.

civil commitment. A procedure whereby a person can be legally certified as mentally ill and hospitalized, even against his or her will. Compare *criminal commitment* and *outpatient commitment.*

classical conditioning. A basic form of learning, sometimes referred to as Pavlovian conditioning, in which a neutral stimulus is repeatedly paired with another stimulus (called the unconditioned stimulus, UCS) that naturally elicits a certain desired response (called the unconditioned response, UCR). After repeated trials, the neutral stimulus becomes a conditioned stimulus (CS) and evokes the same or a similar response, now called the conditioned response (CR). Compare *operant conditioning*.

client-centered therapy. A humanistic-existential insight therapy, developed by Carl Rogers, that emphasizes the importance of the therapist understanding the client's subjective experiences and assisting the client to gain more awareness of current motivations for behavior: the goal is not only to reduce anxieties but also to foster actualization of the client's potential.

clinical interview. General term for conversation between a clinician and a patient that is aimed at determining diagnosis, history, causes for problems, and possible treatment options.

clinical psychologist. An individual who has earned a Ph.D. degree in psychology or a Psy. D. and whose training has included an internship in a mental hospital or clinic.

clinical significance. The degree to which effect size is large enough to be meaningful in predicting or treating a clinical disorder. Compare *statistical significance.*

cocaine. A pain-reducing, stimulating, and addictive alkaloid obtained from coca leaves that increases mental powers, produces euphoria, heightens sexual desire, and in large doses causes paranoia and hallucinations.

cognition. The process of knowing; the thinking, judging, reasoning, and planning activities of the human mind. Behavior is now often explained as depending on these processes.

cognitive behavior therapy (CBT). Behavior therapy that incorporates theory and research on cognitive processes such as thoughts, perceptions, judgments, self-statements, and tacit assumptions; a blend of both the cognitive and behavioral paradigms.

cognitive behavioral paradigm. General view that people can best be understood by studying how they perceive and structure their experiences and how this influences behavior.

cognitive biases. Tendencies to perceive events in a negative manner, for example, by attending to or remembering negative information more than positive information; hypothesized to be driven by underlying negative schemata.

cognitive enhancement therapy (CET). Also known as cognitive training, treatment that seeks to improve basic cognitive functions such as verbal learning ability in people with schizophrenia, meanwhile reducing symptoms as well.

cognitive restructuring. Any behavior therapy procedure that attempts to alter the manner in which a client thinks about life so that he or she changes overt behavior and emotions.

cognitive therapy. See *cognitive restructuring.* See also *cognitive behavior therapy.*

cohort effects. The consequences of having been born in a given year and having grown up during a particular time period with its own unique pressures, problems, challenges, and opportunities. Compare *age effects.*

collective unconscious. Jung's concept that every human being carries within the wisdom, ideas, and strivings of those who have come before.

common factors. An approach to psychotherapeutic integration that aims to understand the common ingredients that work across different forms of therapy, such as rationale for how treatment will take place, therapist expectations for change, and a strong therapeutic relationship.

communication disorders. Learning disabilities in a child who fails to develop to the degree expected by his or her intellectual level in a specific language skill area; include expressive language disorder, phonological disorder, and stuttering.

comorbidity. The co-occurrence of two disorders, as when a person has depression and social phobia.

competency to stand trial. A legal decision as to whether a person can participate meaningfully in his or her own defense.

compulsion. The irresistible impulse to repeat an irrational act or thought over and over again. Compare *obsession.*

concordance. As applied in behavior genetics, the similarity in psychiatric diagnosis or in other traits within a pair of twins.

concurrent validity. See *validity.*

conditioned response (CR). See *classical conditioning.*

conditioned stimulus (CS). See *classical conditioning.*

conduct disorder. Pattern of extreme disobedience in youngsters, including theft, vandalism, lying, and early drug use; may be precursor of antisocial personality disorder.

confidentiality. A principle observed by lawyers, doctors, pastors, psychologists, and psychiatrists which dictates that the contents of a professional and private relationship are not divulged to anyone else. See also *privileged communication.*

construct validity. The extent to which scores or ratings on an assessment instrument relate to other variables or behaviors according to some theory or hypothesis.

consummatory pleasure. Pleasure experienced in-the-moment or in the presence of a pleasurable stimulus. See *anticipatory pleasure*.

content validity. See *validity.*

control group. Those for whom the active condition of the independent variable is not administered, thus forming a baseline against which the effects of the active condition of the independent variable can be evaluated.

controlled drinking. A pattern of alcohol consumption that is moderate, avoiding the extremes of total abstinence and of inebriation.

conversion disorder. A somatoform disorder in which sensory or motor function is impaired, even though there is no detectable neurological explanation for the deficits.

coping. How people try to deal with problems, in particular the typically negative emotions elicited by stress; generally includes problem-focused, emotion-focused, and avoidance actions and efforts.

coronary heart disease (CHD). Angina pectoris, chest pains caused by insufficient supply of blood and thus oxygen to the heart; and myocardial infarction, or heart attack, in which the blood and oxygen supply is reduced so much that heart muscles are damaged.

corpus callosum. The large band of nerve fibers connecting the two cerebral hemispheres.

correlation. The tendency for two variables, such as height and weight, to covary.

correlation coefficient. A statistic ranging in value from –1.00 to +1.00 that measures the degree to which two variables are related. The sign indicates whether the relationship is positive or negative, and the magnitude indicates the strength of the relationship.

correlational method. The research strategy used to establish whether two or more variables are related without manipulating the independent variable. Relationships may be positive—as values for one variable increase, those for the other do also—or negative—as values for one variable increase, those for the other decrease. Compare *experiment.*

cortisol. A "stress hormone" secreted by the adrenal cortices; helps the body prepare to face threats.

counseling psychologist. A doctoral-level mental health professional whose training is similar to that of a clinical psychologist, though usually with less emphasis on research and serious psychopathology.

crack. A rock-crystal form of cocaine that is heated, melted, and smoked; more often used in poorer urban areas than conventional cocaine.

criminal commitment. A procedure whereby a person is confined in a mental hospital either for determination of competency to stand trial or after acquittal by reason of insanity. Compare *civil commitment.*

criterion validity. See *validity.*

cross-dependent. Acting on the same receptors, as methadone does with heroin.

cross-fostering. Research method that studies offspring who were adopted and reared completely apart from their biological parents, where the adoptive parent has a particular disorder but the biological parent does not, thereby introducing the influence of being raised by disordered parents.

cross-sectional design. Studies in which different age groups are compared at the same time. Compare *longitudinal design.*

CT or **CAT scan.** Refers to computerized axial tomography, a method of diagnosis in which X-rays are taken from different angles and then analyzed by computer to produce a representation of the part of the body in cross section.

cultural competence. The capacity of a therapist to understand the patient's cultural framework and its implications for therapeutic work.

Cushing's syndrome. An endocrine disorder usually affecting young women, produced by oversecretion of cortisone and marked by mood swings, irritability, agitation, and physical disfigurement.

cyclothymic disorder. A form of bipolar disorder characterized by swings between elation and depression over at least a 2-year period, but with moods not so severe as manic or major depressive episodes.

cytokines. Immune system molecules, released by activated macrophages, which help initiate such bodily responses to infection as fatigue, fever, and activation of the HPA axis.

defense mechanisms. In psychoanalytic theory, reality-distorting strategies unconsciously adopted to protect the ego from anxiety.

delirium. A state of great mental confusion in which consciousness is clouded, attention cannot be sustained, and the stream of thought and speech is incoherent. The person is probably disoriented, emotionally erratic, restless or lethargic, and often has illusions, delusions, and hallucinations.

delirium tremens (DTs). One of the withdrawal symptoms that sometimes occurs when a period of heavy alcohol consumption is terminated; marked by fever, sweating, trembling, cognitive impairment, and hallucinations.

delusional disorder. A disorder in which the individual has persistent delusions and is very often contentious but has no disorganized thinking or hallucinations.

delusions. Beliefs contrary to reality, firmly held in spite of evidence to the contrary and common in paranoid disorders: of control, belief that one is being manipulated by some external force such as radar, television, or a creature from outer space; of grandeur, belief that one is an especially important or powerful person; of persecution, belief that one is being plotted against or oppressed by others.

dementia. Deterioration of mental faculties—memory, judgment, abstract thought, control of impulses, intellectual ability—that impairs social and occupational functioning and eventually changes the personality. See *Alzheimer's disease.*

dementia praecox. An older term for schizophrenia, believed then to be an incurable and progressive deterioration of mental functioning beginning in adolescence.

dementia with Lewy bodies (DLB). Form of dementia recently categorized as distinct from Parkinson's disease; characterized by shuffling gait, memory loss, and hallucinations and delusions.

demonology. The doctrine that a person's abnormal behavior is caused by an autonomous evil spirit.

dependent personality disorder. A disorder in which people are overly concerned about maintaining relationships. People with this disorder often allow others to make decisions for them and are reticent to make demands that could challenge relationships.

dependent variable. In a psychological experiment, the behavior that is measured and is expected to change with manipulation of the independent variable.

depersonalization. An alteration in perception of the self in which the individual loses a sense of reality and feels estranged from the self and perhaps separated from the body; may be a temporary reaction to stress and fatigue or part of panic disorder, depersonalization disorder, or schizophrenia.

depersonalization disorder. A dissociative disorder in which the individual feels unreal and estranged from the self and surroundings enough to disrupt functioning. People with this disorder may feel that their extremities have changed in size or that they are watching themselves from a distance.

derealization. Loss of the sense that the surroundings are real; present in several psychological disorders, such as panic disorder, depersonalization disorder, and schizophrenia.

desire phase. The first stage of the sexual response cycle, characterized by sexual interest or desire, often associated with sexually arousing fantasies.

detoxification. The initial stage in weaning an addicted person from a drug; involves medical supervision of the sometimes painful withdrawal.

developmental psychopathology. The field that studies disorders of childhood within the context of normal life-span development.

diagnosis. The determination that the set of symptoms or problems of a patient indicates a particular disorder.

Diagnostic and Statistical Manual of Mental Disorders. See *DSM-IV-TR.*

dialectical behavior therapy. A therapeutic approach to borderline personality disorder that combines client-centered empathy and acceptance with behavioral problem solving, social skills training, and limit setting.

diathesis. Predisposition toward a disease or abnormality.

diathesis–stress. As applied in psychopathology, a view that assumes that individuals predisposed toward a particular mental disorder will be particularly affected by stress and will then manifest abnormal behavior.

dimensional classification. An approach to assessment in which a person is placed on a continuum. Compare *categorical classification.*

directionality problem. A difficulty that arises in the correlational method of research when it is known that two variables are related but it is unclear which is causing the other.

disorder of written expression. Difficulties writing without errors in spelling, grammar, or punctuation.

disorganized behavior. Symptom of schizophrenia that is marked by odd behaviors that do not appear organized, such as bouts of agitation, unusual dress, or childlike, silly behavior.

disorganized schizophrenia. In this subtype of schizophrenia (formerly called hebephrenia), the person has diffuse and regressive symptoms; is given to silliness, facial grimaces, and inconsequential rituals; and has constantly changeable moods and poor hygiene.

disorganized speech. Speech found in schizophrenia patients that is marked by poorly organized ideas and speech that is difficult for others to understand; also known as formal thought disorder.

disorganized symptoms. Broad category of symptoms in schizophrenia that includes disorganized speech, disorganized thinking, and disorganized behavior.

disorientation. A state of mental confusion with respect to time, place, identity of self, other persons, and objects.

dissociation. A process whereby a group of mental processes is split off from the main stream of consciousness, or behavior loses its relationship with the rest of the personality.

dissociative amnesia. A dissociative disorder in which the person suddenly becomes unable to recall important personal information to an extent that cannot be explained by ordinary forgetfulness.

dissociative disorders. Disorders in which the normal integration of consciousness, memory, or identity is suddenly and temporarily altered; include dissociative amnesia, dissociative fugue, dissociative identity disorder (multiple personality), and depersonalization disorder.

dissociative fugue. Disorder in which the person experiences total amnesia, moves, and establishes a new identity.

dissociative identity disorder (DID). A rare dissociative disorder (formerly called multiple personality disorder, or MPD) in which two or more fairly distinct and separate personalities are present within the same individual, each with his or her own memories, relationships, and behavior patterns, with only one of them dominant at any given time.

dizygotic (DZ) twins. Birth partners who developed from separate fertilized eggs and who are only 50 percent alike genetically, just as siblings born from different pregnancies involving the same father; also called fraternal twins. Compare *monozygotic twins.*

dopamine. Central nervous system neurotransmitter, a catecholamine that is also a precursor of norepinephrine and apparently figures in schizophrenia and Parkinson's disease.

dopamine theory. The view that schizophrenia is linked to an increase in the number of dopamine receptors.

double-blind procedure. A method for reducing the biasing effects of the expectations of research participant and experimenter; neither is allowed to know whether the independent variable of the experiment is being applied to the participant.

Down syndrome (trisomy 21). A form of mental retardation caused by a third copy of a particular chromosome; involves an IQ usually less than 50 as well as distinctive physical characteristics.

DSM-IV-TR. The current *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

dyslexia (reading disorder). A learning disorder involving significant difficulty with word recognition, reading comprehension, and (typically) spelling.

dyspareunia. Persistent or recurrent pain during sexual intercourse not attributable to a medical problem.

dysthymic disorder. Depressive symptoms that last for at least 2 years but do not meet criteria for the diagnosis of major depressive disorder.

echolalia. The immediate or delayed repetition of the words of others, often found in autistic children.

ecological momentary assessment (EMA). Form of self-observation involving collection of data in real time (e.g., diaries) regarding thoughts, moods, and stressors.

Ecstasy. A relatively new hallucinogen, chemically similar to mescaline and the amphetamines.

effectiveness. How well a therapeutic treatment works in the real world, in the hands of broader samples of nonacademic, less supervised therapists. Compare *efficacy.*

efficacy. How well a therapeutic treatment works under rarified, academic research conditions. Compare *effectiveness.*

ego. In psychoanalytic theory, the predominantly conscious part of the personality, responsible for decision making and for dealing with reality.

ego analysis. An important set of modifications of classical psychoanalysis, based on a conception of the human being as having a stronger, more autonomous ego with gratifications independent of id satisfactions. Sometimes called ego psychology.

egoistic suicide. As defined by Durkheim, self-annihilation committed because the individual feels extreme alienation from others and from society.

electrocardiogram (EKG). A recording of the electrical activity of the heart, made with an electrocardiograph.

electroconvulsive therapy (ECT). A treatment that produces a convulsion by passing electric current through the brain; despite public concerns about this treatment, it can be useful in alleviating profound depression.

electrodermal responding. A recording of the minute electrical activity of the sweat glands on the skin, allowing inference of an emotional state.

electroencephalogram (EEG). A graphic recording of electrical activity of the brain, usually of the cerebral cortex, but sometimes of lower areas.

emotion. The expression, experience, and physiology that guide responses to problems and challenges in the environment.

emotion-focused therapy. An experiential therapeutic approach developed by Greanberg that focuses on helping clients differentiate maladaptive from adaptive emotions, as well as promoting better acceptance, understanding, and regulation of emotions.

empathy. Awareness and understanding of another's feelings and thoughts.

empirically supported treatments (ESTs). Approaches whose efficacy has been demonstrated and documented through research that meets the APA's standards for research on psychotherapy.

endorphins. Opiates produced within the body; may have an important role in the processes by which the body builds up tolerance to drugs and is distressed by their withdrawal.

enzyme. A complex protein that acts as a catalyst in regulating metabolic activities.

epidemiology. The study of the frequency and distribution of illness in a population.

episodic disorder. A condition, such as major depressive disorder, whose symptoms dissipate but that tends to recur.

essential hypertension. A disorder characterized by high blood pressure that cannot be traced to an organic cause; over time causes degeneration of small arteries, enlargement of the heart, and kidney damage.

etiology. All the factors that contribute to the development of an illness or disorder.

excitement phase. As applied by Masters and Johnson, the second stage of the sexual response cycle, characterized by pleasure associated with increased blood flow to the genitalia.

executive functioning. The cognitive capacity to plan how to do a task, how to devise strategies, and how to monitor one's performance.

exhibitionism. Marked preference for obtaining sexual gratification by exposing one's genitals to an unwilling observer.

exorcism. The casting out of evil spirits by ritualistic chanting or torture.

experiment. The most powerful research technique for determining causal relationships; involves the manipulation of an independent variable, the measurement of a dependent variable, and the random assignment of participants to the several different conditions being investigated. Compare *correlational method.*

experimental effect. A statistically significant difference between two groups experiencing different manipulations of the independent variable.

explicit memory. Memory involving the conscious recall of experiences; the area of deficits typically seen in dissociative amnesia. Compare *implicit memory.*

exposure. Real-life (in vivo) or imaginal confrontation of a feared object or situation, especially as a component of systematic desensitization. See also *imaginal exposure*.

exposure and response prevention (ERP). The most widely used and accepted treatment of obsessive-compulsive disorder, in which the sufferer is prevented from engaging in compulsive ritual activity and instead faces the anxiety provoked by the stimulus, leading eventually to extinction of the conditioned response (anxiety).

expressed emotion (EE). Hostility, criticism, and emotional overinvolvement directed from other people toward the patient, usually within a family.

expressive language disorder. Communication disorder of childhood involving difficulties expressing thoughts and emotions in speech.

external validity. The extent to which the results of a study can be considered generalizable.

externalizing disorders. Domain of childhood disorders characterized by outward-directed behaviors, such as aggressiveness, noncompliance, overactivity, and impulsiveness; the category includes attention-deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder. Compare *internalizing disorders.*

extinction. The elimination of a classically conditioned response by the omission of the unconditioned stimulus. In operant conditioning, the elimination of the conditioned response by the omission of reinforcement.

extraversion. Personality trait associated with frequent experiences of positive affect and social engagement.

factitious disorder. Disorder in which the individual's physical or psychological symptoms appear under voluntary control and are adopted merely to assume the role of a sick person; called factitious disorder by proxy or Munchausen syndrome when a parent produces a physical illness in a child.

falsifiability. The extent to which a scientific assertion is amenable to systematic probes, any one of which could negate the scientist's expectations.

family method. A research strategy in behavior genetics in which the frequency of a trait or of abnormal behavior is determined in relatives who have varying percentages of shared genetic background.

family-focused treatment (FFT). With the goal of reducing the likelihood of relapse of bipolar disorder or schizophrenia, treatment that aims to educate the person's family about illness, enhance communication, and develop problem-solving skills.

fear. A reaction to real or perceived immediate danger in the present; can involve arousal, or sympathetic nervous system activity.

fear circuit. Set of brain structures, including the amygdala, that tend to be activated when the individual is feeling anxious or fearful; especially active among people with anxiety disorders.

fear-of-fear hypothesis. A cognitive model for the etiology of agoraphobia; suggests the condition is driven by negative thoughts about the consequences of having a panic attack in public.

female orgasmic disorder. A recurrent and persistent delay or absence of orgasm in a woman during sexual activity adequate in focus, intensity, and duration; in many instances the woman may experience considerable sexual excitement.

female sexual arousal disorder. Formerly called frigidity, the inability of a female to reach or maintain the lubrication–swelling stage of sexual excitement or to enjoy a subjective sense of pleasure or excitement during sexual activity.

fetal alcohol syndrome (FAS). Retarded growth of the developing fetus and infant involving cranial, facial, and limb anomalies as well as mental retardation; caused by heavy consumption of alcohol by the mother during pregnancy.

fetishism. Reliance on an inanimate object for sexual arousal.

five-factor model. A personality theory that isolates five major dimensions of personality: neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness.

fixation. In psychoanalytic theory, the arrest of psychosexual development at a particular stage through too much or too little gratification at that stage.

flashback. An unpredictable recurrence of experiences from an earlier drug high.

flat affect. A negative symptom of schizophrenia that involves a lack of outward expression of emotion.

flight of ideas. A symptom of mania that involves a rapid shift in conversation from one subject to another with only superficial associative connections.

forced rape. The legal term for rape, forced sexual intercourse, or other (especially) penetrative sexual activity with another person. Compare *statutory rape.*

fragile X syndrome. Malformation (or even breakage) of the X chromosome, associated with moderate mental retardation; symptoms include large, underdeveloped ears; a long, thin face; a broad nasal root; enlarged testicles in males; and, in many cases, attention deficits and hyperactivity.

free association. A key psychoanalytic procedure in which the analysand is encouraged to give free rein to his or her thoughts and feelings, verbalizing whatever comes into the mind without monitoring its content. The assumption is that over time, repressed material will come forth for examination by both analysand and psychoanalyst.

frontal lobe. The anterior portion of each cerebral hemisphere, in front of the central sulcus; active in reasoning and other higher mental processes.

frontal-subcortical dementias. Dementias that involve impairment of both cognitive and motor functions; include Huntington's chorea, Parkinson's disease, normal pressure hydrocephalus, and vascular dementia.

frontotemporal dementia (FTD). Dementia that begins typically in the mid to late fifties, characterized by deficits in executive functions such as planning, problem solving, and goal-directed behavior as well as recognition and comprehension of emotions in others. Compare *Alzheimer's disease.*

frotteurism. The sexually oriented touching of an unsuspecting person, typically in public places that provide an easy means of escape.

functional magnetic resonance imaging (fMRI). Modification of magnetic resonance imaging (MRI) that allows researchers to take pictures of the brain so quickly that metabolic changes can be measured, resulting in a picture of the brain at work rather than of its structure alone.

functional social support. The quality of a person's relationships, for example, a good versus a distressed marriage. Compare *structural social support.*

G-proteins. Guanine nucleotide-binding proteins that serve to modulate activity within the postsynaptic cell, are implicated in mania and depression, and are possibly the intracellular target of lithium.

gamma-aminobutyric acid (GABA). Inhibitory neurotransmitter that may be involved in the anxiety disorders.

gender identity. The ingrained sense a person has of being either a man or a woman.

gender identity disorder. Adult disorder in which there is an incongruence between anatomic sex and self-identified gender that causes distress for the person.

gene. The smallest portion of DNA within a chromosome that functions as a piece of functional hereditary information.

gene expression. The switching on and off of the reading (transcription and translation) of genes into their products (usually proteins) and thus their associated phenotypes.

gene–environment interaction. The influence of genetics on an individual's sensitivity or reaction to an environmental event. Compare *reciprocal gene–environment interaction.*

general adaptation syndrome (GAS). Hans Selye's model to describe the biological reaction of an organism to sustained and unrelenting stress; the several stages culminate in death, in extreme circumstances.

general paresis. Infection of the central nervous system by the spirochete *Treponema pallidum*, which destroys brain tissue; marked by eye disturbances, tremors, and disordered speech as well as severe intellectual deterioration and psychotic symptoms.

generalized anxiety disorder (GAD). Disorder characterized by anxiety so chronic, persistent, and pervasive that it seems free-floating. The individual is jittery and strained, distractible, and worried that something bad is about to happen. A pounding heart, fast pulse and breathing, sweating, flushing, muscle aches, a lump in the throat, and an upset gastrointestinal tract are some of the bodily indications.

genetic marker. A DNA polymorphism linked to a gene critical to the inheritance of a particular form of psychopathology. See *linkage analysis.*

genetic paradigm. Since the early twentieth century, the approach to human behavior that focuses on both heritability of traits and complex interactions between genes and environment.

genital stage. In psychoanalytic theory, the final psychosexual stage, reached in adulthood, in which heterosexual interests predominate.

genotype. An individual's unobservable, genetic constitution, that is, the totality of genes present in the cells of an individual; often applied to the genes contributing to a single trait. Compare *phenotype.*

Gestalt therapy. A humanistic therapy, developed by Fritz Perls, that encourages clients to satisfy emerging needs so that their innate goodness can be expressed, to increase their awareness of unacknowledged feelings, and to reclaim parts of their personality that have been denied or disowned.

grandiose delusions. Found in paranoid schizophrenia, delusional disorder, and mania, an exaggerated sense of one's importance, power, knowledge, or identity. See also *delusions.*

gray matter. The neural tissue—made up largely of nerve cell bodies—that constitutes the cortex covering the cerebral hemisphere, the nuclei in lower brain areas, columns of the spinal cord, and the ganglia of the autonomic nervous system. Compare *white matter.*

guilty but mentally ill (GBMI). Insanity plea in which a mentally ill person can be held morally and legally responsible for a crime but can then, in theory, be sent to a prison hospital or other suitable facility for psychiatric treatment rather than to a regular prison for punishment. In reality, however, people judged GBMI are usually put in the general prison population, where they may or may not receive treatment. Compare *not guilty by reason of insanity.*

hallucinations. Perceptions in any sensory modality without relevant and adequate external stimuli.

hallucinogen. A drug or chemical, such as LSD, psilocybin, or mescaline, whose effects include hallucinations; often called a psychedelic.

harmful dysfunction. Proposed definition of mental disorder that contains both a value judgment (harmful) and a putatively objective scientific component (dysfunction).

hashish. The dried resin of the cannabis plant, stronger in its effects than the dried leaves and stems that constitute marijuana.

health psychology. A branch of psychology dealing with the role of psychological factors in health and illness. See also *behavioral medicine.*

heritability. The extent to which variability in a particular behavior/disorder within a population can be attributed to genetic factors.

heroin. An extremely addictive narcotic drug derived from morphine.

high-risk method. A research technique involving the intensive examination of people, such as the offspring of people with schizophrenia, who have a high probability of later developing a disorder.

hippocampus. In the subcortical region of the brain, the long, tubelike structure that stretches from the septal area into the temporal lobe.

histrionic personality disorder. Personality disorder defined by overly dramatic behavior, emotional excess, and sexually provocative behavior.

hopelessness theory. Cognitive theory of depression that began with learned helplessness theory, was modified to incorporate attributions, and has been modified again to emphasize hopelessness—an expectation that desirable outcomes will not occur and that no available responses can change the situation.

HPA axis. The neuroendocrine connections among hypothalamus, pituitary gland, and adrenal cortex, central to the body's response to stress.

humanistic therapy. An insight therapy that emphasizes freedom of choice, growth of human potential, the joys of being a human being, and the importance of the patient's phenomenology; sometimes called an experiential therapy.

hydrocodone. An opiate combined with other drugs such as acetaminophen to produce prescription pain medications, including the commonly abused drug Vicodin. See also *oxycodone*.

hypnosis. A trancelike state or behavior resembling sleep, induced by suggestion, characterized primarily by increased suggestibility.

hypoactive sexual desire disorder. Absence of or deficiency in sexual fantasies and urges. Compare *sexual aversion disorder.*

hypochondriasis. A somatoform disorder in which the person, misinterpreting rather ordinary physical sensations, is preoccupied with fears of having a serious disease.

hypomania. An extremely happy or irritable mood accompanied by symptoms like increased energy and decreased need for sleep, but without the significant functional impairment associated with mania.

hypothalamus. In the subcortical region of the brain, the structure that regulates many visceral processes, including metabolism, temperature, perspiration, blood pressure, sleeping, and appetite.

hypothesis. Specific expectation or prediction about what should occur or be found if a theory is true or valid.

id. In psychoanalytic theory, that part of the personality present at birth, comprising all the energy of the psyche and expressed as biological urges that strive continually for gratification.

ideas of reference. Delusional thinking that reads personal significance into seemingly trivial remarks or activities of others and completely unrelated events.

imaginal exposure. Treatment for anxiety disorders that involves visualizing feared scenes for extended periods of time. Frequently used in the treatment of posttraumatic stress disorder when in vivo exposure to the initial trauma cannot be conducted.

implicit memory. Memory that underlies behavior but is based on experiences that cannot be consciously recalled; typically not compromised in cases of dissociative amnesia. Compare *explicit memory.*

in absentia. Literally, "in one's absence." Courts are concerned that a person be able to participate personally and meaningfully in his or her own trial and not be tried in absentia because of a distracting mental disorder.

in vivo. As applied in psychology, taking place in a real-life situation.

inappropriate affect. Emotional responses that are out of context, such as laughter when hearing sad news.

incest. Sexual relations between close relatives, most often between daughter and father or between brother and sister.

incidence. In epidemiological studies of a particular disorder, the rate at which new cases occur in a given place at a given time. Compare *prevalence*.

independent variable. In a psychological experiment, the factor, experience, or treatment that is under the control of the experimenter and that is expected to have an effect on participants as assessed by changes in the dependent variable.

index case (proband). The person who in a genetic investigation bears the diagnosis or trait in which the investigator is interested.

individual psychology. A variation of Freud's psychoanalysis introduced by Alfred Adler, focusing less on biological drives and more on such factors as people's conscious beliefs and goals for self-betterment.

informed consent. The agreement of a person to serve as a research participant or to enter therapy after being told the possible outcomes, both benefits and risks.

insanity defense. The legal argument that a defendant should not be held responsible for an illegal act if the conduct is attributable to mental illness. See *not guilty by reason of insanity* and *guilty but mentally ill.*

intelligence quotient (IQ). A standardized measure indicating how far an individual's raw score on an intelligence test is from the average raw score of his or her chronological age group.

intelligence test. A standardized means of assessing a person's current mental ability, for example, the Stanford–Binet test or the Wechsler Adult Intelligence Scale.

interleukin-6 (IL-6). A proinflammatory cytokine; elevated levels can result from stress as well as infection and have been linked to numerous diseases in older adults.

internal consistency reliability. See *reliability.*

internal validity. See *validity.*

internalizing disorders. Domain of childhood disorders characterized by inward-focused experiences and behaviors, such as depression, social withdrawal, and anxiety; the category includes childhood anxiety and mood disorders. Compare *externalizing disorders.*

interoceptive conditioning. Classical conditioning of panic attacks in response to internal bodily sensations of arousal (as opposed to the external situations that trigger anxiety).

interpersonal psychotherapy (IPT). A short-term, here-and-now focused psychological treatment initially developed for depression and influenced by the psychodynamic emphasis on relationships.

interpretation. In psychoanalysis, a key procedure in which the psychoanalyst points out to the analysand where resistance exists and what certain dreams and verbalizations reveal about impulses repressed in the unconscious; more generally, any statement by a therapist that construes the client's problem in a new way.

interrater reliability. See *reliability.*

irresistible impulse. The term used in an 1834 Ohio court ruling on criminal responsibility which determined that an insanity defense can be established by proving that the accused had an uncontrollable urge to perform the act.

joint attention. Interactions between two people require paying attention to each other, whether speaking or communicating emotion nonverbally. This is impaired in children with autism.

la belle indifférence. The blasé attitude people with conversion disorder have toward their symptoms.

latency period. In psychoanalytic theory, the years between ages 6 and 12, during which id impulses play a minor role in motivation.

law of effect. A principle of learning that holds that behavior is acquired by virtue of its consequences.

learned helplessness theory. The theory of depression etiology that individuals, through unpleasant experiences and traumas against which their efforts were ineffective, acquire passivity and a sense of being unable to act and to control their lives.

learning disabilities. General term for learning disorders, communication disorders, and motor skills disorder.

learning disorders. A set of developmental disorders encompassing dyslexia, mathematics disorder, and disorder of written expression; characterized by failure to develop in a specific academic area to the degree expected by the child's intellectual level.

least restrictive alternative. The legal principle according to which a hospitalized patient must be treated in a setting that imposes as few restrictions as possible on his or her freedom.

libido. Freudian term for the life-integrating instinct or force of the id; sometimes equated with sexual drive.

linkage analysis. A molecular genetic technique wherein occurrence of a disorder in a family is evaluated in parallel with inheritance of a known genetic (DNA) marker.

lithium. A drug useful in treating both mania and depression in bipolar disorder.

locus ceruleus. The brain region in the fear circuit that is especially important in panic disorder; the major source in the brain of norepinephrine, which helps trigger sympathetic nervous system activity.

longitudinal design. Investigation that collects information on the same individuals repeatedly over time, perhaps over many years, in an effort to determine how phenomena change. Compare *cross-sectional design.*

loose associations (derailment). In schizophrenia, an aspect of disorganized thinking wherein the patient has difficulty sticking to one topic and drifts off on a train of associations evoked by an idea from the past.

LSD. *d*-lysergic acid diethylamide, a drug synthesized in 1938 and discovered by accident to be a hallucinogen in 1943.

magnetic resonance imaging (MRI). A technique for measuring the structure (or, in the case of functional magnetic resonance imaging, the activity) of the living brain. The person is placed inside a large circular magnet that causes hydrogen atoms to move; the return of the atoms to their original positions when the current to the magnet is turned off is translated by a computer into pictures of brain tissue.

major depressive disorder (MDD). A disorder of individuals who have experienced episodes of depression but not of mania. Depression episodes are marked by sadness or loss of pleasure, accompanied by symptoms such as feelings of worthlessness and guilt, withdrawal from others, loss of sleep, appetite, sexual desire, and either lethargy or agitation.

male erectile disorder. A recurrent and persistent inability to attain or maintain an erection until completion of sexual activity.

male orgasmic disorder. A recurrent and persistent delay or absence of ejaculation after an adequate phase of sexual excitement.

malingering. Faking a physical or psychological incapacity in order to avoid a responsibility or gain an end, where the goal is readily recognized from the individual's circumstances distinct from conversion disorder, in which the incapacity is assumed to be beyond voluntary control.

mania. Intense elation or irritability, accompanied by symptoms such as excessive talkativeness, rapid thoughts, distractibility, grandiose plans, heightened activity, and insensitivity to the negative consequences of actions.

marriage and family therapist. A mental health professional who specializes in treating couples and families and how these relationships impact mental health. Training can be at the masters or Ph.D. level, and some M.S.W. programs offer training in marriage and family therapy.

marijuana. A drug derived from the dried and ground leaves and stems of the female hemp plant *Cannabis sativa.*

mathematics disorder. Learning disorder characterized by difficulty recalling arithmetic facts, counting objects, and aligning numbers in columns.

MDA. Methylenedioxyamphetamine, a chemical component of Ecstasy; first synthesized in 1910 but not broadly known as a psychedelic until the 1960s.

MDMA. Methylenedioxymethamphetamine, a chemical component of Ecstasy; initially used as an appetite suppressant for World War I soldiers and derived from precursors found in nutmeg, dill, saffron, and sassafras.

melancholic. Subtype of major depressive disorder in which the individual is unable to feel better even momentarily when something good happens, regularly feels worse in the morning and awakens early, and suffers a deepening of other symptoms of depression.

mental disorder. The DSM-IV-TR defines mental disorder as a clinically significant behavioral or psychological syndrome or patterns. The definition includes a number of key features, including distress, disability or impaired functioning, violation of social norms, and dysfunction.

mental retardation. Subnormal intellectual functioning associated with impairment in adaptive behavior and identified at an early age.

mescaline. A hallucinogen and alkaloid that is the active ingredient of peyote.

mesmerize. The first term for *hypnotize*, after Franz Anton Mesmer, an Austrian physician who in the late eighteenth century treated and cured hysterical or conversion disorders with what he considered the animal magnetism emanating from his body and permeating the universe.

meta-analysis. A quantitative method of analyzing the results of a set of studies on a topic, by standardizing the results.

metabolic syndrome (of CHD). Combination of particular risk factors—abdominal obesity, insulin resistance, high blood pressure, low HDL cholesterol, and heightened inflammation—disposing to onset of coronary heart disease.

metabolite. A chemical breakdown product of an endogenous molecule, such as a neurotransmitter, or of an exogenous drug; used to gauge current or recent level of its precursor.

metacognition. The knowledge people have about the way they know and learn about their world, for example, recognizing the usefulness of a map in finding their way in a new city.

methadone. A synthetic addictive heroin substitute for treating those addicted to heroin that eliminates its effects and the cravings.

methamphetamine. An amphetamine derivative whose abuse skyrocketed in the 1990s.

mindfulness-based cognitive therapy (MBCT). Recent adaptation of cognitive therapy/restructuring that focuses on relapse prevention after successful treatment for recurrent episodes of major depression; aims to "decenter" the person's perspective in order to break the cycle between sadness and thinking patterns.

Minnesota Multiphasic Personality Inventory (MMPI). A lengthy personality inventory that identifies individuals with states such as anxiety, depression, masculinity–femininity, and paranoia, through their true–false replies to groups of statements.

mixed episodes. Bipolar episodes characterized by severe symptoms of both mania and depression within the same week.

M'Naghten rule. An 1843 British court decision stating that an insanity defense can be established by proving that the defendant did not know what he or she was doing or did not realize that it was wrong.

modeling. Learning by observing and imitating the behavior of others, or teaching by demonstrating and providing opportunities for imitation.

molecular genetics. Studies that seek to determine the components of a trait that are heritable by identifying relevant genes and their functions.

monoamine oxidase (MAO) inhibitors. A group of antidepressant drugs that prevent the enzyme monoamine oxidase from deactivating catecholamines and indolamines.

monozygotic (MZ) twins. Genetically identical twins who have developed from a single fertilized egg. Compare *dizygotic twins.*

mood disorders. Disorders, such as depressive disorders or mania, in which there are disabling disturbances in emotion.

moral treatment. A therapeutic regimen, introduced by Philippe Pinel during the French Revolution, whereby mentally ill patients were released from their restraints and were treated with compassion and dignity rather than with contempt and denigration.

morphine. An addictive narcotic alkaloid extracted from opium, used primarily as an analgesic and as a sedative.

motor skills disorder. A learning disability characterized by marked impairment in the development of motor coordination that is not accounted for by a physical disorder such as cerebral palsy.

Mowrer's two-factor model. Mowrer's theory of avoidance learning according to which (1) fear is attached to a neutral stimulus by pairing it with a noxious unconditioned stimulus, and (2) a person learns to escape the fear elicited by the conditioned stimulus, thereby avoiding the unconditioned stimulus.

multiaxial classification system. Classification having several dimensions, all of which are employed in categorizing; DSM-IV-TR is an example.

multisystemic treatment (MST). Treatment for serious juvenile offenders that involves delivering intensive and comprehensive therapy services in the community, targeting the adolescent, the family, the school, and, in some cases, the peer group, in ecologically valid settings and using varied techniques.

myocardial infarction. Heart attack. See *coronary heart disease.*

narcissistic personality disorder. Personality disorder defined by extreme selfishness and self-centeredness; a grandiose view of one's uniqueness, achievements, and talents; an insatiable craving for admiration and approval from others; willingness to exploit others to achieve goals; and expectation of much more from others than one is willing to give in return.

negative affect. Constellation of negative emotions that is elevated in both anxiety and depression.

negative reinforcement. The strengthening of a tendency to exhibit desired behavior by rewarding responses in that situation with the removal of an aversive stimulus.

negative symptoms. Behavioral deficits in schizophrenia, which include flat affect, anhedonia, asociality, alogia, and avolition. Compare *positive symptoms.*

negative triad. In Beck's theory of depression, a person's negative views of the self, the world, and the future, in a reciprocal causal relationship with pessimistic assumptions (schemata) and cognitive biases such as selective abstraction.

nerve impulse. A wave of depolarization that propagates along the neuron and causes the release of neurotransmitter; action potential.

neurofibrillary tangles. Abnormal protein filaments present in the cell bodies of brain cells in patients with Alzheimer's disease.

neurologist. A physician who specializes in medical diseases that affect the nervous system, such as muscular dystrophy, cerebral palsy, or Alzheimer's disease.

neuron. A single nerve cell.

neuropsychological tests. Psychological tests, such as the Luria–Nebraska, that can detect impairment in different parts of the brain.

neuropsychologist. A psychologist who studies how brain dysfunction affects cognition, emotion, and behavior.

neuroscience paradigm. A broad theoretical view that holds that mental disorders are caused in part by some aberrant process directed by the brain.

neuroses. Old term for a large group of nonpsychotic disorders characterized by unrealistic anxiety, depression, and other associated problems. See *anxiety disorders.*

neuroticism. The tendency to react to events with greater-than-average negative affect; a strong predictor of onset of anxiety disorders and depression.

neurotransmitters. Chemical substances important in transferring a nerve impulse from one neuron to another; for example, serotonin and norepinephrine.

nicotine. The principal alkaloid of tobacco (an addicting agent).

nitrous oxide. A gas that, when inhaled, produces euphoria and sometimes giddiness.

nonshared environment. Factors distinct among family members, such as relationships with friends or specific experiences unique to a person. Compare *shared environment.*

nonverbal memories. Memories based on connections between sensory stimuli and external events.

norepinephrine. A catecholamine neurotransmitter of the central nervous system, disturbances in the tracts of which apparently figure in depression and mania. It is also a sympathetic nervous system neurotransmitter, a hormone released in addition to epinephrine and similar in action, and a strong vasoconstrictor.

not guilty by reason of insanity (NGRI). Insanity plea that specifies an individual is not to be held legally responsible for the crime because the person had a mental illness at the time of the crime. Different states and federal law have different standards for defining mental illness and what must be demonstrated by the defense.

In most cases, the defense must show that because of the mental illness, the accused person could not conform his or her behavior to the law and did not know right from wrong when the crime was committed. Compare *guilty but mentally ill.*

obese. Currently defined as exhibiting a body mass index (BMI) of greater than 30.

Object relations theory. Variant of psychoanalytic theory that focuses on the way children internalize (*introject*) images of the people who are important to them (e.g., their parents), such that these internalized images (*object representations*) become part of the ego and influence how the person reacts to the world.

obsession. An intrusive and recurring thought that seems irrational and uncontrollable to the person experiencing it. Compare *compulsion.*

obsessive-compulsive disorder (OCD). An anxiety disorder in which the mind is flooded with persistent and uncontrollable thoughts or the individual is compelled to repeat certain acts again and again, causing significant distress and interference with everyday functioning.

obsessive-compulsive personality disorder. Personality disorder defined by inordinate difficulty making decisions, hyperconcern with details and efficiency, and poor relations with others due to demands that things be done just so, as well as the person's unduly conventional, serious, formal, and stingy emotions.

occipital lobe. The posterior portion of each cerebral hemisphere, situated behind the parietal lobe and above the temporal lobes; responsible for reception and analysis of visual information and for some visual memory.

operant conditioning. The acquisition or elimination of a response as a function of the environmental contingencies of reinforcement and punishment. Compare *classical conditioning.*

opiates. A group of addictive sedatives that in moderate doses relieve pain and induce sleep.

opium. One of the opiates, the dried, milky juice obtained from the immature fruit of the opium poppy; an addictive narcotic that produces euphoria and drowsiness while reducing pain.

oppositional defiant disorder. An externalizing disorder of children marked by high levels of disobedience to authority but lacking the extremes of conduct disorder.

oral stage. In psychoanalytic theory, the first psychosexual stage, which extends into the second year; during it the mouth is the principal erogenous zone.

orbitofrontal cortex. The portion of the frontal lobe located just above the eyes; one of three closely related brain regions that are unusually active in individuals with obsessive-compulsive disorder.

orgasm phase. The third stage of the sexual response cycle, characterized by a peak of sexual pleasure, generally including ejaculation in men and contraction of the outer vaginal walls in women.

outcome research. Research on the efficacy of psychotherapy. Compare *process research.*

outpatient commitment. A form of civil commitment consistent with the principle of least restrictive alternative, whereby the person is not hospitalized but rather is allowed to remain free in the community under legal/medical constraints that ensure, for example, that prescribed medication is taken and other measures are observed.

oxycodone. An opiate combined with other drugs to produce prescription pain medications, including the commonly abused drug OxyContin. See also *hydrocodone.*

pain disorder. A somatoform disorder in which the person complains of severe and prolonged pain that is not fully explainable by organic pathology and is thus assumed to be caused or intensified by psychological factors.

panic attack. A sudden attack of intense apprehension, terror, and impending doom, accompanied by symptoms such as labored breathing, nausea, chest pain, feelings of choking and smothering, heart palpitations, dizziness, sweating, and trembling.

panic control therapy (PCT). A cognitive behavior treatment, based on the tendency of individuals with panic disorder to overreact to bodily stimuli, in which sensations are induced physically and coped with under safe conditions.

panic disorder. An anxiety disorder in which the individual has sudden, inexplicable, and frequent panic attacks; in DSM-IV-TR, diagnosed as with or without agoraphobia. See *panic attack.*

paradigm. A set of basic assumptions that outlines the universe of scientific inquiry, specifying both the concepts regarded as legitimate and the methods to be used in collecting and interpreting data.

paranoia. The general term for delusions of persecution, of grandiosity, or both; found in several pathological conditions, delusional disorders, paranoid schizophrenia, and paranoid personality disorder but can also be produced by large doses of certain drugs, such as cocaine or alcohol.

paranoid personality disorder. Personality disorder defined by expectation of mistreatment at the hands of others, suspicion, secretiveness, jealousy, argumentativeness, unwillingness to accept blame, and cold and unemotional affect.

paranoid schizophrenia. A type of schizophrenia in which the patient has numerous systematized delusions as well as hallucinations and ideas of reference. He or she may also be agitated, angry, and argumentative.

paraphilias. Sexual attraction to unusual objects and sexual activities unusual in nature.

parasympathetic nervous system. The division of the autonomic nervous system that is involved with maintenance; controls many of the internal organs and is active primarily when the organism is not aroused. Compare *sympathetic nervous system.*

parent management training (PMT). Behavioral program in which parents are taught to modify their responses to their children so that prosocial rather than antisocial behavior is consistently rewarded.

parietal lobe. The middle division of each cerebral hemisphere, situated behind the central sulcus and above the lateral sulcus; the receiving center for sensations of the skin and of bodily positions.

PCP. Phencyclidine, also known by street names such as angel dust, PeaCE Pill, and zombie; this very powerful and hazardous drug causes profound disorientation, agitated and often violent behavior, and even seizures, coma, and death.

pedophilia. A paraphilia defined by a marked preference for obtaining sexual gratification through contact with people defined legally as underage.

penile plethysmograph. A device for detecting blood flow and thus for recording changes in the size of the penis.

personality disorders. A group of disorders, listed separately on Axis II of the DSM-IV-TR, involving long-standing, inflexible, and maladaptive personality traits that impair social and occupational functioning.

personality inventory. A self-report questionnaire comprised of statements assessing habitual behavioral and affective tendencies.

pervasive developmental disorders. Severe childhood conditions, encompassing autistic disorder, Rett's disorder, childhood disintegrative disorder, and Asperger's disorder, marked by profound disturbances in social relations and oddities in behavior.

PET scan. Computer-generated picture of the living brain, created by analysis of emissions from radioactive isotopes injected into the bloodstream.

phallic stage. In psychoanalytic theory, the third psychosexual stage, extending from ages 3 to 5 or 6, during which maximal gratification is obtained from genital stimulation.

phenotype. The totality of physical characteristics and behavioral traits of an individual, or a particular trait exhibited by an individual; the product of interactions between genetics and the environment over the course of development. Compare *genotype.*

phenylketonuria (PKU). A genetic deficiency in a liver enzyme, phenylalanine hydroxylase, that causes severe mental retardation unless phenylalanine can be largely restricted from the diet.

phobia. An anxiety disorder in which there is intense fear and avoidance of specific objects and situations, recognized as irrational by the individual.

phonological disorder. Communication disorder in childhood in which some words sound like baby talk because the person is not able to make certain speech sounds.

placebo. Any inactive therapy or chemical agent, or any attribute or component of such a therapy or chemical, that affects a person's behavior for reasons related to his or her expectation of change.

placebo effect. The action of a drug or psychological treatment that is not attributable to any specific operations of the agent. For example, a tranquilizer can reduce anxiety both because of its special biochemical action and because the recipient expects relief. See *placebo.*

plaques. Small, round areas composed of remnants of lost neurons and beta-amyloid, a waxy protein deposit; present in the brains of patients with Alzheimer's disease.

pleasure principle. In psychoanalytic theory, the demanding manner by which the id operates, seeking immediate gratification of its needs.

polydrug abuse. The misuse of more than one drug at a time, such as drinking heavily and taking cocaine.

polygenic. As applied to psychopathology or any other trait, caused by multiple genes contributing their effects, typically during multiple stages of development.

polymorphism. Any specific difference in DNA sequence that exists within a population.

positive affect. A constellation of particular positive emotions, such as excitement, that also reflect a general engagement with the environment; dampened in depression but not in anxiety.

positive reinforcement. The strengthening of a tendency to exhibit desired behavior by rewarding responses in that situation with a desired reward.

positive symptoms. Behavioral excesses in schizophrenia, such as hallucinations and delusions. Compare *negative symptoms.*

postpartum onset. Onset within 4 weeks postpartum, characterizing a subtype of episodes of major depressive disorder or mania.

posttraumatic model (of DID). Etiological model of dissociative identity disorder that assumes the condition begins in childhood as a result of severe physical or sexual abuse. Compare *sociocognitive model.*

posttraumatic stress disorder (PTSD). An anxiety disorder in which a particularly stressful event, such as military combat, rape, or a natural disaster, brings in its aftermath intrusive reexperiencing of the trauma, a numbing of responsiveness to the outside world, estrangement from others, and a tendency to be easily startled, as well as nightmares, recurrent dreams, and otherwise disturbed sleep.

predictive validity. See *validity.*

predisposition. An inclination or diathesis to respond in a certain way, either inborn or acquired; in abnormal psychology, a factor that lowers the ability to withstand stress and inclines the individual toward pathology.

prefrontal cortex. The region of the frontal lobe of the brain that helps maintain an image of threats and rewards faced, as well as maintain focus and plan relevant to those threats and rewards.

premature ejaculation. Inability of the male to inhibit his orgasm long enough for mutually satisfying sexual relations.

prepared learning. In classical conditioning theory, a biological predisposition to associate particular stimuli readily with the unconditioned stimulus.

prevalence. In epidemiological studies of a disorder, the percentage of a population that has the disorder at a given time. Compare *incidence*.

privileged communication. The communication between parties in a confidential relationship that is protected by statute, which a spouse, doctor, lawyer, pastor, psychologist, or psychiatrist thus cannot be forced to disclose, except under unusual circumstances.

process research. Research on the mechanisms by which a therapy may bring improvement. Compare *outcome research.*

prognosis. A prediction of the likely course and outcome of an illness. Compare *diagnosis*.

projective hypothesis. The notion that standard but highly unstructured stimuli, as found in the Rorschach assessment's series of inkblots, are necessary to bypass defenses in order to reveal unconscious motives and conflicts.

projective test. A psychological assessment device, such as the Rorschach series of inkblots, employing a set of standard but vague stimuli, on the assumption that unstructured material will allow unconscious motivations and fears to be uncovered.

pronoun reversal. A speech problem in which the child refers to himself or herself as "he," "she," or "you" and uses "I" or "me" in referring to others; often found in the speech of children with autistic disorder.

pruning. In neural development, the selective loss of synaptic connections, especially in the fine-tuning of brain regions devoted to sensory processing.

psilocybin. A psychedelic drug extracted from the mushroom *Psilocybe mexicana.*

psyche. In psychoanalytic theory, the totality of the id, ego, and superego, including both conscious and unconscious components.

psychiatric nurse. A nurse, typically with a bachelor's degree, who receives specialized training in mental illness. A nurse practitioner may prescribe psychiatric medications.

psychiatrist. A physician (M.D.) who has taken specialized postdoctoral training, called a residency, in the diagnosis, treatment, and prevention of mental disorders.

psychoactive medications. Prescribed chemical compounds—for example, Prozac—having a psychological effect that alters mood or thought process.

psychoanalysis. Primarily the therapy procedures pioneered by Freud, entailing free association, dream analysis, and working through the transference neurosis. More recently the term has come to encompass the numerous variations on basic Freudian therapy.

psychodynamic paradigm. General view based on psychodynamic and psychoanalytic theory.

psychoanalytic theory. Theory originating with Freud that psychopathology results from unconscious conflicts in the individual.

psychoeducational approaches. Especially with bipolar disorder and schizophrenia, the component of treatment that helps people learn about symptoms, expected time course, triggers for symptoms, and treatment strategies.

psychological factors affecting medical condition. A diagnosis in DSM-IV-TR that a physical illness is caused in part or exacerbated by psychological stress.

psychological tests. Standardized procedures designed to measure performance on a particular task or to assess personality.

psychoneuroimmunology. Field that studies how psychological factors (especially stressors) impact the immune system (adversely).

psychopathology. The field concerned with the nature and development of mental disorders.

psychopathy. A personality syndrome related to antisocial personality disorder but defined by an absence of emotion, impulsivity, manipulativeness, and irresponsibility.

psychophysiology. The discipline concerned with the bodily changes that accompany psychological events.

psychotherapy. A primarily verbal means of helping troubled individuals change their thoughts, feelings, and behavior to reduce distress and to achieve greater life satisfaction.

psychotic features. Delusions or hallucinations characterizing a subtype of episodes of major depressive disorder or mania. Also used to refer to positive symptoms of schizophrenia.

random assignment. A method of assigning people to groups by chance (e.g., using a flip of a coin). The procedure helps to ensure that groups are comparable before the experimental manipulation begins.

randomized controlled trials (RCTs). Studies in which clients are randomly assigned to receive either active treatment or a comparison (a placebo condition involving no treatment, or else an active-treatment control group that receives another treatment); experimental treatment studies, where the independent variable is the treatment type and the dependent variable is client outcome.

rapid cycling. Term applied to bipolar disorders if the person has experienced at least four episodes within the past year.

rational-emotive behavior therapy (REBT). A cognitive-restructuring behavior therapy introduced by Albert Ellis and based on the assumption that much disordered behavior is rooted in absolutistic, unrealistic demands and goals, such as, "I must be universally loved."

reactivity. The phenomenon wherein behavior changes because it is being observed.

reading disorder. See *dyslexia.*

reality principle. In psychoanalytic theory, the manner in which the ego delays gratification and otherwise deals with the environment in a planned, rational fashion.

receptor. A protein embedded in a neural cell membrane that interacts with one or more neurotransmitters. Nonneural receptor proteins include hormone receptors.

reciprocal gene–environment interaction. The genetic predisposition for an individual to seek out certain environments that increase the risk of developing a particular disorder. Compare *gene–environment interaction.*

reliability. The extent to which a test, measurement, or classification system produces the same scientific observation each time it is applied. Reliability types include test–retest, the relationship between the scores that a person achieves when he or she takes the same test twice; interrater, the relationship between the judgments that at least two raters make independently about a phenomenon; split-half, the relationship between two halves of an assessment instrument that have been determined to be equivalent; alternate-form, the relationship between scores achieved by people when they complete two versions of a test that are judged to be equivalent; and internal consistency, the degree to which different items of an assessment are related to one another.

repression. A defense mechanism whereby impulses and thoughts unacceptable to the ego are pushed into the unconscious.

residual schizophrenia. Diagnosis given to patients who have had an episode of schizophrenia but who presently show no psychotic symptoms, though signs of the disorder do exist.

resolution phase. The fourth and final stage of the sexual response cycle, characterized by an abatement of muscle tension, relaxation, and a sense of well-being.

Rett's disorder. A very rare pervasive developmental disorder found only in girls, with onset in the first or second year of life; symptoms include decelerated head growth, lost ability to use hands purposefully, uncoordinated walking, poor speech production and comprehension, and poor interpersonal relations. The child may improve later in life but usually will remain severely or profoundly mentally retarded.

reuptake. Cellular process by which released neurotransmitters are taken back into the presynaptic cell, terminating their present postsynaptic effect but making them available for subsequent modulation of nerve impulse transmission.

reversal (ABAB) design. An experimental design in which behavior is measured during a baseline period (A), during a period when a treatment is introduced (B), during the reinstatement of the conditions that prevailed in the baseline period (A), and finally during a reintroduction of the treatment (B); commonly used in operant research to isolate cause–effect relationships.

reward system. System of brain structures involved in the motivation to pursue rewards. Believed to be involved in depression, mania, schizophrenia, and substance dependence.

risk factor. A condition or variable that increases the likelihood of developing a disorder.

Rorschach Inkblot Test. A projective test in which the examinee is instructed to interpret a series of 10 inkblots reproduced on cards.

safety behaviors. Behaviors used to avoid experiencing anxiety in feared situations, such as the tendency of people with social phobia to avoid looking at other people (so as to avoid perceiving negative feedback) or the tendency of people with panic disorder to avoid exercise (so as to avoid somatic arousal that could trigger a panic attack).

schema. A mental structure for organizing information about the world. Pl.: *schemata*.

schizoaffective disorder. Diagnosis applied when a patient has symptoms of both mood disorder and either schizophreniform disorder or schizophrenia.

schizoid personality disorder. Personality disorder defined by emotional aloofness; indifference to the praise, criticism, and feelings of others; maintenance of few, if any, close friendships; and solitary interests.

schizophrenia. A group of psychotic disorders characterized by major disturbances in thought, emotion, and behavior; disordered thinking in which ideas are not logically related; faulty perception and attention; bizarre disturbances in motor activity; flat or inappropriate emotions; reduced tolerance for stress in interpersonal relations and withdrawal from people and reality, often into a fantasy life of delusions and hallucinations. See *schizoaffective disorder*, *schizophreniform disorder*, and *brief psychotic disorder.*

schizophreniform disorder. Diagnosis given to people who have all the symptoms of schizophrenia for more than 2 weeks but less than 6 months. See *brief psychotic disorder.*

schizotypal personality disorder. Personality disorder defined by eccentricity, oddities of thought and perception (magical thinking, illusions, depersonalization, derealization), digressive speech involving overelaborations, and social isolation; under stress, behavior may appear psychotic.

school phobia. An acute, irrational dread of attending school, usually accompanied by somatic complaints; the most common phobia of childhood.

second-generation antipsychotic drugs. Any of several drugs, such as clozapine, used to treat schizophrenia that produce fewer motor side effects than traditional antipsychotics while reducing positive and disorganized symptoms at least as effectively; may, however, be associated with increased and serious side effects of other varieties.

second messengers. Intracellular molecules whose levels are increased by sustained activity of neurotransmitter, for example, receptors, and which affect the resting states of ion channels or regulate gene expression of receptor molecules, thus modulating the cell's sensitivity to neurotransmitter.

secondhand smoke. Also referred to as environmental tobacco smoke (ETS), the smoke from the burning end of a cigarette; contains higher concentrations of ammonia, carbon monoxide, nicotine, and tar than the smoke inhaled by the smoker.

sedatives. Drugs that slow bodily activities, especially those of the central nervous system; used to reduce pain and tension and to induce relaxation and sleep.

selective mortality. The tendency for less healthy individuals to die more quickly, which leads to biased samples in long-term follow-up studies.

selective serotonin reuptake inhibitors (SSRIs). Any of various drugs that inhibit the presynaptic reuptake of the neurotransmitter serotonin, thereby prolonging its effects on postsynaptic neurons.

self-actualization. Fulfilling one's potential as an always growing human being; believed by client-centered therapists to be the core motive of all humans.

self-monitoring. In behavioral assessment, a procedure whereby the individual observes and reports certain aspects of his or her own behavior, thoughts, or emotions.

sensate focus. A term applied to exercises prescribed at the beginning of the Masters and Johnson sex therapy program, in which partners are instructed to fondle each other to give pleasure but to refrain from intercourse, thus reducing anxiety about sexual performance.

separation anxiety disorder. A disorder in which the child feels intense fear and distress when away from someone on whom he or she is very dependent; said to be a significant cause of school phobia.

septal area. In the subcortical region of the brain, the area anterior to the thalamus.

serotonin. A neurotransmitter of the central nervous system whose disturbances apparently figure in depression.

serotonin transporter gene. A particular gene critical to the gene–environment interactions that apparently contribute to the development of depression.

sex-reassignment surgery. An operation removing existing genitalia and constructing a substitute for the genitals of the opposite sex.

sexual aversion disorder. Avoidance of nearly all genital contact with other people. Compare *hypoactive sexual desire disorder*.

sexual dysfunctions. Dysfunctions in which the appetitive or psychophysiological changes of the normal sexual response cycle are inhibited. Compare *hypoactive sexual desire disorder.*

sexual masochism. A marked preference for obtaining or increasing sexual gratification through subjection to pain or humiliation.

sexual orientation. An individual's emotional, romantic, or sexual attraction toward other people that is stable and enduring.

sexual response cycle. The general pattern of sexual physical processes and feelings, made up of four phases: appetitive interest, excitement, orgasm, and resolution.

sexual sadism. A marked preference for obtaining or increasing sexual gratification by inflicting pain or humiliation on another person.

shaping. In operant conditioning, reinforcing responses that are successively closer approximations to the desired behavior.

shared environment. Factors that family members have in common, such as income level, child-rearing practices, and parental marital status and quality. Compare *nonshared environment.*

single-subject experimental design. A design for an experiment conducted with a single subject. Typically, behavior is measured within a baseline condition, then during an experimental or treatment condition, and finally within the baseline condition again.

social phobia. A collection of fears linked to the presence of other people.

social selection theory. An attempt to explain the correlation between social class and schizophrenia by arguing that people with schizophrenia tend to move downward in socioeconomic status. Compare *sociogenic hypothesis.*

social selectivity. The late-life shift in interest away from seeking new social interactions and toward cultivating those few social relationships that matter most, such as with family and close friends.

social worker. A mental health professional who holds a master of social work (M.S.W.) degree.

social skills training. Behavior therapy procedures, such as modeling and behavior rehearsal, for teaching individuals how to meet others, talk to them and maintain eye contact, give and receive criticism, offer and accept compliments, make requests and express feelings, and otherwise improve their relations with other people.

sociocognitive model (of DID). Etiological model of dissociative identity disorder that considers the condition to be the result of learning to enact social roles, though not through conscious deception, but in response to suggestion. Compare *posttraumatic model (of DID).*

sociogenic hypothesis. An idea that seeks causes in social conditions, for example, that being in a low social class can cause one to become schizophrenic. Compare *social selection theory.*

somatic arousal. Sweaty palms, fast heart rate, and so on; expected to increase in anxiety but not in depression.

somatic nervous system. The division of the nervous system that controls muscles under voluntary control. Compare *autonomic nervous system.*

somatization disorder. A somatoform disorder, once called Briquet's syndrome, in which the person continually seeks medical help for recurrent and multiple physical symptoms that have no discoverable physical cause, despite a complicated medical history that is dramatically presented. Compare *hypochondriasis.*

somatoform disorders. Disorders in which symptoms suggest a physical problem but have no known physiological cause; believed to be linked to psychological conflicts and needs but not voluntarily assumed. See *somatization disorder (Briquet's syndrome)*, *conversion disorder*, *pain disorder*, and *hypochondriasis.*

specific phobia. An unwarranted fear and avoidance of a specific object or circumstance, for example, fear of nonpoisonous snakes or fear of heights.

spectator role. As applied by Masters and Johnson, a pattern of behavior in which the individual's focus on and concern with sexual performance causes him or her to be an observer rather than a participant and thus impedes natural sexual responses.

standardization. The process of constructing a normed assessment procedure that meets the various psychometric criteria for reliability and validity.

statistical significance. A result that has a low probability of having occurred by chance alone and is by convention regarded as important. Compare *clinical significance.*

statutory rape. Sexual intercourse between an adult and someone who is under the age of consent, as fixed by local statute. Compare *forced rape.*

stepped care. The practice of beginning treatment with the least intrusive intervention possible and moving on to more intensive efforts only if necessary.

stigma. The pernicious beliefs and attitudes held by a society, ascribed to groups considered deviant in some manner, such as people with mental illness.

stimulant. A drug, such as cocaine, that increases alertness and motor activity and at the same time reduces fatigue, allowing an individual to remain awake for an extended period of time.

stress. State of an organism subjected to a stressor; can take the form of increased autonomic activity and in the long term can cause breakdown of an organ or development of a mental disorder.

stress management. A range of psychological procedures that help people control and reduce their stress or anxiety.

structural social support. A person's network of social relationships, for example, number of friends. Compare *functional social support.*

structured interview. An interview in which the questions are set out in a prescribed fashion for the interviewer; assists professionals in making diagnostic decisions based on standardized criteria.

stuttering. Communication disorder of childhood marked by frequent and pronounced verbal dysfluencies, such as repetitions of certain sounds.

substance abuse. The use of a drug to such an extent that the person is often intoxicated throughout the day and fails in important obligations and in attempts to abstain, but there is no physiological dependence.

substance dependence. The abuse of a drug sometimes accompanied by a physiological dependence on it, made evident by tolerance and withdrawal symptoms; also called addiction.

substance-related disorders. Disorders in which drugs such as alcohol and cocaine are abused to such an extent that behavior becomes maladaptive; social and occupational functioning are impaired, and control or abstinence becomes impossible. Reliance on the drug may be either psychological, as in substance abuse, or physiological, as in substance dependence (addiction).

subthreshold symptoms. Symptoms of a disorder that are clinically significant but do not meet full diagnostic criteria.

suicide. The intentional taking of one's own life.

suicide prevention centers. Staffed primarily by paraprofessionals who are trained to be empathic and to encourage suicidal callers—assumed to be ambivalent—to consider nondestructive ways of dealing with what is bothering them.

superego. In psychoanalytic theory, the part of the personality that acts as the conscience and reflects society's moral standards as learned from parents and teachers.

sympathetic nervous system. The division of the autonomic nervous system that acts on bodily systems—for example, contracting the blood vessels, reducing activity of the intestines, and increasing the heartbeat—to prepare the organism for exertion, emotional stress, or extreme cold. Compare *parasympathetic nervous system*.

symptom. An observable physiological or psychological manifestation of a disease.

synapse. Small gap between two neurons where the nerve signal passes electrically or chemically from the axon of the first to the dendrites, cell body, or axon of the second.

systematic desensitization. A major behavior therapy procedure that has a fearful person, while deeply relaxed, imagine a series of progressively more fearsome situations, such that fear is dispelled as a response incompatible with relaxation; useful for treating psychological problems in which anxiety is the principal difficulty.

tardive dyskinesia. A muscular disturbance of patients who have taken phenothiazines for a very long time, marked by involuntary motor movements such as lip smacking and chin wagging.

temporal lobe. A large region of each cerebral hemisphere situated below the lateral sulcus and in front of the occipital lobe; contains primary auditory and general association areas.

test–retest reliability. See *reliability.*

thalamus. A major brain relay station consisting of two egg-shaped lobes; receives impulses from all sensory areas except the olfactory and transmits them to the cerebrum for higher processing.

Thematic Apperception Test (TAT). A projective test consisting of black-and-white pictures, each depicting a potentially emotion-laden situation, about each of which the examinee is instructed to make up a story. See also *projective hypothesis.*

theory. A formally stated and coherent set of propositions that explain and logically order a range of phenomena, generating testable predictions or hypotheses.

therapeutic (working) alliance. The collaborative relationship between therapist and patient, in which they share an affective bond and an ability to agree on treatment goals.

third-variable problem. The difficulty in the correlational method of research whereby the relationship between two variables may be attributable to a third factor.

thought suppression. Key feature of obsessive-compulsive disorder; has the paradoxical effect of inducing preoccupation with the object of thought.

time-of-measurement effects. A possible confound in longitudinal studies whereby conditions at a particular point in time can have a specific effect on a variable that is being studied over time.

time-out. An operant-conditioning procedure in which, after bad behavior, the person is temporarily removed from a setting where reinforcers can be obtained and placed in a less desirable setting, for example, in a boring room.

token economy. A behavior therapy procedure, based on operant-conditioning principles, in which hospitalized patients are given scrip rewards, such as poker chips, for socially constructive behavior. The tokens can be exchanged for desirable items and activities such as cigarettes and extra time away from the ward.

tolerance. A physiological process in which greater and greater amounts of an addictive drug are required to produce the same effect. See also *substance dependence.*

transference. The venting of the analysand's emotions, either positive or negative, by treating the psychoanalyst as the symbolic representative of someone important in the past.

transvestic fetishism. The practice of dressing in the clothing of the opposite sex, for the purpose of sexual arousal.

tricyclic antidepressants. A group of antidepressants with molecular structures characterized by three fused rings; interfere with the reuptake of norepinephrine and serotonin.

tryptophan. Amino acid that is the major precursor of serotonin; experimental depletion has found that a lowered serotonin level causes temporary depressive symptoms in people with a personal or family history of depression.

twin method. Research strategy in behavior genetics in which concordance rates of monozygotic and dizygotic twins are compared.

Type A behavior pattern. One of two contrasting psychological patterns revealed through studies seeking the cause of coronary heart disease. Type A people are competitive, rushed, hostile, and overcommitted to their work, and are believed to be at heightened risk for heart disease; Type B people are more relaxed and relatively free of pressure.

unconditional positive regard. According to Rogers, a crucial attitude for the client-centered therapist to adopt toward the client, who needs to feel complete acceptance as a person in order to evaluate the extent to which current behavior contributes to self-actualization.

unconditioned response (UCR). See *classical conditioning.*

unconditioned stimulus (UCS). See *classical conditioning.*

unconscious. A state of unawareness without sensation or thought; in psychoanalytic theory, the part of the personality, in particular the id impulses or energy, of which the ego is unaware.

undifferentiated schizophrenia. Diagnosis for patients whose symptoms either do not fit any listed category of schizophrenia or meet the criteria for more than one subtype.

vaginismus. Painful, spasmodic contractions of the outer third of the vagina, making penetration impossible or extremely difficult.

validity. In research, includes internal, the extent to which results can be confidently attributed to the manipulation of the independent variable, and external, the extent to which results can be generalized to other populations and settings. Validity as applied to psychiatric diagnoses includes concurrent, the extent to which previously undiscovered features are found among patients with the same diagnosis, and predictive, the extent to which predictions can be made about the future behavior of patients with the same diagnosis. Validity as applied to psychological and psychiatric measures includes content validity, the extent to which a measure adequately samples the domain of interest, and criterion, the extent to which a measure is associated in an expected way with some other measure (the criterion). See also *construct validity.*

ventricles. Cavities deep within the brain, filled with cerebrospinal fluid, that connect to the spinal cord.

voyeurism. Marked preference for obtaining sexual gratification by watching others in a state of undress or having sexual relations.

white matter. Neural tissue, particularly of the brain and spinal cord, consisting of tracts or bundles of myelinated (sheathed) nerve fibers. Compare *gray matter.*

withdrawal. Negative physiological and psychological reactions evidenced when a person suddenly stops taking an addictive drug; cramps, restlessness, and even death are examples. See *substance dependence.*

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