Measuring cognitive performance has been a hallmark of clinical psychology since its origin. Knowledge of a client’s level of cognitive functioning, including both strengths and deficits, can help a clinical psychologist with diagnosis and treatment of many presenting problems. Some assessments, such as those for learning disabilities, mental retardation, or giftedness, focus on cognitive issues from the start. In other assessments, like those focusing on mood disorders or disruptive behavior, cognitive tests can provide important contextual information.
This chapter focuses on three types of tests, each related to cognitive functioning in some way, but each with a distinct purpose. **Intelligence tests** measure a client’s intellectual abilities. **Achievement tests**, in contrast, measure what a client has accomplished with those intellectual abilities. **Neuropsychological tests** focus on issues of cognitive or brain dysfunction, including the effects of brain injuries and illnesses.

**INTELLIGENCE TESTING**

**Classic Theories of Intelligence**

The specific intelligence tests used by contemporary clinical psychologists are rooted in contrasting theories of intelligence. Each of these theories puts forth a different answer to the essential question: What is intelligence? Actually, there has never been a consensus among clinical psychologists regarding the definition of intelligence. Experts in this area of clinical psychology have emphasized many abilities as central to intelligence: speed of mental processing, sensory capacity, abstract thinking, imagination, adaptability, capacity to learn through experience, memory, reasoning, and inhibition of instinct, to name a few (as summarized by Sternberg, 2000 and Wasserman & Tulsky, 2005). In the debate about defining intelligence, perhaps no specific issue has received as much attention as the singular versus plural nature of intelligence. In other words, is intelligence one thing or many things?
Charles Spearman: Intelligence Is One Thing

In the early 1900s, Charles Spearman proposed a theory: Intelligence is a singular characteristic. Spearman labeled this characteristic “g” for general intelligence and argued that it represented a person’s global, overall intellectual ability. His theory was based on research in which he measured many different, specific capabilities of his participants, including academic abilities and sensory-discrimination tasks. The primary finding was a strong correlation between this wide range of abilities, suggesting that, a single factor underlies them all. Spearman did acknowledge that more specific abilities (“s”) existed, but he argued that they played a relatively minor role in intelligence. Essentially, according to Spearman, intelligence was one thing (Brody, 2000).

Louis Thurstone: Intelligence Is Many Things

Louis Thurstone was among the first and the strongest opponents to Spearman’s singular theory of intelligence. According to Thurstone, intelligence should not be understood as a single, unified ability but as numerous distinct abilities that had little relationship to each other. Among his other contributions in the first half of the 1900s, Thurstone was a pioneer of the statistical procedure called multiple factor analysis, which enabled him to identify underlying factors in a large data set. When he performed these statistical analyses on examinations of various intellectual abilities, he could have found one dominant factor underlying all abilities. Instead, he found several independent factors. These factors were given labels such as verbal comprehension, numerical ability, spatial reasoning, and memory. The specific names and number of the factors are less important, however, than Thurstone’s fundamental point: Intelligence is not one thing, it is many things (Brody, 2000). Thus, according to Thurstone, if you know how capable someone is regarding, say, mathematics, you cannot predict with confidence how capable that person is regarding, say, verbal skills.

Eventually, Spearman and Thurstone each acknowledged the validity of the arguments of the other and came to somewhat of a compromise. They settled on a hierarchical model of intelligence in which specific abilities (“s”) existed and were important, but they were all at least somewhat related to each other and to a global, overall, general intelligence (“g”).

More Contemporary Theories of Intelligence

Other theories of intelligence have emerged since the debates between Spearman and Thurstone, most of which provide a fresh perspective on the singular versus plural issue (Brody, 2000; Davidson & Downing, 2000). For example, in the latter half of the 1900s, James Cattell proposed two separate intelligences:
If You’ve Watched Michael Jordan, Then You Understand the Challenges of Defining and Assessing Intelligence

Michael Jordan is undoubtedly one of the greatest basketball players of all time. His five MVP awards and six NBA championships provide indisputable proof. But if we broaden the question—is Michael Jordan a great athlete?—we can begin to appreciate some of the challenges in defining ability, whether athletic or intellectual.

In 1993, after 9 extremely successful years in the NBA, Jordan decided (to the surprise of many) to leave basketball and focus on baseball. He signed on with the Birmingham Barons, a Double-A level minor league team, and in a word, he struggled. His prowess did not easily transfer from the basketball court to the baseball diamond. Instead of the familiar highlights of acrobatic dunks and picturesque jump shots, sports fans saw Jordan flailing at curve balls and misjudging fly balls. His hitting and fielding improved slightly but not enough to advance any closer to the major leagues.

Should we expect that a person who excels at one sport would similarly excel at others? If so, perhaps each of us possesses a general athletic ability that influences our performance at any sport—a lot like Spearman’s concept of a general intelligence (“g”). If not, perhaps each of us has a number of specific athletic abilities that are unrelated to each other—a lot like Thurstone’s theory of specific (“s”), multiple intelligences.

Which theory does the example of Michael Jordan support? On the one hand, the contrast between Jordan’s basketball excellence and baseball mediocrity supports the idea that our abilities are independent. Indeed, in the history of athletics, there have been very few people (e.g., Jim Thorpe, Bo Jackson) who have reached the highest level of multiple sports. On the other hand, despite focusing exclusively on basketball for many years, Jordan was able to, with minimal preparation, step onto a minor league baseball team and hold his own. He may not have excelled, but he did achieve some success at a level of baseball that far exceeds the talents of the majority of players. This would suggest that he possesses some fundamental, general athletic ability that applies, to some extent, to any sport. And most of us can recall classmates who starred in multiple sports in high school. Perhaps Michael Jordan’s experiences best support the hierarchical models of ability, which acknowledge a general, across-the-board ability (of athletics or intelligence) as well as more specific talents (basketball vs. baseball, math vs. verbal skills) that are influenced by the general ability but may be somewhat independent as well.

In your personal experience, does athletic ability seem to be one thing or many things? Consider the athletic abilities of people you have known (or perhaps played with or against)—are the best at one sport typically among the best at other sports? What about intellectual ability? Among your friends and family, do people seem to have a singular intelligence that influences all of their abilities or many distinct abilities that operate independently?
fluid intelligence—the ability to reason when faced with novel problems—and crystallized intelligence—the body of knowledge one has accumulated as a result of life experiences. With exactly two very broad categories of intelligence, Cattell’s theory falls somewhere between Spearman’s theory of a singular intelligence and Thurstone’s theory of many intelligences. More recently, new hierarchical models of intelligence have emerged as well, including John Carroll’s three-stratum theory of intelligence (Carroll, 2005) in which intelligence operates at three levels: a single “g” at the top, 8 broad factors immediately beneath “g,” and more than 60 highly specific abilities beneath these broad factors. This model, like most contemporary models of intelligence, not only acknowledges “g” but also recognizes that more specific abilities exist as well (Wasserman & Tulsky, 2005). As we will see in this chapter, most contemporary intelligence tests mirror this view by producing a single overall score—one number to represent how intelligent a person is—in addition to a number of other scores representing more specific abilities. The Wechsler intelligence tests are among these.

Wechsler Intelligence Tests

Since David Wechsler’s earliest attempts to measure intelligence in the early 1900s, the tests that bear his name have risen to prominence among clinical psychologists. There are three separate Wechsler intelligence tests, each the most highly respected and popular among clinical psychologists for its respective age range. The names and current editions of the Wechsler intelligence tests are as follows:

- Wechsler Adult Intelligence Scale—Third Edition (WAIS-III)
- Wechsler Intelligence Scale for Children—Fourth Edition (WISC-IV)
- Wechsler Preschool and Primary Scale of Intelligence—Third Edition (WPPSI-III)

Table 9.1 provides a brief description each of these Wechsler intelligence tests, as well as the other intelligence, achievement, and neuropsychological tests covered in detail in this chapter.

Collectively, the three Wechsler intelligence tests cover virtually the entire life span. They vary slightly from each other, as necessitated by the demands of measuring intelligence at different ages. And in practical terms, they are indeed separate tests rather than slight variants of each other. (They are purchased as separate kits, with separate manuals, answer sheets, materials, etc.) However, the three Wechsler intelligence tests share many fundamental characteristics:
They yield a single full-scale intelligence score, four index scores, and about a dozen (give or take a few, depending on optional subtests chosen) specific subtest scores. Together, this collection of scores indicates that the Wechsler tests employ a hierarchical model of intelligence (as discussed above), in which the full-scale intelligence score reflects a general, global level of intelligence (“g”), and the index/factor scores and subtest scores represent increasingly specific areas of ability (“s”). These scores allow clinical psychologists to focus broadly or narrowly when making interpretations regarding intellectual ability.

They are administered one-on-one and face-to-face. In other words, the Wechsler tests cannot be administered to a group of examinees at the same time, nor are they entirely pencil-and-paper tests (e.g., multiple choice, true/false, essay) that examinees simply administer to themselves. Administration of the Wechsler
intelligence tests is a structured interpersonal interaction requiring extensive training, typically received during graduate programs in clinical psychology.

- Each subtest is brief (lasting about 2–10 minutes) and consists of items that increase in difficulty as the subtest progresses. Most often, the subtests are designed such that examinees continue until they fail a predetermined number of consecutive items (or “max out,” to state it informally). The nature of the tasks performed varies widely across the dozen or so subtests but includes both verbal and nonverbal tasks. (More detailed descriptions of the subtests follow shortly.)

- Although each of the three Wechsler tests has a small number of unique subtests, most subtests appear in all three tests and form the core of the Wechsler battery. These common subtests are described in detail in Table 9.2.

- Originally, the Wechsler tests were designed with two categories of subtests: verbal and performance. (“Performance” was essentially equivalent to “nonverbal.”) In more recent years, statistical tests including factor analyses have concluded that the subtests don’t, in fact, cluster together into those two groups. Instead, they cluster together in four, rather than two, factors. Thus, the original verbal/performance split has been replaced by four factors, each receiving contributions from several subtests. These four factors form the names of the four index scores common to all Wechsler intelligence tests:
  - Verbal Comprehension Index—a measure of verbal concept formation and verbal reasoning
  - Perceptual Reasoning Index (called Perceptual Organization Index in the WAIS)—a measure of fluid reasoning, spatial processing, and visual-motor integration
  - Working Memory Index—a measure of the capacity to store, transform, and recall incoming information and data in short-term memory
  - Processing Speed Index—a measure of the ability to rapidly and accurately process simple or rote information

- They feature large, carefully collected sets of normative data. That is, the manual for each Wechsler test includes norms collected from about 2,000 people (to be exact, 2,450 for the WAIS-III, 2,200 for the WISC-IV, and 1,700 for the WPPSI-III). This normative group closely matches recent U.S. Census data in terms of gender, age, race/ethnicity, and geographic region, among other variables (Zhu & Weiss, 2005). So, when an examinee takes a Wechsler intelligence test, the examinee’s performance is compared with the performance of a large, same-age sample of individuals representing a wide-scale national sample.

- The full-scale and index scores generated by the Wechsler tests are “IQ” scores, meaning that they reflect an intelligence “quotient.” This quotient is the result of a division problem in which the examinees’ raw scores are compared with
### Table 9.2  Subtests Common to Wechsler Tests of Intelligence

<table>
<thead>
<tr>
<th>Subtest Name</th>
<th>Description of Examinee’s Task</th>
<th>Simulated Item(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocabulary</td>
<td>Orally explain the meaning of a word</td>
<td>• What does “consistent” mean?&lt;br&gt;• What is an “intersection”?</td>
</tr>
<tr>
<td>Similarities</td>
<td>Orally explain how two things or concepts are alike</td>
<td>• How are a door and a window alike?&lt;br&gt;• How are success and failure alike?</td>
</tr>
<tr>
<td>Information</td>
<td>Orally answer questions focusing on specific items of general knowledge</td>
<td>• On what continent is Spain?&lt;br&gt;• How many cents is a quarter worth?</td>
</tr>
<tr>
<td>Comprehension</td>
<td>Orally answer questions about general social principles and social situations</td>
<td>• Why is it important for people to show identification before being allowed to vote?&lt;br&gt;• What are some advantages of using only the minimal amount of water necessary in our homes?</td>
</tr>
<tr>
<td>Block Design</td>
<td>Re-create a specific pattern or design of colored blocks</td>
<td></td>
</tr>
<tr>
<td>Picture Completion</td>
<td>View picture of a simple object or scene and identify the important part that is missing</td>
<td></td>
</tr>
<tr>
<td>Subtest Name</td>
<td>Description of Examinee’s Task</td>
<td>Simulated Item(s)</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Matrix Reasoning</td>
<td>View an incomplete matrix and select the missing portion from multiple choices provided</td>
<td><img src="image" alt="Matrix Reasoning" /></td>
</tr>
<tr>
<td>Coding</td>
<td>Using pencil and paper, repeatedly copy simple shapes/symbols in appropriate spaces according to a key provided</td>
<td><img src="image" alt="Coding" /></td>
</tr>
<tr>
<td>Symbol Search</td>
<td>Scan a group of visual shapes/symbols to determine if target shape(s)/symbol(s) appear in group</td>
<td><img src="image" alt="Symbol Search" /></td>
</tr>
</tbody>
</table>
age-based expectations. For all Wechsler tests, mean IQ scores (full-scale and index) are 100, with a standard deviation of 15. For each subtest, a score of 10 is average, with a standard deviation of 3.

- The Wechsler intelligence tests are all backed by very impressive psychometric data. That is, a large number of empirical studies suggest that these tests have the characteristics that clinical psychologists should seek in any test: strong reliability and validity. They measure what they intend to measure, and they do so consistently (Lichtenberger & Kaufman, 2004; Zhu & Weiss, 2005).

- The Wechsler intelligence tests—and most other intelligence tests, for that matter—are used for a wide range of clinical applications, including evaluations that focus on issues of learning disabilities, mental retardation, developmental delays, giftedness, educational and vocational planning, school placement and qualification, and other targeted assessment questions (Zhu & Weiss, 2005). They can also be used to provide general intelligence information in more broader contexts, including a comprehensive assessment of a client whose presenting problems are more neuropsychological (e.g., Alzheimer’s disease), emotional (e.g., mood disorders), or behavioral (e.g., attention deficit/hyperactivity disorder [ADHD]).

- Generally, the Wechsler intelligence tests have a number of notable strengths: They have impressive reliability and validity; they feature comprehensive and recent normative data; they cover an extremely wide age range; they provide full-scale, index, and subtest scores that have great clinical utility; and at this point in their history, they are very familiar to most clinical psychologists. On the other hand, these tests have received criticism for some limitations: Some subtests may be culturally loaded or biased, the connection between the tests and day-to-day life (ecological validity) may be limited, and scoring can be complex or subjective on some subtests (Groth-Marnat, 2003; Zhu & Weiss, 2005). On the whole, however, the Wechsler tests are held in high esteem by clinical psychologists.

Stanford-Binet Intelligence Scales—Fifth Edition (SB5)

The Stanford-Binet intelligence tests have a rich history in clinical psychology. The first editions of the Stanford-Binet intelligence test dominated the field in the early 1900s until Wechsler’s tests began to provide competition. Although Wechsler’s tests have taken a leading role in recent decades, the Stanford-Binet remains highly respected and offers an approach to assessing intelligence that is both similar to and different from that of Wechsler’s tests.

The most recent revision of the Stanford-Binet, the Stanford-Binet Intelligence Scales—Fifth Edition (SB5), is like the Wechsler tests in many ways. It is administered face-to-face and one-on-one. It employs a hierarchical model of intelligence and therefore yields a singular measure of full-scale IQ (or “g”), five factor scores,
and many more specific subtest scores. It features the same means (100) and standard deviations (15) as the Wechsler intelligence tests for its full-scale and factor scores. Its psychometric data, including reliability and validity, is similarly strong.

The SB5 differs from the Wechsler tests in some important ways, however. Rather than three separate tests for three different age ranges, the SB5 covers the entire life-span (ages 2–85+) as a single test. The normative sample is like those of Wechsler tests in that it matches recent U.S. Census data on important variables, but it additionally includes normative data from individuals with specific relevant diagnoses, including learning disabilities, mental retardation, and ADHD. Its subtests include extensions at the low- and high-end—in other words, a greater number of very easy and very difficult items—as an effort to more accurately assess people at the extremes, including those who may be profoundly mentally retarded or highly gifted (Kamphaus & Kroncke, 2004).

Perhaps the most important difference between the SB5 and the Wechsler tests involves their specific factors and subtests. Whereas the Wechsler tests feature four factors, each of which yields an index score, the SB5 features five, described briefly here:

- **Fluid Reasoning**—the ability to solve novel problems
- **Knowledge**—general information accumulated over time via personal experiences including education, home, and environment
- **Quantitative Reasoning**—the ability to solve numerical problems
- **Visual-Spatial Processing**—the ability to analyze visually presented information, including relationships between objects, spatial orientation, assembling pieces to make a whole, and detect visual patterns
- **Working Memory**—the ability to hold and transform information in short-term memory

Each of these five factors is measured both verbally and nonverbally, a deliberate innovation that is new to the SB5 and to IQ tests more generally. Each of these 10 areas (five factors, each measured both verbally and nonverbally) is assessed by one to three specific types of items (Kamphaus & Kroncke, 2004).

Overall, current editions of the Wechsler tests may have become more widely used than the current edition of the Stanford-Binet, but the SB5 continues to hold a similar position of respect and, in some settings, popularity that it has for the last century.

### Additional Tests of Intelligence: Addressing Cultural Fairness

Especially in recent years, one of the primary criticisms of the Wechsler tests, the SB5, and other renowned IQ tests has centered on issues of cultural fairness. Specifically, these tests have been described as featuring numerous subtests,
especially those relying on verbal skills, which place individuals from minority cultural groups at a disadvantage. In other words, to the extent that an intelligence test is based upon culture-specific concepts, it may unfairly assess the intelligence of people of other cultures. Certainly, the authors of prominent tests, including the Wechsler tests and the SB5, have made significant efforts to make recent editions of their tests less culturally biased or loaded. But entirely new tests have also emerged, with the explicit purpose of measuring IQ in a more culturally fair way.

A leading example of such a test is the Universal Nonverbal Intelligence Test (UNIT) (McCallum & Bracken, 2005). Originally published in 1996, the UNIT is a completely language-free test of intelligence. It requires no speaking or shared understanding of language between the person administering the test and the person taking it. Like the Wechsler and Stanford-Binet intelligence tests, the UNIT is administered one-on-one and face-to-face, but rather than using verbal instructions, the examiner presents instructions via eight specific hand gestures taught in the test manual and demonstrated in an accompanying video. Additionally, the responses of the examinee all consist of either pointing with fingers or minor manipulation of objects with hands or fingers.

The UNIT is appropriate for children aged 5 to 17 years and was normed on 2,100 children who match recent U.S. Census data in terms of age, sex, race, parent education, community size, geographic region, and ethnicity. A small body of psychometric data on the UNIT has been published and suggests generally acceptable reliability and validity.

The UNIT consists of six subtests organized into a two-tiered model of intelligence. The two tiers are identified as Memory and Reasoning. The three subtests contributing to the memory tier are

- **Object Memory**, in which the examinee views a visual assortment of common objects for 5 seconds and then views a larger array and identifies the objects from the first array.
- **Spatial Memory**, in which the examinee recalls the placement of colored chips on a $3 \times 3$ or $4 \times 4$ grid.
- **Symbolic Memory**, in which the examinee recalls and re-creates sequences of visually presented symbols.

The three subtests contributing to the reasoning tier are

- **Cube Design**, in which the examinee arranges colored blocks in a specific three-dimensional design.
- **Mazes**, in which the examinee completes traditional maze puzzles.
- **Analogic Reasoning**, in which the examinee solves analogy problems that are presented visually rather than verbally.
The UNIT is not without its shortcomings. It assesses a more limited range of abilities than more traditional IQ tests, it is appropriate only for school-age children (no preschool or adult version has yet been developed), and its psychometric data, although encouraging, is limited in quantity. Additionally, as a relative newcomer to the intelligence test field, the structure and format of the UNIT is unfamiliar to many clinical psychologists. Such limitations are common to nonverbal or “culture-free” tests more generally (Ortiz & Dynda, 2005). However, the development and increasing acceptance of the UNIT and similar tests represent a significant step forward in the culturally sensitive practice of intelligence assessment. Considering the large numbers of non-English-speaking people in the United States—nearly 47 million, and on the rise (U.S. Census Bureau, 2003)—clinical psychologists will increasingly require intelligence tests that are applicable and fair to clients of a broad cultural and linguistic range.

ACHIEVEMENT TESTING

Achievement Versus Intelligence

Clinical psychologists assess clients’ intelligence but with separate tests they also assess clients’ achievement. What’s the difference between intelligence and
Defining Intelligence Around the World

What is intelligence? It depends on the cultural values of those we ask. When we direct the question to people outside of traditional Western culture, the answer sometimes features characteristics that are quite different from definitions that Spearman, Thurstone, Cattell, or Carroll have proposed (as summarized by Sternberg, 2000):

• In some societies in Africa, intelligence consists largely of skills that preserve and assist interpersonal relationships, both between and within groups. Interviews with some residents of Zambia, for example, suggest that cooperation, deference, respect for elders, and acceptance of social responsibilities characterize intelligent people.

• In Zimbabwe, the word for intelligence—"ngware"—literally translates into a prudent and cautious approach to life and especially to social relationships.

• In some Asian cultures, the definition of intelligence also involves heavy doses of social responsibility. More specifically, Taoist conceptions of intelligence highlight humility, independent (rather than conventional) standards of judgment, and thorough knowledge of self.

• The emphasis on social duties as central to intelligence appears in some Hispanic cultures as well. In fact, in a study of parents of schoolchildren in San Jose, California, in the 1990s, parents of Hispanic descent rated social competence as more closely related to intelligence than did parents of European descent.

• The Western emphasis on speed of mental processing is not shared by all ethnic groups. In fact, some ethnic groups may value depth of thought more highly than speed of thought and may look unfavorably or doubtfully upon work performed very quickly.

This variety of defining characteristics of intelligence raises a number of important questions. Is the definition of intelligence completely dependent upon cultural context, or are there some aspects of intelligence that are universal? To what extent should intelligence tests reflect the alternate definitions of intelligence held around the world or around the United States? Where should we draw the line between personality traits and intelligence? And, as Spearman and Thurstone debated many years ago, is intelligence one thing or many things?
achievement? As we have discussed, intelligence refers to a person’s cognitive capacity. In short, intelligence is what a person can accomplish intellectually. In contrast, achievement is what a person has accomplished, especially in the kinds of subjects that people learn in school, such as reading, spelling, writing, or math. Achievement tests typically produce age- or grade-equivalency scores, as well as standard scores that can be easily compared with those of intelligence tests.

If intelligence reflects a person’s intellectual potential, and achievement reflects what a person actually does with that potential, a comparison of the two can be quite meaningful. Clinical psychologists often say that IQ “predicts” achievement; that is, if you know a person’s IQ, you would expect that person’s achievement level to correspond. That prediction is usually correct, but there are exceptions. A person with higher achievement than IQ is essentially an academic overachiever, someone who somehow accomplishes more than his or her intelligence would predict. The other type of discrepancy—in which a person’s achievement level falls significantly below their intelligence level—is actually of greater interest to clinical psychologists. In fact, according to DSM-IV, a discrepancy of this type is the basis of a learning disability diagnosis. For this reason, achievement tests are very commonly used in tandem with intelligence tests in learning disability evaluations. In fact, to facilitate comparison, most achievement tests adopt the same benchmark scores as intelligence tests, including standard scores with means of 100 and standard deviations of 15.

Figure 9.1 provides an example of a learning disability report regarding a fictional client. It illustrates the use of the WISC-IV as a measure of intelligence and the WIAT-II (described below) as a measure of achievement. (Note that this is an abbreviated sample report; an actual clinical report may be lengthier and involve more comprehensive data about the client.) In this fictional evaluation, Dr. Li, a clinical psychologist, has administered intelligence and achievement tests to Sam, a 9-year-old third grader. The WISC-IV results show that Sam’s IQ is consistently above average: His full-scale IQ is 115, his index scores all fall within a few points of 115, and his subtest scores all fall in the 10 to 13 range. We would expect Sam’s achievement to be commensurate—that is, about equal—to these IQ scores, and for the most part, they are. However, his scores on math-related subtests, and the Mathematics Composite score to which they contribute, are much lower. The marked discrepancy between Sam’s intelligence and his achievement level in math alerts Dr. Li to the likelihood that Sam has a learning disability in the area of math. A learning disability diagnosis of this type can enable students like Sam to obtain special educational services that may not have otherwise been available.
**Name of Client:** Sam B.
**Age:** 9 years, 1 month
**Education:** Currently in 3rd grade

**Reason for Referral:** Sam’s homeroom teacher, Ms. G., suggested to Sam’s parents that Sam should be evaluated for a learning disability in the area of math.

**Assessment Methods Used:**
- Clinical interview with Sam
- Interview with Mr. Don B. and Ms. Terri B., Sam’s mother and father
- Consultation with Ms. G., Sam’s current homeroom teacher
- Review of educational records (provided by Sam’s parents and Ms. G.)
- Wechsler Intelligence Test for Children—Fourth Edition (WISC-IV)
- Wechsler Individual Achievement Test—Second Edition (WIAT-II)

**Background Information:** Sam B. is a 9-year-old third grade student at Lakeview Elementary School, which he has attended since kindergarten. At the most recent parent-teacher conference, Sam’s homeroom teacher, Ms. G., mentioned to Sam’s parents that Sam appears to struggle with math. She stated that Sam puts forth appropriate effort but struggles with many mathematical concepts. Sam’s parents concurred that he has struggled with numbers, and they have also noticed that most of Sam’s same-age friends perform math at a noticeably higher level than Sam. Both his teacher and his parents believe that Sam is a bright boy, and they emphasized that he excels in some other areas, but that math appears to be a weakness for him. Sam agreed that math is a challenge, stating that “it’s really hard for me—harder than other things, no matter how much I try.”

Sam, his parents, and his teacher report that he has many friends and is doing well socially. In general, he appears happy and does not exhibit symptoms of anxiety, depression, or other psychological problems. His parents report that Sam has experienced no serious illnesses, injuries, or developmental abnormalities, and that he is currently taking no medication.

**Behavioral Observations:** Sam was generally well behaved and compliant during the testing. He cooperated with all of the evaluator’s instructions. He was interpersonally appropriate and appeared to put forth appropriate effort on all tests. He appeared attentive throughout all aspects of the testing.

**Test Results:** The Wechsler Intelligence Test for Children—Fourth Edition (WISC-IV) was used to measure Sam’s intelligence. Results of this test are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Standard Score</th>
<th>Subtest Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Scale IQ</strong></td>
<td>119</td>
<td></td>
</tr>
<tr>
<td><strong>Verbal Comprehension Composite</strong></td>
<td>114</td>
<td></td>
</tr>
<tr>
<td><strong>Similarities</strong></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td><strong>Vocabulary</strong></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td><strong>Comprehension</strong></td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

_Figure 9.1 Sample (Abbreviated) Clinical Report with WISC-IV and WIAT-II Results_
Sam's Full Scale IQ score of 119 is significantly above average and is higher than 90% of children his age. His performance was generally consistent across subtests, and as a result his scores on the four Composites were also consistently above average. Overall, Sam's intellectual ability appears significantly above average across all areas examined.

The Wechsler Individual Achievement Test—Second Edition (WIAT-II) was used to measure Sam's academic achievement. Results of this test are as follows:

<table>
<thead>
<tr>
<th>Standard Score</th>
<th>Subtest Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptual Reasoning Composite</td>
<td>112</td>
</tr>
<tr>
<td>Block Design</td>
<td>11</td>
</tr>
<tr>
<td>Picture Concepts</td>
<td>12</td>
</tr>
<tr>
<td>Matrix Reasoning</td>
<td>13</td>
</tr>
<tr>
<td>Working Memory Composite</td>
<td>116</td>
</tr>
<tr>
<td>Digit Span</td>
<td>13</td>
</tr>
<tr>
<td>Letter-Number Sequencing</td>
<td>13</td>
</tr>
<tr>
<td>Processing Speed Composite</td>
<td>115</td>
</tr>
<tr>
<td>Coding</td>
<td>14</td>
</tr>
<tr>
<td>Symbol Search</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Score</th>
<th>Age Equivalent</th>
<th>Grade Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Composites</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Composite</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>Reading Composite</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>Word Reading</td>
<td>111</td>
<td>10:4</td>
</tr>
<tr>
<td>Reading Comprehension</td>
<td>111</td>
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<td>Pseudoword Decoding</td>
<td>116</td>
<td>13:8</td>
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<td>Mathematics Composite</td>
<td>80</td>
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<td>Numerical Operations</td>
<td>85</td>
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</tr>
<tr>
<td>Math Reasoning</td>
<td>78</td>
<td>7:4</td>
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</table>

(Continued)
Achievement tests come in many varieties. Some measure a single area of achievement in detail, such as the KeyMath or the Gray Oral Reading achievement tests. Others are more comprehensive featuring a wide range of subtests. Examples of these include the Woodcock Johnson Tests of Achievement, the Wide Range Achievement Test, and the Wechsler Individual Achievement Test, which we consider below in more detail.

**Wechsler Individual Achievement Test—Second Edition (WIAT-II)**

The **Wechsler Individual Achievement Test—Second Edition (WIAT-II)** is a comprehensive achievement test for clients of age 4 to 85 years. Like the Wechsler intelligence tests, the WIAT-II is administered face-to-face and one-on-one.

<table>
<thead>
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<th></th>
<th>Standard Score</th>
<th>Age Equivalent</th>
<th>Grade Equivalent</th>
</tr>
</thead>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Spelling</td>
<td>114</td>
<td>10:8</td>
<td>5:2</td>
</tr>
<tr>
<td>Written Expression</td>
<td>115</td>
<td>11:8</td>
<td>5:8</td>
</tr>
<tr>
<td>Oral Language Composite</td>
<td>115</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening Comprehension</td>
<td>112</td>
<td>11:0</td>
<td>5:5</td>
</tr>
<tr>
<td>Oral Expression</td>
<td>113</td>
<td>15:0</td>
<td>12:9</td>
</tr>
</tbody>
</table>

Figure 9.1 (Continued)

In most areas, including Reading, Written Language, and Oral Language, Sam’s achievement (as measured by the WIAT-II) appears commensurate with his intelligence (as measured by the WISC-IV). However, a significant discrepancy exists between Sam’s achievement in math and his intelligence. Sam’s scores on the Math Reasoning and Numerical Operations subtests were relatively low, as was the Mathematics Composite to which they contribute. These levels of achievement in math are below expectations based on Sam’s intellectual ability.

**Summary and Recommendations:** Sam B., a 9-year-old third grader, was evaluated for a learning disability in mathematics. Sam, his parents, and his homeroom teacher had reported that Sam appeared to struggle atypically with math. A comparison of his intellectual ability (measured by the WISC-IV) and his academic achievement (measured by the WIAT-II) suggests that Sam does, in fact, have a learning disability in mathematics. His overall IQ is significantly above average, and his intellectual abilities appear consistent across specific areas. His levels of achievement in most areas (including reading, written language, and oral language) are commensurate with his intelligence, but his level of achievement in math is much lower. It is recommended that those involved in Sam’s education take note of this learning disability diagnosis and offer Sam any specialized services available to address it.
The WIAT-II measures achievement in four broad areas: reading, math, written language, and oral language. Each of these broad areas is assessed by two or three subtests. The Reading Composite derives from scores on three subtests: Word Reading (reading isolated words), Pseudoword Decoding (using phonetic skills to sound out nonsense words, like “plore” or “tharch”), and Reading Comprehension (reading sentences or passages and answering questions about their content). The Mathematics Composite derives from two subtests: Numerical Operations (written math problems) and Math Reasoning (word problems, numerical pattern, statistics and probability questions, etc.). The Written Language Composite derives from two subtests: Spelling (increasingly difficult words) and Written Expression (constructing sentences, paragraphs, or essays as instructed). The Oral Language Composite derives from two subtests: Listening Comprehension (paying attention to orally presented information and answering questions about it) and Oral Expression (using speech to repeat spoken material, create stories about presented pictures, provide directions, etc.).

The WIAT-II yields standard scores on the same scale as most intelligence tests: a mean of 100 and a standard deviation of 15. It also yields age- and grade-equivalencies for each subtest. The test was standardized on more than 5,500 people who were chosen to match recent U.S. Census data in terms of sex, age, race/ethnicity, geographic region, and parent education level. About 1,100 of the individuals in the standardization sample also took the age-appropriate Wechsler intelligence scale, so the WIAT-II is “linked” to the Wechsler IQ tests, which enhances the validity of comparisons between these two types of tests. Overall, the reliability and validity data supporting the WIAT-II is quite strong.

NEUROPSYCHOLOGICAL TESTING

Neuropsychological testing represents a specialized area of assessment within clinical psychology. The intent of neuropsychological tests is to measure cognitive functioning or impairment of the brain and its specific components or structures. Medical procedures such as computed tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET) scans can show that part of the brain looks abnormal, but neuropsychological tests show how that part of the brain is actually functioning. Such tests are especially useful for targeted assessment of problems that might result from a head injury, prolonged alcohol or drug use, or a degenerative brain illness.

Some neuropsychological testing procedures are lengthy, comprehensive batteries that include a broad array of subtests. The patterns of scores on these subtests can go a long way toward pinpointing specific cognitive weaknesses. Other neuropsychological tests are much briefer and are typically used as screens for neuropsychological impairment rather than full-fledged neuropsychological
assessment tools. Let's consider one of the batteries—the Halstead-Reitan—and one of the screens—the Bender-Gestalt—in more detail.

**Halstead-Reitan Neuropsychological Battery**

The **Halstead-Reitan Neuropsychological Battery (HRB)** is a battery of eight standardized neuropsychological tests. It is suitable for clients of age 15 years and above, but alternate versions are available for younger clients. The HRB is only administered as a whole battery; its components are not to be administered separately. Thus, it is a thorough (and rather lengthy) neuropsychological battery. Essentially, its primary purpose is to identify people with brain damage and, to the extent possible, provide detailed information or hypotheses about any brain damage identified, including specific cognitive impairments or physiological regions of the brain that may be deficient. The findings of the HRB can help in diagnosis and treatment of problems related to brain malfunction (Broshek & Barth, 2000).

Some of the eight tests in the HRB involve sight, whereas others involve hearing, touch, motor skills, and pencil-and-paper tasks. An example of one of the tests of the HRB is the Trail Making Test, which resembles the familiar “dot-to-dot” puzzles that children complete, but this test is timed, contains both numbers and letters, and produces a rather haphazard line instead of an identifiable figure or shape. A second example is the Category Test, in which a client sees a pattern of shapes and designs on a screen and presses the key (1–4) that is suggested by the pattern. Clients hear a bell when correct and a buzzer when wrong, and their successes and failures are noted by the examiner. The Finger Tapping (or Finger Oscillation) Test is a third example; in this test, clients tap a single typewriter key as rapidly as they can with the index finger for 10-second intervals. The number of taps they can produce, averaged across multiple attempts with each hand, estimates motor speed (Goldstein & Sanders, 2004; Reitan & Wolfson, 2004).

The examiner using the HRB compares a client’s test scores to published norms to assess overall performance and also to each other to determine the client’s own relative strengths and weaknesses. Interpretation of results can include detailed inferences about specific neuropsychological pathologies and the localization of problems in cognitive functioning (e.g., a particular lobe or hemisphere of the brain).

In the decades since it was introduced, the HRB has been evaluated more than any other comprehensive neuropsychological test. These studies suggest strongly that the HRB and each of its tests have been established as reliable and valid. Additional strengths of the HRB include its comprehensiveness and clinical usefulness. Drawbacks of the HRB include its length (and corresponding expense), inflexibility (as a fixed battery), and a limited overlap with real-life, day-to-day tasks (Broshek & Barth, 2000).
The HRB may be the most commonly administered comprehensive neuropsychological battery (Guilmette & Faust, 1991), but a respected and popular alternative is the **Luria-Nebraska Neuropsychological Battery (LNNB)**. The LNNB is similar to the HRB in that it is a wide-ranging test of neuropsychological functioning. It consists of 12 scales, with a similar range to that of the HRB. A primary difference is the LNNB’s emphasis on qualitative data in addition to quantitative data. In other words, to a greater extent than the HRB, the LNNB relies upon qualitative written comments from the examiner about the testing process. These comments describe what the examiner observed about the client, such as problems comprehending the test (e.g., confusion, poor attention); how or why the client is missing items (e.g., slow movement, sight or hearing problems, speech flaws); or unusual behaviors (e.g., inappropriate emotional reactions, hyperactivity, distraction). Another difference between the HRB and the LNNB is that the LNNB tends to be slightly briefer. Like the HRB, the LNNB has a strong body of psychometric data supporting its reliability and validity (Golden, 2004; Golden, Freshwater, & Vayalakkara, 2000).

**Bender Visual-Motor Gestalt Test—Second Edition (Bender-Gestalt-II)**

The original Bender-Gestalt test, published in 1938, is the most commonly used neuropsychological screen among clinical psychologists (Watkins et al., 1995). The test is a straightforward copying task: The client is given a pencil, blank paper, and nine simple geometric designs (primarily made of combinations of circles, dots, lines, angles, and basic shapes) and is asked to copy each design as accurately as possible. It measures visuocostructive abilities, which are also commonly known as perceptual-motor or visual-spatial skills (Lacks, 2000). The **Bender Visual-Motor Gestalt Test—Second Edition (Bender-Gestalt-II)** is quite similar to the original Bender-Gestalt, but it offers memory tasks and additional stimuli.

This test is remarkably brief—on average, it takes only 6 minutes to administer (Lacks, 2000). It is appropriate for clients of any age above 3 years. For these reasons, clinical psychologists frequently include it as a quick “check” for neuropsychological problems. In other words, if it is already established that the client being evaluated has or is strongly suspected to have a neuropsychological problem, it is likely that the clinical psychologist will select a more comprehensive battery, like the HRB or the LNNB, rather than the Bender-Gestalt. However, when the evaluation is for another purpose and the clinical psychologist simply wants a rapid appraisal of overall neuropsychological functioning, the Bender-Gestalt can be a good choice. Its results cannot specify locations of brain damage, but poor performance on the Bender-Gestalt can suggest brain damage in a diffuse way. As
such, it can alert the clinical psychologist to the general presence of neuropsychological problems, and more thorough testing can subsequently be conducted. Poor performance on the Bender-Gestalt is indicated by a variety of errors that clients may make in copying the figures, including figures in which details are missing or are notably inexact; figures that collide with each other on the page; inability to accurately “close” shapes like circles or squares; disproportionate size of a figure or part of a figure; and angles in copied figures that do not match the angles in the originals (Lacks, 1999).

Another common neurological screen among clinical psychologists is the Rey-Osterrieth Complex Figure Test, originally published in 1941. This test is also a brief pencil-and-paper drawing task, but it involves only a single, more complex figure. The Rey-Osterrieth also features the use of pencils of different colors at various points in the test; this way, the examiner can trace the client’s sequential approach to this complex copying task. It also includes a memory component, in which clients are asked 3 to 60 minutes after copying the form to reproduce it again from memory (Helmes, 2000; Lacks, 2000).

**CHAPTER SUMMARY**

Clinical psychologists use intelligence tests, achievement tests, and neuropsychological tests to assess various intellectual capacities of their clients. The most widely accepted intelligence tests endorse a hierarchical model of intelligence, as indicated by the fact that they yield a single overall intelligence score as well as more specific index, factor, or subtest scores. The Wechsler intelligence tests, including the WAIS-III for adults, the WISC-IV for school-age children, and the WPSSI-III for preschoolers, rank among the most commonly used and psychometrically sound measures of intelligence. Each Wechsler test features about a dozen subtests grouped into four factors, each of which contributes to the full-scale IQ. The Stanford-Binet intelligence test, which covers the entire age range in a single version, is also frequently used, especially among clinical psychologists who may be testing clients at the extremes of the intelligence range. Concerns about the cultural fairness of prominent intelligence tests has fostered the development of less culturally dependent tests such as the Universal Nonverbal Intelligence Test (UNIT), which does not depend upon linguistic compatibility between examiner and client. Whereas intelligence tests measure abilities, achievement tests such as the WIAT-II measure accomplishments, particularly in core academic areas such as math and reading. A significant discrepancy between
intelligence and achievement in a particular area is the basis of a learning disorder diagnosis. Neuropsychological tests are intended to measure cognitive function and dysfunction and in some cases to localize impairment to a particular region of the brain. Some neuropsychological measures are lengthy and comprehensive, such as the Halstead-Reitan Neuropsychological Battery (HRB) and Luria-Nebraska Neuropsychological Battery (LNNB); others, such as the Bender-Gestalt-II and Rey-Osterrieth Complex Figure Test, are briefer screens for neuropsychological problems.

**KEY TERMS AND NAMES**

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Intelligence tests</th>
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<tr>
<td>Achievement tests</td>
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</tr>
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<td>(Bender-Gestalt-II)</td>
<td>knowledge</td>
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<td>Charles Spearman</td>
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<td>Crystallized intelligence</td>
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<td>Neuropsychological tests</td>
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<td>Normative data</td>
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<td>Perceptual Reasoning Index</td>
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<td>“g”</td>
<td>Processing Speed Index</td>
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<td>Working Memory Index</td>
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**CRITICAL THINKING QUESTIONS**

1. In your opinion, what aspects of intelligence do contemporary intelligence tests overemphasize?

2. In your opinion, what aspects of intelligence do contemporary intelligence tests overlook?

3. To what extent do you agree with the idea that intelligence is a single ability (“g”), as opposed to separate unrelated abilities (“s”)?

4. Which subtests of the Wechsler intelligence tests seem most culturally fair? Which seem most potentially culturally unfair?

5. Learning disability diagnoses are based upon a discrepancy between intelligence and achievement. In your opinion, how large should that discrepancy be to justify a learning disability diagnosis and the special educational services that typically accompany it?
Clinical psychologists have developed many different approaches to assessing clients’ personality and behavior. But before we examine any specific tests or methods, there are two important, overarching themes to emphasize: multimethod assessment and culturally competent assessment.
MULTIMETHOD ASSESSMENT

No measure of personality or behavior is perfect. Some have excellent reliability, validity, and clinical utility, but even these have their limitations. For that reason, it is important for clinical psychologists not to rely exclusively on any single assessment method. Instead, personality is best assessed by using multiple methods, including tests of different types, interview data, observations, or other sources. Each method offers a unique perspective on the client, and often they converge on similar conclusions. To the extent that these conclusions are supported by multiple tests rather than only one, the clinical psychologist can assert them with confidence.

The advantages of multimethod assessment hold true even in less formal and professional settings. Consider a situation in which you are getting to know someone, such as in a new dating relationship. Your initial “assessment” of your partner’s personality may take place on the first date—at a restaurant and a movie, perhaps. As the relationship continues, you’ll have a chance to “assess” your partner’s personality using other “methods”—you’ll see his or her personality and behavior with family, with friends, at parties, at home, at work, at school, and so on. You may get a strong first impression on the first date, but you probably won’t feel that you genuinely know and understand your partner’s personality until you’ve “assessed” him or her in a variety of contexts because each situation will reveal a different aspect of personality. In a more professional sense, the same applies to clinical psychologists “getting to know” a client via personality tests: Each method offers a unique perspective, and although some may be more enlightening than others, it is the integration of multiple methods that ultimately proves most informative.

CULTURALLY COMPETENT ASSESSMENT

Cultural competence is essential across all activities of clinical psychologists, especially personality assessment. Simply put, every culture has its own definitions of “normal” and its own variations of “abnormal” as well. A personality
assessment conducted without knowledge or sensitivity to these cultural specifics can be a dangerous thing; in fact, it has been labeled “cultural malpractice” by some (e.g., Dana, 2005). A primary danger lies in the possibility of overpathologizing—that is, viewing as abnormal that which is culturally normal. In other words, the clinical psychologist must appreciate the meaning of a behavior, thought, or feeling within the context of the client’s culture, which may differ from the context of the psychologist’s own culture.

As an example of overpathologizing, consider Duron, a 45-year-old African American client who was urged by his wife and children to seek psychotherapy. On the intake form Duron completed in the waiting room of Dr. Platt, a white clinical psychologist, he indicated that he was struggling with symptoms of depression and excessive alcohol use. But as Duron and Dr. Platt spoke during the initial session, Dr. Platt was struck by what he considered excessive suspiciousness. He noticed that Duron was somewhat reluctant to reveal details about himself, posed numerous questions about confidentiality, and asked “Why do you need to know that?” several times in response to interview questions. Duron did not schedule a second appointment when the first appointment ended, and Dr. Platt interpreted this as a sign of distrust. By the end of the session, Dr. Platt was convinced that Duron’s primary problem was not depression or alcohol abuse but paranoia. He subsequently administered personality tests to Duron and interpreted the results to support his hypothesis that Duron was paranoid. Of course, Dr. Platt’s mistake throughout this assessment process was his lack of knowledge of African American cultural norms, especially as they relate to seeking psychological services from white therapists. In this situation, African Americans often exhibit a guardedness justified by many years of formal and informal racial prejudice, oppression, and betrayal (Boyd-Franklin, 1989; Hines & Boyd-Franklin, 2005; Maultsby, 1982). Through Dr. Platt’s cultural insensitivity and ethnocentrism, he wrongly judged Duron’s behavior as pathologically paranoid when in fact it was reasonable to expect based on Duron’s cultural background.

In Duron’s case, the source of the cultural bias was the clinician himself. During personality assessment, the bias can actually stem from a number of other sources as well, including the test and the service delivery method (Dana, 2005). For example, a test can be biased if it features language or structure that is culture specific rather than universally applicable. The test may also include norms that are not adequately culturally inclusive, resulting in a comparison of the client’s scores with the scores of an inappropriate reference group (see Box 10.1). Additionally, the service delivery method (essentially, the way the clinician uses the test) can be biased by...
including interpersonal interaction or an approach to time and task that is inconsistent with some cultures. Whether the bias stems from the clinician, the test, or the service delivery method, the clinical psychologist is responsible for recognizing and minimizing it in order to conduct culturally competent assessments.

**Box 10.1 Considering Culture**

**Culture-Specific Norms for Personality Tests**

Claudia is a Cuban-American woman who has just completed the MMPI-2, a popular multiple choice pencil-and-paper personality test for adults (covered later in this chapter). The MMPI-2 yields a wide variety of scores on variables such as depression, anxiety, paranoia, schizophrenia, mania, and others. To score Claudia’s test, her clinical psychologist will compare her responses to those of a “normative” group of people who took the test prior to its publication and whose scores form the basis of the norms tables in the MMPI-2 manual. What cultural characteristics should the people in the normative group have? In other words, to whom, specifically, should Claudia’s scores be compared?

The possibilities range from very broad groups to very specific groups. Most broadly, the normative group could be a cultural mix representative of the U.S. population, and Claudia’s scores could be compared to the entire group as a whole. On the other hand, a more narrowly defined normative group could be used, such as Cuban-Americans or females. In fact, we could combine these variables and consider a even more culturally specific group: Cuban-American females.

There would be advantages to ignoring the culture-specific norms and instead comparing Claudia’s scores to the entire normative sample (which, for the MMPI-2, consists of 2,600 adults). The full normative sample is, by definition, larger than any cultural subset. Only a small fraction of those 2,600 adults were Cuban-American females, and such a small group may not be statistically representative of Cuban-American females more generally. Test-developers and researchers could make efforts to establish sufficiently large normative groups specific to each culture, but this could prove excessively costly and time-consuming, especially if many cultural variables are considered in combination (Cuban-American females of Claudia’s age range and religion, for example).
On the other hand, there would be advantages to comparing Claudia’s scores to culture-specific norms. By doing so, we could assure that Claudia’s responses are being evaluated in a culturally sensitive manner. We could reduce the chances of overpathologizing her scores, a risk involved in comparing them to norms that do not reflect her own cultural background and values. Comparing Claudia’s scores only to the scores of others like her prevents an ethnocentric judgment of Claudia’s mental health according to standards established by others culturally unlike her.

In actual practice, clinical psychologists compare client test data to both broad, heterogeneous normative groups and more specific, homogeneous normative groups. The MMPI-2 manual, for example, does not include ethnicity-specific norms, but it does include gender-specific norms, and in the years since the MMPI-2 was published, numerous researchers have established and published more culturally specific normative information for clinical psychologists to use (e.g., Butcher, Cheung, & Lim, 2003; Dana, 1995; McNulty et al., 1997; Velasquez et al., 2004). One solution to this quandary is to consider both broad and culture-specific normative data. Both can provide meaningful comparisons for a client’s responses to a personality test.

**OBJECTIVE PERSONALITY TESTS**

Generally speaking, personality tests can be placed in one of two categories: objective and projective. **Objective personality tests** include unambiguous test items, offer clients a limited range of responses, and are objectively scored. Most often, the objective personality tests that clinical psychologists use are questionnaires that clients complete with pencil and paper (or in some cases, on a computer). They typically involve a series of direct, brief statements or questions and either true/false or multiple choice response options in which clients indicate the extent to which the statement or question applies to them. By contrast, **projective personality tests** feature ambiguous stimuli and an open-ended range of client responses. They are based on the assumption that clients reveal their personalities by the way they make sense of vaguely defined objects or situations. Projective personality tests will be covered in more detail in a later section. For now, let’s consider some of the most commonly used and reputable objective personality tests.

**Minnesota Multiphasic Personality Inventory-2 (MMPI-2)**

The **Minnesota Multiphasic Personality Inventory-2 (MMPI-2)** is both the most popular and the most psychometrically sound objective personality test used
by clinical psychologists (Butcher & Beutler, 2003; Camara, Nathan, & Puente, 2000; Frauenhoffer, Ross, Gfeller, Searight, & Piotrowski, 1998). The format of the MMPI-2 is simple: The client reads 567 self-descriptive sentences and, using a pencil-and-paper answer sheet, marks each sentence as either true or false as it applies to him or her. The items span a very wide range of behavior, feelings, and attitudes. A few simulated MMPI-2 items appear in Box 10.2.

### Box 10.2 Simulated MMPI-2 Items

- I feel like I am low on energy much of the time.
- I often find myself in conflicts with people in authority.
- During times of stress, I usually experience an upset stomach.
- Most of the people I know have plans to hurt me in some way.
- I have visions of things that aren’t real and that other people can’t see.
- I enjoy going to social events with dozens of people.
- I often can’t stop worrying about things even when there is no reason for the worry.

The MMPI-2 is a revision of the original MMPI, which was published in 1943. When Starke Hathaway and J. C. McKinley, the authors of the original MMPI, began their work in the 1930s, they sought an objective way to measure psychopathology. Numerous questionnaires of this type were available at that time, but none were based on a solid empirical foundation as the MMPI would be. When creating a personality test, it is relatively easy for an author to create a list of items that should, theoretically, elicit different responses from “normal” and “abnormal” people of various categories. Hathaway and McKinley chose to take on a greater challenge: to create a list of items that empirically elicits different responses from people in these normal and abnormal groups.

Hathaway and McKinley succeeded in creating such a list of items by using a method of test construction called **empirical criterion keying**. Essentially, this method involves identifying distinct groups of people, asking all of them to respond to the same test items, and comparing responses between groups. If an item elicits different responses from one group than from another, it’s a worthy item and should be included on the final version of the test. If the groups answer an item similarly, the item is discarded because it does not help to categorize a client in one group or the other. When empirical criterion keying is used, it doesn’t matter whether an item
should, in theory, differentiate two groups; it only matters whether an item does, in actuality, differentiate two groups. As an example, consider the simulated item “I have visions of things that aren’t real and that other people can’t see.” In theory, we may expect schizophrenics to endorse this item far more often than nonschizophrenics. According to the empirical criterion keying method, this theoretical expectation is not enough. It must be supported by evidence that schizophrenics do, in fact, endorse this item far more often than nonschizophrenics. According to the empirical criterion keying method, only if the two groups actually respond differently to the item should it be included on the final version of the test.

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**Box 10.3 Metaphorically Speaking**

**If You’ve Shopped on Amazon.com,**
**You Understand Empirical Criterion Keying**

How do the people at amazon.com (or most other online shopping sites) decide which items to suggest to customers? Actually, they use a strategy very similar to empirical criterion keying. As you read through the description of a CD, DVD, or book on amazon.com, the listing always includes the section: “Customers who bought this item also bought . . .” The site uses its sales statistics to link certain items together: People who bought the Dixie Chicks’ new CD also bought Neil Young’s latest CD; people who bought *Pirates of the Caribbean* bought *The Da Vinci Code*; and people who buy John Grisham’s books also buy James Patterson’s.

The important point is that these suggestions are based on empirical data—not theory, common sense, logic, or any other nonempirical criteria. In other words, the people at amazon.com could, if they chose to, recommend to fans of *Pirates of the Caribbean* other DVDs that would seem, theoretically, to make sense. Rather than stating “Customers who bought this item also bought . . .” they could tell us that “Customers who like this item might also like . . .” The “might also like” list would include DVDs similar in some way to *Pirates of the Caribbean*—other movies starring Johnny Depp, other movies with a pirate theme, other movies by the same director, etc.

Instead, the suggestions from amazon.com are based entirely on connections between movies according to empirical sales data. Perhaps your intuition wouldn’t have told you that customers who bought *Pirates of the Caribbean* also bought *The Da Vinci Code*, *Cars*, and *Superman Returns*, but according to sales data, they did. None of these “also bought” movies features Johnny Depp or a pirate adventure, but nonetheless, the sales figures demonstrate empirically that they sell to the same audience. Appearance on the list of suggestions has nothing to do with a connection between movies in terms of actors, subject matter, or any other criteria besides empirical sales data.

*(Continued)*
In a similar way, the creators of the MMPI were blindly empirical when they constructed their tests. Previous designers of personality tests had primarily relied upon items that they believed would separate abnormal people from normal people. The MMPI's creators instead insisted that an item would be included in their test only if it demonstrated empirically that it produced different responses from people in different groups. It didn't matter whether the item should distinguish the groups according to intuition, logic, common sense, or clinical wisdom; what mattered was whether the empirical data showed that the item did distinguish between groups. As a hypothetical example, if the item “I cry a lot” did not separate depressed people from non-depressed people, it would be eliminated from the test, even if in theory it seems like an obvious distinction between the two groups. And if a seemingly unrelated item like, say, “I prefer apples to oranges” did separate depressed people from non-depressed people, it would be kept, despite no conceptual connection to depression.

What do you think of the “Customers who bought this item also bought...” suggestion lists on Web sites such as amazon.com? What are the benefits and drawbacks to using an empirical criterion keying approach to creating such suggestion lists? Similarly, how do you evaluate the empirical criterion keying approach to personality test construction? What are its benefits and drawbacks?

For Hathaway and McKinley, the distinct groups upon whom potential items were evaluated consisted of people who had been diagnosed with particular mental disorders (e.g., depressed, paranoid, schizophrenic, anxious, sociopathic, and hypochondriacal groups) and a group of “normals” who did not have a mental health diagnosis at all. Although they began the process with more than 1,000 potential items, only 550 were retained after the empirical criterion keying method was complete. The items appeared in the test in random order, but for scoring purposes, they were organized into groups related to 10 specific pathologies. Each of those 10 groups of items represented a clinical scale, and the higher a client scored on a particular scale, the greater the likelihood that they demonstrated that form of psychopathology. The 10 clinical scales remain the same in the MMPI-2 and are described in Table 10.1.

(Some of the names of the clinical scales may seem unfamiliar, but they actually refer to very familiar and common clinical issues. The unfamiliar terms were commonly used when the MMPI was originally created, and they were retained in the MMPI-2 to maintain continuity even though some have become outdated. For example, Scale 4, “Psychopathic Deviate,” would probably be labeled “Antisocial” today. And the name for Scale 7, “Psychasthenia,” is an obsolete word that was roughly equivalent to “Anxiety.”)
Table 10.1  Clinical Scales of the MMPI, MMPI-2, and MMPI-A

<table>
<thead>
<tr>
<th>Scale Number</th>
<th>Scale Name</th>
<th>Abbreviation</th>
<th>Description of High Scale Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypochondriasis</td>
<td>Hs</td>
<td>Somatic problems, excessive bodily concern, weakness, ailments, complaining and whiny</td>
</tr>
<tr>
<td>2</td>
<td>Depression</td>
<td>D</td>
<td>Depressed, unhappy, low confidence, pessimistic</td>
</tr>
<tr>
<td>3</td>
<td>Hysteria</td>
<td>Hy</td>
<td>Vague medical reactions to stress, somatic symptoms, denial of conflict and anger</td>
</tr>
<tr>
<td>4</td>
<td>Psychopathic Deviate</td>
<td>Pd</td>
<td>Antisocial, rebellious, blaming others, poor consideration of consequences of actions</td>
</tr>
<tr>
<td>5</td>
<td>Masculinity- femininity</td>
<td>Mf</td>
<td>Rejection of traditional gender roles, effeminate men, masculine women</td>
</tr>
<tr>
<td>6</td>
<td>Paranoia</td>
<td>Pa</td>
<td>Suspicious, guarded, hypersensitive, belief that others intend to harm</td>
</tr>
<tr>
<td>7</td>
<td>Psychasthenia</td>
<td>Pt</td>
<td>Anxious, nervous, tense, worrisome, obsessive</td>
</tr>
<tr>
<td>8</td>
<td>Schizophrenia</td>
<td>Sc</td>
<td>Psychotic, disorganized or bizarre thought process, unconventional, hallucinations, delusions, alienated</td>
</tr>
<tr>
<td>9</td>
<td>Mania</td>
<td>Ma</td>
<td>Manic, elevated mood, energetic, overactive, accelerated movement and speech, flight of ideas</td>
</tr>
<tr>
<td>10</td>
<td>Social Introversion</td>
<td>Si</td>
<td>Introverted, shy, reserved, more comfortable alone than with others</td>
</tr>
</tbody>
</table>

Sources: Archer (1997) and Butcher (1999).
Another important feature introduced by the MMPI (and retained in the MMPI-2) was a way to assess the client’s test-taking attitudes. Hathaway and McKinley realized that self-report instruments are vulnerable to insincere efforts on behalf of the client. Some clients may intentionally exaggerate their symptoms (“fake bad”) to appear more impaired than they really are; others may intentionally minimize their symptoms (“fake good”) to appear healthier than they really are. Still other clients may respond randomly without paying much attention to items at all. The MMPI and MMPI-2 include a number of items designed to “catch” these test-taking attitudes. When these responses to these items are grouped together, they constitute the test’s validity scales. These validity scales inform the clinical psychologist about the client’s approach to the test, and allow the psychologist to determine whether the test is valid and what kinds of adjustments might be appropriate to make during the process of interpreting the clinical scales. The MMPI and MMPI-2 contain three specific validity scales: L (Lying, suggesting “faking good”), K (Defensiveness, also suggesting “faking good”), and F (Infrequency, suggesting “faking bad”).

As an example of the importance of validity scales, consider Tammy, a 24-year-old woman on trial for armed robbery. Her attorney has argued that Tammy is seriously mentally ill and that as a result she should be found not guilty by reason of insanity and placed in a psychiatric treatment center rather than imprisoned. The judge in Tammy’s case orders Tammy to undergo a psychological examination, and Dr. Reed, the clinical psychologist in the case, uses the MMPI-2 among other tests. Dr. Reed finds that many of Tammy’s MMPI-2 clinical scales, especially scales 2 (Depression) and 8 (Schizophrenia), are extremely high. Alone, this information would suggest that Tammy is experiencing significant psychopathology. However, Tammy’s MMPI-2 validity scales (especially her F scale) strongly suggest that she “faked bad” on the test; that is, she exaggerated her symptoms in an attempt to look more pathological than she truly is. (Clinical psychologists often use the term “malingering” to describe this type of deliberate behavior.) With this information, Dr. Reed may determine that Tammy’s MMPI-2 results are altogether invalid or may interpret the clinical scales with the knowledge that Tammy tended to overstate her problems.

The MMPI grew tremendously in popularity from the 1940s to the 1980s, and was eventually replaced by the MMPI-2 in 1989. The revision process addressed several weaknesses that had become increasingly problematic for the original MMPI. Foremost among these weaknesses was the inadequate normative sample of the original MMPI. The “normal” group to which the clinical groups were compared consisted of 724 individuals from Minnesota in the 1940s. (To be specific, they were visitors to the University of Minnesota Hospital.) This group was overwhelmingly rural and white, and as such, they were not at all an adequate microcosm of the U.S. population. So, for the MMPI-2, normative data was solicited from a much larger and demographically diverse group. In all, the MMPI-2 normative group includes 2,600 people from seven states who closely matched U.S. Census data from the
1980s regarding age, ethnicity, and marital status (Butcher, 1999; Greene & Clopton, 2004). Other improvements included the removal or revision of some test items with outdated or awkward wording. Otherwise, the authors of the MMPI-2 sought to keep the revised version as similar as possible to the original MMPI to take advantage of the familiarity of the test to many clinical psychologists and the enormous body of literature that had accumulated regarding the MMPI.

Soon after the MMPI-2 was published, an alternate version of the MMPI was created for younger clients. Whereas the MMPI-2 is appropriate only for adults (18 years and older), the Minnesota Multiphasic Personality Inventory—Adolescent (MMPI-A) was designed for clients aged 14 to 18 years. It was published in 1992 and is very similar in administration, format, scoring, and interpretation as the MMPI-2. It is a true/false pencil-and-paper test consisting of 478 items. Some of its items are shared with the MMPI-2, and some are original items targeting common teen issues such as school, family, substance use, and peer relations. It yields the same validity scales and clinical scales as the MMPI-2. It was normed on 2,500 adolescents chosen to match 1980 U.S. Census data on many important demographic variables (Archer, 1997; Baer & Rinaldo, 2004).

The MMPI-2 and MMPI-A yield the same 10 clinical scale scores that the original MMPI yielded. After considering the validity scores, clinical psychologists interpret the MMPI-2 or MMPI-A by considering the clinical scale scores that are most elevated above normal levels. In some cases, a single clinical scale score will stand out; in others, two or three clinical scale scores may be elevated. As shorthand, clinical psychologists often use the elevated scale numbers (“code-types”) to refer to a client’s profile, as in, “her MMPI-A profile is a 3/6,” or “his MMPI-2 is a 2/4/8.” Once these high clinical scales are identified, clinical psychologists turn to the empirical literature describing clients with that pattern of elevations. Numerous books and computer programs, many of which were authored by individuals involved in the creation of the MMPI, MMPI-2, or MMPI-A, supply psychologists with this interpretive information. In addition to the 10 clinical scales, a number of additional scales—known as supplemental scales and content scales—have been developed to measure other, often more specific aspects of personality and pathology (Butcher, 1999; Butcher & Beutler, 2003).

The MMPI-2 is extremely well supported by research on its psychometric characteristics. Thousands of studies examine some aspect of reliability or validity regarding the MMPI tests, and consistently the results have been very positive. In short, the MMPI-2 is established as a reliable and valid test of personality and psychopathology, justifying its extensive use by clinical psychologists (Greene & Clopton, 2004). Although the research base is not as extensive, similar conclusions have been reached for the MMPI-A (Archer, 1997; Baer & Rinaldo, 2004).

The MMPI-2 and MMPI-A are currently used for a wide variety of purposes in a wide variety of settings. They are considered comprehensive tests of personality
characteristics and psychopathology, and they can be helpful in forming DSM diagnoses and suggesting placement (e.g., inpatient vs. outpatient) and treatment. They are also used in numerous specialty areas of psychology, including forensic settings and personnel testing (Butcher, 1999).

The MMPI-2 and MMPI-A tests are not without limitations. They have been criticized for being too lengthy, requiring reading ability and prolonged attention beyond the ability of some clients, and being susceptible to “faking” by sophisticated clients who can outwit the validity scales. A final criticism of the MMPI tests focuses on their emphasis on psychopathology as the factors that comprise personality. That is, the clinical scales of the MMPI tests describe a client’s personality by describing the extent to which they have various pathologies (depression, schizophrenia, etc.) as opposed to emphasizing other aspects of personality, such as normal traits or strengths.

Clinical psychologists use numerous other objective personality tests that are similar to the MMPI tests in some ways, yet different in some important ways as well. Examples include the MCMI-III, which emphasizes Axis II disorders; the NEO-PI-R, which emphasizes normal personality traits; and the CPI-III, which emphasizes positive aspects of personality.

**Millon Clinical Multiaxial Inventory-III (MCMI-III)**

The *Millon Clinical Multiaxial Inventory-III (MCMI-III)* is like the MMPI-2 in many ways: It is a comprehensive personality test in a self-report, pencil-and-paper, true/false format. The primary difference between the tests is the MCMI-III’s emphasis on personality disorders. Although it does feature scales for many clinical syndromes related to Axis I disorders such as depression, anxiety, and posttraumatic stress, the MCMI-III is notable for its many scales related to the personality disorders on Axis II of DSM. In fact, the MCMI-III features separate clinical scales corresponding to each of the 10 current personality disorders (e.g., Antisocial, Borderline, Narcissistic, Paranoid). It also includes clinical scales for other forms of personality pathology that have been considered for inclusion as disorders in DSM but are currently omitted (e.g., Self-Defeating, Negativistic/Passive-Aggressive, Depressive) (Retzlaff & Dunn, 2003).

The MCMI was originally created in 1977 by Theodore Millon, a widely recognized scholar on personality disorders. The current version, MCMI-III, was published in 1994 to correspond with the publication of DSM-IV. The MCMI-III consists of 175 true/false items. In addition to its clinical scales, it includes “modifier indices,” which function similarly to the validity scales of the MMPI tests by assessing the test-taking attitude of the client. Reliability and validity data for the MCMI-III are strong, suggesting that it is a wise choice for clinical psychologists who seek a broad assessment of personality with an emphasis on Axis II personality disorders (Meagher, Grossman, & Millon, 2004).
NEO Personality Inventory—Revised (NEO-PI-R)

As stated above, the MMPI emphasizes the pathological aspects of personality by producing scores that indicate the extent to which the client is symptomatic of various disorders. The authors of the NEO Personality Inventory—Revised (NEO-PI-R), Paul Costa and Robert McCrae, sought to create a personality measure that assesses “normal” personality characteristics. The five characteristics measured by their test emerge from decades of research on normal personality, much of which was factor analytic in nature. In short, the authors of the NEO-PI-R (who also put forth the corresponding five-factor or “big five” model of personality) argue that the many words that our language offers for describing personality traits “cluster” into five fundamental traits of personality that characterize everyone in varying degrees. These traits—Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness—are the five primary scales yielded by the NEO-PI-R and are described in Table 10.2. The NEO-PI-R also produces 30 “facet” scores (6 facets within each of the 5 domains) to offer more specific descriptions of components within each trait (Costa & McCrae, 1992).

Table 10.2  Normal Personality Traits Assessed by the NEO-PI-R

<table>
<thead>
<tr>
<th>Trait/Scale</th>
<th>Description of High Score</th>
<th>Description of Low Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroticism</td>
<td>Prone to emotional distress, negative affect, anxiety, sadness,</td>
<td>Emotionally stable, even tempered, secure even under stressful conditions</td>
</tr>
<tr>
<td>Extraversion</td>
<td>Sociable, talkative, outgoing, prefer to be with others</td>
<td>Introverted, reserved, shy, prefer to be alone</td>
</tr>
<tr>
<td>Openness</td>
<td>Curious about novel ideas values, imaginative, unconventional</td>
<td>Conventional, conservative, traditional, prefer familiar ideas and values</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>Sympathetic, cooperative, accommodating, prefer to avoid conflict</td>
<td>Hardheaded, competitive, egocentric, uncooperative, unsympathetic</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>Organized, purposeful, disciplined, methodical, tend to make and carry out plans</td>
<td>Easygoing, spontaneous, disorganized, spur-of-the-moment, laid-back</td>
</tr>
</tbody>
</table>

In terms of format, the NEO-PI-R is comparable with the other objective personality tests described in this chapter. It is a 240-item pencil-and-paper self-report questionnaire. The items are short statements with multiple choice responses ranging from “Strongly Agree” to “Strongly Disagree.” The original NEO Personality Inventory was published in 1985, with the current edition, NEO-PI-R, arriving in 1992. A short form (60 items) of this test, the **NEO Five Factor Inventory (NEO-FFI)**, is also available but produces a less detailed profile. Psychometric data on the NEO-PI-R suggests that it has very strong reliability and validity (Costa & McCrae, 1992).

The NEO-PI-R has been criticized for its lack of validity scales. Unlike the MMPI tests and the MCMI-III, the NEO-PI-R lacks any substantive measurement of the test taker’s approach to the test, leaving it rather vulnerable to “faking” or inattention by clients. Clinicians have also commented on the test’s limited clinical utility, especially regarding diagnosis. Although the NEO-PI-R can indicate that an individual is extremely high or low in any of the five fundamental personality traits, such extreme scores do not readily translate into specific, diagnosable mental disorders. However, there are strong suggestions in some recent research that some disorders, especially personality disorders, correlate strongly with particular combinations of high scores on NEO-PI-R scales, which bolsters the clinical utility of the NEO-PI-R for many psychologists (Costa & Widiger, 2001).

**California Personality Inventory-III (CPI-III)**

The **California Personality Inventory-III (CPI-III)** goes a step further than the NEO-PI-R in deemphasizing pathology as the defining characteristic of personality. Whereas the MMPI tests emphasize pathology and the NEO-PI-R emphasizes normal traits, the CPI-III emphasizes the positive attributes of personality. The CPI-III, published in 1996, was designed to assess the strengths, assets, and internal resources of clients (Donnay & Elliott, 2003).

The CPI-III is a pencil-and-paper, self-report questionnaire including 434 true/false items. It yields scores on 20 scales, the names of which reflect the positive nature of this test: Independence, Self-Acceptance, Empathy, Tolerance, Responsibility, and Flexibility, among others. The CPI-III test is consistent with the recent movement within the mental health field toward **positive psychology**, which accentuates the strong and healthy rather than the pathological aspects of human behavior (Donnay & Elliott, 2003; Seligman & Csikszentmihalyi, 2000). Clinical psychologists who endorse the positive psychology approach find the CPI-III uniquely valuable; those who do not, or whose primary task is the diagnosis of mental disorders, may prefer other measures.
Beck Depression Inventory-II (BDI-II)

Comprehensive objective personality tests—like the MMPI tests, the MCM-III, the NEO-PI-R, and the CPI-III—provide clinical psychologists with a broad overview of personality and provide scores on a broad range of variables. But sometimes, clinical psychologists prefer more targeted, noncomprehensive objective measures. These tests are typically briefer and focus exclusively on one characteristic, such as depression, anxiety, or eating disorders. The Beck Depression Inventory-II (BDI-II) is a widely respected and used example of this type of test.

The BDI-II is a self-report pencil-and-paper test that assesses depressive symptoms in adults and adolescents. The original BDI was created by Aaron Beck, a leader in cognitive therapy of depression and other disorders, in the 1960s; the current revision was published in 1996. The BDI-II is very brief—only 21 items, usually requiring 5 to 10 minutes to complete. Each item is a set of four statements regarding a particular symptom of depression, listed in order of increasing severity. The client chooses the one sentence in each set that best describes their personal experience during the previous two weeks (a time period chosen to match DSM-IV criteria). The 21 item scores are summed to produce a total score, which reflects the client’s overall level of depression (Brantley, Dutton, & Wood, 2004).

As a simulated sample BDI-II item, consider the following set of statements, of which the client would choose one:

- I never think about dying. (0 points)
- I occasionally think about dying. (1 point)
- I frequently think about dying. (2 points)
- I constantly think about dying. (3 points)

The BDI-II lacks validity scales, and of course, its scope is much more limited than the other objective tests discussed in this chapter. However, its reliability and validity are strongly established (Brantley et al., 2004), and it is a frequent choice of psychologists seeking a quick, empirically sound answer to a specific assessment question regarding depression.

PROJECTIVE PERSONALITY TESTS

Objective personality tests are based on the assumption that personality is best assessed by directly asking people to describe themselves. Projective personality tests are based on a fundamentally different assumption: People will “project” their personalities if presented with unstructured, ambiguous stimuli and an unrestricted opportunity to respond. Imagine a group of people lying on the ground,
looking up at the same series of vaguely shaped clouds in the sky. The way each person makes sense of the series of clouds implies something about that person’s personality according to supporters of projective personality tests. To extend this analogy, projective personality tests are similar to a series of “clouds” that psychologists display to clients. Clients are given freedom to make sense of these stimuli in any way they choose—they are not restricted to multiple choice or true/false options. Clients’ responses may be compared with those of others in a normative group, and psychologists will ultimately form hypotheses about the clients’ personality based on their responses.

The lack of objectivity, especially in scoring and interpreting, highlights the most frequently cited shortcoming of projective personality tests. Critics of projective tests stress that they are far too inferential to be empirically sound; that is, they rely too heavily on a psychologist’s unique way of scoring and interpreting a client’s responses. In an objective test in which a client’s responses consist of “true” or “false,” scoring is standardized and consistent. But in a projective test in which each client produces unique responses, scoring may vary across psychologists. Additionally, once items are scored, the process of assigning meaning to them is, according to many, less systematic and more idiosyncratic in projective tests. Indeed, projective tests have declined in popularity in recent decades, to the satisfaction of critics who claim that their reliability and validity are insufficient to justify psychologists using them or graduate programs teaching them (e.g., Lilienfeld, Wood, & Garb, 2000). However, other experts in the field of projective personality testing have argued vigorously in favor of their use. A recent review of 184 meta-analytic studies of the psychometric characteristics of personality tests found that the reliability and validity of common projectives like the Rorschach Inkblot Method and the Thematic Apperception Test (TAT), when scored systematically and accurately, are roughly equal to those of commonly used objective personality tests (Meyer, 2004). This controversy continues, and although projective personality tests may not be as popular as they once were, recent surveys of psychologists suggest that some, including the Rorschach, the TAT, and sentence completion tests, remain very much a part of contemporary clinical psychology (e.g., Watkins et al., 1995).

**Rorschach Inkblot Method**

In 1921, Hermann Rorschach created the Rorschach Inkblot Method. Rorschach was a Swiss psychiatrist who, as a child, played a game in which participants looked at vague blots of ink and said what they saw in the blots. As an adult, he decided to apply a similar method to his patients, with the hypothesis that their responses would reveal their personality characteristics (Weiner, 2004).
For his test, Rorschach created 10 inkblots, 5 with only black ink and the other 5 with multiple colors. Administration occurs in two phases. In the “response” or “free association” phase, the psychologist presents one inkblot card at a time, asks “What might this be?,” and writes down the client’s responses verbatim. After the client has responded to all 10 cards, the “inquiry” phase begins, in which the psychologist reads the client’s responses aloud and asks the client to describe exactly where in the inkblot each response was located and what features of the inkblot caused the client to offer that response. A simulated Rorschach inkblot appears in Photo 10.2.

When Rorschach published his inkblots in 1921, they were not accompanied by a scoring method. Rorschach died about a year later, and in his absence, numerous scoring systems were independently created and used in the United States and Europe. Ultimately, John Exner combined aspects of many scoring systems to create the Comprehensive System, which has become the most common method of scoring the Rorschach (Exner, 1986; Wood, Nezworski, Lilienfeld, & Garb, 2003). Exner’s Comprehensive System includes normative data collected from thousands of children and adults; thus, the Rorschach can be used with clients across almost the entire lifespan.

When a clinical psychologist uses Exner’s Comprehensive System, each Rorschach response is coded in many ways. The scoring of a Rorschach response has as much to do with the process by which the client made sense of the blot as the content of the client’s perceptions. In other words, how the client perceives the blot is no less important than what the client sees. A small sample of the many variables examined by the Comprehensive System includes the following:

- **Location.** Does the response involve the whole inkblot, a large portion of it, or a small detail?
- **Determinants.** What aspect of the inkblot—its form, color, shading, etc.—caused the client to make a particular response?
- **Form Quality.** Is the response easily identifiable and conventional? Or is it unique or distorted?
- **Popular.** Each card has a response or two that occurs relatively frequently. How often does the client offer these popular responses?
• Content. What kinds of objects appear with unusual frequency in the clients’ responses? People, animals, food, clothing, explosions, body parts, nature, or other categories of items?

After each response is scored, the scores are combined into a variety of indices, and the scores and indices are then interpreted. Although interpretive strategies vary somewhat and some may be more empirically based than others, a rule of thumb is that the way the client makes sense of the inkblots parallels the way the client makes sense of the world. Consider, for example, the Form Quality variable described above. Clients who consistently offer distorted, atypical perceptions of inkblots are thought to do similar things in life—misperceive situations, use distorted judgment, or make sense of things in an unconventional manner. Or, consider the Location variable. A client whose responses almost always incorporate the whole inkblot may tend to focus on the “big picture” of life rather than “breaking it down” into smaller pieces or attending to details, whereas a client whose responses always involve very small parts of the inkblot may tend to focus excessively on details and overlook the “big picture” in day-to-day life.

Together, the multitude of variables yielded by the Comprehensive System shed light on many aspects of personality. However, the psychometric foundation underlying the Rorschach has, for some, cast doubt on the clinical conclusions it can offer. Supporters of the Rorschach point out that the reliability data regarding scoring, especially test-retest reliability, is quite strong according to some studies, and that validity for the Rorschach has been measured at a comparable level to that of the MMPI tests (e.g., Meyer, 2004; Rose, Kaser-Boyd, & Maloney, 2001). However, many critics of the Rorschach have pointed out some serious shortcomings: Numerous studies have found weak reliability and validity data; scoring and interpretation guidelines are complex, and psychologists do not always follow them as closely as they should; moreover, norms for the Rorschach may be inadequate for some populations (as summarized by Wood, Nezworski, et al., 2003). Controversy regarding the scientific status of the Rorschach has raged in recent years, and although it remains widely used and respected by many clinical psychologists today, the long-term future of the Rorschach depends largely upon how that controversy is resolved.

Thematic Apperception Test (TAT)

The Thematic Apperception Test (TAT), published by Henry Murray and Christiana Morgan, is similar to the Rorschach in that it involves presenting the client with a series of cards, each featuring an ambiguous stimulus (Morgan & Murray, 1935; Murray, 1943). Unlike the Rorschach cards, however, the TAT
cards feature interpersonal scenes rather than inkblots. The task of the client is to create a story to go along with each scene. They are asked to consider not only what is happening in the scene at the moment but also what happened before and what may happen after the scene. They are also asked to describe what the characters may be thinking and feeling (Bellak, 1993). Although the TAT is considered a global measure of personality by many, its strength may lie in its ability to measure interpersonal relationship tendencies.

Box 10.4 features an actual TAT card, along with a variety of simulated responses. What inferences would you make about the person telling each of the stories? Compare your interpretations to those of your classmates or friends—how consistent are the interpretations? (Note that the actual interpretation of TAT responses would emphasize recurring themes across multiple stories rather than an interpretation based on a single story.)

**Box 10.4 TAT—Card 12F With Simulated Responses**

1. “This is a mother and daughter. The mother is just thinking about how much her daughter has grown—she remembers like yesterday when her daughter was a little girl, and now she’s a young woman, and the mother is very proud of her. She wants to figure out a way to tell her how proud she is and how much she loves her. She will just come out and say it, and they’ll hug, and it’ll be a nice, touching moment between the two of them.”

2. “She’s a thief—you can tell by the look in her eyes. She’s sneaking up behind this other woman, who has no idea she’s even there. She’s gonna grab her wallet out of her purse very slowly—she’s gonna pick her pocket. Then she’ll quietly walk away, and the younger woman won’t even know what happened until later when she realizes her wallet’s gone. She’s done this a million times before, and she’ll do it again, probably today. She gets a thrill out of it, plus she gets the money. She’ll probably never stop, because she never gets caught.”

(Continued)
The TAT includes a total of 31 cards, but psychologists typically select their own subset of cards—often about 10 or so—to administer to a particular client. As the client tells stories aloud and the psychologist writes them down, the psychologist may ask questions during a client’s story to solicit more information, and can remind the client of the initial instructions as well. Henry Murray offered a scoring system for the TAT emphasizing “needs” of the main characters, “press” from the environment, and other variables. Others have offered additional formal scoring
systems, but for the most part, formal TAT scoring systems have been “neglected or ignored” (Moretti & Rossini, 2004, p. 357). Currently, the TAT is often analyzed without formal scoring at all: “[M]ost clinicians today seem to rely on their own impressionistic inferences,” resulting in “idiosyncratic and inconsistent” use of the TAT (Moretti & Rossini, 2004, p. 357). Thus, TAT interpretation is more art than science. A client’s story may be interpreted one way by one psychologist but very differently by another.

As a result of this nonempirical scoring and interpretation procedure, the TAT is not a preferred test among clinical psychologists who insist upon assessment methods supported by strong psychometric data. The validity and reliability of the TAT are less well established than those of other personality tests, largely because the scoring, interpretation, or the administration is not uniform across psychologists. Henry Murray (1943) himself stated that “the conclusions that are reached by an analysis of TAT stories must be regarded as good ‘leads’ or working hypotheses to be verified by other methods, rather than as proved facts” (p. 14)—a statement applicable to all assessment methods, especially those with debatable scientific status. Nonetheless, the use of the TAT continues, as well as the use of the related Children’s Apperception Test (CAT) and Senior Apperception Test (SAT) (Bellak, 1993), based on the hypothesis that “the stories we tell say something about who we are” (Moretti & Rossini, 2004, p. 357).

Sentence Completion Tests

In sentence completion tests, the ambiguous stimuli are neither inkblots nor interpersonal scenes; instead, they are the beginnings of sentences. The assumption is that a client’s personality is revealed by the endings they add and the sentences they create. Although there are many projective tests using the sentence completion format, the Rotter Incomplete Sentences Blank (RISB) tests are by far the most widely known and commonly used (Sherry, Dahlen, & Holaday, 2004). The original RISB was published in 1950, with the most recent revised edition (including High School, College, and Adult versions) appearing in 1992. The RISB tests include 40 written sentence “stems” referring to various aspects of the client’s life. Each stem is followed by blank space in which the client completes the sentence. Simulated sentence stems similar to those in the RISB include

- I enjoy ________________________________.
- It makes me furious ____________________.
- I feel very nervous ____________________.
- My proudest moment ____________________.
- My greatest weakness ____________________.
Like the TAT, the RISB includes a formal scoring system, but clinical psychologists may not use it regularly, and when they do, scoring is highly dependent upon the clinical judgment of the psychologist. Thus, its scientific standing is questionable. However, the RISB can “flesh out” the information obtained through other tests, including objective personality tests (Sherry et al., 2004). For example, a clinical psychologist may conclude that a client is depressed after the client obtains a very high score on the Depression scale (Scale 2) of the MMPI-2. But that scale score alone offers no explanation of the qualitative aspects of the depression, or what the depression is “about.” If the client answered the simulated RISB items above by stating that “I enjoy . . . very few things now that my spouse is gone,” “It makes me furious . . . that life is so unfair,” and “I feel very nervous . . . when I think about living alone,” the clinical psychologist can hypothesize that the client’s depression relates closely to the loss of this significant relationship.

**BEHAVIORAL ASSESSMENT**

Most clinical psychologists would consider all of the objective and projective measures described so far in this chapter to be traditional personality assessment techniques. These traditional techniques share a few basic, implicit assumptions,

- Personality is a stable, internal construct. In other words, behavior is determined primarily by characteristics or dispositions “inside” the person.
- Assessing personality requires a high degree of inference. That is, clinical psychologists use the data provided by personality tests (e.g., MMPI-2 scale scores, Rorschach responses) to deduce or speculate about problem behaviors that clients may actually experience.
- Client behaviors are signs of deep-seated, underlying issues or problems, sometimes taking the form of DSM diagnoses.

**Behavioral assessment** challenges all of these assumptions and offers a fundamentally different approach to assessment (Heiby & Haynes, 2004; Ollendick, Alvarez, & Greene, 2004). According to behavioral assessment, client behaviors are not signs of underlying issues or problems; instead, those behaviors are the problems. Another way to state this is that the behavior a client demonstrates is a sample of the problem itself, not a sign of some deeper, underlying problem. For example, if Zach, a 9-year-old child, argues with teachers often at school, “arguing with teachers” is the problem. It is unnecessary and unwise, according to behavioral assessors, to understand Zach’s arguing as “symptomatic” of a deeply rooted issue, such as oppositional defiant disorder. So to assess the problem,
assessment techniques should involve as little inference as possible. Rather than inkblots or questionnaires that may get at the problem indirectly, behavioral assessors would choose the most direct way to measure Zach’s problem behavior: observation of Zach in his classroom. By rejecting the idea that Zach “has” some internal disorder or trait that underlies his arguing, behavioral assessors demonstrate their rejection of the more fundamental idea that enduring, internal “personality” characteristics cause all behavior. Instead, behavioral assessors argue that external, situational factors determine our behavior.

**Techniques in Behavioral Assessment**

The most essential technique in behavioral assessment is **behavioral observation** or the direct, systematic observation of a client’s behavior in the natural environment (Ollendick et al., 2004). Also known as **naturalistic observation**, this practice involves taking a direct sample of the problem at the site where it occurs (home, work, school, public places, etc.). The first step in behavioral observation involves identifying and operationally defining the problem behavior. This takes place via interviews, behavioral checklists, consultation with those who have observed the client (family members, coworkers, teachers, etc.), or self-monitoring by the client. Once the target behavior is identified and defined, systematic observation takes place. This process usually involves tallying the frequency, duration, or intensity of the target behavior across specified time periods. Such direct observation can provide a far more accurate assessment of problem behavior than merely asking the client to verbally recall or summarize it during an interview or on a questionnaire (Ollendick et al., 2004).

Behavioral observation also typically includes keeping a record of the events that occur immediately before and after the target behavior. Noting these events allows for clinical psychologists to understand the functionality of a particular behavior or how the behavior relates to the environment and contingencies that surround it (Heiby & Haynes, 2004). As an example, let’s consider 9-year-old Zach again. If Zach’s clinical psychologist, Dr. Davis, was conducting a behavioral observation, Dr. Davis would visit Zach’s classroom with an explicit definition of the arguing behavior and would systematically keep track of its occurrence. However, Dr. Davis would also take note of the antecedents and consequences of Zach’s behavior. Perhaps Zach’s arguments are consistently preceded by a particular stimulus (e.g., a direct question from the teacher or an in-class math assignment) or followed by a particular consequence (e.g., prolonged attention from the teacher or removal from the room). These events surrounding Zach’s behavior can offer important information regarding the functionality of the target behavior.
Technology in Behavioral Assessment

Especially in recent years, computers and other forms of technology have been used productively by behavioral assessors. In the description above of Dr. Davis’ behavioral observation of Zach, Dr. Davis could have used a laptop computer or handheld “palm”-style device to record her observations. Numerous software programs have emerged, allowing for simultaneous recording of multiple variables, instant graphing and statistical analysis of behavior patterns, and other advanced, time-saving features. In fact, clients themselves can benefit from the use of technology in behavioral assessment. For example, clients often conduct self-monitoring, either as a way of defining the target behavior or measuring changes in it over time. This self-monitoring has traditionally been done with pencil-and-paper journals, but computers and handheld devices offer a method that can be more convenient (for e-mailing and downloading records) and private (if the device has a password protection feature). Additionally, many of these devices have alarm features, which can increase clients’ compliance with self-monitoring schedules (Richard & Lauterbach, 2003).

CHAPTER SUMMARY

The personality assessment techniques traditionally used by clinical psychologists can generally be divided into objective and projective tests. Objective personality tests are typically pencil-and-paper questionnaires featuring unambiguous stimuli, a limited range of responses, and a self-report format. Some of these tests assess test-takers’ attitudes as well as clinically relevant variables, which aids in interpretation of test results. Examples of objective personality tests include the MMPI-2, which focuses on various types of psychopathology; the MCMI-III, which focuses on personality disorders; the NEO-PI-R, which focuses on normal personality traits; the CPI-III, which focuses on strengths rather than disorders; and the BDI-II, which is a relatively brief, more targeted test assessing depression only. Projective personality tests involve ambiguous stimuli, an unlimited range of responses, and are viewed by many as less psychometrically sound than objective tests. Examples of projective personality tests include the Rorschach Inkblot Technique; the TAT, in which clients respond to interpersonal scenes rather than inkblots; and sentence completion tests, in which clients fill in the end of unfinished sentence stems. Unlike traditional clinical assessment involving objective or projective testing, behavioral assessment involves a more direct and less inferential approach to client’s problems. Behavioral assessors
employ techniques such as behavioral observation and client self-monitoring with the belief that problem behavior is the clinical issue, rather than a sign of a deeper underlying issue. Regardless of the techniques they choose when assessing personality or behavior, clinical psychologists typically use multiple methods and strive for cultural competence.

### Key Terms and Names

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<th>Term</th>
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<tr>
<td>Aaron Beck</td>
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<td>Beck Depression Inventory-II (BDI-II)</td>
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<td>Rorschach Inkblot Method</td>
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<td>Rotter Incomplete Sentences Blank (RISB)</td>
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self-monitoring  
Senior Apperception Test (SAT)  
sentence completion tests  
Starke Hathaway  
supplemental scales  

test-taking attitudes  
Thematic Apperception Test (TAT)  
Theodore Millon  
traditional personality assessment  
validity scales

CRITICAL THINKING QUESTIONS

1. In your opinion, what are the most important strengths and weaknesses of projective personality tests?

2. In your opinion, what are the most important strengths and weaknesses of objective personality tests?

3. If you were designing an objective personality test, how would you go about creating a measure of test-taking attitudes (like the validity scales of the MMPI-2)?

4. The NEO-PI-R is founded on the idea that all people share the same five fundamental personality characteristics and that we differ only in the strength of these characteristics. Do you agree that all people share the same personality characteristics, or do you believe that some people have qualitatively different characteristics than others?

5. In your opinion, for what clinical problems does behavioral assessment seem best suited?
Part III

PSYCHOTHERAPY

Visit the study site at www.sagepub.com/pomerantzcpestudy for practice quizzes and other study resources.
With this chapter, we begin our exploration of psychotherapy, the most common professional activity of clinical psychologists (Norcross, Karpiak, et al., 2005). Upcoming chapters will offer details on specific approaches to psychotherapy, including psychoanalytic/psychodynamic, humanistic, behavioral,
and cognitive techniques. But in this chapter, we consider some important “across-the-board” psychotherapy issues, including how well it works and how it has been practiced by clinical psychologists.

**DOES PSYCHOTHERAPY WORK?**

Questions about the outcome of psychotherapy have been prominent throughout the history of clinical psychology, and studies investigating these questions have taken many forms. Through the mid-1900s, most of the evidence offered in support of psychotherapy came in the form of anecdotes, testimonials, and case studies—essentially, subjective descriptions of individual clients’ progress, usually written by the therapists themselves. Controlled, empirical studies of therapy outcome didn’t appear regularly until the 1950s (Weissmark & Giacomo, 1998). **Hans Eysenck** (1952) published a historic study during this early period. Its claims were noteworthy and controversial: After reviewing some of the early empirical studies on psychotherapy outcome, Eysenck concluded that most clients got better without therapy and that in general, psychotherapy was of little benefit. His scientific methods have since been criticized and his claims overturned, but Eysenck’s allegation that therapy doesn’t work inspired thousands of subsequent empirical studies on therapy outcome.

Many of those empirical studies on therapy outcome were conducted in the 1960s and 1970s. By the late 1970s and 1980s, meta-analyses began to appear. **A meta-analysis** statistically combines the results of many—in some cases, hundreds—separate studies to create numerical representations of the effects of psychotherapy as tested across massive numbers of settings, therapists, and clients. As we will see shortly, these meta-analyses have yielded consistently supportive results about how well psychotherapy works. But before exploring those results, let’s consider just some of the methodological issues involved in a simple investigation of psychotherapy outcome.

**Who, When, and How Should Researchers Ask?**

Designing and running an empirical study to measure the outcome of psychotherapy can be a complex task for researchers. One of the fundamental questions they must answer involves the fact that different people involved in the therapy may have different vantage points on the results of the therapy. Whose opinion should researchers seek?

**Hans Strupp**, a legendary and pioneering psychotherapy researcher, identified three parties who have a stake in how well therapy works and who may have different opinions about what constitutes a successful therapy outcome. He and his colleagues have labeled their theory the **tripartite model** (with “tripartite” literally meaning “three parties”) (Strupp, 1996; Strupp & Hadley, 1977; Strupp, Hadley, &
Gomes-Schwartz, 1977). One party, of course, is the client. After all, clients are the ones whose lives are affected by therapy, and improving their lives in some meaningful way is presumably the focus of the therapy. Clients’ opinions about therapy outcome are extremely valuable, but they can also be extremely biased. Some clients may be overly eager to see positive results, especially after investing significant time and money, and therefore overestimate therapy’s benefits. Other clients’ opinions about psychotherapy may be negatively influenced by the very factors that brought them to therapy in the first place—for example, a depressed client who tends to interpret events in an unrealistically negative way may apply that kind of distorted thinking to his or her therapy also. So, a researcher may choose to turn to the therapist—the second party—as another source of feedback. The therapist typically has more experience in mental health issues than the client and may therefore have more reasonable expectations. However, therapists’ views can be biased as well. Therapists witness only a fraction of clients’ lives, and they may feel that negative evaluations may reflect poorly on their own therapeutic skills. The third party identified by Strupp and his colleagues, “society,” can take the form of any outsider to the therapy process who has an interest in how therapy progresses. This can include the general public, the legal system, clients’ family and friends, clients’ employers, and especially today, managed care companies who pay the psychotherapy bill. These third parties tend to bring a perspective that emphasizes the client’s ability to perform expected duties in a stable, predictable, unproblematic way.

**Box 11.1 Considering Culture**

**Culture-Specific Expectations About Psychotherapy**

Our discussion about psychotherapy outcome, especially from the client’s perspective, must take into consideration the fact that clients from diverse cultures often hold widely varying expectations about the psychotherapy process. A culturally competent therapist will be able to attain more successful psychotherapy outcome by appreciating the presumptions related to each client’s cultural background.

As it is traditionally practiced in North America and the Western world, psychotherapy involves verbally discussing one’s problems, focusing attention on them, and gaining greater understanding or control over them. These basic processes clash with cultural values common to some non-Western cultures whose members often prefer to “conceal” rather than “reveal” (Toukmanian & Brouwers, 1998). Individuals from Eastern cultures often prefer the avoidance, rather than the confrontation, of negative thoughts. Thus, the communication styles of clients with psychotherapists—in simplest terms, the extent to which they are comfortable self-disclosing about problematic behaviors, thoughts, and feelings—may depend significantly on their cultural values.

(Continued)
Certainly, the question of who to ask is crucial to the process of measuring therapy outcome. Thankfully, researchers need not choose a single perspective exclusively; they can and often do solicit multiple opinions.

Regardless of who the researchers ask about therapy outcome, when should they ask? Perhaps the obvious answer is immediately after therapy ends. At that point, it would be reasonable to expect some improvement from the client’s initial level of functioning. But how long should those benefits last? Is it reasonable to expect that therapy’s benefits would continue to be evident 1 month, 6 months, 2 years, or 5 years down the road? And what about benefits before therapy ends? Should there be some evidence of improvement at various points in therapy or perhaps even at each session? Again, shrewd researchers may choose multiple answers to the question of when, either within or across psychotherapy studies. But it is evident that the time at which the researchers answer this question may influence the results they see.

Photo 11.1 Individuals from diverse cultural backgrounds come to psychotherapy with very different expectations about the behaviors of clients and therapists.

A client’s willingness to self-disclose to a psychotherapist may also depend on the individualistic versus collectivistic nature of a client’s culture. Western cultures tend to foster an individualistic way of life, emphasizing self-reliance and self-determination. In contrast, Eastern cultures tend to encourage collectivism, whereby the needs of the family/group and the relationships that bind the family/group take priority over individual goals. Thus, whereas a client of European descent may feel slightly uncomfortable discussing a personal problem or shortcoming, a client of Asian descent may feel a much stronger sense of shame about a similar problem or shortcoming because of his perception that the problem reflects upon his family members as well (Sue & Sue, 2003; Toukmanian & Brouwers, 1998).

Training psychotherapists to be culturally competent is the foundation on which they can build an appreciation of client’s expectations about psychotherapy. Toukmanian and Brouwers (1998) recommend that training in psychotherapy emphasize the personal development of the therapist’s attitude toward diverse cultures. This training should encompass four levels: self-understanding (of one’s own cultural values), listening to clients’ cultural values, accepting clients’ cultural values, and understanding clients’ cultural values.

If you were the client, how important would it be for your psychotherapist to appreciate your expectations about psychotherapy that relate to your cultural background? Specifically, which values would be most important to recognize?
Finally, researchers have many options regarding how they measure the outcome of psychotherapy. If they choose to solicit opinions of an interested party, they can use questionnaires or interviews. Of course, the content and structure of these questionnaires or interviews will have an impact on the data they yield. Researchers may elect to use a more behavioral measure of therapy outcome instead. As an example, consider a researcher who seeks to determine the outcome of psychotherapy for a boy treated for ADHD. Rather than asking the boy, his therapist, his parents, or his teachers, a researcher could directly observe the boy at school or at home to determine if his behavior has changed since therapy began. As with the questions of who and when, the researcher’s decision regarding how psychotherapy outcome is measured can shape the results of the investigation.

EFFICACY VERSUS EFFECTIVENESS OF PSYCHOTHERAPY

Empirical studies of psychotherapy outcome generally fall into two categories. The extent to which psychotherapy works “in the lab” refers to its efficacy. Most recent studies of psychotherapy outcome are efficacy studies. They maximize internal validity—that is, the ability to draw conclusions about the cause-effect relationship between therapy and outcome—by controlling as many aspects of therapy as possible. Efficacy studies typically feature well-defined groups of patients, usually meeting diagnostic criteria for a chosen disorder but no others; manualized treatment guidelines to minimize variability between therapists; and random assignment to control and treatment groups (Nathan & Gorman, 2002).

In contrast, the extent to which psychotherapy works “in the real world” refers to its effectiveness. Effectiveness studies tend to include a wider range of clients, including those with complex diagnostic profiles; allow for greater variability between therapists’ method; and may or may not include a control group for comparison to a treatment group. Effectiveness studies lack the internal validity of efficacy studies because the researchers control and manipulate fewer variables. However, effectiveness studies typically have greater external validity than efficacy studies because their methods better match therapy that actually takes place in clinics, private practices, hospitals, and other realistic settings (Nathan & Gorman, 2002).

Results of Efficacy Studies

Thousands of efficacy studies of psychotherapy have accumulated in recent decades; in fact, the number of reviews and meta-analyses that serve as summaries of individual studies now numbers in the hundreds as well. Again and again, these research efforts yield the same affirmative conclusion: Psychotherapy works. For
example, a primary finding of a landmark meta-analysis of 475 psychotherapy efficacy studies (M. L. Smith et al., 1980) was that the average effect size for psychotherapy was .85, indicating that “the average person who receives therapy is better off at the end of it than 80 percent of the persons who do not” (p. 87). More recent meta-analyses of therapy efficacy studies (e.g., Shapiro & Shapiro, 1982), including some very large-scale mega-reviews of meta-analyses (e.g., Lipsey & Wilson, 1993; Luborsky et al., 2002) have confirmed these findings. Summarizing their recent comprehensive review of psychotherapy efficacy data, Lambert and Ogles (2004) stated, “. . . the pervasive theme of this large body of psychotherapy research must remain the same—psychotherapy is beneficial. This consistent finding across thousands of studies and hundreds of meta-analyses is seemingly undeniable” (p. 148).

Not only does psychotherapy work, its benefits appear to endure over long periods of time, exceed placebo effects, and represent clinically (not just statistically) significant change in clients’ well-being (e.g., Lambert & Ogles, 2004; M. L. Smith et al., 1980). It should be noted that psychotherapy is not a panacea—a small minority of therapy clients do appear to worsen during the therapy process (Striano, 1988; Strupp et al., 1977). However, these negative effects clearly appear to be the exception rather than the rule.

Results of Effectiveness Studies

Effectiveness studies have not been conducted as frequently as efficacy studies, but those that have been conducted have generated similarly positive results. So, whereas efficacy studies indicate that psychotherapy works when tested in controlled settings, effectiveness studies indicate that psychotherapy works as it is commonly applied in realistic settings.

As an example of an effectiveness study, consider the investigation conducted by Consumer Reports magazine in 1995 (Consumer Reports, 1995; Seligman, 1995). The popular magazine—the same one that surveys its subscribers about their experiences with cars, DVD players, and laundry detergent—surveyed its many subscribers about their experiences with psychotherapy. The primary finding was that for the vast majority of respondents, psychotherapy had very positive, lasting effects. As stated by Seligman (1995),

There were a number of clear-cut results, among them:

- Treatment by a mental health professional usually worked. Most respondents got a lot better.
- Averaged over all mental health professionals, of the 426 people who were feeling very poor when they began therapy, 87% were feeling very good, good, or at least so-so by the time of the survey. Of the 786 people who were
feeling fairly poor at the outset, 92% were feeling very good, good, or at least so-so by the time of the survey. These findings converge with meta-analyses of efficacy (Lipsey & Wilson, 1993; Shapiro & Shapiro, 1982; Smith, Miller, & Glass, 1980). (p. 6)

Like any effectiveness study, the Consumer Reports study is constrained by some troubling methodological questions (Seligman, 1995). For example, was there a sampling bias such that those whose therapy experience was successful were most likely to respond? Of the many clients who improved, how many would have improved without psychotherapy (i.e., in a control group)? How reliable and valid are clients’ own self-reports about psychotherapy outcome, especially after months or years have elapsed? Nonetheless, effectiveness studies like this one complement efficacy studies, and together they very strongly support the benefits of psychotherapy.

WHICH TYPE OF PSYCHOTHERAPY IS BEST?

Soon after the finding that psychotherapy works started to become an established fact, infighting began among the various orientations and approaches about which had the strongest empirical support. Each claimed superiority over the others, and as the language below implies, the competition was quite fierce:

Although there were many combatants—Freudians versus cognitivists versus humanists—the principals in this war were behaviorists and nonbehaviorists. These groups have called each other names and traded high sounding insults. But the issue was not over psychotherapy versus no psychotherapy, but brand A psychotherapy versus brand B psychotherapy . . . Different forms of therapy were viewed as adversaries, competitors, or contestants, and the arena of conflict was the controlled experiment. (M. L. Smith et al., 1980, pp. 2–3)

The “Dodo Bird Verdict” and Common Factors

Indeed, many empirical outcome studies throughout the latter half of the 1900s have pitted one form of therapy against another. The collective results of these studies have, again and again, yielded a result that surprised many in the field: a virtual tie. In other words, in the hundreds of empirical studies designed to compare the efficacy of one form of therapy with the efficacy of another, the typical result is that the competing therapies are found to work about equally well (Lambert & Ogles, 2004; Norcross & Newman, 1992; M. L. Smith et al., 1980; Wampold, 2001; Weissmark & Giacomo, 1998). In one of the earliest review articles to reach this conclusion, the authors borrowed a line from the dodo bird in Alice in Wonderland
who, after judging a race between many competitors, stated that “everyone has won and all must have prizes” (Luborsky, Singer, & Luborsky, 1975, p. 995).

How could the “dodo bird verdict” apply to psychotherapy outcome? The various forms of psychotherapy—psychoanalysis, humanism, cognitive, behavioral, and others—are indeed quite discrepant from each other, so how could they consistently produce such similar results? Most researchers explain this finding by pointing to common factors across all forms of psychotherapy (e.g., Wampold, 2001). That is, although proponents of each school of therapy tout the unique and distinctive aspects of their own approaches, they all share some fundamental components as well. Actually, the notion that different therapies benefit from the same underlying mechanisms was suggested as early as the 1930s (Rosenzweig, 1936) and has been reiterated numerous times since (e.g., Frank, 1961; Torrey, 1986). The difference in the most recent versions of this argument is that they are supported by extensive empirical data on psychotherapy outcome.

It is important to recognize that these common factors are not merely present, they are therapeutic. They function as “active ingredients” in all forms of psychotherapy, which helps to explain the comparable results of the various approaches: “All of the specific types of therapy achieve virtually equal—or insignificantly different—benefits because of a common core of curative processes” (Lambert & Ogles, 2004; Wampold, 2001, p. ix). So what are the common factors make up this common core of curative processes?

Therapeutic Relationship/Alliance

Of the many common factors for psychotherapy outcome that have been proposed, the leading candidate is a strong relationship between therapist and client (Prochaska & Norcross, 2007). This relationship goes by many names: therapeutic relationship, therapeutic alliance, working alliance. In fact, the word “alliance” is perhaps the most illustrative of the nature of this relationship—a coalition, a partnership between two allies working in a trusting relationship toward a mutual goal.

Numerous studies have concluded that the therapeutic relationship is perhaps the most crucial single aspect of therapy. Specifically, researchers have argued that the quality of the therapeutic relationship is the best predictor of therapy outcome and that it accounts for more variability in therapy outcome than the techniques specific to any given therapy approach (e.g., Prochaska & Norcross, 2007; Wampold, 2001). The strength of the therapeutic relationship is especially important from the client’s point of view; after all, it is the client’s perception of this relationship that facilitates positive change. It is also interesting to note that the quality of the therapeutic relationship is vital to therapy regardless of how much emphasis the therapist places on it. Some therapists (e.g., behaviorists) tend to deemphasize therapy relationships, others tend to pay it moderate attention.
(e.g., cognitive therapists), and others tend to focus heavily on it (e.g., humanists and psychoanalysts), but through the eyes of the client, the therapeutic relationship remains a consistently vital component of psychotherapy (Prochaska & Norcross, 2007).

**Other Common Factors**

The therapeutic relationship is not the only common factor that psychotherapy researchers have proposed. **Hope** (or positive expectations) has also received support as a common factor (Prochaska & Norcross, 2007). Simply stated, therapists of all kinds provide hope or an optimism that things will begin to improve. Although the mechanism by which this improvement will take place may differ, the improvement may actually begin before any techniques, per se, have been applied. Anyone who has walked despairingly into a physician’s office, or even a car repair shop, and received a confidently delivered message that the problem can be fixed understands the curative power of hope.

**Attention** may also be a common factor across psychotherapies. Also known as the Hawthorne effect (a name derived from classic organizational psychology studies in which factory workers’ performance improved as a result of being observed), the attention that the therapist and client direct toward the client’s issues may represent a novel approach to the problem. That is, clients may have previously attempted to ignore problems that are ultimately addressed in therapy. Simply by openly acknowledging a problem and focusing on it with the therapist, a client may begin to experience improvement, even before formal intervention begins. In addition to the therapeutic relationship, hope, and attention, other common factors that researchers have proposed include reinforcement of novel behaviors, desensitization to threatening stimuli, confronting a problem, and skill training (Prochaska & Norcross, 2007).

Is it possible that the common factors underlying all forms of psychotherapy occur in a predictable sequence? Lambert and Ogles (2004) put forth a **three-stage sequential model of common factors**, beginning with the “support factors” stage—common factors such as a strong therapist-client relationship, therapist

*Photo 11.2* The relationship or “alliance” between therapist and client is a common factor for therapeutic success.
If You Use Toothpaste, Then You Understand Common Factors in Psychotherapy

Toothpaste companies spend a lot of time and money convincing us that, because of some “special” feature, their product is the best. Crest, Colgate, Aim, Gleem, Aquafresh—all make claims that they have something unique that sets their toothpaste apart. You’ve probably tried a few yourself: toothpastes with baking soda, with mouthwash, with sparkles, in a stand-up tube, in winter-fresh gel, and so on.

Ever read the list of ingredients on one of those tubes of toothpaste? Beneath the full list of ingredients, you’ll see a separate, important category: “Active Ingredient.” And that category only has one item listed: fluoride. That’s true across all of the brands, all of the varieties. In other words, although the manufacturers and advertisers try to sell us on the unique features—extra ingredients, special flavors—what makes one toothpaste work is the same thing that makes its competitors work: fluoride. (That’s why our dentists rarely mention a specific brand when they remind us to brush—as long as it has fluoride, any brand will prevent cavities about as well as the others.)

Decades of outcome studies have suggested that the same type of phenomenon has taken place in the psychotherapy field. Each “brand” of psychotherapy has promoted its unique features, those aspects that distinguish it and supposedly make it better than the other brands. But those claims are contradicted by the consistent result of many controlled, empirical psychotherapy outcome studies: Different forms of psychotherapy work about equally. Consequently, it makes sense to speculate about the underlying common ingredient—the “fluoride” of psychotherapy.

So, what is the “fluoride” of psychotherapy? At this point, the therapeutic relationship/alliance has emerged as the leading candidate. That is, a strong relationship between therapist and client has proven beneficial, regardless of whether the therapist in that relationship uses psychoanalytic, humanistic, cognitive, or behavioral techniques. Other common factors have garnered significant attention and support from psychotherapy researchers as well, including hope/optimism and attention (Prochaska & Norcross, 2007). Perhaps various forms of psychotherapy share not a single ingredient (like toothpastes share fluoride), but a “common core” of ingredients, in which some of the factors described here combine to help a client (Wampold, 2001, p. ix).

The fact that fluoride is the common active ingredient in all toothpastes doesn’t make us indifferent about selecting one for ourselves. Just as you wouldn’t choose a toothpaste that costs too much or tastes bad to you, you wouldn’t choose a therapy that you found unjustifiably expensive or simply not palatable. Instead, with either toothpaste or therapy, your choice reflects your personal values and preferences about the means by which the active ingredients are delivered.
warmth and acceptance, and trust. They label the second stage “learning factors,” including such aspects as changing expectations about oneself, changes in thought patterns, corrective emotional experiences, and new insights. The third and final stage consists of “action factors,” such as taking risks, facing fears, practicing and mastering new behaviors, and working through problems. In brief, this sequential model suggests that psychotherapists of all kinds help clients by moving them through three common steps: connecting with them and understanding their problems; facilitating change in their beliefs and attitudes about their problems; and finally, encouraging new and more productive behaviors.

It is interesting to compare this three-step sequence with the more informal process of helping a friend who comes to you with a personal problem. Typically, we begin by communicating understanding and compassion, then move on to help them see their problem in a new light, and ultimately help them develop a strategy and take new action to address it. If we skip any of these steps or do them “out of order,” the helping process may be hindered. By the same token, some friends (or clients) may need more time at certain stages and less time at others—perhaps more support and less action or vice versa. And cultural factors can play an important role in the value of each stage to the person seeking help, as members of some groups may tend to favor support, learning, or action.

Reconsidering the Dodo Bird Verdict—
Specific Treatments for Specific Disorders

The dodo bird verdict has not gone unchallenged. Although it is a widely accepted finding in the field that the various forms of psychotherapy are, in general, equally effective, some researchers have made the case that certain psychotherapies are, in fact, superior to others in the treatment of specific problems (e.g., Chambless & Ollendick, 2001).

Dianne Chambless, a prolific and highly respected psychotherapy researcher, has argued strongly against the idea that all psychotherapy approaches are equally efficacious (e.g., Chambless & Ollendick, 2001). For instance, in her 2002 article (fittingly titled “Beware the Dodo Bird: Dangers of Overgeneralization”), Chambless points out that although empirical studies have compared many therapies with each other, there are many specific comparisons—certain therapies for certain disorders—that studies have not yet examined. Thus, it would be premature to conclude that all therapies are equal for all disorders, even if equal efficacy has been the typical finding in studies so far. Additionally, as described in Chapter 3, Chambless is a champion of the movement toward manualized, evidence-based treatments and has led the task forces that established criteria for efficacious treatments for specific disorders and determined which therapies made that list (Chambless et al., 1996, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).
Are Evidence-Based Treatments Appropriate for Diverse Clients?

A form of psychotherapy becomes an evidence-based treatment when empirical studies demonstrate that it produces successful results with clients. But what if the clients from the study differ in important ways from clients who might receive the treatment in the real world? Can we expect similarly positive results with all clients?

Empirical studies of psychotherapy have done a poor job of including diverse populations in their clinical trials, according to some recent criticisms. Specifically, a series of entries to a recent book titled *Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions* (Norcross, Beutler, & Levant, 2006) argue strongly that studies examining the efficacy of manualized therapies have commonly neglected issues of

- ethnicity
- gender
- disability
- lesbian, gay, bisexual, or transgendered (LGBT) clients

Regarding ethnicity, Sue and Zane (2006) report that despite the massive number of clinical studies evaluating the efficacy of specific therapies since 1986 (encompassing about 10,000 clients), the number of these studies that measured the efficacy of the treatment according to ethnicity or race is zero. Further, in about half of these studies, ethnicity information was not reported at all, and in most of the rest, very few minority clients were included. Regarding people with disabilities, Olkin and Taliaferro (2006) report that they “have been unable to locate any published materials on [evidence-based practices] and people with disabilities,” which “fuels our concern that [evidence-based practice] will develop without due consideration of this minority group” (pp. 353–354). L. S. Brown (2006) and Levant and Silverstein (2006) offer comparable summaries regarding inattention to LGBT and gender issues, respectively. Not only are clients from these diverse groups often omitted from clinical trials, the authors of the clinical studies (and the therapy manuals they test) rarely suggest specific adaptations to their treatment to better suit any such clients.

For a moment, imagine that you are a psychotherapy client. Your clinical psychologist informs you that a particular form of therapy has been shown in a series of studies to successfully treat the disorder with which you have been diagnosed. How important is it to you that the clients on whom the therapy was successfully tested may differ from you in important ways? If a particular form of therapy has been shown in a series of studies to...
The contention made by Chambless and others that the dodo bird verdict is inaccurate—and that therefore, common factors should take a back seat to specific ingredients in each therapy technique—has itself been countered by other leading psychotherapy researchers (e.g., Norcross, 2002). For example, in their 2002 article (aptly titled “Let’s Face Facts: Common Factors Are More Potent Than Specific Therapy Ingredients”), Stanley Messer and Bruce Wampold review the literature on therapy efficacy and conclude that “the preponderance of evidence points to the widespread operation of common factors such as therapist-client alliance...in determining treatment outcome” (p. 21). They further argue that the prescriptive approach to therapy—in which specific therapy techniques are viewed as the treatment of choice for specific disorders—should be replaced by an approach that more broadly emphasizes common factors, especially the therapeutic relationship.

WHAT TYPES OF PSYCHOTHERAPY DO CLINICAL PSYCHOLOGISTS PRACTICE?

The Past and Present

Six times since 1960, researchers have surveyed the Division of Clinical Psychology (Division 12) of the American Psychological Association to assess, among other things, the type or orientation of psychotherapy that its members practice. The most recent of these surveys incorporates responses from 654 clinical psychologists and includes a comparative review of the five previous surveys as well (Norcross, Karpiak, et al., 2005). These results are summarized in Table 11.1. Several observations and trends in Table 11.1 are noteworthy:

- Eclectic/integrative therapy has been the most commonly endorsed orientation in every survey summarized in the table. That is, through the latter half of the 1900s and the first few years of the 2000s, more psychologists describe
themselves as “mutts” who blend multiple approaches or use an assortment of therapies than as “purebreds” who practice one type exclusively.

- The endorsement of psychodynamic/psychoanalytic therapy has declined significantly since 1960, when it far exceeded any other single approach and rivaled the eclectic/integrative approach in terms of popularity. In 2003, only 15% of clinical psychologists endorsed it as their primary orientation—half of the percentage reported just 22 years earlier. Nonetheless, psychodynamic/psychoanalytic therapy remains the second most commonly endorsed orientation among the single-school approaches.

- Cognitive therapy has witnessed a remarkable rise in popularity, especially since the 1980s. Prior to 1980s, the unpopularity of the cognitive approach suggested that it was hardly worth including on these surveys, but by 2003, it had become by far the most commonly endorsed single-school approach and nearly equal to the eclectic/integrative approach.

Table 11.1  Percentage of Clinical Psychologists Endorsing Leading Primary Theoretical Orientations Since 1960

<table>
<thead>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclectic/Integrative</td>
<td>36</td>
<td>55</td>
<td>31</td>
<td>29</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>Cognitive</td>
<td>—</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Psychodynamic/Psychoanalytic</td>
<td>35</td>
<td>16</td>
<td>30</td>
<td>21</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Behavioral</td>
<td>8</td>
<td>10</td>
<td>14</td>
<td>16</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Humanistic/Rogerian/Existential/Gestalt</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>


The same survey (Norcross, Karpiak, et al., 2005) offers a description of the formats, or modalities, most commonly used by clinical psychologists. Table 11.2 presents highlights of these results for clinical psychologists responding to the most recent edition of the survey. As the table indicates, psychotherapy with individual clients dominates the professional activities of contemporary clinical psychologists. Almost all (98%) conduct some individual therapy, and it constitutes about ¾ of the time they spend doing therapy. However, the other formats of therapy—couples/marital therapy, family therapy, and group therapy—are also practiced by sizable numbers of clinical psychologists.
The Future

The practice of psychotherapy among clinical psychologists has certainly changed in the last half century. How might it change in the near future? Sixty-two psychotherapy experts, including many editors of leading journals in the field, were surveyed about the trends they foresee for the near future (Norcross, Hedges, & Prochaska, 2002). The results included several provocative predictions, including a rise in the use of

- cognitive and behavioral approaches to therapy,
- culturally sensitive therapy,
- eclectic/integrative approaches to therapy, and
- empirically supported or evidence-based forms of therapy.

The survey also suggested that classic psychoanalysis will continue to decline in use in the near future. Of course, only time will tell if these predictions are accurate.

Eclectic and Integrative Approaches

Eclectic and integrative approaches to psychotherapy hold a unique position among clinical psychologists, as we have seen. Whereas the various single-school forms of therapy have risen and fallen in popularity over the years, eclectic/integrative therapy has remained more popular than any of them (Norcross, Karpia, et al., 2005). Moreover, they are expected to become even more popular in the near future (Norcross, Hedges, & Prochaska, 2002).

Although the terms are often linked and both involve multiple therapy approaches, an eclectic approach to therapy actually differs in important ways from an integrative approach. **Eclectic** therapy involves selecting the best

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**Table 11.2  Involvement of Clinical Psychologists in Various Psychotherapy Formats**

<table>
<thead>
<tr>
<th>Psychotherapy Format</th>
<th>Percentage of Clinical Psychologists Who Practice It</th>
<th>Mean Percentage of Therapy Time It Occupies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>98</td>
<td>76</td>
</tr>
<tr>
<td>Couples/Marital</td>
<td>55</td>
<td>9</td>
</tr>
<tr>
<td>Family</td>
<td>39</td>
<td>9</td>
</tr>
<tr>
<td>Group</td>
<td>20</td>
<td>6</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from Norcross, Karpia, and Santoro (2005).
treatment for a given client based on empirical data from studies of the treatment of similar clients (Gold, 1996; Norcross & Newman, 1992). In other words, a truly eclectic therapist turns to the empirical literature as soon as the diagnosis is made, and practices whatever technique the literature prescribes for that diagnosis. So if the empirical literature dictates it, an eclectic therapist might practice cognitive therapy with a 9:00 a.m. client with generalized anxiety disorder, behavioral therapy with a 10:00 a.m. client with a phobia, and so on.

An integrative approach to therapy, on the other hand, involves blending techniques in order to create an entirely new, hybrid form of therapy. An integrative therapist may combine elements of psychoanalytic, cognitive, behavioral, humanistic, or other therapies into a personal therapy style applied to a wide range of clients.

In 1977, Paul Wachtel was one of the first to successfully integrate complementary (some might have said incompatible) approaches, namely psychoanalysis and behavior therapy. Soon after, especially in the 1980s, integrative therapy grew into a full-fledged movement. One of the champions of this movement has been John Norcross, who explained that the psychotherapy integration movement grew out of “a dissatisfaction with single-school approaches and a concomitant desire to look across and beyond school boundaries to see what can be learned from other ways of thinking about psychotherapy and behavior change” (Norcross & Newman, 1992, p. 4). Norcross and Newman identify a number of factors that have fostered the popularity of integrative forms of psychotherapy, especially since the 1980s. Among the most important of these factors are two that we have identified in this chapter: The lack of differential effectiveness among therapies and the recognition that common factors contribute significantly to therapy outcome.

DENISE: A FICTIONAL CLIENT TO CONSIDER FROM MULTIPLE PERSPECTIVES

The next four chapters of this book will each feature a specific approach to psychotherapy: psychoanalytic, humanistic, behavioral, and cognitive. To fully illustrate each, we will consider a therapy summary of a fictional client named Denise. (As this chapter indicates, if Denise was a real client seen by a real clinical psychologist, she would be most likely to receive eclectic or integrative treatment, but therapy summaries of the single-school approaches will nonetheless exemplify the elements of the various approaches.) As therapy summaries, these reports appear in the past tense, as if Denise completed a full course of the featured treatment and the therapist has written a synopsis of the treatment that might be useful if Denise was to return later or resume therapy with another therapist.

As with any client, Denise’s cultural background is an important aspect of her therapy. In creating this fictional client, many of her demographic characteristics
If You Know the Difference Between a Fruit Salad and a Smoothie, You Understand the Difference Between Eclectic and Integrative Psychotherapists

A fruit salad includes a variety of ingredients, but each bite brings only one flavor: the fork may stab a strawberry first, a blueberry next, and a pineapple chunk third. Each piece is pure, discrete, and easily distinguished from the others. But in a smoothie made of these ingredients, every sip includes the same combination of ingredients, and the taste of every sip reflects that unique blend. Mixed together, the ingredients create a distinct concoction with a taste wholly its own.

An eclectic approach to psychotherapy is a lot like a fruit salad. Eclectic therapists use a pure, discrete approach to therapy with each client, and they choose that approach according to empirical support. They allow empirical studies of psychotherapy efficacy to direct them toward the therapy most likely to succeed for a particular diagnosis. As described in Chapter 3, recent publications have supplied therapists with lists of the most empirically supported treatments for particular disorders (e.g., Chambless et al., 1998). An eclectic therapist would refer to such a list for each client separately. Because such lists prescribe very different forms of therapy for various disorders, eclectic therapists must be versatile enough to practice many techniques competently. Eclectic therapists have no loyalty to any particular approach to therapy; their loyalty is to the empirical data.

Integrative therapy, in contrast, is more like a smoothie—a custom blend of ingredients into an original creation. This “hybrid” approach to therapy is often used across clients and across diagnoses. Thus, integrative therapists are less concerned with employing evidence-based, manualized techniques in their pure form; instead, they are concerned with synthesizing the best features of various theories of psychotherapy. Whereas an eclectic therapist’s approach might contrast greatly from one client to the next (depending on empirical data for treatments of various disorders), an integrative therapist’s approach might remain a bit more constant, just as in a smoothie, the flavor combination doesn’t vary much from sip to sip.

As a clinical psychologist, which of these approaches to therapy—eclectic or integrative—would you prefer? If you were the client, which approach might you prefer your clinical psychologist to take? What are the pros and cons of each approach?
were selected because they match descriptions of individuals most likely to seek psychotherapy (Vessey & Howard, 1993). Of course, culturally competent clinical psychologists may make adjustments to therapy for clients with similar presenting problems but different cultural characteristics.

A full description of Denise is presented here:

**Box 11.5  Denise: A Fictional Client to Consider From Multiple Perspectives**

Denise is a 30-year-old, single, heterosexual Caucasian woman who has lived her entire life in a large Midwestern city. She has no history of significant illness or injury and is in generally good health. Denise grew up as the fifth of six children in a middle-class family in which both parents worked full time. She attended 2 years of college immediately after high school, but transferred to culinary school where she graduated near the top of her class. She currently lives alone and maintains an upper-middle-class lifestyle.

Denise has worked as the only chef in a small upscale restaurant for about 5 years. Denise has enjoyed her job very much. One of her favorite aspects of her job has always been coming out of the kitchen to ask customers how they were enjoying their meal, especially because the feedback she received from them was almost exclusively positive. The owner of the restaurant has allowed Denise to do this because he believed it added a personal touch to the dining experience. Another of her favorite aspects of the job has been the creative freedom she has enjoyed in the kitchen. The owner has allowed her to create her own unique entrees and change them as frequently as she likes.

Recently, though, Denise's feelings toward her job have changed drastically. A new owner took over the restaurant, and the new owner firmly stated to Denise that her job was to stay in the kitchen preparing food and not to talk with customers at all. The new owner has also provided Denise with a strict, predetermined, permanent menu that the owner alone created and that Denise must now follow. She finds this revised job description very inconsistent with her own personal style, and she sorely misses both the praise she has become accustomed to receiving from customers and the opportunities to create her own dishes.

Since this change was implemented, Denise has been experiencing mild to moderate depressive symptoms including sadness, loss of interest in daily activities, low energy, difficulty sleeping, and difficulty concentrating. She has had difficulty getting to work on time and preparing dishes in a timely and conscientious manner, and her exercise routine, which had been very regular, is now sporadic. Sometimes Denise suspects that the new owner may have implemented this new policy specifically to hurt her. She states that she wants to return to the way she felt before this happened, and she is concerned that if she cannot overcome this problem, her performance at work will suffer to the extent that she will lose her job.
CHAPTER SUMMARY

Psychotherapy is the most common professional activity of clinical psychologists. Following some published doubts about its efficacy in the 1950s, researchers in the subsequent decades amassed enormous amounts of empirical outcome data, much of which has been combined in meta-analyses, supporting the conclusion that for the vast majority of clients, psychotherapy works. Outcome studies that have compared the efficacy of various approaches to therapy with each other have consistently resulted in a virtual tie, a finding that has been nicknamed the dodo bird verdict. The presence of common factors across all forms of therapy, including a strong therapeutic relationship, hope, and attention, may underlie their equal efficacy. More recent and targeted outcome studies focusing on particular manualized therapies for particular disorders have given rise to further debate about the relative contributions of the common factors versus specific therapy techniques. All empirical psychotherapy outcome studies must address numerous methodological issues, including who, when, and how to ask about the outcome of therapy. Additionally, efficacy studies, which assess how well a therapy works “in the lab,” should be understood in conjunction with effectiveness studies, which assess how well a therapy works “in the real world.” Surveys indicate that since 1960, the eclectic/integrative therapy orientation has been most commonly endorsed by clinical psychologists, and among single-school approaches, the psychodynamic/psychoanalytic orientation has been on the decline whereas the cognitive orientation has been on the rise.

KEY TERMS AND NAMES

attention  efficacy
Bruce Wampold  Hans Eysenck
common factors  Hans Strupp
Dianne Chambless  hope
dodo bird verdict  integrative
eclectic  John Norcross
effectiveness  meta-analysis
CRITICAL THINKING QUESTIONS

1. According to the tripartite model, parties other than the client and the therapist can have a meaningful perspective on the outcome of a client’s psychotherapy. Specifically, which third parties might have the most valid perspective? Clients’ partners, friends, kids, supervisors, coworkers, managed care companies, or someone else?

2. What conclusions do you draw from the results of large-scale effectiveness studies such as the 1995 Consumer Reports study?

3. When graduate programs train their students in psychotherapy, to what extent should they emphasize common factors (e.g., forming and maintaining strong therapeutic relationships) as opposed to specific therapy techniques?

4. Consider the three-step sequential model of common factors. In your opinion, would men and women tend to move through the sequence identically? What steps might each group tend to emphasize or deemphasize?

5. What are the implications of the finding that the eclectic/integrative orientation has been the most commonly endorsed orientation among clinical psychologists in surveys since 1960?
Chapter 12

**PSYCHODYNAMIC PSYCHOTHERAPY**

<table>
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<tr>
<th>Defining Psychodynamic Psychotherapy</th>
<th>Oral Stage</th>
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<tbody>
<tr>
<td>Goal of Psychodynamic Psychotherapy</td>
<td>Anal Stage</td>
</tr>
<tr>
<td>Accessing the Unconscious</td>
<td>Phallic Stage</td>
</tr>
</tbody>
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**More Contemporary Forms of Psychodynamic Psychotherapy**

- Interpersonal Therapy
- Time-Limited Dynamic Psychotherapy

**Outcome Issues**

- **Box 12.1. Metaphorically Speaking:** *If You’ve Been to a Movie Theater, You Understand Projection*
- **Box 12.2. Considering Culture:** *Culture-Specific Responses to the “Blank Screen” Therapist*
- **Box 12.3. Metaphorically Speaking:** *If You’ve Watched the Olympics, You Understand Allegiance Effects*
- **Box 12.4. Denise in Psychodynamic Psychotherapy***

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This chapter and the three that follow each focus on a prominent approach to psychotherapy. We begin with the psychodynamic approach for multiple reasons. For one, psychodynamic therapy came first historically. In fact, for much of the first half of the 1900s, the psychodynamic approach was so dominant that it was practically synonymous with psychotherapy itself. Also, many of the therapies
that arose in later decades—including humanism, behaviorism, and cognitivism—were reactions against the psychodynamic approach. Many of the pioneers of the nonpsychodynamic therapies were actually initially trained in psychodynamic programs but later abandoned that approach to create something different. So, although psychodynamic therapy may have declined in popularity among clinical psychologists in recent decades, it remains quite popular and relevant, and it continues to exert significant influence on contemporary clinical psychology.

DEFINING PSYCHODYNAMIC PSYCHOTHERAPY

For the sake of simplicity, in this chapter we will use the term “psychodynamic psychotherapy” to cover an extensive range of therapies. Our use of the term refers broadly to the pioneering work of Sigmund Freud and all subsequent efforts to revise and expand on it. Thus, it includes Freud’s original approach to therapy, which in its classic form is known as “psychoanalysis.” Of course, Freud had many intellectual descendants, including some who were his contemporaries (like Carl Jung, Alfred Adler, and Erik Erikson) and others whose ideas arrived in subsequent generations (like his daughter Anna Freud, Harry Stack Sullivan, Freida Fromm-Reichmann, Melanie Klein, Karen Horney, D. W. Winnicott, and Hans Kohut). At various points in the evolution of his theory by others, Freud’s original term “psychoanalysis” was replaced by terms such as “psychoanalytic psychotherapy,” “neo-Freudian” therapy, and “psychodynamic psychotherapy,” each of which has generated even more specific terms for its offshoots. Rather than trying to make demarcations and distinctions among so many overlapping terms, our purposes in this chapter are best served by choosing a single term—psychodynamic psychotherapy—to represent them all.

GOAL OF PSYCHODYNAMIC PSYCHOTHERAPY

The primary goal of psychodynamic psychotherapy is to make the unconscious conscious (Karon & Widener, 1995; Prochaska & Norcross, 2007). Psychodynamic psychotherapists help their clients become aware of thoughts, feelings, and other
mental activity of which the clients are unaware at the start of therapy. The word “insight,” used often by psychodynamic therapists and clients alike, captures this phenomenon—looking inside oneself and noticing something that had previously gone unseen. Once we become aware of unconscious processes, we can make efforts to deliberately control them, rather than them controlling us.

Of course, the process of making the unconscious conscious presumes that an unconscious part of our mind exists in the first place. This fundamental idea—the existence of the unconscious—is one of Freud’s most important and enduring contributions to clinical psychology (Kernberg, 2004). Before Freud, there was little acknowledgment among mental health professionals about any mental activity occurring outside of our awareness. Freud changed the way we think about ourselves by proposing “mental processes that are outside the awareness of the individual and that have important, powerful influences on conscious experiences” (Karon & Widener, 1995, p. 26). According to Freud and his psychodynamic followers, not only does the unconscious exist, it also exerts a powerful influence on our day-to-day and minute-to-minute lives. In fact, they argue that unconscious processes underlie depression, anxiety, personality disorders, eating disorders, and all other forms of psychopathology that clinical psychologists treat. Thus, gaining access to it is vital.

Accessing the Unconscious

Psychodynamic psychotherapists gain an appreciation of their clients’ unconscious process in a variety of ways. Of course, these methods are quite inferential: Rather than understanding a client’s unconscious in an empirical, factual way, psychodynamic psychotherapists understand it through inference, deduction, and conjecture. In more casual language, psychodynamic psychotherapists try to “read” their clients and hypothesize about their unconscious activity using the following processes.

Free Association

Free association is a technique in which psychodynamic psychotherapists simply ask clients to say whatever comes to mind without censoring themselves at all. The client’s task is to verbalize any thought that occurs, no matter how nonsensical, inappropriate, illogical, or unimportant it may seem (Kernberg, 2004; Skelton, 2006). It may sound straightforward enough, but free association is no easy task. Consider how rare it is for any of us to speak with complete spontaneity, without editing ourselves in one way or another. Perhaps the only times we hear such speech in daily life is when we listen to very young children or very intoxicated
adults. Nonetheless, the words of people in such states of mind can be very revealing about their innermost thoughts and feelings, according to the psychodynamic approach. If clients can feel relaxed enough to engage in free association, their unconscious processes can become more evident to the psychodynamic psychotherapist and ultimately to themselves.

It is important to distinguish free association from word association, a technique associated with Carl Jung. In word association, the therapist presents the client with a list of words. After hearing each word, the client is to respond with the first word that comes to mind. Jungian therapists have often developed hypotheses about clients based on the content of their associations or the amount of time it takes them to respond to certain words (Hall & Nordby, 1973). In contrast, free association involves no stimulus at all from the therapist.

**Freudian “Slips”**

According to psychodynamic psychotherapists, all of our behavior is determined; there is no such thing as a random mistake, accident, or slip. So, if a behavior can’t be explained by motivations of which we are aware, unconscious motivations must be the cause. In this way, when we get something wrong or “forget” something, we reveal unconscious wishes. Psychodynamic psychotherapists who witness a client’s slips of the tongue during a session or who hear clients’ stories of such events may be able to glimpse the clients’ underlying intentions. Although most examples of **Freudian slips** are verbal, they can be behavioral as well:

- Ray, a 52-year-old man who lived in New Jersey, was asked by his older sister Tanya to fly home to Ohio. The reason for the meeting was that their 80-year-old father had become quite ill in recent months, and although he currently lived alone, Tanya felt that they should discuss assisted living or nursing home options. Ray agreed to fly home, but a few hours before the flight, he lost his car keys. He found them at the last minute, but on the way to the airport he missed the airport exit off the highway (an exit he had taken dozens of times before). The combination of losing the keys and missing the exit resulted in Ray missing his flight. His “mistakes” uncover that unconsciously, Ray dreaded the meeting and wanted to avoid it. He was fearful of the conflicts that would arise with Tanya as well as the sight of his father as unable to take care of himself.

- Liz and Amy, both 25 years old, have been very close friends since age 18 when they were roommates during their first year of college. At that time, Liz began dating Sean. They continued dating for the next 5 years and got married when Liz was 23. Liz and Sean just had their first baby, a boy named Benjamin. Amy is happy for them, and she is one of many to bring a gift for the new baby. In her card, Amy congratulated the couple on the birth of “Benjamine.” Her unique
misspelling of the baby’s name combines the words “Benjamin” and “mine,” revealing Amy’s unconscious wish that she, rather than Liz, had dated, married, and had a child with Sean.

• Occasionally, network TV provides a good example of a Freudian slip. On a memorable episode of the sitcom *Friends*, Ross Geller and his fiancée Emily are getting married. During the ceremony, when asked to repeat the words “I take thee Emily . . .,” Ross mistakenly replaces “Emily” with “Rachel.” He tries in vain to explain it away as a meaningless slip of the tongue, but Emily (and, of course, all of the viewers) recognize that although he may not realize it consciously, Ross truly wishes he was marrying his long-time friend Rachel rather than Emily.

**Dreams**

Although some emphasize dreams more than others, psychodynamic psychotherapists generally believe that our dreams communicate unconscious material. Freud theorized that when we sleep, our minds convert latent content (the raw thoughts and feelings of the unconscious) to manifest content (the actual plot of the dream as we remember it). This process, called dream work, uses symbols to express wishes, which can result in unconscious wishes appearing in a very distorted or disguised form.

![Photo 12.2](image) The analysis of dreams is one of many ways that psychodynamic therapists attempt to access the unconscious.
In psychodynamic psychotherapy, the therapist analyzes dreams by attempting to uncover the unconscious meaning behind them—essentially, undoing the dream work. Often, the therapist asks the client to help in the dream interpretation process by explaining the personal meaning of the symbols appearing in the dream. As an example, if a client has a dream about, say, a table, the therapist may be unsure about what the table represents. However, if the client explains that the particular table that appeared in the dream was very reminiscent of the one she remembers from her childhood in her grandmother’s house, the connotations of that symbol may become more apparent. Of course, even with the client’s help, dream interpretations (and other attempts to understand the unconscious) remain inferential rather than factual.

Freud famously called dreams the “royal road” to unconscious material (Freud, 1900). Although dreams are certainly still valued, the contemporary perspective is more inclusive of other paths as well: “Today the psychoanalytic view is that there are many ‘royal roads’ to the unconscious” (Kernberg, 2004, p. 18).

**Resistance**

Sometimes, when certain issues come up during the course therapy, clients make it clear that they “don’t want to go there.” They communicate their reluctance in a variety of ways, some obvious, some subtle. They might change the subject, suddenly remembering something new they intended to discuss. They might fill sessions with talk of unessential topics. They might show up late to subsequent appointments or miss them altogether.

Psychodynamic psychotherapists have a name for this client behavior: resistance (Dewald, 1964; Karon & Widener, 1995). When clients sense that certain unconscious thoughts and feelings are being laid bare too extensively or too quickly, they feel anxious. That anxiety motivates them to create distractions or obstacles that impede the exploration of those thoughts and feelings. Psychodynamic psychotherapists could be frustrated by clients’ resistance, but more often they are intrigued by it and use it to guide future efforts. When they notice resistance, they assume that the therapy has “struck a nerve,” and although the client may not be willing to delve into the issue at the moment, the resistance itself may be an important factor in the client’s daily life and could become a productive topic of conversation later in therapy.

As an example, consider Talia, a 24-year-old client who has grown up with a physically abusive father. In therapy, she had no trouble voicing her resentment toward her father; in fact, it was a prominent theme of her sessions. Her psychodynamic psychotherapist, Dr. Harrison, noticed that Talia rarely spoke of her mother, who also lived in the home throughout Talia’s childhood. At one point
during a discussion of her father’s impact on her life, Dr. Harrison asked Talia whether her mother was aware of her father’s abuse toward her. Talia replied, but in a way that sidestepped Dr. Harrison’s question: “I just hate him so much for what he did to me.” Later in the session, Dr. Harrison asked Talia if anyone knew about the abuse as it was happening to her. Talia abruptly changed the subject, suddenly remembering an unrelated event that had happened the day before. Talia missed her next appointment and was late to the one after that. Dr. Harrison developed the hypothesis that Talia may hold some strong unconscious feelings of resentment for her mother, who may have known about the abuse but did nothing to stop it. Dr. Harrison also speculated that Talia was uncomfortable acknowledging this buried resentment of her mother, so she found ways to avoid the topic. In future sessions, Dr. Harrison pointed out to Talia her avoidance of this topic, and they discussed the possibility that Talia felt anger toward her mother, as well as Talia’s reluctance to discuss that feeling.

**Defense Mechanisms**

Psychodynamic psychotherapists believe that by identifying clients’ unconscious defense mechanisms and bringing them into the clients’ awareness, they can improve the quality of their clients’ lives. Before we examine the defense mechanisms in detail, however, let’s review the personality components that, according to Freud, produce them.

Freud’s structural model of the mind includes three forces, the interaction of which takes place largely outside of our awareness: the id, the superego, and the ego. The **id** is the part of the mind that generates all of the pleasure-seeking, selfish, indulgent, animalistic impulses. It seeks immediate satisfaction of its wishes, most of which are biological in nature, and is oblivious to any consequences. In contrast, the **superego** is the part of the mind that establishes rules, restrictions, and prohibitions. It tells us what we “should” do, and it often uses guilt to discourage us from overindulging in immediate pleasure. Whereas Freud believed the id was inborn, he theorized that the superego became a part of the mind through experiences with authority figures, especially parents. Essentially, the superego is an internalization of the rules and morals taught to each of us, and it stands in direct opposition to the id (Kernberg, 2004; Moore & Fine, 1990; Skelton, 2006).

So, according to Freud, our unconscious mental processes involve a constant battle between an id demanding instant gratification and a superego demanding constant restraint. How does the mind manage these battles? What does it do with the conflicted impulses? These responsibilities fall to the **ego**, the third component in Freud’s structural model of the mind. The ego is a mediator, a compromise maker between the id and the superego. It faces the challenge of partially satisfying both
of these opposing forces, while also meeting the demands of reality. The ego can be quite creative in the ways it handles id/superego conflict. Over time, it develops a collection of techniques on which it can rely. It is this set of techniques that Freud and his followers call defense mechanisms.

So what are the common defense mechanisms? Although Sigmund Freud offered descriptions of many, his followers, including his daughter Anna Freud, have added to the list (A. Freud, 1936; Dewald, 1964; Sandler & Freud, 1985). Let’s consider some of the most commonly acknowledged defense mechanisms, keeping in mind that all of them occur unconsciously. Examples will follow the series of definitions.

- **Repression.** When the id has an impulse and the superego rejects it, the ego can **repress** conscious awareness of the impulse and id/superego conflict around it. In other words, the ego can take the impulse and the internal conflict it creates and “sweep them under the rug” so that we never even become aware that we had them in the first place. *Denial* is a similar defense mechanism, but it usually refers to events that happen to us rather than impulses that come from within us.

- **Projection.** When the id has an impulse and the superego rejects it, the ego can **project** the id impulse onto other people around us. In this way, we try to convince ourselves that the unacceptable impulse belongs to someone else, not to ourselves. Essentially, we attribute our most objectionable qualities onto others, and in the process might cast ourselves as possible recipients of the others’ unacceptable behavior rather than the ones with the impulse to carry it out ourselves.

- **Reaction formation.** When the id has an impulse and the superego rejects it, the ego can **form a reaction against** the id impulse—essentially, do the exact opposite. So, when the id urges us to do something selfish, we don’t simply resist the temptation; we do something selfless, as if overcompensating for the original id impulse.

- **Displacement.** When the id has an impulse and the superego rejects it, the ego can **displace** the id impulse toward a safer target. Rather than aiming the id’s desired action at whom or what it wants, we redirect the impulse toward another person or object to minimize the repercussions—this way, the superego is somewhat satisfied as well. The phrase “kicking the dog” has been used to describe displacement, illustrating how the ego can reroute destructive urges.

- **Sublimation.** When the id has an impulse and the superego rejects it, the ego can **sublimate** it—essentially, redirect it in such a way that the resulting behavior actually benefits others. Unlike “kicking the dog,” in which no one benefits from the behavior (especially the dog), sublimation allows the id to do what it wants, and in the process, others are helped rather than harmed.
To illustrate these five defense mechanisms, let’s choose on a specific id impulse—physical aggression—and imagine how the ego might manage the internal conflict caused when the superego rejects it. Your ego could repress the impulse, in which case you would never be aware that you had it in the first place. It could project the impulse onto others, such that you became convinced that they—not you—had the impulse to attack. It could form a reaction against the impulse, in

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**Box 12.1 Metaphorically Speaking**

*If You’ve Been to a Movie Theater, You Understand Projection*

When you’re sitting in a theater, where’s the movie? The obvious answer is that the movie is on the screen in front of you, but that’s actually incorrect. A *projection* of the movie is on the screen; the movie itself is on a reel in the projector behind you.

Projection as a defense mechanism works very similarly to projection in the movie theater, with the ego as the movie projector and the id impulse as the movie. The ego takes an id impulse and “projects” it out of the person and onto others. Thus, the person sees it in others, but not in the self. As an example, consider Randy, who frequently has the id impulse “I want to steal.” By projecting this id impulse, Randy sees this impulse on others, but not on himself. If Randy literally had a projector on his forehead (pardon the absurd image), his projection of the sentence “I want to steal” onto everyone around him would be obvious. When Randy sees others walking around with “I want to steal” written across their shirts (while remaining oblivious of the fact that the message actually originates inside himself), he may very well become convinced that he is surrounded by thieves.

Randy’s case illustrates that when an individual relies heavily on a single defense mechanism, that defense mechanism becomes a prominent feature of the individual’s personality. To some extent, a defense mechanism can define a person or at least the kind of problems they bring to therapy. It would certainly be no surprise to find that Randy suffers from paranoia of one kind or another (perhaps paranoid personality disorder, or a paranoid subtype of schizophrenia) because he views others as crooks and himself as a potential victim. Psychodynamic psychotherapists would aim to make Randy more aware of his own unconscious processes, including his tendency to project his own unacceptable unconscious wishes onto others.

To illustrate these five defense mechanisms, let’s choose on a specific id impulse—physical aggression—and imagine how the ego might manage the internal conflict caused when the superego rejects it. Your ego could repress the impulse, in which case you would never be aware that you had it in the first place. It could project the impulse onto others, such that you became convinced that they—not you—had the impulse to attack. It could form a reaction against the impulse, in
which case you would do the opposite of physical aggression—you might be exceedingly gentle and kind with others or dedicate yourself to nonviolent causes. It could displace the impulse to be aggressive onto a safer target; if your id truly wanted to hit your boss, you might instead redirect the aggression toward a friend, family member, partner, pet, or even a punching bag or a video game enemy. Finally, it could sublimate the impulse, in which case you would behave in a physically aggressive way that actually benefited society—perhaps as a police officer subduing criminals or even as a surgeon whose incisions heal rather than harm.

Psychodynamic psychotherapists believe that some of these defense mechanisms are more mature or healthy than others (Dewald, 1964; Freud, 1905; Karon & Widener, 1995). For example, denial and repression are considered rather immature, largely because they don’t effectively satisfy the id, so similar id demands resurface later. At the other end of the spectrum, sublimation is viewed as uniquely mature because it satisfies the individual’s id impulses and a societal need simultaneously. Of course, the goal of psychodynamic psychotherapy is to help clients become aware of their unconscious processes, including their defense mechanisms. As clients become enlightened about defense mechanisms they use, they can exert some control over them and in the process move toward more mature ways of managing their internal conflicts.

Defense mechanisms may be easier to understand if we consider alternate definitions of some core Freudian terms: id, superego, and ego. Freud wrote in German, and some of his followers have argued that when his terms were translated into English, the translators made the curious choices of “id,” “superego,” and “ego,” which are actually Latin terms uncommon to everyday English. Some have argued that Freud’s concept of the id would be better translated as “it”: the part of you that is animalistic rather than human (not “he” or “she”). The superego might be better understood as the “over-me”: an internalization of the rules and demands that came from authority figures, especially parents. And ego, therefore, refers to “me”: the person negotiating between the demands for instant pleasure and the demands to follow rules (Karon & Widener, 1995). This alternate terminology helps to personify the ego and highlights the fact that defense mechanisms don’t merely characterize some abstract component of the mind (the “ego”); they actually characterize the whole person, and in many cases, the problems he or she brings to a clinical psychologist.

**Transference**

Of all of the ways to access a client’s unconscious material, transference may be most essential to the psychodynamic approach. It is “generally regarded as the most important focus” of psychodynamic psychotherapy (Galatzer-Levy, Bachrach, Skolnikoff, & Waldron, 2000, p. 27) and seen as “the most powerful tool” of those who conduct it (Karon & Widener, 1995, p. 27).
Transference refers to the tendency of clients to form relationships with therapists in which they unconsciously and unrealistically expect the therapist to behave like important people from the clients’ past. In other words, without realizing it, a client “transfers” the feelings, expectations, and assumptions from early relationships—usually parental relationships—onto the relationship with the therapist. Essentially, clients allow powerful previous relationships to distort their view of the therapist, and in subtle ways they “prejudge” the therapist as a person whose responses will echo those of mom, dad, or some other important early figure.

Perhaps the concept of transference is best illustrated through an everyday example. (After all, psychodynamic psychotherapists believe that transference is not exclusive to therapy but present in all kinds of relationships.) Consider Asaan, a 7-year-old boy who has taken piano lessons from Ms. Terrell since age 4. Ms. Terrell is a harsh, demanding teacher. She expects excellence from her students, and when they fall short, she scolds them unsympathetically. She also makes insulting and discouraging comments such as “That’s terrible,” “You’re wasting your parents’ money,” and “How many times do I have to teach you this song before you get it right?” As you might expect, Asaan has developed strong feelings toward Ms. Terrell over the years. Specifically, he fears and resents her. At the age of 7, Asaan’s family moves to another city, and his parents arrange for him to take piano lessons from a new teacher, Ms. Wallace. At his first lesson with Ms. Wallace, Asaan makes a mistake, and—before Ms. Wallace responds at all—strong feelings well up inside of Asaan. He anticipates Ms. Wallace’s comments—he “knows” that she’s thinking “That’s terrible,” etc.—and starts to feel fear and resentment toward Ms. Wallace in exactly the same way he did toward Ms. Terrell. In short, Asaan unknowingly transfers the feelings and expectations from his early, formative relationship with a piano teacher (Ms. Terrell) toward his subsequent teacher (Ms. Wallace). What he doesn’t yet realize is that in reality, his new teacher is a world apart from his old teacher: Ms. Wallace is extremely supportive, kind, and complimentary toward her students. In time, Asaan may grow to appreciate Ms. Wallace more realistically, but at least at first, his unrealistic, unconscious transference toward her will distort his perception of her and the way they interact with each other.

What happened to Asaan and his piano teachers happens to all of us, according to psychodynamic theory, in a much broader sense. We all experience powerful early relationships in our formative years—especially with parents—and those relationships shape our expectations for future relationships. Thus, when we meet new people and begin to form friendships, romantic partnerships, or work relationships with them, our responses toward them might not be totally objective. Instead, to the extent that our new friends, partners, or coworkers evoke the important people with whom we had our primary, early relationships, we may unconsciously jump to conclusions about them and develop feelings toward them that aren’t actually
warranted. The role of the psychodynamic psychotherapist is to help clients become aware of their own transference tendencies and the ways in which these unrealistic perceptions of others affect their relationships and their lives. Once aware of these tendencies, clients can make conscious efforts to manage them.

Rather than learning about clients’ transference indirectly through clients’ descriptions of their relationships with others, psychodynamic psychotherapists seek to experience that transference firsthand. In other words, psychodynamic psychotherapists presume that clients will bring similar transference issues to the client-therapist relationship that they do to many of the other relationships in their lives. This way, the therapist gets a direct, personal understanding of the expectations and emotions that the client unknowingly assigns to new relationships. After the therapist identifies these transference tendencies in the client-therapist relationship, the therapist can call the client’s attention to them—in other words, offer interpretation of the transference.

The “blank screen” role of the psychodynamic psychotherapist is essential to the transference process. Psychodynamic psychotherapists typically reveal very little about themselves to their clients through either verbal or nonverbal communication. (In fact, this was a primary reason why Freud had clients lie on a couch while he sat behind them in a chair, out of their line of sight.) Consider the example of Asaan and his new piano teacher, Ms. Wallace, once again. If Ms. Wallace decided that from the beginning, she was going to reveal as little as possible about her own personality—essentially, stay “blank” to Asaan—she could conclude that any feelings Asaan has toward her are based purely on transference from past relationships. If she gives him nothing to respond to—communicates very little verbally and nonverbally, keeps a neutral emotional tone—and Asaan nonetheless expresses resentment and fear toward her, Ms. Wallace can conclude that those feelings are left over from earlier relationships; after all, she couldn’t have elicited them herself. For a piano teacher, this would be unusual behavior. But for a psychodynamic psychotherapist, it is quite common and purposeful.

As a clinical example of transference, consider Felicia, a 27-year-old client seeing Dr. Kirk, a psychodynamic psychotherapist, for depressive symptoms after breaking up with her boyfriend, Dave. At her first appointment, Felicia begins to describe her situation—the relationship with Dave, how they broke up, how she feels about it—but about 10 minutes in, she stops herself and apologizes to Dr. Kirk: “I’m sorry, I know I’m wasting your time. This is really boring, and you’re probably thinking, ‘I wish I could just tell her to shut up.’” Dr. Kirk encourages Felicia to continue describing her breakup and her depression, and she does, but after 15 more minutes she interrupts herself again: “This is such a stupid problem. I just need to learn how to get over it. I should leave and let you get to the more important things you have to do today.” It’s important to note that Dr. Kirk was
Many psychodynamic psychotherapists make great efforts to remain “blank screens” to their clients. They don’t self-disclose much at all through their words or their actions, so clients may learn very little about the therapist’s personal background. Family, religion, values, hobbies, and the like remain unknown. This blank screen role facilitates transference, which is essential to the psychodynamic process. When a client reacts emotionally to a therapist whose own words and actions couldn’t have provoked the reaction, the therapist can be sure that those feelings are the remnants of a previous relationship. The therapist can help the client become more aware of this transference and how it affects relationships in the client’s real life.

But how do clients of various cultures respond to a “blank screen” therapist? Are all clients seeking therapists who play this role in their lives? Some have argued that clients outside mainstream U.S. culture might benefit most from therapists whose roles in their lives are at odds with the blank screen role of psychodynamic psychotherapists. For instance, Atkinson, Thompson, and Grant (1993) argued that among diverse clients, there is tremendous cultural variation in the services they want their therapists to perform or the functions they want them to serve. Specifically, these authors have identified eight distinct therapist roles that clients may seek:

- Adviser
- Advocate
- Facilitator of indigenous support systems
- Facilitator of indigenous healing systems
- Consultant
- Change agent
- Counselor
- Psychotherapist

Whereas some of these roles, especially those near the end of the list, may be compatible with the psychodynamic blank screen role, some of the roles near the top of the list may clash with it. For example, as an adviser or an advocate, it’s likely that the therapist would be expected to reveal something personal, such as values and experiences. And certainly, as a facilitator of indigenous support or healing systems, the therapist would at the very least indicate a familiarity and endorsement of these systems and may also make known personal background information in the process.

Atkinson et al. (1993) argue that people less acculturated to mainstream U.S. culture tend to favor the first four roles on the list, whereas people with higher levels of acculturation tend to favor the last four. Indeed, clients of low levels of acculturation may be looking for something very different than traditional psychodynamic psychotherapy when they decide to seek help for a psychological or emotional problem. In your opinion, how rigid do psychodynamic psychotherapists have to be regarding the blank screen role? To what extent can psychodynamic psychotherapy be adapted to accommodate diverse clients?
not, in fact, bored with Felicia. He wasn’t falling asleep, staring out the window, or glancing at his watch. He had remained attentive and interested, but in spite of this, Felicia was convinced that Dr. Kirk could have no interest in her. In effect, Dr. Kirk had been a blank screen, but when Felicia looked at it, she saw disinterest and impatience.

Why would she have done this? The answer came in time, as Felicia explained to Dr. Kirk that throughout her childhood, her father had been disinterested and impatient toward her. He had consistently given Felicia the message that she was unworthy of his time and attention. Felicia not only transferred those feelings and expectations onto Dr. Kirk, but as Dr. Kirk learned, she had done something very similar with numerous boyfriends, including Dave. Over and over, without realizing it, she had ended or sabotaged seemingly strong dating relationships by repeatedly insisting to her boyfriends that she couldn’t be worth their while. This wasn’t, in reality, what the boyfriends thought, but her experience with her father had left her unconsciously biased toward assuming this response from the men in her life. Unlike Dave or any of her other boyfriends, Dr. Kirk was able to identify this transference—to “catch” Felicia doing it, and point it out to her—when she unconsciously directed her expectations for disinterest and impatience toward him. With continued discussion with Dr. Kirk, Felicia gradually became more aware of this tendency in herself. When she started her next dating relationship, she was able to “catch” her own unrealistic transference feelings toward her new boyfriend and replace them with a more realistic, objective appraisal.

As a final note on transference, it’s important to remember that therapists are people too, and just as clients can transfer onto therapists, therapists can transfer onto clients. Psychodynamic psychotherapists call this transference by therapists toward clients countertransference (Dewald, 1964; Skelton, 2006), and generally, they strive to minimize it because it involves a reaction to the client that is unconsciously distorted by the therapist’s own personal experiences. One reason that many psychodynamic training programs require trainees to be clients in psychodynamic psychotherapy themselves is to become aware of their own unconscious issues, so they won’t arise as countertransference toward their own clients (Erwin, 2002; Moore & Fine, 1990).

**PSYCHOSEXUAL STAGES: CLINICAL IMPLICATIONS**

Freud’s psychosexual stages of development—oral, anal, phallic, latency, and genital—are among the most widely known aspects of his theory. Rather than restating the explanations found in introductory psychology textbooks, let’s consider the implications most relevant to clinical psychologists, and to the psychodynamic psychotherapy approach in particular.
Of the five stages, the first three have generally received the most attention from psychodynamic psychotherapists, especially regarding fixation (Karon & Widener, 1995). **Fixation** refers to the idea that as children move through the developmental stages, they may become emotionally “stuck” at any one of them to some extent, and may continue to struggle with issues related to that stage for many years, often well into adulthood. Although fixation can happen for a variety of reasons, most often it occurs when parents either do “too much” or “too little” in response to the child’s needs at a certain developmental point.

**Oral Stage**

Consider the **oral stage**, which takes place during roughly the first year and a half of a child’s life. During this time, the child experiences all pleasurable sensations through the mouth, and feeding (breast or bottle) is the focal issue. Of course, kids whose parents mismanage this stage may display blatantly “oral” behaviors later in life: smoking, overeating, drinking, nail biting, etc. Many of the consequences are not so obvious, however. According to psychodynamic theory, a primary issue at this stage is dependency. Babies are, after all, utterly dependent on others for survival and comfort. They cannot feed, clothe, bathe, protect, or otherwise take care of themselves, so they must depend on the adults in their lives. (Perhaps the adult equivalent of this is the hospital patient who is entirely debilitated by illness or injury, and whose only resource is to call the staff for help.) If parents overindulge children in the oral stage, children may learn that depending on others always works out wonderfully, and in fact, other people exist solely to anticipate and meet your needs. Such children may develop overly trusting, naive, unrealistically optimistic personalities, and as adults, will form relationships accordingly. On the other hand, if parents are not responsive enough to children during the oral stage,
children may learn that depending on others never works out, and in fact, other people have no interest in helping you at all. Such children may develop overly mistrusting, suspicious, and unrealistically pessimistic personalities, and as adults, will form relationships accordingly. These oral issues, especially in extreme form, are often at the root of clients’ individual and interpersonal problems and the focus of psychodynamic psychotherapy.

**Anal Stage**

The **anal stage** follows the oral stage, occurring when the child is approximately 1.5 to 3 years old. Toilet training is a primary task of this stage, but it is not the only way in which children are learning to control themselves. Indeed, control is the central issue of this stage. At this age, adults (especially parents) begin to place demands on children regarding their speech and behavior. If parents are too demanding of children at this stage, children can become overly concerned about getting everything just right. In the bathroom, this may mean “no accidents,” but more generally, it means having everything in exactly the right place at the right time. These children often grow to become adults who think obsessively and behave compulsively in order to stay in control: they have meticulously organized desks, their daily schedules are programmed from start to finish, and the cars get oil changes exactly every 3,000 miles. By contrast, if parents are too lenient toward children at this stage, children can become lax about organization, and this trait can continue into adulthood: their desks are covered in messy piles, their schedules are sloppy and haphazard, and their cars get oil changes “whenever.” These “neat freak” or “slob” tendencies can have significant clinical implications, including anxiety disorders such as obsessive compulsive disorder and relationship problems stemming from incompatible living styles.

**Phallic Stage**

The **phallic stage**, taking place from about age 3 to about age 6, is one of Freud’s most controversial. In fact, many of the ideas originally contained in Freud’s description of this stage, especially those closely tied to gender-specific biology, have fallen out of favor and are widely disputed by contemporary psychodynamic psychotherapists (Karon & Widener, 1995; Erwin, 2002). What remains is the fundamental idea implied by the Oedipus and Electra complexes: children at this age wish to have a special, close relationship with parents. It is the parents’ response to the child’s wish that is the crucial issue for clinical psychologists, because this parental response powerfully shapes the children’s view of themselves. This view of the self—essentially, self-worth—is the key consequence of the phallic stage. Of course, the ideal situation is for parents to respond positively to kids’ overtures. But
when parents respond too positively, when they reciprocate the child’s wishes too strongly, they overinflate the child’s sense of self. Such children may grow into adults whose opinion of themselves are so unrealistically high that they strike others as arrogant or egotistical. Conversely, parents who reject their child’s wishes for a special, close relationship can wound a child’s sense of self-worth. These kids can grow up to become adults who devalue themselves, and who are overly insecure and self-doubting. (Felicia, the clinical example in the section on transference above, is an example.) As with the other psychosexual stages, the phallic stage often gives rise to issues discussed in psychodynamic psychotherapy, including disorders like depression, dysthymia, anxiety, relationship problems, and any other issue that can involve issues of self-worth.

MORE CONTEMPORARY FORMS OF PSYCHODYNAMIC PSYCHOTHERAPY

Since its origins with Freud, psychodynamic psychotherapy has been reinvented in countless forms (Orlinsky & Howard, 1995). Most of these revisions have deemphasized the biological and sexual elements of the theory. For example, ego psychology, as exemplified by Erik Erikson and his eight-stage theory of development, revised Freud’s psychosexual stages to highlight social relationships and emphasized the adaptive tendencies of the ego over the pleasure-based drive of the id. The object relations school, led by Melanie Klein, Otto Kernberg, Ronald Fairbairn, and others, deemphasized internal conflict (id vs. superego) and instead emphasized relationships between internalized “objects” (essentially, important people from the client’s life). The self-psychology school of Hans Kohut and others emphasizes parental roles in the child’s development of self, with special attention paid to the meaning of narcissism at various points, including in therapy (Karon & Widener, 1995; Skelton, 2006).

Other revisions of the Freudian approach have cast doubt on Freud’s theories regarding females and their development. Karen Horney was one such critic of Freud, publishing many articles and books in the early- to mid-1900s that opposed many of Freud’s ideas, including his assumptions that females felt inherently inferior and envious toward males. Her commentaries on Freud and her own gender-specific developmental theories represented “...a courageous attempt to reform the accepted psychoanalytic ideas on women” (Westkott, 1986, p. 9). Moreover, Horney’s writings influenced more recent feminist theorists, including Nancy Chodorow and Carol Gilligan, who have further advanced theories of female development that account for the experience of girls and women more authentically than Freud’s original theories and do not represent variants of male development (Chodorow, 1978; Gilligan, 1982).
Throughout its history and in all of its many variations, psychodynamic psychotherapy has always been among the longest and most expensive forms of psychotherapy, a mismatch for our current society characterized by a desire for fast results and managed care companies reluctant to pay for treatment they view as excessive (Galatzer-Levy et al., 2000). As a result, most of the recent variations of psychodynamic psychotherapy have emphasized efficiency. Levenson, Butler, and Beitman (1997) list a spectrum of recent, specific, brief psychodynamic psychotherapies:

- Interpersonal Therapy
- Time-Limited Dynamic Psychotherapy
- Supportive Therapy
- Time-Limited Therapy
- Short-Term Dynamic Therapy for posttraumatic stress disorder
- Brief Dynamic Therapy for substance abuse disorders
- Brief Psychodynamic Psychotherapy with Children

Some of the therapies on this list, especially the first two, have garnered significant attention in recent years. Let’s consider them in detail as examples of contemporary variations of psychodynamic psychotherapy.

**Interpersonal Therapy**

Interpersonal Therapy (IPT), which derives from the interpersonal school of psychodynamic thought of which Harry Stack Sullivan was a leader, was developed in the 1980s by Gerald Klerman, Myrna Weissman, and colleagues. It was originally created to treat depression (e.g., Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, 1995), but it has since been used to treat numerous other disorders. It is designed to last 14 to 18 sessions, and as such, its goals are more focused and limited than structural change of the entire personality. Its methods are outlined in a manual with specific therapeutic guidelines (Klerman et al., 1984).

The fundamental assumption of IPT is that depression happens in the context of interpersonal relationships, so improving the client’s relationships with others will facilitate improvement in the client’s depressive symptoms. It focuses on current interpersonal relationships and role expectations and tends to deemphasize some of the aspects of more traditional psychodynamic psychotherapy related to intrapsychic structure and childhood fixations (Levenson et al., 1997; Weissman, 1995).

IPT proceeds in three stages. The first stage (about two sessions in most cases) involves categorizing the client’s problems into one of four categories: grief, interpersonal disputes, role transitions, and interpersonal deficits. The intermediate sessions (10–12 sessions) emphasize improving the client’s problems as identified...
in the first stage. Common psychodynamic methods are used, including a focus on current emotions explorations of transference and resistance. Also, the intermediate stage often includes an educational component in which the therapist teaches the client about depression and its symptoms. The final stage (2–4 sessions) involves a review of the client’s accomplishments, recognition of the client’s capacity to succeed over depression without the therapist’s continued help, and efforts to prevent relapse (Klerman et al., 1984; Levenson et al., 1997).

IPT is one of the few specific forms of psychodynamic psychotherapy for which researchers have gathered a sizable amount of empirical evidence. In other words, efficacy studies have found that IPT works for depressed individuals, and it appears on published lists of therapies that are known to be successful for particular disorders (e.g., Chambless et al., 1998; Nathan & Gorman, 2002).

**Time-Limited Dynamic Psychotherapy**

**Time-Limited Dynamic Psychotherapy (TLDP)** is a modern application of the often-referenced “corrective emotional experience” (Alexander & French, 1946): Clients will bring to therapy the same transference issues that they bring to many of their other relationships, and the therapist’s task is to make sure that this time, the interaction will end differently. In other words, if the client’s relationship with the therapist follows the same unconscious “script” as the client’s other relationships, it may end badly, but if the therapist can make the client more aware of this script and offer a chance to enact a healthier, more realistic one, the “emotional experience” will be “corrective” or therapeutic (Binder, Strupp, & Henry, 1995).

TLDP is experiential in nature; the here-and-now relationship between therapist and client is the main tool for therapeutic change. The therapist’s primary task is to identify the “script” that the client appears to be unknowingly following. This script is the byproduct of previous relationships (often with parents), in which the client learned what to expect from others. The TLDP therapist assumes that the client’s problems are at least partially due to an application of this script to inappropriate relationships or situations. In other words, a client may get into frequent arguments with a romantic partner because he “knows” what his partner may be thinking and feeling, but this “knowledge” is unrealistic and mistaken. When the client tries to enact the same script with the therapist, the therapist recognizes it, refuses to be provoked or prodded into it, and points out this process to the client. In this way, they do not perpetuate the outdated script, and the client is forced to develop a new, more realistic way of relating to others that is not bound by the assumptions of the script that they had been unconsciously following (Binder et al., 1995).

When therapists conduct TLDP, they often use a visual diagram called the cyclical maladaptive pattern. It is a working model of the client’s primary issues organized into four categories: acts of self (how a person actually behaves in public; for
example, a client has a job interview); expectations about others’ reactions (“I’m sure the interviewer didn’t like me”); acts of others toward the self (the interviewer says “Your application looks great. We’ll call you in the next two weeks,” and the client interprets this as rejection); and acts of the self toward the self (the client tells self “You are such a failure” and spends next day alone and miserable). By identifying these four components of the cycle, TLDP therapists can help clients become more aware of specific thoughts and behaviors that contribute to the faulty script that they may enact, as well as healthier alternatives to these thoughts and behaviors.

**OUTCOME ISSUES**

The nature of psychodynamic psychotherapy makes it especially difficult to gauge its effects. From an empirical researcher’s point of view, the challenge of defining and measuring the outcome of psychodynamic psychotherapy can be overwhelming: how, exactly, do we know how well it has worked? Can we measure the extent to which the unconscious has been made conscious? Can we calculate the amount of insight that a client has achieved or the extent to which their relationships have improved? These questions haunt psychodynamic psychotherapy and elicit criticism from those who prefer therapies of other kinds. Additionally, these questions help us understand why such a small number of psychodynamic therapies have been manualized, subjected to empirical trials, or included on lists of treatments that work.

In spite of these methodological challenges, there have been many attempts to measure the outcome of psychodynamic psychotherapy. A recent large-scale review of psychodynamic and psychoanalytic outcome studies that, in total, included almost 2,000 clients treated by about 500 therapists across a wide range of settings suggested that the vast majority of clients improve substantially (Galatzer-Levy et al., 2000). And of course, the meta-analyses discussed in Chapter 11—the ones that led to the overall conclusion that therapies of different kinds tend to be about equally effective—include many varieties of psychodynamic therapy.

Interestingly, in some meta-analyses, psychodynamic therapies are found to be effective, but a bit less so than other forms of therapy. These slight discrepancies disappear, however, when allegiance effects are taken into account. **Allegiance effects** refer to the influence of researchers’ own biases and preferences on the outcome of their empirical studies. Typically, the researchers who conduct empirical studies of psychotherapy outcome, including meta-analyses, are not psychodynamic in their own orientation. Instead, they tend to be behavioral or cognitive, which are the two broad categories of therapy to which psychoanalysis was found to be slightly inferior in some meta-analyses (Prochaska & Norcross, 2007).

Allegiance effects can be quite powerful: Luborsky et al. (1999) evaluated many comparative reviews of the psychotherapy literature and comparative studies of
If You’ve Watched the Olympics, You Understand Allegiance Effects

When we watch Olympic events like gymnastics or ice skating on TV, we see not only the judges’ scores but the judges’ nationality as well. In fact, in the on-screen graphic, each judges’ individual score appears in a box just below the flag and abbreviation of the judge’s country. Why is the judge’s country relevant? Perhaps the assumption is that the judges’ allegiance to their home countries limits their objectivity. Even if they make efforts against it, they may root for a particular country, and that rooting may influence the way they judge the performances of the athletes. With the athletes’ countries known to the judges, who themselves are citizens of certain countries, allegiance effects may be unavoidable in the Olympics.

Allegiance effects may be unavoidable in psychotherapy outcome research too. The situation is very similar to the Olympics: the researchers who judge the “performance” of various therapies are themselves either supporters or opponents of some of those therapies. Of course, these researchers should be completely objective, and they may believe that they are, but according to Luborsky et al. (1999), most are not. Their own preferences for certain kinds of therapy and against others appear to powerfully influence the results of the studies they conduct. In fact, Luborsky et al. report that allegiance effects can account for about 2/3 of the variance in outcomes of treatment comparisons! Just as Olympic judges might have a underlying favoritism for the athletes from their own countries, psychotherapy outcome researchers might have a underlying favoritism for the therapies from their own orientations.

The Olympic judge’s flag is revealed for all to see, but the psychotherapy outcome researcher’s allegiance is often unknown. When Luborsky et al. (1999) conducted their study on allegiance effects, they had to contact the researchers who had published psychotherapy outcome research, as well as those researcher’s colleagues, to determine the researchers’ orientations. In your opinion, should psychotherapy outcome researchers be more forthcoming about their own orientations, perhaps including this information in the studies they publish, because these orientations may bring about biases? Should researchers make efforts to conduct studies in collaborative groups that contain members of various orientations, so they counterbalance each others’ biases? What other measures can psychotherapy outcome researchers take to limit the allegiance effect?

Box 12.3 Metaphorically Speaking

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Box 12.4 Denise in Psychodynamic Psychotherapy

Denise attended 50 sessions over a 1-year period. At my request, she provided background information about her childhood, including the fact that she was the fifth of six children and that her parents both worked full time. She explained that because of these factors, she received very little attention or praise from her parents throughout childhood. She described her depression stemming from recent changes at work and stated that the most upsetting part of the change was the new restaurant owner’s insistence that she stop visiting with diners. She sorely missed their positive feedback about her dishes. In addition to sadness and other common depressive symptoms, Denise also listed a lack of energy that resulted in her being late to work and preparing dishes more slowly than usual. It was also noteworthy that Denise believed that the new owner may have made these changes with the intention of hurting Denise.

Based on this information, my initial conceptualization of Denise included the following hypotheses:

- Denise was dealing with emotional issues from the phallic stage of development, and she may have been partially fixated at that stage. At the points in childhood when Denise sought a special, intimate relationship with a parent, the parent did not provide it. As a result, she lacked self-esteem and sought it from outside sources. The strongest of these sources—the feedback of the diners in her restaurant—had been cut off by the new owner, contributing greatly to her depression.

- Denise was struggling with unacceptable impulses of anger toward the new restaurant owner and was using defense mechanisms—projection, most obviously—to deal with them. Denise stated that she believed that new owner was trying to hurt her by instituting the new policies, but this seems like an unlikely motivation for the new owner. Instead, it is probable that Denise is the one with the hurtful intentions toward the new owner, but rather than acknowledge them, she kept them unconscious by projecting them onto the owner, thus portraying the owner as the “bad” person and herself as the innocent victim.

- Denise’s unconscious anger toward the new owner also revealed itself through her lateness and slow work. Although she attributed these behaviors to her lack of energy, they may have been unconsciously motivated acts of aggression toward the new owner and the new policies. Several of the specific stories she told—the time she “accidentally” dropped an entrée in the kitchen, and the times she “forgot” to set her alarm—appear to fall in the category of Freudian slips.

My relationship with Denise was marked by numerous examples of resistance and transference. Regarding the resistance, Denise often changed the
Psychodynamic psychotherapy is founded on the theories of Sigmund Freud. It presumes the presence of a powerful unconscious component of the mind, and its primary goal is insight or making unconscious processes conscious. It is a highly inferential approach to psychotherapy, in which problems and therapy’s impact on them are difficult to assess objectively or empirically.

Psychodynamic psychotherapists gain access to clients’ unconscious in numerous ways, including free association, Freudian slips, dreams, and resistance that clients display during therapy. The ongoing unconscious subject in subtle and clever ways when I asked questions regarding the new owner or her feelings toward her parents. Once, after a session ended in the middle of a particularly intense discussion of her work situation, she was 20 minutes late to her next appointment. Another time, she followed a session in which we examined her feelings toward her parents with a session in which she insisted upon focusing on a seemingly minor argument with a previously unmentioned friend. Regarding the transference, Denise often seemed to assume that I didn’t think she was worthy of my attention, and in fact, she said so on many occasions. She also sought my praise on frequent occasions, sometimes directly asking me for feedback after describing something she had accomplished.

The main intention behind my interventions with Denise was to make her more conscious of her unconscious processes. On various occasions, I offered interpretations of her actions. I mentioned that perhaps she had hurtful feelings toward the new owner, rather than vice versa. I asked questions that led her to consider whether her slow and sloppy performance at work may have been motivated by her own wishes. I discussed with her the role that the diners’ feedback played in context of the attention and praise that her parents did not provide. And perhaps most importantly, I pointed out to her the unconscious tendencies (transference) that she brought to the relationship with me, even though our relationship did not realistically merit them: the assumption that I would dismiss her and her need for my praise and admiration. The discussion of transference was especially productive because it shed light on some of Denise’s previous relationships as well. Slowly, with continued conversation in all of these areas, Denise was able to achieve significant insight into her unconscious processes. By doing so, she was able to view others more realistically, control her motivations more deliberately, and her depressive symptoms eventually lifted.
conflict between the id and the superego requires the ego to mediate by employing defense mechanisms such as repression, projection, reaction formation, displacement, and sublimation. Reliance on particular defense mechanisms can characterize an individual’s personality as well as the clinical issues they bring to therapy. Clients often experience transference toward their psychodynamic therapists, in which they unknowingly and unrealistically expect the therapist to relate to them like important people from the clients’ past have related to them. Psychodynamic therapists often assume a “blank screen” role to facilitate this transference process, and assume that the client may have transferred similarly onto other people with whom they have formed relationships. Psychodynamic therapists also pay significant attention to clinical issues that may stem from fixation at an early psychosexual stage of development (e.g., oral, anal, or phallic). Psychodynamic psychotherapy has traditionally been relatively long-term, but shorter versions, such as Interpersonal Therapy and Time-Limited Dynamic Psychotherapy, have emerged in recent decades, and evidence has begun to accumulate attesting to their efficacy, especially with depressed clients. Overall, the nature of psychodynamic psychotherapy has hindered the collection of empirical outcome data, but the data that have been collected suggest that it is roughly as effective as other forms of psychotherapy.

**KEY TERMS AND NAMES**

- allegiance effects
- anal stage
- “blank screen” role
- countertransference
- defense mechanisms
- displacement
- dream work
- dreams
- ego
- ego psychology
- fixation
- free association
- Freudian slips
- id
- inferential
- insight
- Interpersonal Therapy (IPT)
- interpretation
- latent content
- manifest content
Psychodynamic Psychotherapy

object relations
oral stage
phallic stage
projection
psychodynamic psychotherapy
reaction formation
repression
resistance

self-psychology
Sigmund Freud
sublimation
superego
Time-Limited Dynamic Psychotherapy (TLDP)
transference
unconscious

CRITICAL THINKING QUESTIONS

1. To what extent do you believe that insight, or making the unconscious conscious, is essential to overcoming psychological problems?

2. To what extent do you believe that Freudian slips accurately reveal unconscious wishes?

3. Box 12.2 lists eight distinct therapist roles that clients may seek. If you were the client, which would you seek? To what extent would a psychodynamic psychotherapist match that role?

4. Many psychodynamic graduate training programs require their trainees to undergo therapy themselves. If you were the client, how would you feel about the fact that your therapist had (or had never) been in therapy?

5. What efforts should psychotherapy outcome researchers make to minimize allegiance effects?
Like most psychologists of his era, **Carl Rogers** was trained psychodynamically (Prochaska & Norcross, 2007). But he didn’t stay psychodynamic for long. He came to disagree with many of Freud’s presumptions about therapy and more fundamentally, about people. Along with **Abraham Maslow**, Rogers pioneered the humanistic movement in psychology and its clinical application, **humanistic therapy**.

The humanistic approach to understanding people stood in opposition to the biologically based, id-dominated, cynical Freudian view that prevailed at the time. Maslow (1968) summarized its theoretical foundation:

> Inner nature [of people] seems not to be intrinsically or primarily or necessarily evil . . . Human nature is not nearly as bad as it has been thought to be . . .
Since this inner nature is good or neutral rather than bad, it is best to bring it out and encourage it rather than to suppress it. If it is permitted to guide our life, we grow healthy, fruitful, and happy. If this essential core of the person is denied or suppressed, [the person] gets sick sometimes in obvious ways, sometimes in subtle ways, sometimes immediately, sometimes later. (pp. 3–4)

Rogers applied this theory to people with psychological problems and in doing so offered an approach to therapy that remains quite influential today.

To simplify our discussion, in this chapter we’ll use the term “humanistic” to cover the family of therapies created by Rogers and his followers. At various times, the terms “nondirective,” “client-centered,” and “person-centered” have been used by Rogers and others to describe these approaches.

**HUMANISTIC CONCEPTS: CLINICAL IMPLICATIONS**

Picture a small plant, just sprouting from the soil. We can confidently make several assumptions about this plant. First, we assume that the plant has an innate tendency to grow. In other words, given the proper environment, healthy growth will naturally occur. Second, we assume that the plant’s growth utterly depends on sunlight—without it, it simply won’t thrive. Third, we assume that if sunlight is only available from certain directions, the plant will bend, twist, or even contort its growth to reach it. Certain branches may blossom while others wither, and the plant may take on an unexpected shape in the process, but the nourishment from the sun is so essential that the plant will alter itself quite drastically to attain it. Of course, if sunlight comes from all directions, the plant need not alter itself at all. It can simply bloom according to its own inherent potential.

There are compelling parallels between this plant and human beings, according to the humanistic approach. Humanists assume that people, like plants, arrive with an inborn tendency to grow. Humanists call this tendency **self-actualization** and presume that if the person’s environment fosters it, self-actualization proceeds without interference (Cain, 2002). Humanists also
recognize that people need certain things to live, and just as plants need sunlight, people need positive regard. **Positive regard**, from the humanistic point of view, is essentially the warmth, love, and acceptance of those around us. (Rogers’s frequently used term—“**prizing**”—may best capture this experience of receiving positive regard from others [e.g., Rogers, 1959].) As children, we bask in the glow of positive regard from our parents; like plants with sunlight, we need it to grow. If we discover that our parents provide positive regard only when we behave in certain ways, we will emphasize certain aspects (“branches”) of ourselves and suppress others in order to attain it. The end result may be a version of ourselves that is markedly different from the version that might have blossomed if our parents had provided positive regard no matter what.

**GOAL OF HUMANISTIC PSYCHOTHERAPY**

The primary goal of humanistic psychotherapy is to foster self-actualization. Humanists believe that psychological problems—depression, anxiety, personality disorders, eating disorders, and most other forms of psychopathology—are the byproducts of a stifled growth process. People who seek professional help for psychological problems have within them the capacity and the will to grow toward health, but somehow, their growth has been interrupted or distorted. The task of the humanistic therapist is, through the therapeutic relationship, create a climate in which the client can resume their natural growth toward psychological wellness.

If each of us is guided by the self-actualization tendency from the beginning of our lives, how could we find ourselves depressed, anxious, or otherwise struggling with psychological issues? The answer lies in the fact that the need for positive
regard can, at times, override the natural tendency to self-actualize. That is, when we face an either-or choice between receiving positive regard from the important people in our lives and following our own natural inclinations, we may, out of necessity, choose the positive regard.

Problems arise when this positive regard is conditional rather than unconditional. Conditional positive regard communicates that we are prized “only if” we meet certain conditions. If you consider your own family or those of your best childhood friends, you can probably identify some of the conditions of worth that parents placed on their children. These conditions weren’t posted as a list on the refrigerator, but they were clearly communicated nonetheless: we’ll love you only if you get good grades, dress how we like, adopt our values, excel in sports, don’t gain weight, stay out of trouble, and so on. Usually, kids can keenly sense the conditions their parents place on their acceptance, and because they need their parents’ acceptance, they do their best to meet these conditions. In the process, however, they often go astray of their own self-actualization tendency, which may have guided them in another direction. Thus, when they compare the selves they actually are—the real self—to the selves they could be if they fulfilled their own potential—the ideal self—they perceive a discrepancy. Humanists use the term incongruence to describe this discrepancy, and they view it as the root of psychopathology. In contrast, congruence—a match between the real self and the ideal self—is achieved when self-actualization is allowed to guide a person’s life without interference by any conditions of worth, and as a result, mental health is optimized. That is, congruence happens when a person experiences unconditional positive regard from others. No “only if” conditions are placed upon them for acceptance, so they are free to develop and grow according to their own self-actualization tendency.

It’s important to note that although conditions of worth originally come from others, they can eventually become incorporated into our own views of ourselves. That is, conditional positive regard from others brings forth conditional positive self-regard, whereas unconditional positive regard from others brings forth unconditional positive self-regard. The important people in our lives communicate to us what is lovable, acceptable, or “prizeworthy” about ourselves—the whole self, or only certain aspects—and eventually, we adopt those views in our evaluations of ourselves.

As an example of these humanistic principles, consider Mark, a first-year college student. Unlike many of his classmates who are undecided about a major or a career path, Mark long ago decided that he would become a lawyer. During his
first month on campus, he declared himself a pre-law major, planned a 4-year plan of undergraduate courses designed to enhance his chances of getting into law school, and made a preliminary list of law schools to which he intended to apply. Mark’s interest in law was strongly encouraged by his parents. Both of them, as well as Mark’s only sibling, are accomplished attorneys themselves. During Mark’s childhood, they frequently commented on Mark’s potential as a lawyer—“With these good grades, you’re on the path to a top-notch law school,” “It’s wonderful knowing that we’ll be able to hand the firm over to you someday,” and “Listen to the argument he’s putting up about his curfew—he’s gonna make a great courtroom attorney someday!” At various points in his childhood, Mark showed interest in other activities, such as acting, sports, and journalism, but his parents never paid much attention to those activities or accomplishments. They were much more interested in his debate club activities, which they viewed as a precursor to his legal career, than his plays, soccer games, or school newspaper articles.

In his second semester, Mark took an art history course to fulfill an elective requirement. Although he was reluctant to admit it, he found himself fascinated by the subject—much more than he was with law. During his free time, he found himself reading ahead in his art history textbook and searching related topics online. He even borrowed some painting materials from his roommate and tried his hand at painting. When his parents arrived for a visit, however, he hid his interest in art from them. He sensed that they would reject it and more significantly, reject him if they sensed he was passionate about it. They had made it clear that their acceptance of him was contingent upon choosing law as a career path, and Mark sensed that they may not support him—emotionally, financially, or in any other way—if he followed his own intrinsic interests. Mark eventually became a lawyer, and although he achieved some success, he was always unhappy about the artistic side of himself that was never allowed to grow. In fact, Mark came to realize that whereas the legal “branch” of himself received plenty of “sunlight,” numerous other branches had been neglected. When he compared his real life—as a lawyer with no other developed interests, abilities, or skills—with the ideal self he could have been, he noticed an incongruence that left him feeling dissatisfied and unhappy. If Mark was to find himself in a meaningful relationship with someone who prized him “no matter what”—a humanistic therapist, for example—he might be able to view himself more unconditionally, follow his own self-actualization tendencies, and achieve greater congruence between his real and ideal selves.
ELEMENTS OF HUMANISTIC PSYCHOTHERAPY

Because self-actualization is a primary, natural tendency in all people, the therapist need only make the conditions right for it to occur. The therapist does not directly heal the client, per se; instead, the therapist fosters the client’s self-healing tendencies toward growth. The therapist accomplishes this by creating a therapist-client relationship characterized by three essential therapeutic conditions (Cain, 2002; Prochaska & Norcross, 2007; Rogers, 1957, 1959).

Empathy

A therapist experiences empathy for a client when the therapist is able to sense the client’s emotions, just as the client would, to perceive and understand the events of their lives in a compassionate way. Empathy involves a deep, nonjudgmental understanding of the client’s experiences in which the therapist’s own values and point of view are temporarily suspended. The therapist sees life through the client’s eyes and adopts the client’s frame of reference (Rogers, 1980). Indeed, the term “client-centered therapy,” often used synonymously with humanistic therapy, reflects this emphasis on empathic understanding (Bozarth, 1997).

When a therapist empathizes accurately and communicates that empathy effectively, it can have a profound, positive impact on the client. Empathy can enable clients to clarify their own feelings for themselves, and have more confidence in the emotions they experience. It can also make a client feel valued and supported as an individual (Cain, 2002).

Unconditional Positive Regard

Unconditional positive regard (UPR) is, essentially, full acceptance of another person “no matter what.” Rogers (1959) stated that the therapist proving UPR to a client

prizes the client in a total, rather than a conditional, way. [The therapist] does not accept certain feelings in the client and disapprove of others . . . It means making no judgments. It involves as much feeling of acceptance for the client’s expression of painful, hostile, defensive, or abnormal feelings as for [the client’s] expression of good, positive, mature feelings. (pp. 13–14)

Recalling the plant metaphor, sunlight is to plants like positive regard is to people. So, a therapist providing UPR is very much like unobstructed sunlight coming from every direction. UPR allows clients to grow in a purely self-directed way,
Empathy Across Cultures

According to the humanistic approach, empathy is fundamental to successful psychotherapy. But does culture place limits on the extent to which a therapist can empathize? To what extent can therapists accurately, genuinely empathize with clients who differ markedly from themselves in terms of ethnicity, gender, age, or other variables?

Consider Stephanie, a 38-year-old woman seeking therapy for depressive symptoms arising after a recent miscarriage. Would a female therapist be more capable of empathizing with Stephanie than a male therapist? If the female therapist had never had a miscarriage, would that limit her ability to empathize? What if the female therapist had never been pregnant?

Or, consider Namrata and Amit, a married couple seeking therapy. Both Namrata and Amit moved from India to the United States as children, and they both speak Hindi and English fluently. They are expecting their first child in about a month, and they are arguing intensely about the language they will speak at home after the baby is born. Namrata believes that they should speak only English at home, in an effort to enhance their child’s ability to compete in schools and job markets in which she expects English to be the dominant language. Amit believes that they should speak Hindi at home, in an effort to enhance their child’s connection to their heritage and culture. If an Indian, bilingual (Hindi/English) therapist is available, would that therapist have a greater capacity for empathy than a non-Indian therapist or a therapist who spoke only English? If so, would it matter if that therapist had no children?

Finally, consider Faye, a 75-year-old woman struggling with issues of loss and health. Specifically, her spouse and several of her best friends have died in recent years, and her own health has declined significantly as well. Until 10 years ago she was quite healthy and strong, but she now finds herself in a wheelchair and dependent upon caretakers for basic tasks. Can a therapist half her age who has never experienced such loss or decline genuinely empathize with Faye?

In general, can the personal background or experience of the therapist influence the therapist’s ability to empathize with clients? Are some clients’ problems so specific to their gender, ethnicity, age, or other variables that only someone with the same background can truly appreciate how the clients may feel? Or are our emotional reactions universal even though the events that evoke them may differ? Little empirical research has been conducted on this topic (e.g., Eisenberg, 2000; Feldstein, 1987; Graham & Ickes, 1997; Lennon & Eisenberg, 1987), and that which has been conducted has been marked by inconsistent results.

As a clinical psychologist, would you feel confident in your capacity for empathy for all clients? As a client, would you seek a clinical psychologist whose cultural background matched yours with the assumption that it would maximize their empathic understanding?
with no need for concern about losing the respect or acceptance of the other person in the relationship. It contributes to a climate in which clients realize they are free to be wholly true to themselves, without modifying, amending, or retooling themselves to meet the standards of another person. When therapists unconditionally prize clients, over time, the client may come to unconditionally prize themselves, which facilitates higher levels of congruence and self-actualization.

Each of us has experienced relationships in which we were appreciated not for our whole selves, but for some specific features of ourselves—personality traits, behaviors, even material things. Although it may not be stated explicitly, the other person in the relationship makes it clear that they will continue to accept us as long as we show them the sides of ourselves that they like and hide the sides they don’t. According to humanists, such relationships impede growth, and eventually, cause us to drift away from our true selves. Therefore, as therapists, humanistic therapists make it a top priority to accept the client entirely and unconditionally. This provides an opportunity for the client to grow naturally into their own potential rather than being pressured to grow in various directions by others.

**Genuineness**

Empathy and UPR are worthless if they aren’t honest. Humanistic therapists must therefore be genuine in their relationships with clients. They don’t act empathic toward clients or act like they unconditionally prize them. Instead, they truly are empathic toward clients and truly do unconditionally prize them. This genuineness—which Rogers and his followers have also called therapist congruence, because there is a match between the therapist’s real and ideal selves—is the opposite of playing a role or putting up a front. When we sense others (friends, family, or therapists) doing that, we tend not to reveal much of ourselves. On the other hand, when we sense that others authentically care about us and accept us, we tend to open up and engage more fully in the relationship (Rogers, 1959).

Being genuine with clients helps humanistic therapists establish therapeutic relationships that feel “real.” Such relationships differ strikingly from therapist/client relationships in which the therapist hides behind a facade of professionalism; instead, the therapist’s personality plays a more prominent role. As might be expected, Rogers and other humanists encourage a relatively high degree of transparency by the therapist. Unlike the “blank screen” psychodynamic therapist, humanists tend to be more forthcoming and candid about their own thoughts and feelings during sessions. However, they understand that the sessions are for the benefit of the client, not the therapist, and their self-disclosures are guided by this goal (Rogers, 1957).

These three conditions—empathy, UPR, and genuineness—are the essential elements of the relationship between humanistic therapists and their clients,
which, in turn, is the cornerstone of the humanistic approach to psychotherapy. As Rogers (1961, pp. 37–38) explained it:

If I can create a relationship characterized on my part:

- By a genuineness and transparency, in which I am my real feelings;
- By a warm acceptance of and prizing of the other person as a separate individual;
- By a sensitive ability to see his world and himself as he sees them;

Then the other individual in the relationship:

- Will experience and understand aspects of himself which previously he has repressed;
- Will find himself becoming better integrated, more able to function effectively;
- Will become more similar to the person he would like to be;
- Will be more self-directing and self-confident;
- Will become more of a person, more unique and more self-expressive;
- Will be more understanding, more acceptant of others;
- Will be able to cope with the problems of life more adequately and more comfortably

Necessary and Sufficient?

When Rogers described empathy, UPR, and genuineness as the three core conditions for successful psychotherapy, he wasn’t merely suggesting that they might be effective for some clients. His claim was much bolder: those three conditions were both necessary and sufficient for psychotherapy to be successful with any client (Rogers, 1957). In other words, Rogers argued that to facilitate growth and self-actualization in clients with any kinds of problems, the therapist must provide only empathy, UPR, and genuineness. No additional techniques or procedures are necessary.

Rogers’s assertion that these three elements are both necessary and sufficient for successful psychotherapy has generated a significant amount of controversy and research. Through the mid-1970s, the research was generally supportive of Rogers’s claim, but since that point, results have been more uncertain and inconsistent. More recent research suggests that Rogers’s core therapy ingredients are probably necessary, but not always sufficient, for psychotherapy to succeed. Perhaps they are best understood as a prerequisite for good therapy, a set of conditions that may be enough to facilitate significant improvement in some clients or set the stage for additional therapeutic methods that will cause significant improvement in others. Another interesting way of understanding Rogers’s three core conditions is to see them as essential parts of the therapeutic relationship,
whether the therapist is explicitly humanistic or not. Stated differently, perhaps empathy, UPR, and genuineness are common factors, which (as we discussed in more detail in Chapter 11) contribute heavily to the success of all kinds of psychotherapy (Bozarth, Zimring, & Tausch, 2002).

**Therapist Attitudes, Not Behaviors**

Whether empathy, UPR, and genuineness are necessary, sufficient, or both, it is important to remember that humanists view them as attitudes, not behaviors (e.g., Bozarth, 1997). Humanists balk at formulaic, mechanical approaches to therapy, and as such, they tend not to offer many specific suggestions about what therapists should do with clients. Rather, they emphasize how therapist should be with clients:

Contrary to the opinion of a great many psychotherapists, I have long held that it is not the technical skill or training of the therapist that determines his success—not, for example, his skillful dream interpretations, his sensitive reflections of feeling, his handling of the transference, his subtle use of positive reinforcement. Instead, I believe it is the presence of certain attitudes in the therapist, which are communicated to, and perceived by, the client, that effect success in psychotherapy. (Rogers, 1959, p. 10)

**REFLECTION: AN IMPORTANT THERAPIST RESPONSE**

Although they believe that the therapist’s attitude is more vital than any particular therapist action, humanists generally agree that one therapist behavior—reflection—can contribute significantly to the success of psychotherapy. It serves as a mechanism by which empathy, UPR, and genuineness can be communicated and as an expression of the attitudes that humanists emphasize.

Reflection takes place when a therapist responds to a client by rephrasing or restating the client’s statements in a way that highlights the client’s feelings or emotions (Campbell, 2004). Reflection is not a mere parroting of the client’s words to show that they have been heard but a comment by the therapist that shows the therapist’s appreciation of the client’s emotional experience as well. (In fact, humanists often use the phrase “reflection of feeling” instead of the shorthand “reflection” to illustrate the emphasis on emotion.) When they reflect, humanistic therapists mirror their clients’ affect, even if that affect is not explicitly stated.

As an example, consider Rosa, a single mother of two children (aged 7 and 9 years) who works a full-time job. Rosa tells her humanistic therapist about a typical day:

I get up at 6:00, make the kids’ lunches, take them to the bus stop, get myself ready for work, and get there by 8:30. I’m at work until 4:30, fight traffic to
pick the kids up from after-school care by 5:00, and then make dinner. After dinner, I help the kids with their homework and get them to bed, at which point I have time to clean the house, pay the bills, and do the other stuff I need to do around the house. The next day, it’s the same thing all over again.

Rosa’s therapist could assure Rosa that she was paying attention by merely repeating some of the facts: up at 6:00, at work by 8:30, pick up kids by 5:00, and so on. However, an effective reflection of feelings would pick up on the emotional connotations of Rosa’s statements, perhaps communicated by her tone of voice or body language more than the words she chooses: “It’s a long, demanding day, and it sounds like you’d be exhausted by the end of it. Seems like you might feel underappreciated, and maybe frustrated about your situation. Is that how you feel?” By mirroring the emotions in Rosa’s words rather than just the words themselves, her therapist expresses empathy. By doing so nonjudgmentally, she communicates UPR. And by doing so honestly, she communicates genuineness. In combination and over time, these three conditions contribute to a strong therapeutic relationship and facilitate Rosa’s growth.

Late in his career, Rogers expressed some regret about the way that “reflection of feeling” had been used by many inside and outside of the humanistic movement. He was particularly unhappy with the fact that reflection had been mistakenly taught and misunderstood “as a technique, and sometimes a very wooden technique at that” (Rogers, 1986, p. 375). Above all, Rogers believed, reflection should be an attitude rather than a technical skill. And this attitude should include some humility, which can be lost when therapists reflect mechanically. When they reflect, therapists should not be telling clients how they feel, but instead should be asking clients if their understanding of the clients’ feelings is correct. In other words, therapists should not become overconfident in their ability to read clients’ emotions and should always defer to the clients’ expertise on their own feelings. Rogers went so far as to “suggest that these therapist responses be labeled not ‘Reflections of Feeling,’ but ‘Testing Understandings,’ or ‘Checking Perceptions.’ Such terms would, I believe, be more accurate [in communicating] a questioning desire rather than an intent to ‘reflect’” (Rogers, 1986, p. 375). Although the terms “reflection” and “reflection of feeling” have remained, Rogers’ reminders about the way it should be understood and used are nonetheless important.

ALTERNATIVES TO HUMANISM

Historical Alternatives

Throughout the history of clinical psychology, numerous forms of psychotherapy have been influenced significantly by humanism. Here, we will discuss two of
the most notable of these historical approaches—existential therapy and gestalt therapy. Although it is accurate to say that their heydays have passed, they nonetheless hold a significant place in the evolution of psychotherapy and continue to influence many therapists today.

**Existential psychotherapy** is an approach to therapy originally developed by Rollo May, Victor Frankl, and Irvin Yalom. It centers on the premise that each person is essentially alone in the world and that realization of this fact can overwhelm
us with anxiety. This anxiety may take a number of forms and is the root of all psychopathology. In addition to the inescapable conclusion of aloneness, existential theory holds that other inevitabilities of human life, especially death, contribute to a powerful sense of meaninglessness in many people. Existential therapists place great emphasis on client’s ability to overcome meaninglessness by creating their own meaning through the decisions they make. They especially encourage clients to make choices that are true to themselves in the present and future, rather than choices that are determined by restrictive relationships they have had in the past. They empathize with the client’s reaction to the unavoidable facts of existence, but through questionning and discussion, they aid clients in assuming control and assigning significance to their lives (Frankl, 1963; May, 1983; Yalom, 1980).

**Gestalt therapy** was founded by Fritz Perls, and it emphasizes a holistic approach to enhancing the client’s experience. This experience includes both mental and physical perceptions, and gestalt therapists attend to both of these aspects of client communication. In practice, Gestalt therapists encourage clients to reach their full potential, often through the use of role-play techniques. They deemphasize clients’ past experiences and instead focus almost exclusively on the present moment (labeled as “the now”). Integration and awareness of all parts of the self is viewed as a sign of personal growth, and as such, it is thought to correlate with psychological well-being (Fagan & Shepherd, 1970; Mackewn, 1997; Perls, 1969).

**Contemporary Alternatives**

In more recent years, new offshoots of humanistic therapy have emerged. For example, William Miller describes his **motivational interviewing (MI)** approach to therapy as a revised application of basic humanistic principles. MI was originally developed to treat addictive behaviors such as substance abuse, but it has been used with a wide range of client problems. MI centers on addressing clients’ ambivalence or uncertainty about making major changes to their way of life. Whereas many therapists might label such ambivalence as resistance, denial, or a lack of motivation, MI therapists acknowledge that it is a normal challenge for anyone facing the difficult decision of continuing with an unhealthy familiar lifestyle or committing to live in a more healthy but unfamiliar way. They don’t pressure clients to change, since such tactics may backfire, resulting in clients arguing against their own improvement. Instead, they help clients see the discrepancy between their behavior and their own values (as Rogers would call it, their incongruence). By doing so, they help clients decide to change for themselves (Miller & Rollnick, 2002; Moyers, 1998).

The central principles of MI reveal its humanistic roots (Miller & Rollnick, 2002; Moyers, 1998):
- **Expressing empathy.** Taking the client’s point of view and honoring their feelings about their experiences are vital to MI.

- **Developing the discrepancy.** MI therapists highlight how a client’s behavior is inconsistent with their goals or values. This enhances the client’s self-motivation to change, and puts them (rather than the therapist) in the position to argue for a new way of living.

- **Avoiding argumentation.** MI therapists do not directly confront clients, even if clients are engaging in self-destructive behaviors. They recognize that clients must choose to change rather than being strong-armed by a therapist.

- **Rolling with resistance.** When clients express hesitancy to change, MI therapists accept and reflect it rather than battle against it.

- **Supporting self-efficacy.** MI therapists make efforts to communicate to clients that they have the power to improve themselves. The role of the therapist is facilitative; it is the client who has the most power for change.

Numerous empirical studies have been conducted on the efficacy of MI, particularly in the area of problem drinking. A meta-analysis of 30 such studies was very supportive (Burke, Arkowitz, & Menchola, 2003).

Another modern adaptation of humanism has been developed by Arthur Bohart and Karen Tallman. The title of the book in which they describe their approach— *How Clients Make Therapy Work: The Process of Active Self-Healing*—illustrates its emphasis (Bohart & Tallman, 1999). Bohart and Tallman argue that therapy is most effective when the therapist recognizes that

> the client is a creative, active being, capable of generating his or her own solutions to personal problems if given the proper learning climate. For us, therapy is the process of trying to create a better problem-solving climate rather than one of trying to fix the person. (p. xi)

The therapist’s role, then, is not of a technician, but a collaborator with clients whose views and opinions are respected. Bohart and Tallman are explicit in their intention of offering a modern therapy that goes against the current movement toward symptom-focused, manualized, technique-dominated approaches to therapy. Such approaches, they believe, place the client in a passive role and underestimate their own abilities to improve their lives. Bohart and Tallman believe that therapists should mobilize clients to help themselves, rather than paternalistically presuming they cannot and applying prescribed techniques to them.

Finally, the positive psychology movement, which emerged in the 1990s under the leadership of Martin Seligman and has expanded rapidly in the 2000s, overlaps
with some of the fundamental underpinnings of humanistic psychotherapy. Positive psychology is a broad-based approach that emphasizes human strengths rather than pathology. It acknowledges the inherent potential of individuals to develop positive attributes based on such assets as hope, wisdom, creativity, courage, autonomy, optimism, responsibility, and growth. Moreover, it suggests that bolstering these strengths is an often overlooked way of preventing psychological problems like depression and anxiety, or improving those who already experience them (Seligman, 2003; Seligman & Csikszentmihalyi, 2000; Seligman & Peterson, 2003). Although positive psychology does not claim to explicitly derive from humanism, both positive psychology and humanism share a basic view of people as possessing inborn strengths and capabilities that can guide them throughout their lifetime and buffer them from unhappiness and a corresponding commitment to clinical work designed to enhance those strengths and capabilities. Unlike practitioners of most of other current forms of psychotherapy who focus more exclusively on a disease-based model, therapists influenced by positive psychology assume a therapeutic role that “embraces both healing what is weak and nurturing what is strong” (Seligman & Peterson, p. 313). The latter emphasis—nurturing what is strong in clients—is a contemporary echo of Rogers’s original theories.

OUTCOME ISSUES

Despite the empirical challenges inherent to humanistic psychotherapy—how to define and measure self-actualization and how to translate the humanistic attitude into well-defined therapist behaviors—Carl Rogers was a pioneer of psychotherapy outcome research. His approach may not lend itself to empirical tests as much as some other approaches to therapy (such as behaviorism); nonetheless, he often attempted to present his ideas as testable hypotheses, and included with his theoretical writings many ideas for empirical studies (Bozarth et al., 2002; Cain, 2002; Elliott, 2002).

As a professor at Ohio State University in the early 1940s, Rogers was the first to audio record psychotherapy sessions and play them back on 78 RPM phonographs, and along with training, research was a primary use for this technology (Rogers, 1942). Soon after, he and his colleagues published some of the earliest controlled studies of psychotherapy outcome (Elliott, 2002). By the 1960s and 1970s, however, few humanistic therapists were carrying on Rogers’s tradition in empirical research. A resurgence of research interest took place in the 1990s, as represented in some recent meta-analyses of humanistic therapy outcome studies (Elliott, 1996, 2002; Greenberg, Elliott, & Lietaer, 1994). The most recent of these meta-analyses (Elliott, 2002) was also the largest in scope, incorporating 86 separate studies of humanistic therapy that collectively reported on the results of more than 5,000 clients’ experiences. The results, after controlling for researcher
allegiance effects, indicate that humanistic therapies are generally about as effective as the other major approaches to psychotherapy. Similar results, of course, were obtained in the numerous broader meta-analyses in which humanistic therapies were directly compared with many other types of psychotherapy, leading to the dodo bird verdict discussed in more detail in Chapter 11 (Luborsky et al., 1975, 2002). Those few meta-analyses that found humanistic therapies to be very slightly less efficacious than other forms were typically influenced by researcher allegiance effects (as described in Chapter 12) (Luborsky et al., 1999).

**Box 13.3 Denise in Humanistic Psychotherapy**

In our first sessions, Denise directed our conversations toward two topics—her current dissatisfaction with her job and some personal family history that she saw as relevant. She informed me that as a kid, she felt loved by her mother and father but only as long as she didn’t stray too far from their expectations for her. One of these expectations, Denise explained, involved cooking. During her elementary and middle school years, she demonstrated a remarkable interest and talent in the kitchen, and with two working parents and five siblings, the family came to rely on Denise to prepare meals. She explained that she felt like her family came to value her for what she could accomplish in the kitchen. Denise explained to me that until recently, her job as a chef had given her similar opportunities for appreciation for her cooking but that the new owner’s policy that she stay in the kitchen and not talk with the customers had put an end to that.

Seeing this experience through Denise’s eyes, I could certainly understand why she had been feeling depressed. She had learned early on in her life that the important people prize her only for certain parts of who she was, and like any of us, she needed that prizing enough to meet their conditions. Eventually, she came to see herself in very much the same way her family saw her—in other words, their conditional positive regard had become conditional positive self-regard. I wondered if, in the process of doing what others wanted from her, she had neglected some other aspects of her identity. If so, that must have been a frustrating experience for her. Perhaps there was more to appreciate about Denise than her cooking abilities; in fact, maybe her worth as a person wasn’t tied to cooking at all.

In therapy, I did my best to communicate my empathy to Denise—about her experience growing up, as well as the recent changes at work. I remember some of our exchanges very vividly. Once, after she had spent about 10 minutes listing the differences the new restaurant owner had imposed—“He makes the menu decisions, he won’t let me talk with the customers,” and so on—I tried to reflect the feelings I sensed through her words, her tone of voice, and facial expressions: “You seem upset about these changes—disappointed, and maybe a little angry too—am I right about that? Do you have other feelings about it?”
Although many of the important people in Denise’s life had valued her for certain things—cooking, to be specific—I had a different appreciation of her. I saw Denise (as I see all of my clients) as a worthy person no matter what she chose to do, and I suspected that she had the potential to be more multifaceted than her family, her boss, and herself had allowed her to be. After a number of sessions, as she began to feel more comfortable with me, Denise mentioned, with some hesitancy, that sometimes she didn’t even like to cook and that occasionally she found it monotonous and boring. She seemed to expect disapproval from me about this, but I was just as accepting of this feeling as I was of any of Denise’s feelings. A bit later, she mentioned that there were other activities she felt more passionate, or at least curious, about but had never allowed herself to think of them as anything more than “dreams” or “fantasies.” I pursued this topic with interest, and Denise had the courage to explain that she had always been fascinated with repairing cars. Her brothers and her father had done a lot of this during her childhood, but Denise was told that it “wasn’t for her.” I felt that any of Denise’s interests were worthwhile, as long as they were true to herself, and I did my best to make this known to her.

Another aspect of Denise’s personality that emerged over time was her bitter anger toward her family (about her past) and her new boss (about her current situation). I didn’t see this anger at the beginning of therapy, but as time went on, she revealed it first through occasional comments about being “bothered” or “perturbed” and eventually through rants and outbursts that involved shouting and tears. I believed that these moments of anger were important to Denise because they were honest expressions of emotion, and although she seemed to originally assume that such outward anger was unacceptable, I did my best to let her know that I accepted her no matter how she felt.

With time, Denise seemed to internalize my unconditional prizing of her. She seemed to accept herself more fully and completely, allowing herself to recognize a wider range of feelings and interests than she had before. She even explored professional opportunities outside of cooking (including a car technician training program). And at her current job, she no longer missed the positive feedback from the diners as sorely as she had before, largely because she wasn’t so dependent on it. Instead of seeking positive regard from others based on their conditions, Denise was able to give herself positive regard unconditionally.

CHAPTER SUMMARY

Carl Rogers and his colleagues founded the humanistic approach to psychotherapy on a view of people as inherently striving to grow in a positive, healthy way. This self-actualization tendency at times conflicts with the need for positive self-regard (or “prizing”) from others, particularly when others provide positive self-regard conditionally. In these situations, individuals experience incongruence between their real and ideal selves, and psychological
problems ensue. Humanistic therapists foster self-actualization in their clients by establishing a therapeutic relationship in which conditions of worth are absent and congruence is encouraged. More specifically, humanistic therapists provide the three conditions that Rogers identified as necessary and sufficient for therapeutic gain: empathy, unconditional positive regard, and genuineness. These three conditions are defined more as therapist attitudes than techniques, but one therapist response, reflection of feeling, is a key component of humanistic therapy. The fundamental relationship-based elements of humanistic therapy may constitute common factors across many forms of therapy practiced by therapists who don’t identify themselves as humanistic per se. A variety of contemporary approaches, including motivational interviewing and positive psychology, are strongly influenced by humanistic principles. Despite Rogers’s role as a pioneer of therapy outcome research, empirical research on the benefits of humanistic therapy has not been as extensive in recent decades as some other forms of therapy. Those outcome studies that have been completed suggest that in general, humanistic psychotherapy is approximately as beneficial as most other approaches.

KEY TERMS AND NAMES

Abraham Maslow
Carl Rogers
conditions of worth
congruence
empathy
existential psychotherapy
genuineness
gestalt therapy
humanistic therapy
ideal self
incongruence

motivational interviewing (MI)
positive psychology
positive regard
prizing
real self
reflection
self-actualization
three essential therapeutic conditions
unconditional positive regard (UPR)
CRITICAL THINKING QUESTIONS

1. To what extent do you agree with the humanistic idea, as stated by Abraham Maslow (1968, pp. 3–4) that our “inner nature is good or neutral rather than bad,” and “if it is permitted to guide our life, we grow healthy, fruitful, and happy”?

2. What are some of the most common conditions of worth that you have seen parents place on children? What effects of these conditions of worth have you observed?

3. Rogers argued that empathy, unconditional positive regard, and genuineness were not only necessary but also sufficient for psychotherapeutic benefit. In your opinion, for which clinical problems is this statement most and least valid?

4. Which of the Rogers’s three essential therapeutic conditions seems most essential to you? Which seems least essential?

5. Considering the discussion of cross-cultural empathy in Box 13.1, do you believe that a therapist who is culturally similar to a client has a greater capacity for empathy than an equally competent but culturally dissimilar therapist?
Perhaps the best way to transition from the previous chapters on psychodynamic and humanistic therapy to the current chapter on behavioral therapy is to imagine that your clinical psychology class includes one very empirically oriented (and outspoken) student. When your professor discusses a psychodynamic
therapy concept such as, say, defense mechanisms, your classmate raises his hand and asks, “How can you be sure that’s what happens in the mind? Can you scientifically test that theory?” When your professor describes the three “necessary and sufficient” conditions for successful therapy according the humanistic approach, your classmate interrupts to ask, “How, exactly, do you define empathy, unconditional positive regard, and genuineness—what specific therapist behaviors do they consist of? And if those conditions really do help a client self-actualize, how exactly would you be able to observe or measure that outcome?”

Again and again, your professor would have little choice but to respond to your classmate’s questions by conceding that the psychodynamic and humanistic approaches to therapy are not entirely empirical. In spite of their intuitive appeal and their clinical successes, they are characterized by speculations about mental processes that can’t be precisely defined, directly observed, or scientifically tested. If your classmate insists on a therapy approach grounded in empiricism, he’ll need to look elsewhere—to behavioral therapy.

**ORIGINS OF BEHAVIORAL PSYCHOTHERAPY**

**Behavioral psychotherapy** is the clinical application of behavioral principles, which have theoretical and experimental roots extending back hundreds of years. A landmark in the history of behaviorism is the work of **Ivan Pavlov**, whose contributions took place in Russia in the late 1800s and early 1900s. Pavlov did not begin his career with aspirations related to psychology at all. In fact, he was a physiologist who studied the digestive systems of dogs. Routinely, Pavlov and his coworkers would present food to dogs and measure the amount of saliva the dogs produced—a natural, automatic response of any canine shown a potential meal. At one point, he noticed that the dogs were salivating before the food was presented. Pavlov first saw this untimely salivating as a problem, and he tried to minimize it so that it wouldn’t adversely affect the digestion data he was trying to collect. Later, he came to realize that he had inadvertently come across a remarkable phenomenon, which was ultimately labeled classical conditioning. Through their experience, Pavlov’s dogs had learned that food was often preceded by a particular stimulus: the sight of the researcher, the sound of the food being prepared, or similar events. Soon the dogs were salivating as soon as they perceived a stimulus that, through repeated pairing with food, predicted food. Classical conditioning eventually replaced digestive research as Pavlov’s primary interest, and using a bell as the precursor to food, he conducted many pioneering studies on the topic (Hunt, 1993;
A bit later in this chapter, we’ll examine classical conditioning and its clinical applications in more detail.

The work of Pavlov and other Russian researchers made its way to the United States via John Watson. In the early 1900s, Watson fervently argued that the lessons learned from Pavlov’s dogs applied to human behavior as well, and that as a result, psychology should refrain from focusing on the inner workings of the mind and should instead examine the ways in which conditioning shapes behavior. Watson was among the first prominent figures in American psychology to argue that psychology should study only overt, observable responses and the overt, observable stimuli that precede them rather than the inner workings of the mind that may occur in between. Feelings, thoughts, consciousness, and other internal, mental processes were simply not suitable for scientific study; nor were they as powerful as conditioning in determining behavior (Hunt, 1993; Kazdin, 1978; Watson, 1924).

While Pavlov and Watson ushered in classical conditioning to the field of psychology, a second essential type of conditioning—operant conditioning—was heralded by Edward Lee Thorndike and B. F. Skinner. Actually, Thorndike’s primary contribution, based on his research with cats, was a rather straightforward theory he called the law of effect (Thorndike, 1931). Essentially, Thorndike’s law of effect stated that all organisms pay attention to the consequences (or effects) of their actions. Actions that are followed by pleasurable consequences are more likely to recur, whereas actions that are followed by unpleasant consequences are less likely to recur. Skinner effectively devoted much of his life’s work to experimentation on the law of effect, and he made the case that operant conditioning, the mechanism by which the law of effect influenced behavior, was as great an influence on human behavior as classical conditioning. Skinner’s research and writings became tremendously influential to the behavioral perspective on the origins of psychological problems and the techniques by which they could be treated (Bjork, 1993; Hunt, 1993; Kazdin, 1978). Thus, through Pavlov, Watson, Thorndike, and Skinner, behaviorism evolved from basic research on animal behavior to an applied form of psychotherapy.
GOAL OF BEHAVIORAL PSYCHOTHERAPY

The primary goal of behavioral psychotherapy is observable behavior change. This goal stands in stark contrast to the goals of the psychodynamic and humanistic approaches, each of which emphasize internal, mental processes—making the unconscious conscious and fostering self-actualization, respectively. In fact, the emergence and rise of the behavioral approach stemmed from strong dissatisfaction with numerous aspects of the psychodynamic approach that dominated through the early and mid-1900s. As a reaction against perceived weaknesses of the prominent approaches of the times, early behaviorists forged a new therapy differentiated from the outset by a distinct set of characteristics (Kazdin, 1978, 1980; Prochaska & Norcross, 2007; Yates, 1970).

Emphasis on Empiricism

Behavioral therapists take the stance that the study of human behavior, whether normal or abnormal, should be scientific (Kazdin, 1978; Yates, 1970). As such, clinical psychologists treating clients should employ methods that can be scientifically evaluated. Theories regarding the treatment of problem behaviors should be stated as testable hypotheses; in this way, they can be supported, refuted, modified, and retested. In contrast, if theories of change are not stated as testable hypotheses, they lack scientific rigor and might be best classified as conjecture, inference, or even guesswork. Of course, any scientific process involves data collection, and behavioral therapy is no exception. Behavioral therapists regularly collect empirical data on their clients—as a baseline measure at the outset of therapy, at various points during the therapy to evaluate changes from session to session, and at the end of therapy as a final assessment of change.

Expanding on the scientific nature of behavioral therapy, Truax (2002) explains that “the endeavor of developing and testing hypotheses in the real clinical setting is much like that of a scientist” (p. 5). Indeed, behavioral therapy is a clinical application of the five steps that are common to the scientific method across all disciplines. Table 14.1 summarizes this association between the scientific method and behavioral therapy.

Defining Problems Behaviorally

According to behavioral therapists, client behaviors are not symptoms of some underlying problem—those behaviors are the problem. For example, consider Ryan, who has a habit of excessively checking the front door of his apartment at bedtime to make sure it’s locked. According to behavioral therapists, Ryan’s door-checking
habit is exactly that—a habit. It need not signify that a deeper, diagnosable problem resides within Ryan. Behavior therapists would see little benefit in defining Ryan’s problem as obsessive-compulsive disorder, because to do so would suggest that the door checking is part of a cluster of symptoms that share a common source within Ryan’s mind. They would prefer not to make unproven (actually, unprovable) inferences about the internal causes of Ryan’s behavior, and instead focus exclusively on Ryan’s door-checking behavior itself as the problem to be addressed.

From the behavioral point of view, a benefit of defining problems in behavioral terms is that such definitions make it easy to identify target behaviors and measure changes in therapy. Such definitions can differ quite drastically from the definitions offered by clients of their own problems. As an example, consider Amber, a 30-year-old client who sought help from Dr. Tyler, a behavioral therapist, because

Table 14.1  Application of the Steps of the Scientific Method by Behavioral Therapists

<table>
<thead>
<tr>
<th>Steps of the Scientific Method</th>
<th>How Applied by Behavioral Therapists</th>
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<tbody>
<tr>
<td>1. Observing a phenomenon</td>
<td>Assessing client behavior via observation, interview, or testing</td>
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<tr>
<td></td>
<td>Defining a target behavior</td>
</tr>
<tr>
<td></td>
<td>Establishing a baseline level of target behavior</td>
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<tr>
<td>2. Developing hypotheses</td>
<td>Functional analysis of target behavior to determine the factors that cause or influence it</td>
</tr>
<tr>
<td>to explain the phenomenon</td>
<td>Establishing specific behavioral goals for treatment</td>
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<tr>
<td></td>
<td>Planning interventions to alter behavior in preferred manner</td>
</tr>
<tr>
<td>3. Testing the hypotheses</td>
<td>Implement interventions as planned</td>
</tr>
<tr>
<td>through experimentation</td>
<td>Collect data on changes in the target behavior</td>
</tr>
<tr>
<td></td>
<td>Compare data collected during or after treatment to baseline data</td>
</tr>
<tr>
<td>4. Observing the outcome of</td>
<td>Compare data to goals</td>
</tr>
<tr>
<td>the tests</td>
<td>Modify treatment plan as suggested by observed outcomes</td>
</tr>
<tr>
<td></td>
<td>Restart scientific process with revised hypotheses</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from Truax (2002).
Amber believed she “had depression.” Amber entered therapy convinced that the depression was an entity, a “thing” within her mind that couldn’t be seen directly but was nonetheless affecting her in numerous adverse ways. She said that the main “symptoms” of her depression were feeling sad and thinking pessimistically. Dr. Tyler redefined Amber’s problems in two important ways. First, she asked Amber to describe the observable, measurable behaviors she most wanted to change. That is, rather than focusing on feelings and thoughts—none of which can be directly observed or measured—Amber was asked to focus on behaviors she performed too often or too rarely. With some help from Dr. Tyler, Amber was able to list many such behaviors: sleeping too much, missing work too frequently, crying too often, and exercising too little. Because these problems are actions that can be observed and measured, they are ideal targets for behavioral interventions. The second way that Dr. Tyler redefined Amber’s problem was to explain to Amber that these behaviors weren’t symptoms of a deeper problem; instead, they were the problems themselves. After establishing baselines—measuring the pretreatment frequencies or durations of Amber’s sleep, work attendance, crying, and exercising—Dr. Tyler proceeded by designing and implementing interventions that targeted each of Amber’s problem behaviors. As therapy progressed, they measured Amber’s behaviors on a regular basis and compared that data with her baseline data to assess her improvement.

Whereas most other types of therapy approaches endorse a “medical model of psychopathology,” the behavioral approach, as exemplified by Dr. Tyler, does not. That is, most other therapy approaches conceptualize psychological problems like physical diseases, especially with regard to the notion of symptoms as manifestations of underlying diseases. Shortness of breath, for example, might be a symptom of asthma; coughing might be a symptom of bronchitis; abdominal pain may be a symptom of an ulcer. Behavioral therapists don’t adopt this medical-model view of psychological problems, largely because the connections between “symptoms” and the underlying “diseases” they indicate are largely speculative in psychology, whereas they are more concrete in medicine. Because we cannot know empirically that a particular behavior is symptomatic of any particular underlying problem, behavioral therapists regard behavioral problems themselves as the most appropriate focus of treatment.

**Measuring Change Observably**

For behavioral therapists, measuring therapy outcome via observable changes goes hand in hand with defining the client’s problems behaviorally from the outset. That is, whereas other kinds of therapists may measure change in clients in
more inferential ways, behavioral therapists use more unambiguous indications of progress.

To illustrate, recall the psychoanalytic and humanistic therapists we studied in the previous chapters. They would have to look in the client’s mind for some indication that their therapy has produced an effect. For empiricists like behavioral therapists, this method of measuring change is unacceptable, primarily because it lacks objectivity. How do we know that the therapist (or the client, or anyone else, for that matter) has a reliable, valid, unbiased take on how much insight the client has gained? How can we be certain that the growth a client has experienced is a result of an improved sense of congruence? Behavioral therapists reject introspection such as this—that is, they reject the notion that we can simply look inside the mind and attain an objective, accurate assessment of change. Instead, they focus on outward demonstrations of change in clients—overt behavior, rather than covert mental processes—as indicators of client change.

Behavior therapists don’t simply reject introspection as a means of measuring change in therapy; indeed, they believe that introspection should have no role at all in the clinical process. Therefore, when they consider the contributing factors to clients’ problems, they emphasize external, environmental factors over internal personality traits. As an example, consider Jack, a 40-year-old man who is seeking therapy from Dr. Herrera, a clinical psychologist with a behavioral orientation. Jack is 100 pounds overweight, and has gained 20 pounds in the last year. He explains to Dr. Herrera that he has tried to lose weight many times but always quits his exercise routine and returns to unhealthy eating habits—chips, cookies, fast food, and so on. At this early point, some therapists would already be speculating about Jack’s internal personality characteristics as a cause of his overeating—for example, a psychodynamic therapist may consider an oral fixation. The problem with such a speculation, from a behavioral point of view, is that it cannot be supported or refuted because it hinges on Jack’s mental processes, which are not directly observable. Dr. Herrera makes no such speculations. Instead, the questions he poses to Jack involve observable aspects of the environment in which Jack lives. In other words, what events precede Jack eating a bag of chips or skipping a workout? What consequences follow these actions? In what settings and under what conditions do the unwanted behaviors take place? Questions such as these make it clear that Dr. Herrera, as a behavioral therapist, looks for the causes of Jack’s problems not within Jack but in the world around him. In other words, Jack’s too-frequent unhealthy eating and too-infrequent exercising are responses to stimuli and consequences from the world around him, rather than expressions of some internal flaw in his personality.
TWO TYPES OF CONDITIONING

As discussed above, behavioral therapists contend that our behavior is the byproduct of conditioning (also known as learning). If conditioning explains all behavior, then by definition it explains the acquisition of disordered behavior as well as the means by which such behavior can be modified by clinical psychologists. Behavioral therapists separate conditioning into two primary types: classical and operant.

Classical Conditioning

Classical conditioning is the type exemplified by Pavlov’s dog studies. In those studies, dogs learned through experience that certain stimuli (a bell, for example) predicted that food would be delivered, and as a result they began to salivate in response to the stimuli. If we examine this process more closely, its four components can be identified. Let’s start before any conditioning takes place, before the dog has had a chance to learn how things work in Pavlov’s lab. In fact, let’s imagine that the dog has just walked into Pavlov’s lab for the first time, so everything that it experiences or does is completely “unconditioned.” In this situation, the dog will salivate when food is presented. So food is the unconditioned stimulus, which evokes salivation, the unconditioned response. No dog needs conditioning to learn that association—it’s inborn. After spending some time in Pavlov’s lab, the dog notices that when a certain bell rings, food comes a few seconds later. In other words, the dog is now becoming conditioned, or learning that sound of the bell predicts the arrival of food. The dog soon begins to salivate in response to the bell. The sound of the bell, which had originally evoked no response at all in the dog, has become a conditioned stimulus, and salivating, when in response to the bell (not the food), is the conditioned response.

There are several aspects of classical conditioning worth emphasizing. First, it is important to note that classical conditioning is a rather passive type of learning. Pavlov’s dogs didn’t need to do much of anything to experience the conditioning, other than remain awake and alert. It’s almost as if the classical conditioning happened to them—some combination of sights, sounds, smells, or tastes occurred in rapid succession, and they happened to be there to experience them. Second, there are a number of variables surrounding the classical conditioning process that can influence behavior. For example, the extent to which an individual demonstrates behavior that has been classically conditioned will depend on the extent to which generalization or discrimination takes place. Generalization occurs when the conditioned response is evoked by stimuli that are similar to, but not an exact match for, the conditioned stimulus.
Discrimination occurs when the conditioned response is not evoked by such a stimulus (Kazdin, 1978, 1980). For example, if Pavlov conditioned a dog to salivate in response to the sound of a particular bell, would the dog also salivate to the sound of a slightly different bell? What about a very different bell, or even a completely different sound, like a drum? As a clinical version of the same questions, imagine that Wayne, a 16-year-old boy, developed a strong fear response to dogs after being viciously attacked by a golden retriever. To what extent would Wayne generalize his fear? Would he be fearful of all golden retrievers, of dogs of any breed, of all animals of any kind? Conversely, might Wayne discriminate such that he responds fearfully to the one dog that attacked him but no others? The extent to which Wayne generalizes or discriminates his fear response would strongly influence the strategy of a behavior therapist helping Wayne overcome his fear.

Operant Conditioning

Operant conditioning occurs when the organism “operates” on the environment, notices the consequences of the behavior, and incorporates those consequences into decisions regarding future behavior. Simply put, “the basic principle of the operant approach is that behavior is a function of its consequences” (Calhoun & Turner, 1981, p. 4). Operant conditioning is a more active style of learning than classical conditioning. For operant conditioning to take place, the organism must take an action of some kind. As a fictional example, imagine that one of Pavlov’s dogs had, during a break in the experimenting, started to whine. If the whining brought forth treats, the dog would be more likely to whine again. If the whining brought forth a whack on the nose, the dog would be less likely to whine again. In either case, the point is that the dog experimented with a new behavior, paid attention to the outcome, and will use that outcome as a factor in future decisions about whining.

Skinner and other proponents of operant conditioning proposed that consequences shape all behavior, including behavior labeled as abnormal. In effect, all our actions are governed by contingencies, by “if . . ., then . . .” statements, including those labeled as abnormal. By changing the contingencies, or revising the “if . . ., then . . .” statements that control a client’s behavior, clinical psychologists can induce significant behavioral changes.

Thus, both classical and operant conditioning can be applied clinically to address problematic or unwanted behaviors in clients. Indeed, these two types of conditioning are the foundations for most behavioral therapy techniques. Let’s examine some of the most widely known and used techniques deriving from classical and operant conditioning.
TECHNIQUES BASED ON CLASSICAL CONDITIONING

Exposure Therapy

Simply put, exposure therapy is the clinical psychologist’s version of “facing your fears.” Phobias, according to the behavioral therapist, are best understood as the result of classical conditioning: A particular stimulus (spiders, heights, the dark, etc.) becomes paired with an aversive outcome (anxiety, pain, etc.). This pairing can be weakened and ultimately eliminated if the client experiences one without the other. That is, when the client is repeatedly “exposed” to the feared object and the expected aversive outcome does not take place, the client no longer experiences the fear response, which is a more appropriate and rational way to react to such harmless stimuli.

As a clinical example, let’s reconsider Wayne, who was described above as having a fear of dogs as a result of a vicious attack. The essential task for a behavioral therapist conducting exposure therapy is to expose Wayne to dog-related stimuli. Based on his attack, Wayne has associated dogs with fear, but the truth is that for the vast majority of dogs, this is simply an inaccurate expectation. Unfortunately for Wayne, his avoidance of dogs since the attack has prevented the opportunity for him to “unlearn” the association between dogs and fear. Through exposure therapy, his behavior therapist gives him exactly that opportunity, and the result of the exposure to dog-related stimuli is that Wayne’s association between dogs and fear is unlearned.

The behavior therapist has several choices to make when conducting exposure therapy. One of the most important involves the imaginal versus in vivo nature of the stimuli to which the client will be exposed. In other words, the client can be asked to imagine anxiety-provoking objects (without

Photo 14.2  Facing feared stimuli—such as dogs, for someone previously attacked by a dog—is the essential element of exposure therapy.
ever being exposed to the real thing) or can be exposed to real-life (in vivo) items or situations that have produced fear. In Wayne’s case, **imaginational exposure** would involve visualizing dogs and dog-related items, whereas **in vivo exposure** would mean that Wayne would directly see, hear, and touch dogs.

Another important choice regarding exposure therapy involves the extent to which the client will be exposed to fear-inducing stimuli: gradually or all at once. The gradual approach is often called **graded exposure**, and it requires the client and therapist to collaboratively create an **anxiety hierarchy** in which they list about 10 stimuli that might induce fear. These stimuli are typically rated by the client on a scale from 0 to 100 in terms of the amount of subjective distress they produce and are then ranked in ascending order. Exposure begins at the lowest level and then proceeds through the hierarchy until the client reaches the highest level. Table 14.2 illustrates a graded in vivo hierarchy for Wayne’s fear of dogs. Exposure that happens all at once rather than gradually is typically called **flooding** if exposures are in vivo or **implosion** if exposures are imaginal. Although either of these all-at-once approaches can produce rapid change quickly, they can also be intolerable or even traumatizing for clients and must be used cautiously (Taylor, 2002; Yates, 1970).

**Table 14.2**  Example of an Anxiety Hierarchy for Graded In Vivo Exposure for Fear of Dogs

<table>
<thead>
<tr>
<th>Stimulus</th>
<th>Subjective Distress (0 = No Fear; 100 = Maximum Fear)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hearing a dog bark in another room</td>
<td>5</td>
</tr>
<tr>
<td>2. Seeing a dog through a window</td>
<td>15</td>
</tr>
<tr>
<td>3. Standing within 20 feet of a dog on a leash</td>
<td>25</td>
</tr>
<tr>
<td>4. Standing within 10 feet of a dog on a leash</td>
<td>35</td>
</tr>
<tr>
<td>5. Standing within 5 feet of a dog on a leash</td>
<td>45</td>
</tr>
<tr>
<td>6. Standing within arm’s length of a dog</td>
<td>55</td>
</tr>
<tr>
<td>7. Petting a dog for 1 second</td>
<td>65</td>
</tr>
<tr>
<td>8. Petting a dog continuously for 10 seconds</td>
<td>75</td>
</tr>
<tr>
<td>9. Petting a dog continuously for 1 minute</td>
<td>85</td>
</tr>
<tr>
<td>10. Petting a dog continuously for 3 minutes</td>
<td>95</td>
</tr>
</tbody>
</table>
Exposure therapies are most commonly used with clients who have phobias and other anxiety disorders. One particular application of exposure therapy, called exposure and response prevention, has received substantial empirical support for the treatment of obsessive-compulsive disorder. It involves graded exposure (as described above) to the obsessive thoughts (e.g., “My hands are filthy—I must wash them”) or the situations that elicit such thoughts while simultaneously preventing the client’s typical response (e.g., hand washing) that brings temporary relief but has come to interfere with the client’s daily life (Rowa, Antony, & Swinson, 2007).

Systematic Desensitization

Systematic desensitization, a treatment also used primarily for phobias and other anxiety disorders, is quite similar to exposure therapy—in fact, exposure to anxiety-provoking stimuli is one of its key components—but rather than simply breaking the association between the feared object and the aversive feeling, systematic desensitization involves re-pairing (or counterconditioning) the feared object with a new response that is incompatible with anxiety. When exposure therapy works, the feared object is eventually paired with nothing (rather than the fear response), but when systematic desensitization works, the feared object is paired with a new response that replaces and blocks the fear response (McGlynn, 2002; Prochaska & Norcross, 2007; Wolpe, 1958, 1969).

Most often, the new response that replaces and blocks the fear response is relaxation. In fact, the first step of systematic desensitization is relaxation training, in which the behavior therapist teaches the client progressive relaxation techniques in which various muscles are systematically tensed and relaxed. Usually the behavior therapist uses scripted instructions during relaxation training, and these instructions can be shared with the client in a variety of forms (written on paper, recorded on CD, etc.) to facilitate practice at home between sessions. Once clients learn and master the relaxation task (usually about half a dozen sessions), they move through an anxiety hierarchy as described in the section above on exposure therapy. The only difference is that prior to each exposure, the client achieves a relaxed state, such that exposure to the anxiety-producing stimulus becomes paired with relaxation, which inhibits anxiety. Thus, the feared object is no longer paired with anxiety, but instead is paired with relaxation, and gradually, the fear is overcome (McGlynn, 2002; Prochaska & Norcross, 2007; Wolpe, 1958, 1969).

In Wayne’s case, a behavior therapist using systematic desensitization would construct the anxiety hierarchy and conduct the exposures just as in exposure therapy, but relaxation training would happen first and the relaxation response would be deliberately evoked during the exposure process to facilitate the replacement of anxiety with a new, anxiety-preventing response.
Assertiveness Training

Assertiveness training is a specific application of classical conditioning that targets clients’ social anxieties. It is best suited for people whose timid, apprehensive, or ineffectual social behavior has a negative impact on their lives. In practical terms, it can help clients insist on appropriate service (in a restaurant, for example); ask someone out on a date; request a raise at work; or say no to an unreasonable demand.

Assertiveness training definitely includes elements of exposure therapy, and it may include elements of systematic desensitization as well (Gambrill, 2002; Prochaska & Norcross, 2007). The exposure comes in the form of facing interpersonal fears. That is, people who have problems with assertiveness usually avoid situations in which assertiveness might be called for, so by simply exposing themselves to such situations and producing any kind of assertive response, they are taking a significant step forward. The counterconditioning component of systematic desensitization may also come into play, with assertiveness replacing relaxation as the new response that replaces and inhibits anxiety.

Assertiveness training usually begins with direct instructions from the behavior therapist in which the client is taught specifically what to say and do in a particular situation. Next, effective assertive behaviors are modeled for the client. The behavior therapist often does this modeling, but video-recorded models or even live actors can be used as well. Subsequently, the client is given an opportunity to rehearse the assertive behavior in a role-play situation, and the therapist provides specific, constructive feedback. Eventually, clients are given targeted homework assignments in which they are expected to practice their improving assertiveness skills in the “real world” (Gambrill, 2002).

As a clinical example, consider Deborah, a 26-year-old woman who became engaged a few months ago. She described to Dr. Paxton, her behaviorally oriented clinical psychologist, that as she began to make arrangements for her wedding—the guest list, the menu, the flowers, the band, her dress, and so on—she became increasingly frustrated with others “making decisions for her.” Specifically, she said that her mother and her sister had been telling her what to do, and she had had a very difficult time telling them to “butt out.” As an example, she described a recent trip to the wedding dress shop. She had been to the store alone previously and tentatively chosen a dress for herself. When she went back to the store to try on the dress for her mother and sister, they pressured her to try on other dresses and eventually convinced her to buy a dress that she had seen but disliked when she was at the store the first time. Deborah wished she could have taken charge of the situation at the wedding dress shop but told Dr. Paxton that she just couldn’t. She added that her day ended by crying about this experience to her fiancée, who,
rather than responding with the empathy she sought, told her she needed to stand up to her mother and sister.

Dr. Paxton conducted assertiveness training with Deborah. First, she taught Deborah some specific, appropriately assertive phrases to say, such as “Thanks for your input, but this is my decision to make,” and “I really want you to be a part of this with me, but I need to have the final say.” Dr. Paxton also coached Deborah on some specific behaviors involved in assertive responses, such as direct eye contact and appropriate volume and tone in her voice. Next, Dr. Paxton modeled these responses for her. Deborah then rehearsed the assertive responses, with Dr. Paxton playing the role of Deborah’s mother or sister. Dr. Paxton offered some helpful feedback, including praise for saying the right things, and reminders to make direct eye contact. Together, Deborah and Dr. Paxton came up with some homework assignments that could help Deborah “build up” to the confrontations she anticipated with her mother and sister. These homework assignments involved asserting herself to her mother and sister about less significant upcoming decisions in which they would probably pressure her, such as what she should order at lunch when they went out next Saturday. With time and practice, Deborah’s skill in asserting herself increased while her anxiety about asserting herself decreased.

Box 14.1  Considering Culture

Assertiveness training, as a form of behavioral therapy, is based on the assumption that assertiveness is a good thing: “A value stance . . . is associated with assertion training. It is assumed that people have a right to express their feelings in a way that subjugates neither others nor themselves, and that well-being includes this expression” (Gambrill, 2002, p. 121). Do all cultures hold this value equally?

Some would argue strongly that they do not. Sue and Sue (2003), for example, point out that “individualism, autonomy, and the ability to become your own person are perceived as healthy and desirable goals” (p. 106) in Western, individualistic cultures, but “not all cultures view individualism as a positive orientation . . . In many non-Western cultures, identity is not seen apart from the group orientation (collectivism)” (p. 107). A lack of appreciation of this important distinction between individualistic and collectivistic cultures can lead therapists to overpathologize members of some cultures as overly dependent or unable to assert themselves.

In a discussion of cultural issues relevant to psychotherapy with Native American clients, Sutton and Broken Nose (2005) offer two case studies illustrating this concern. In the first, a Native American couple open a restaurant, and all aspects of the new business are successful except for the fact that the couple choose not to charge their family members for
Moreover, they define family broadly enough to include distant relatives, in-laws, and the like. Because they serve free meals to so many people, the restaurant struggles financially. In the second case study, a Native American college student receives a fellowship to fund his studies but feels compelled to share his money, apartment, and time with siblings and other family members. Their presence causes significant financial and practical obstacles for the student's ability to succeed in school.

Although Native American culture is certainly not the only culture with some degree of collectivist values (Asian cultures, among others, provide more examples), these scenarios highlight some of the sensitivities that clinical psychologists should have when considering assertiveness training. In your opinion, in either of the two case studies described above, would assertiveness training be clinically effective? Would it be culturally appropriate? Should it be adjusted in some way to better match the client's cultural values? Should some alternative treatment be considered?

TECHNIQUES BASED ON OPERANT CONDITIONING

Contingency Management

Contingencies are the “if . . ., then . . .” statements that, according to behavioral therapists, govern our behavior. So if the goal is to change behavior, a powerful way to do so is to change the contingencies controlling it. Behavioral psychotherapists call this process contingency management. All behavior occurs because of its consequences, and if those consequences change, the behavior will change correspondingly (Kearney & Vecchio, 2002).

Reinforcement and Punishment

The consequences of a behavior—the words that complete the “then . . .” phrase in our contingencies—can be categorized as either reinforcements or punishments. Reinforcement is defined as any consequence that makes a behavior more likely to recur in the future. In contrast, punishment is defined as any consequence that makes a behavior less likely to recur in the future. It’s important to note the room for individual differences implied by these two definitions. Very few things are either reinforcing or punishing to all people in all situations. That which is punishing to one person may be reinforcing to another, and vice versa. Behavior therapists who use contingency management remain aware of this phenomenon and therefore seek client input on all prospective contingencies.

Reinforcement and punishment can each be further divided into two types: positive and negative (Higgins, 1999). In this context, positive refers to adding a consequence, whereas negative refers to removing a consequence. So simply put, positive reinforcement means “getting something good” (like food), whereas
negative reinforcement means “losing something bad” (like pain). Notice that both these would increase the likelihood of the behavior recurring. Positive punishment means “getting something bad,” whereas negative punishment means “losing something good.” Notice that both these would decrease the likelihood of the behavior recurring.

Behavior therapists use both reinforcement and punishment during contingency management, but for most clinical situations, reinforcement is generally preferred (e.g., Higgins, 1999). When punishment is used, it must be used ethically, and it is most effective when it occurs immediately, consistently, and is accompanied by the reinforcement of an alternate, more desirable response (Poling, Ehrhardt, & Ervin, 2002). Aversion therapy represents an example of the clinical use of punishment, in which an unwanted behavior (say, drinking alcohol) brings about an aversive stimulus (nausea or electric shock) (Emmelkamp & Kamphuis, 2002).

As a clinical example of the use of the four varieties of reinforcement (reinforcement and punishment, each in positive and negative forms), consider the work of Dr. Howard, a clinical psychologist engaged in behavioral therapy with Patty, a 15-year-old juvenile detention center inmate. Recently, Patty had been prone to bursts of anger and assault when escorted from her cell to daily classroom sessions. Some of Patty’s assaults were so dangerous that they necessitated the use of physical restraints. The consequence for Patty’s outbursts was dismissal from the day’s schooling; she was returned to her cell, where she spent her time leisurely browsing through magazines approved for inmate possession. Dr. Howard analyzed Patty’s outburst behavior and hypothesized that the contingency enacted by the staff was actually reinforcing, not punishing, the outburst response. Dr. Howard discussed with the staff four alternate contingencies, any of which could produce more desirable behavior from Patty:

- Positive reinforcement: If Patty attended her classes without any verbal or physical outbursts, then she received a new magazine of her choice.
- Negative reinforcement: If Patty attended her classes without any outbursts, then her ankle restraints—necessary with the onset of her assaults—would be removed for the next day.
- Positive punishment: If Patty engaged in any type of outburst, then she would receive a 2-hour detention in a cell without magazines.
- Negative punishment: If Patty engaged in any type of outburst, then all her magazines would be confiscated for the next day.

Extinction

When behavior therapists consider the contingencies that have maintained a behavior or new contingencies that may modify it, they often pay close attention
to issues involving extinction. In the context of contingency management, extinction refers to the removal of an expected reinforcement that results in a decrease in the frequency of a behavior (Kearney & Vecchio, 2002; Poling, Ehrhardt, & Jennings, 2002).

As an example, consider Wendy, an 8-year-old second grader whose parents brought her to Dr. Evans, a clinical psychologist with a behavioral orientation. Wendy’s parents explained that in the last 2 weeks Wendy had become extremely difficult at meal times: She cried and screamed about the food that had been prepared, saying that she didn’t like it and it made her stomach hurt. Wendy’s parents expressed confusion at her behavior, specifically because it was the same food she had eaten many times before, and they had taken her to her pediatrician who assured them that Wendy had no stomach ailments. When Dr. Evans asked Wendy’s parents what happened after Wendy cried and screamed at meal times, they explained that they typically allowed her to eat something else. When Dr. Evans inquired further, the parents added that they allowed Wendy to choose any food she wanted, and Wendy usually selected her favorite junk food. Dr. Evans developed a contingency management plan based on extinction. His conceptualization was that Wendy’s crying and screaming behavior was being positively reinforced by the junk food she received after doing so. He explained this conceptualization to Wendy’s parents and recommended that they remove those positive reinforcements—in other words, don’t let her replace the family meal with junk food. They did, and although her behavior initially got worse, within a few days, Wendy stopped crying and screaming at meal time and resumed eating with her family as she had previously.

Wendy’s case exemplifies an important aspect of extinction-based therapies: the extinction burst (Kazdin, 1980; Poling, Ehrhardt, & Jennings, 2002). Immediately after the reinforcement was removed, Wendy’s crying and screaming actually increased—she did it more often and more intensely. Only after her parents “stood their ground” by continuing to withhold the reinforcement did Wendy’s crying and screaming dwindle. It is important for behavior therapists and those working with them to anticipate the extinction burst that predictably occurs immediately after the removal of the reinforcement; otherwise, the person controlling the contingency might mistakenly think that the strategy is backfiring and resume the reinforcement again. If Wendy’s parents had done this—if they had given in to her especially intense fits on the first days of the extinction process—they would have taught Wendy that if she ups the ante, she can still get what she wants. This would have strengthened, rather than extinguished, her crying and screaming behavior.
Token Economies

A token economy is a setting in which clients earn tokens for participating in predetermined target behaviors. These tokens can be exchanged for a number of reinforcements, including food, games, toys, privileges, time participating in a desired activity, or anything else deemed desirable by the client. In some token economies, clients can also lose tokens for engaging in undesired behaviors (Stuve & Salinas, 2002). Token economies are used most often in settings such as inpatient units, correctional facilities, and other sites where clients’ behavior is under ongoing surveillance by supervisory staff. A strength of token economies is their versatility across clients. For example, on a psychiatric inpatient unit, different

Box 14.2 Metaphorically Speaking

If You’ve Lost Money in a Soda Machine, You Understand Extinction and the Extinction Burst

Put the dollar in the slot, push the button, get the soda. Put the dollar in the slot, push the button, get the soda. There is no confusion about the contingency of the soda machine, and for many of us, soda-buying behavior is strengthened on a daily basis by the repeated delivery of the cold, bubbly, sweet reinforcement.

But what if the soda machine malfunctions? What if we put the dollar in the slot, push the button, and get nothing? Of course, in the long run, we’ll stop putting dollars into that machine. In other words, our soda-buying behavior (at least at that particular machine) will extinguish, because the expected reinforcement is no longer forthcoming. In the short run, however, our behavior does not extinguish; in fact, it intensifies. You’ve seen (or maybe you’ve been) the person who just lost money in the soda machine demonstrating the extinction burst—pushing every button, trying a different dollar, hitting the machine, kicking it, tipping it, and so on. It’s as if we’re responding to the soda machine’s refusal to provide the soda with the behavioral statement, “Hey, give me what I’m used to getting!” When the unresponsive soda machine responds with the behavioral statement, “Too bad, you’re not getting it,” we walk away, but it may take a while for us to become entirely convinced.

Actually, the time it takes for us to become convinced that no soda is forthcoming, and for our soda-buying behavior to therefore extinguish, depends on how consistently the soda machine stiffs us. If it is absolutely consistent, we’ll quit pretty quickly. But if we know the machine to be fickle—sometimes the soda comes, sometimes it doesn’t, sometimes it requires a good kick—it may take quite a while for our soda-buying behavior to become extinct. Perhaps a better example of such an inconstant, unpredictable machine is a slot machine, from which “you never know” what you might get (Kazdin, 1980). When behavior therapists use extinction methods with clients, which would you expect to be more successful—the consistent or inconsistent approach to denying expected reinforcement? More generally, how might the consistency of a contingency management technique influence its success in changing behavior?
target behaviors may be identified for each client. One client may earn tokens for making the bed, another for taking a shower, and another for interacting with a group rather than staying alone. Of course, the success of the token economy depends on the perceived value of the reinforcements for which the tokens can be exchanged, so behavioral therapists are careful to select reinforcements that will motivate each client. If you have ever spent any time in a Chuck E. Cheese’s, you’re familiar with the fact that the same “prize” may be valued very differently by different people. When you were 6 years old, you might have spent a lot of time, energy, and money earning enough tokens (tickets) to exchange for stuffed animals, plastic toys, or candy. Today, you might not find those prizes quite as motivating, and your behavior would decrease accordingly. Likewise, a poker chip may not have meant much to you when you were 6, but now, you may have a greater appreciation for its value as a token exchangeable for money (which itself is exchangeable for many reinforcements).

A potential limitation of token economies involves generalization. As discussed above, generalization refers to the application of a learned contingency to similar behaviors or situations. The goal of any token economy is not only to modify behavior in that environment but to modify it across all settings. For example, the psychiatric inpatients mentioned in the preceding paragraph would ideally apply the lessons learned about bed making, bathing, and socializing to the outside world in addition to the psychiatric unit on which they temporarily live. Behavior therapists can use a number of strategies to maximize generalization, including tapering clients off of tokens gradually rather than all at once; using naturally occurring reinforcements (like social praise) rather than artificial reinforcements; gradually increasing the delay between the behavior and the reinforcement; and providing reinforcement in as wide a variety of settings as possible (Stuve & Salinas, 2002).

**Shaping**

Contingency management is often based on reinforcing target behaviors in order to increase their frequency. Sometimes, however, the target behavior is so complex, challenging, or novel for a client that, at the outset of treatment, it simply can’t be done in its entirety. In these cases, behavioral therapists use **shaping**, which involves reinforcing successive approximations of the target behavior. Put another way, shaping is a technique in which the behavior therapist reinforces “baby steps” toward the desired behavior (Kazdin, 1980; Kearney & Vecchio, 2002).

As an example, consider Dina, a 59-year-old client with serious depressive symptoms. Since she began feeling depressed about 3 months ago, Dina has become increasingly withdrawn. She has neither contacted any of her friends (of which she has many), nor has she returned their many calls. She has declined when her
husband has asked her to go out to dinner, and she has refused invitations from her grown daughter to come to her house for a visit. Dr. Stein, Dina’s clinical psychologist, conceptualizes Dina’s problem from a behavioral point of view. That is, Dr. Stein has identified social behavior as the area for improvement and has specifically defined the goal as much more frequent social interactions for Dina: during each week, three phone calls with friends, one dinner out with her husband, and one get-together with her daughter. Dr. Stein realizes, however, that Dina is far from that level of social functioning at the moment. If she waits for Dina to complete all these tasks in a particular week, the wait may be excessive. So, Dr. Stein uses a shaping strategy. First, she determines jointly with Dina a personally meaningful reinforcement: renting a DVD. Then, she establishes the contingency for the first week: If Dina completes at least one social activity (a call to a friend, dinner out with her husband, or a get-together with her daughter), then she can rent a DVD of her choice. The next week, Dr. Stein raises the bar: at least two social activities, one of which must be in person. Dr. Stein continues to raise the bar each week until Dina is completing the full set of target behaviors for several consecutive weeks.

A key variable in any shaping program is the increment between each successive approximation. Behavior therapists must be careful not to make the steps between each new challenge too difficult for the client. By the same token, the steps should not be so small that therapy takes an unnecessarily long time. Thus, in Dina’s case, Dr. Stein should adjust the amount by which she raises the bar if it is evident that Dina finds the tasks either too easy or too hard.
Observational Learning (Modeling)

So far, all the clinical applications of operant conditioning that we have discussed involve clients learning directly from their own experiences. However, much of what we learn comes from contingencies we see applied to other people. This phenomenon is known as observational learning but has also been called modeling and social learning. As an example of observational learning, briefly reconsider the broken soda machine scenario described in Box 14.2. If the soda machine stole the dollar of the person in front of you while you were waiting your turn, would you step up and put your dollar in next?

In clinical practice, observational learning is a technique in which the client observes a demonstration of the desired behavior and is given chances to imitate it (Freeman, 2002). The client typically receives constructive feedback on these imitation efforts as well. The person acting as the model can be the therapist, another live model, or a model who has been video- or audio-recorded. The effects of modeling have been studied extensively by Albert Bandura and others (e.g., Bandura, 1977), producing a sizable body of knowledge regarding key variables in the modeling process. Among the findings are that models are most effective when they are similar to the client, an especially relevant point regarding client diversity in terms of cultural and demographic variables. For example, if Ana, a 19-year-old homosexual Hispanic female college sophomore, is struggling with social skills, the success of an observational learning intervention may depend on the degree to which the model matches Ana in terms of age, sexual orientation, ethnicity, gender, and student status.

Observational learning strategies actually afford clients two different ways to learn. The first is imitation, in which the client simply mimics the modeled behavior. The second is vicarious learning, in which the client observes not only the modeled behavior, but also the model receiving consequences for that modeled behavior. In other words, even without imitation, a client can learn to expect reinforcement or punishment for a target behavior by observing what the model receives (Freeman, 2002). In the case of Ana, vicarious learning would take place if Ana observed the model initiating a conversation with an unknown person and receiving obvious feedback—a kind greeting, a snub, or a neutral response—as a consequence. Of course, Ana’s behavior therapist would try to ensure to the extent feasible that when the desired response is modeled, it is followed by a reinforcement.

Alternatives to Behavior Therapy

Behavioral Consultation

Behavioral consultation is an indirect way for a behavior therapist to modify a client’s behavior. It differs from direct clinical services in that there are always three
parties involved: the client, the consultee, and the consultant (therapist). The consultee is a person who spends significant time in the natural setting with the client and who has some control over the contingencies that govern the client’s behavior. In many cases, the consultee is an adult who supervises a child in some capacity, such as a parent, teacher, or caretaker (Erhlich & Kratochwill, 2002). However, the consultee can also be seeking help with the behavior of an adult client, such as a corporate manager whose aim is to modify the behavior of an employee (Bailey & Burch, 2006). Some of the examples we have considered in this chapter (such as Wendy, the girl who refused to eat the same dinner as her family) have involved a consultation component, but in behavioral consultation, the consultee serves as a true go-between, such that the consultant/therapist and the client may never meet each other.

Behavioral consultation is a flexible process, but it typically involves five stages (Erhlich & Kratochwill, 2002):

- **Initiation of the consulting relationship**, in which the roles and responsibilities of all parties are established.
- **Problem identification**, in which the target behavior is defined, usually through questions involving who, what, where, and when the behavior problem occurs. Baseline and goals are also determined.
- **Problem analysis**, in which the therapist identifies the reinforcement contingency that is maintaining the current behavior.
- **Plan implementation**, in which the consultee carries out the intervention as recommended by the consultant.
- **Plan evaluation**, in which the consultant and consultee measure the client’s progress from baseline and toward goals.

As an example of behavioral consultation, consider Kathleen, a managing partner in a private law firm that employs approximately 20 lawyers. Kathleen seeks the assistance of Dr. Taguchi, a clinical psychologist and behavioral consultant, regarding productivity problems related to a recently hired administrative assistant, Pam. (To clarify, Dr. Taguchi is the consultant, Kathleen is the consultee, and Pam is the client.) Among other things, Kathleen describes one particularly problematic behavior that Pam performs on a regular basis: indulging in long lunches. Specifically, she states that Pam is often out of the office for 2 to 2.5 hours for lunch, always with friends from nearby offices, and that during this time, Pam’s work piles up. The attorneys in the office grow frustrated with Pam’s absence, and they are unable to be as productive as they could otherwise be. Kathleen explains that they had never had such a problem with previous administrative assistants, so she did not present Pam with a clear lunch policy when Pam was initially hired. Dr. Taguchi conceptualized the problem as a contingency in which Pam’s long lunches were reinforced by social interaction and were not punished at all. Dr. Taguchi recommended
that Kathleen determine a reasonable length to allow Pam for lunch and then either punish her for staying out too long or reinforce her for returning on time. Through discussion with Dr. Taguchi, Kathleen decided to use both the punishment and reinforcement strategies: If Pam stayed at lunch longer than 1 hour, her hourly pay was docked, and if Pam returned on time for an entire week, she was allowed to leave work an hour early on Friday. Kathleen implemented the plan, and Pam’s behavior was quickly modified.

**Parent Training**

**Parent training** is a specific form of behavioral consultation in which parents seek help with problematic behaviors of their children. The range of problem behaviors for which parent training can be helpful is vast: Sleep-related problems, bedwetting, hyperactivity, oppositional and defiant behaviors, stuttering, fear of the dark, school phobia, and social skills are a subset (Schaefer & Briesmeister, 1989). Unlike child psychotherapy or family psychotherapy, parent training involves an arrangement in which the consultant (behavior therapist) may never meet the child directly.

As an example of parent training, consider Heather, a single mother of a 7-year-old boy, Danny. Heather sought consultation from Dr. Ogden as a result of Danny’s problematic bedtime behavior. Heather explained that each night, Danny would go through the same bedtime ritual they had gone through for years—put on his pajamas, brush his teeth, read a story with mom, and say goodnight. However, in the last few months, Danny had started calling out “Mommy, I can’t sleep,” after being in bed for about 10 to 15 minutes. When Dr. Ogden asked how Heather responded, she said that she often let him come out of his bedroom, thinking that perhaps he genuinely wasn’t yet tired. Specifically, Heather explained that she often let Danny join her on the couch, where they watched TV and ate snacks for about an hour. Dr. Ogden’s saw Heather’s behavior as strongly reinforcing to
Danny and suggested that Heather no longer provide the reinforcement. Together, they discussed other viable options and decided that the best option would be to no longer allow Danny out of his room after bedtime. Of course, when Heather initially implemented this plan, Danny’s behavior actually worsened (he demonstrated an extinction burst), but Dr. Ogden had warned Heather about this and encouraged her to remain consistent. When they evaluated the plan after several weeks, Heather said that Danny’s behavior had improved, but she pointed out that a few times, Danny had defiantly come out of his room without permission, and Heather was unsure how to respond. Dr. Ogden recommended that Heather punish this behavior, and they agreed that losing deserts for the next day would be a suitable punishment. After this adjustment, Danny’s coming-out-of-bed behavior extinguished.

Teacher Training

Teacher training is quite similar to parent training, but the emphasis is on behaviors that take place at school. Many of these problem behaviors are interpersonal or disruptive in nature, but others are academic and involve refusal to complete assignments and similar task-related behaviors.

Often, when behavioral therapists serve as consultants to teachers, a primary task is to thoroughly analyze the consequences of the child’s behavior. That is, the behavioral consultant can often help the teacher see all of the reinforcement and punishment that a child receives for particular behaviors. As an example, consider Ms. Palmer, a third grade teacher who sought behavioral consultation from Dr. Carr. Ms. Palmer explained that one of her students, Brian, was extremely disruptive in class. In particular, Brian frequently called Ms. Palmer “stupid” and “an idiot” during class. Ms. Palmer couldn’t understand why this behavior persisted, because each time he did this, she punished him by sending him out of the room and later talking with him one-on-one about his inappropriate behavior. Through additional questioning, Dr. Carr uncovered two important facts: When Brian was sent out of the room, he was able to avoid the work the class was doing at that time, much of which Brian found overwhelming; additionally the attention Ms. Palmer gave him during the one-on-one talks actually made Brian feel important, not punished. Thus, although Ms. Palmer intended to punish Brian’s insulting behavior, she was actually reinforcing it. Ms. Palmer was able to find other means of responding to Brian’s insults, including ignoring them, which resulted in a drastic reduction in the target behavior.

OUTCOME ISSUES

In terms of empirical data, behavioral therapies are highly supported. Recent lists of “treatments that work” include disproportionately large numbers of behavioral treatments (e.g., Chambless et al., 1998; Nathan & Gorman, 2002b). Behavioral
therapies have been found efficacious for a wide range of disorders, but the disorders for which they have garnered the most support include anxiety disorders, depression, and children’s behavior disorders (including bedwetting and oppositional behavior) (Prochaska & Norcross, 2007).

Some have pointed out that behavioral therapies populate lists of empirically supported or evidence-based treatments because more than any other form of treatment (e.g., psychodynamic, humanistic, cognitive), they lend themselves to empirical testing. In other words, if the worth of a therapy is to be measured solely via quantifiable measures of objective, observable outcomes, it is no surprise that behavioral therapies would be most successful (e.g., Silverman, 1996). Behavioral therapists have sought from the outset to create such a type of therapy, emphasizing an empirical, scientific approach to therapy as opposed to the more introspective, subjective approach of other approaches, such as psychodynamic and humanistic therapies.

**Box 14.3 Denise in Behavioral Psychotherapy**

During my initial interview with Denise, she explained that she had been experiencing depression-related difficulties since a new owner introduced new policies at the restaurant where she worked as a chef. Denise spent a lot of time providing background information about her childhood. As a behavior therapist, I found this childhood information rather irrelevant to her current problems. Also, Denise spent a lot of time describing her thoughts and feelings regarding the situation at work, but through behaviorally oriented questions, I tried to refocus Denise on overt, observable, measurable behaviors rather than inner mental processes like thoughts and feelings. Eventually, Denise and I identified three specific behaviors that were suitable for intervention: getting to work on time, preparing dishes accurately, and exercising. We agreed that the aim of therapy would be to modify the frequency of each of these behaviors to more desired levels.

Once we had operationally defined these three behaviors, another important initial step was to establish a baseline for each. In other words, we assessed the frequency with which these behaviors were currently taking place to have a basis for comparison after treatment is implemented. Denise informed me that she was currently arriving to work on time only two times a week (out of six work days per week), preparing dishes inaccurately once per work day, and exercising zero times per week. Next, we set specific goals for each of these target behaviors: arriving to work on time 6 days per week, preparing dishes inaccurately only once per week, and exercising four times per week.

(Continued)
I used a contingency management approach incorporating shaping techniques to modify Denise’s behaviors in each of these three areas. First, Denise and I explored a variety of options that might be effective reinforcement for her; we decided that time surfing the Internet, one of her favorite leisure activities, was the most reasonable choice. Then, we established specific contingencies for each of the three target behaviors. The initial contingencies intentionally fell short of the final goal, because the plan was to shape Denise’s behavior by reinforcing behaviors that were “steps in the right direction” and then “raise the bar” after each successful week. The initial contingencies were as follows: If she arrived at work on time on a given day, then she was allowed 20 minutes of Internet surfing; if she prepared all dishes accurately on any given work day, then she was allowed 20 minutes of Internet surfing; if she exercised for at least 30 minutes on any given day, then she was allowed 20 minutes of Internet surfing. Denise was quite successful in meeting these initial goals within 2 weeks, so we gradually began to increase the demands in order to earn the reinforcement. Within a relatively short time (about 8 weeks), Denise was meeting her final behavioral goals in all three areas.

CHAPTER SUMMARY

Behavioral psychotherapy focuses on observable, measurable behavior rather than mental phenomena that can only be indirectly inferred. Problematic or undesirable behavior is viewed as the clinical problem, not as a symptom of some underlying, deeper disorder. The primary goal of behavioral psychotherapy is overt behavioral change, and its methods rely on empirical, testable hypotheses. Behavioral therapists believe that conditioning, either classical or operant, is the primary cause of behavior. As such, their clinical efforts center on altering client’s learned contingencies (via such methods as contingency management or token economies) or breaking clients’ learned associations (via such methods exposure therapy, systematic desensitization, or assertiveness training). Principles of behavioral psychotherapy have also been used in an indirect, consulting capacity, whereby the behavior therapist helps a consultee (e.g., a parent or teacher) apply behavioral techniques with a client (e.g., a child or student). Empirical outcome studies have offered more empirical support for behavioral psychotherapy than for any other approach and the disorders for which behavioral psychotherapy has demonstrated empirical efficacy include anxiety disorders, depression, children’s behavior disorders, and many others.
## KEY TERMS AND NAMES

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<thead>
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<tr>
<td>Albert Bandura</td>
<td>imaginal exposure</td>
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<td>anxiety hierarchy</td>
<td>imitation</td>
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<td>assertiveness training</td>
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<td>B. F. Skinner</td>
<td>introspection</td>
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<td>Ivan Pavlov</td>
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<td>behavioral consultation</td>
<td>John Watson</td>
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<td>behavioral psychotherapy</td>
<td>law of effect</td>
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<td>classical conditioning</td>
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<td>Edward Lee Thorndike</td>
<td>positive punishment</td>
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CRITICAL THINKING QUESTIONS

1. Do you believe that the law of effect is equally powerful in humans and animals?

2. To what extent do you agree that the primary goal of psychotherapy should be observable behavior change?

3. To what extent do you agree with the medical model of psychopathology?

4. In your opinion, what can behavioral therapists do to make imaginal exposure as similar to in vivo exposure as possible?

5. For what types of clinical problems does contingency management seem most and least likely to be beneficial?
Among today’s clinical psychologists, cognitive therapy prevails. Surveys indicate a dramatic increase in the popularity of cognitive therapy, especially since the 1980s (e.g., Norcross, Karpiak, et al., 2005). In fact, far more contemporary clinical psychologists endorse cognitive therapy as their primary orientation than any other single-school approach.

The attraction to the cognitive approach may stem from a variety of factors. Cognitive therapy strikes a balance between some of the other psychotherapeutic options. Like behavioral therapy, it tends to be brief, structured, and targeted.
However, like psychodynamic therapy, it focuses on important mental processes. In some ways, cognitive therapy actually represents a reaction against both the behavioral and psychodynamic approaches. Two important historical developments occurred at around the same time, beginning in the 1950s and 1960s, contributing to the development of cognitive therapy:

- Strict applications of behavioral therapy—techniques based on operant and classical conditioning—didn’t always work. Gradually, behavioral therapists and researchers began to recognize that cognition played a unique and important role in human behavior. The extreme behavioral view that our actions are determined entirely by external stimuli gave way to the notion that internal mental processes can also exert a strong influence (Goldfried, 1995).

- The eventual leaders of the cognitive therapy movement—Aaron Beck and Albert Ellis—grew disillusioned with the psychoanalytic method in which they and most of their cohorts were trained. They sought a new approach to therapy that addressed clients’ symptoms more directly, focused less on the past and more on the present and produced positive results more efficiently. Eventually, Beck and Ellis each broke from psychoanalytic tradition and forged separate but similar styles of therapy to achieve these goals (Ellis, 1962; Keuhlwein, 1993; Prochaska & Norcross, 2007).

Photo 15.1  Aaron Beck (left) and Albert Ellis (right) are pioneers of the cognitive approach to psychotherapy, which is now more widely endorsed by clinical psychologists than any other single-school approach.
So cognitive therapy began as a revision of behavioral therapy within a context of increasing dissatisfaction with the psychodynamic therapy that dominated at the time. Cognitive therapy still overlaps significantly with behavioral therapy: Many cognitive therapists use behavioral techniques also, and a large number of therapists straddle the line by identifying themselves as “cognitive-behavioral.” However, cognitive therapy is not just a minor variation of behavioral therapy in which cognitions complement conditioning. Undoubtedly, cognitive therapy has evolved into its own well-established and commonly practiced approach.

GOAL OF COGNITIVE THERAPY

Simply put, the goal of cognitive therapy is logical thinking. The word “cognition,” after all, is basically synonymous with the word “thought.” Thus, cognitive therapists fundamentally presume that the way we think about events determines the way we respond. In other words, “individuals’ interpretations and perceptions of current situations, events, and problems influence how they react” (J. S. Beck, 2002, p. 163). Psychological problems arise from illogical cognitions. For example, an illogical (or irrational, or unrealistic) interpretation of a life event—a relationship break-up, an F on an exam, a comment from a friend—can cause crippling depression or anxiety. However, psychological wellness stems from logical cognitions. That is, when the cognitions appropriately match the event, they can lead to more adaptive, healthy reactions. Therefore, the role of the cognitive therapist is to fix faulty thinking.

The Importance of Cognition

When they refer to cognitions, cognitive therapists use lots of terms interchangeably: thoughts, beliefs, interpretations, and assumptions, to name a few. Whatever we call them, we often overlook their importance in our day-to-day lives. When someone asks “Why are you so happy?” or “Why are you so sad?,” we typically point to a recent event that made us happy. We portray it as a two-step model, in which things happen, and those things directly influence our feelings. The truth, according to cognitive therapists, is that such a two-step model is flawed; specifically, it’s missing an important step in the middle. The three-step model that cognitive therapists endorse goes like this: Things happen, we interpret those things, and those interpretations directly influence our feelings. Thus, “it is not a situation in and of itself that determines what people feel but rather the way in which they construe a situation” (J. S. Beck, 1995, p. 14). In other words, events don’t make us happy or sad. Instead, the way we think about those events does. (See Figure 15.1).
As an example of the power of our cognitions, consider an unexpected overnight snowfall. At the same time, three neighbors wake up, look out their windows, and see the ground covered in 6 inches of white, with more flakes continuing to fall. In the first house lives a mail carrier who covers her route by foot. For her, the snow causes feelings of dread. It’s important to recognize, however, that between seeing the snow and feeling the dread, she has thoughts: “This is going to be a miserable day. I’ll be cold and wet, I might slip and fall, and my route will take much longer than usual.” Her next-door neighbor owns a snow plow business. He wakes up, sees the same snow, and feels elated. Like his neighbor, somewhere between the sight of the snow and the resulting feeling, the snow-plow driver thinks: “What a great day! I’m going to make a lot of money, not to mention, I’ll be able to help a lot of people.” In the next house, a high school student who didn’t study for today’s biology exam sees the snow and feels tremendous relief. Between the sight and the feeling he thinks, “Whew! School’s going to be cancelled, and I’ll have an extra day to study for that exam. What a lucky break.” The same snowfall caused very different feelings in these three people, illustrating that it’s not the events that happen to us, but the meaning we assign to those events, that shapes our feelings. Even if that process of assigning meaning happens automatically and within a split second, it nonetheless represents a crucial link to our feelings, including feelings characteristic of psychopathology such as depression or anxiety. Thus, these oft-ignored intermediary cognitions are a focal point in cognitive therapy.

**Revising Cognitions**

Once we accept the idea that cognitions determine feelings, revising them becomes the foremost task. Specifically, the goal is to ensure that the thoughts a
person has about particular events rationally and logically correspond to the event itself. If they don’t, they can lead to unnecessary and unpleasant feelings. For example, let’s reconsider the mail carrier described above. It’s reasonable for her to feel some degree of dread about the snow; after all, it will certainly make her day more difficult. But if the thoughts underlying her dread are illogical, they can make the dread excessive. That is, if she thinks, “I’ll get fired if my route takes longer than usual today,” or “I’ll definitely fall on wet pavement and end up with a broken bone or a concussion,” or “I may freeze to death on my route,” she can cripple herself with anxiety or depression. The goals of the cognitive therapist would not be to make this mail carrier feel unrealistically positive—it would hardly be logical for her to jump for joy about this situation—but to help revise her thoughts so they make realistic sense. At the end of this process, she might be just a bit apprehensive or down, which, in comparison to being devastated by anxiety or depression, represents a significantly improved emotional state.

As we’ll see later in this chapter, there are different methods of revising cognitions. (There are also different terms for it, such as restructuring or modifying cognitions.) In general, these methods follow a common three-stage sequence: Illogical cognitions are first identified, then challenged, and eventually replaced with more logical cognitions (J. S. Beck, 1995; Leahy, 2003). The first step—the identification of illogical thoughts—should not be confused with the psychodynamic goal of making the unconscious conscious. Cognitive therapists do not delve into the unconscious depths of the psyche like psychodynamic therapists. They do, however, acknowledge that some of our cognitions are automatic thoughts—that is, they take place in an instant, and without any deliberation. (The student with the surprise snow day described above certainly didn’t need to pause and ponder, “How do I feel about this snow? Hmm, let me mull it over . . .” The interpretation happened far more immediately.) As such, these cognitions can become so routine and habitual that they are hard to recognize. A primary responsibility of the cognitive
therapist, especially early in therapy, is to assist the client in identifying automatic illogical or irrational thoughts.

The second step, in which the illogical cognitions are challenged, also takes a variety of forms. As we’ll see later in this chapter, some therapists rely on the power of verbal persuasion to convince clients to abandon illogical beliefs, whereas others encourage clients to test the accuracy of their beliefs by performing assigned behaviors in the real world. The objective of either of these approaches is to cause the client to doubt the truth of their illogical beliefs and to reach the conclusion that these beliefs should be revised. This revising, the third step in this process, is often difficult for clients to do at first—it can feel foreign, since therapists are asking clients to think in ways opposite to the ways they may have been thinking for many years (Roth, Eng, & Heimberg, 2002). The cognitive therapist may, therefore, take the lead in the initial attempts to revise the client’s thoughts. Ultimately, however, the goal is for clients to be able to revise their own thoughts without therapist input.

The process of revising cognitions should always take place in a context of cultural sensitivity. There is no such thing as universally or absolutely logical thinking. A belief that is logical, rational, or adaptive for members of one culture may be illogical, irrational, or maladaptive for members of another culture. Culturally competent cognitive therapists are aware of the influence that their own cultural background has on their view of logical thinking and are careful not to impose their own cultural values on clients in the process of revising or restructuring clients’ cognitions.

Teaching as a Therapy Tool

Cognitive therapists explicitly include in their duties the education of their clients about the cognitive approach. In other words, cognitive therapists often function as teachers with their clients. For example, they might use a combination of mini-lecture, handouts, and readings to explain to clients the difference between the two-step (events lead directly to feelings) and the preferred three-step (cognitions intervene between events and feelings) models of understanding the sources of our feelings. Moreover, they train clients to recognize illogical thoughts, to assign labels to them, and to track them in a particular written format. And like any good teacher, cognitive therapists aspire for clients to ultimately be able to use the lessons learned to teach themselves rather than remaining dependent on the teacher (J. S. Beck, 1995).

Homework

Another similarity between cognitive therapists and teachers is the assignment of homework (J. S. Beck, 1995; Keuhlwein, 1993; Prochaska & Norcross, 2007).
Cognitive Psychotherapy

Cognitive Therapy With Lesbian, Gay, and Bisexual Clients

For many, life as a lesbian, gay, or bisexual (LGB) person today is quite different from what it was a generation or more ago, as society’s attitudes toward members of the LGB community appear to have become more accepting. However, Purcell, Swann, and Herbert (2003) argue that in spite of these social changes, negative attitudes toward LGB individuals persist in our society, and that these attitudes are reflected even among members of the LGB community themselves. In fact, these authors make the case that “internalized homophobia”—an aversion to homosexuality applied by gay individuals to themselves—pervades LGB culture to some extent. That is, LGB individuals may hold some beliefs that disapprove of their own sexual orientation or lifestyle, such as “Homosexuality is wrong,” or “My family/friends/religion/society will reject me if I come out.” These beliefs could hinder self-respect and self-worth and contribute to depression or other clinically significant problems.

Are such beliefs consistent with contemporary societal values? Or, expressed in terms of cognitive therapy, are such beliefs logical? To the extent that they are not, could cognitive therapy be helpful in identifying their logical flaws, challenging them, and replacing them with more logical thoughts? These questions illustrate the need for cultural competence and cultural self-awareness in clinical psychologists. It is essential for the clinical psychologist to understand these beliefs from the perspective of the client—to see their world through their eyes—to appreciate whether such beliefs are sensible or misguided for them. Clinical psychologists should also be well aware of their own personal views on these issues, and stop themselves from equating their own views with the “logical” way to think. What seems adaptive from the perspective of the clinical psychologist may be maladaptive from the perspective of the client.

Of course, cognitive therapists’ work with LGB clients often focuses on cognitions that have nothing to do with their sexual orientation. Indeed, LGB clients bring the same problems to therapy as heterosexual clients (Martell, Safren, & Prince, 2004), but in addition, they may be struggling with some cognitions related to internalized homophobia as described by Purcell et al. (2003).

What other cultural groups might experience similar “internalized” self-critical cognitions as a reflection of broader societal views? How might a culturally competent cognitive therapist address the logical or illogical nature of those cognitions?
Cognitive therapists strongly believe that much of the work of therapy is conducted between sessions. Much like the time between class meetings of a college course, the time between therapy sessions is used to explore and confirm the lessons learned during the meetings. In some cases, the homework is written: Clients are asked to keep a record of events, cognitions, feelings, and attempts to revise the cognitions to change the feelings they experience. (Later in this chapter, we will examine written formats such as these in more detail.) In other cases, the homework is behavioral: Clients are asked to perform certain behaviors before the next meeting, typically for the purpose of examining the validity of an illogical thought. In either case, discussion of the homework will constitute a significant part of the subsequent session.

A Brief, Structured, Focused Approach

Cognitive therapists strive to achieve a positive therapy outcome quite quickly—typically in less than 15 sessions, but significantly longer in complex or severe cases (J. S. Beck, 1995, 2002; Roth et al., 2002). For outpatients, sessions typically take place once per week, eventually tapering off in frequency as the client improves. Several factors contribute to the efficiency of cognitive therapy, including its focus on the client’s current problems (rather than extensive exploration of the past); a purposeful, goal-oriented focus on clearly identified symptoms; and structured therapy sessions.

The structured nature of cognitive therapy sessions differs sharply from the free-flowing, spontaneous style of humanistic therapy (Pretzer & Beck, 2004). Whereas humanistic (or “client-centered”) therapists allow clients to determine the topics to be discussed during a session, the amount of time spent on each, and the like, cognitive therapists set an agenda (J. S. Beck, 1995; Freeman, Pretzer, Fleming, & Simon, 1990). Typically, each session is sequentially organized into segments (see Table 15.1), and sometimes each segment is allotted a specific amount of time. Of course, the client has input on the content of the agenda for the session, but cognitive therapists usually shun therapy that lacks predetermined, explicit structure.

TWO APPROACHES TO COGNITIVE THERAPY

There are two widely recognized pioneers of cognitive therapy: Albert Ellis and Aaron Beck. As described earlier, each developed his own version of cognitive therapy at approximately the same time, and although each was influenced somewhat by the other, their approaches evolved somewhat independently. The two approaches unquestionably overlap in terms of their emphasis on improving
clients' symptoms via correcting illogical thinking, but the terminology and, at times, the techniques they employ distinguish them from each other. Let's consider each separately.

Albert Ellis

For many years, Albert Ellis called his approach to therapy Rational Emotive Therapy (RET), but later in his career, he altered the name to Rational Emotive Behavior Therapy (REBT). We’ll use the more recent name here, understanding that both refer to Ellis’s version of cognitive therapy.

As the first two words of the REBT label indicate, Ellis’s therapy approach emphasizes a connection between rationality and emotion. Ellis (1962) argues that if we can make our beliefs less irrational, we can live happier lives:

The central theme of [REBT] is that man is a uniquely rational, as well as uniquely irrational animal; that his emotional or psychological disturbances are largely a result of his thinking illogically or irrationally; and that he can rid himself of most of his emotional or mental unhappiness, ineffectuality, and disturbance if he learns to maximize his rational and minimize his irrational thinking. (p. 36)

The ABCDE Model

One of Ellis’s most enduring and clinically useful contributions is his ABCDE model for understanding and recording the impact of cognitions on emotions (also known as the ABC model) (e.g., Dryden, 1995; Ellis & Grieger, 1977; Ellis &
Harper, 1975; Prochasaka & Norcross, 2007). By creating this model, Ellis was able to frame the essential aspects of cognitive therapy into an accessible acronym that enabled its use by thousands of therapists and clients.

In the ABCDE model, A, B, and C represent the three-step model described near the beginning of this chapter in which events lead to thoughts, which in turn lead to feelings. Ellis’s model simply replaces these three terms with more easily remembered terms: Activating event (A), Belief (B), and emotional Consequence (C). According to Ellis, irrational beliefs are toxic because they function as rigid, dogmatic demands that we apply to ourselves—for example, “I must get an A in every class,” “I need to be dating someone,” or “I can’t let my family down.” Although these may be strong preferences, they are not, in fact, “musts” or absolute rules. Moreover, we tend to couple these demands with overestimations of the consequences of failure—“If I don’t get an A, I’ll flunk out of school and end up on the street,” “If I’m not dating anyone, I’m completely worthless,” or “If I let my family down, their disapproval will destroy me.” Ellis sees flawed logic in all of these self-statements, and opportunity for therapeutic benefit in correcting them.

To accomplish this correction, Ellis’s model adds two more steps, D and E. In his model, D stands for Dispute, and E stands for Effective new belief. Specifically, it is the irrational belief (B) that is the target of the dispute. The addition of this step is particularly important within Ellis’s model of cognitive therapy. Ellis’s model not only helps clients identify irrational beliefs (B) that may intervene between the events in their lives (A) and their subsequent feelings (C), it urges clients to dispute those beliefs as well. This can be an empowering experience for clients who have been stuck in an ABC sequence that leaves them feeling perpetually unhappy, anxious, and so on. When they realize that their experience need not stop at C (the unwanted feeling), that they have the right to challenge the belief that caused C and replace it with something more rational, therapeutic benefit is in the works. In Ellis’s model, disputing often takes the form of pointed questions or statements that attack the irrational nature of beliefs, or in labels that can be assigned to irrational beliefs to discredit them. Regardless of the form of the dispute, if it is effective, it affords the client the opportunity to replace the original, irrational belief with an effective new belief (E) that is more rational and leads to less troubling feelings.

As a clinical example, consider Keyon, a 24-year-old man who recently earned a degree in accounting. Keyon sought therapy from Dr. Liu, a clinical psychologist with a cognitive orientation, because he was struggling with excessive anxiety. Specifically, Keyon was scheduled to take the Certified Public Accountant (CPA) exam to become a certified accountant in about 2 months, but his anxiety about the exam was interfering with his preparation. He intended to study for the exam, but when he tried, he was so anxious that he couldn’t concentrate. In fact, just thinking about the CPA exam made Keyon feel panicky. After Dr. Liu
educated Keyon about the cognitive model (specifically, Ellis’s ABCDE model), they were able to identify steps A and C right away: The activating event was studying for (or thinking about) the CPA exam, and the emotional consequence was anxiety. With Dr. Liu’s help, Keyon next identified two beliefs (B) that linked his thoughts of the CPA exam to his feelings of anxiety: “I absolutely have to pass the CPA exam on my first attempt,” and “If I don’t pass the CPA exam on my first attempt, my career is doomed, and that would destroy me.” In the next step, disputing (D), Dr. Liu made efforts to question the logic of Keyon’s beliefs:

Who says you have to pass the CPA exam on your first attempt? I understand that’s a preference, but is it a life-or-death necessity? Realistically, don’t quite a few accountants fail the CPA exam on their first try? And don’t many of them pass it later, and go on to have successful careers? And even if you don’t end up with the career in accounting that you envisioned, does that mean your life is ruined? There are plenty of ways for you to have a rewarding career that don’t involve accounting at all.

In time, Keyon found himself persuaded by the strength of Dr. Liu’s arguments and began to disbelieve his own irrational thoughts. Eventually, he was able to replace his original, irrational beliefs with effective new beliefs (E):

I want to pass the CPA exam on my first attempt, but it’s not an absolute necessity. If I pass it on a later attempt, that will probably work out fine also, and in the big picture, my happiness doesn’t depend entirely on following the career path I’ve envisioned.

These new beliefs greatly reduced Keyon’s anxiety.

The ABCDE model lends itself quite nicely to written format, and cognitive therapists often take advantage of this. It’s likely that Dr. Liu, for example, would have taught Keyon how to view his experiences as ABCDE sequences and chronicle them accordingly. Typically, clients complete forms that are organized into A, B, C, D, and E columns. During sessions or as homework, in retrospect or as an event takes place, clients can sort their experiences into the five-column organizational structure provided by this type of journal form. By doing so, they train themselves to experience life in this sequence. In particular, they become more adept at identifying an irrational belief (B), constructing a dispute (D) in response to the belief, and generating an effective new belief (E). Of course, the goal is not for the clients to depend on this written format for the rest of their lives to feel happier; instead, a five-column ABCDE thought journal can serve as training wheels that stabilize clients while they learn to think more logically, and once they can stabilize themselves, the ABCDE process takes place within the mind, without any outside aids.
Table 15.2 summarizes the full ABCDE acronym, including an applied example from Keyon’s therapy with Dr. Liu.

Table 15.2   Albert Ellis’s ABCDE Model as Applied to a Clinical Example (Keyon)

<table>
<thead>
<tr>
<th>A</th>
<th>Activating Event</th>
<th>Studying for or thinking about the CPA exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Belief</td>
<td>“I absolutely have to pass the CPA exam on my first attempt”; “If I don’t pass the CPA exam on my first attempt, my career is doomed, and that would destroy me”</td>
</tr>
<tr>
<td>C</td>
<td>Consequence (emotional)</td>
<td>Anxiety</td>
</tr>
<tr>
<td>D</td>
<td>Dispute</td>
<td>“Who says you have to pass the CPA exam on your first attempt? I understand that’s a preference, but is it a life-or-death necessity? Realistically, don’t quite a few accountants fail the CPA exam on their first try? And don’t many of them pass it later, and go on to have successful careers? And even if you don’t end up with the career in accounting that you envisioned, does that mean your life is ruined? There are plenty of ways for you to have a rewarding career that don’t involve accounting at all”</td>
</tr>
<tr>
<td>E</td>
<td>Effective New Belief</td>
<td>“I want to pass the CPA exam my on my first attempt, but it’s not an absolute necessity. If I pass it on a later attempt, that will probably work out fine also, and in the big picture, my happiness doesn’t depend entirely on following the career path I’ve imagined”</td>
</tr>
</tbody>
</table>

Aaron Beck

Aaron Beck has always used the general term cognitive therapy to describe his technique. He originally developed his approach as a way to conceptualize and treat depression (e.g., A. T. Beck, 1976; Beck, Rush, Shaw, & Emery, 1979), but it has been very broadly applied since shortly after its inception. An important part of Beck’s theory of depression is his notion of the cognitive triad, in which he argues that three particular cognitions—thoughts about the self, the external world, and the future—all contribute to our mental health. Beck theorized that when all three of these beliefs are negative, they produce depression (Alford & Beck, 1997; J. S. Beck, 1995).

The essence of Beck’s approach to cognitive therapy, like Ellis’s, is to increase the extent to which the client thinks logically. And like Ellis’s, Beck’s approach incorporates a way of organizing clients’ experiences into columns on a written page. In Beck’s brand of cognitive therapy, this form is known as a Dysfunctional
Thought Record (e.g., J. S. Beck, 1995, 2002; Freeman et al., 1990; Leahy, 2003), and although its headings differ a bit from Ellis’s ABCDE acronym, they function very similarly. Typically, the Dysfunctional Thought Record includes columns for

- a brief description of the event/situation,
- automatic thoughts about the event/situation (and the extent to which the client believes these thoughts),
- emotions (and their intensity),
- an adaptive response (identifying the distortion in the automatic thought and challenging it), and
- outcome (emotions after the adaptive response has been identified and the extent to which the client still believes the automatic thoughts).

Conceptually, the columns in Beck’s Dysfunctional Thought Record correspond quite closely to the columns of Ellis’s ABCDE forms. For example, in the fourth column (“adaptive response”) of a Dysfunctional Thought Record, clients perform essentially the same task they would in column D (“Dispute”) of Ellis’s form. For this task, Beck created a vocabulary to identify common ways in which clients’ thoughts can be distorted. This vocabulary has become a vital aspect of cognitive therapy. Let’s consider it here in more detail.

Common Thought Distortions

An essential step in cognitive therapy is to discredit illogical automatic thoughts by labeling them. To facilitate this labeling, Beck and his followers have identified and defined a list of common thought distortions (e.g., Beck et al., 1979; J. S. Beck, 2002; Craighead, Craighead, Kazdin, & Mahoney, 1994; Leahy, 2003). Cognitive therapists teach these terms to clients, often using handouts or take-home readings and train them to use the terms when examining their own thoughts. Examples of these common thought distortions include

- **All-or-nothing thinking.** Irrationally evaluating everything as either wonderful or terrible, with no middle ground or “gray area”
- **Catastrophizing.** Expecting the worst in the future, when realistically, it’s unlikely to occur
- **Magnification/minimization.** For negative events, “making a mountain out of a molehill”; for positive events, playing down their importance
- **Personalization.** Assuming excessive personal responsibility for negative events
- **Overgeneralization.** Applying lessons learned from negative experiences more broadly than is warranted
Mental filtering. Ignoring positive events while focusing excessively on negative events

Mind reading. Presuming to know that others are thinking critically or disapprovingly, when knowing what they think is in fact impossible

In Beck’s cognitive therapy, when clients assign these thought distortion labels to illogical thoughts, the illogical thoughts grow weaker. Labeling thoughts as illogical enables the client to dismiss them and replace them with more adaptive and logical thoughts, which ultimately decrease the client’s psychological distress. As a clinical example, consider Olivia, a 30-year-old woman who was recently divorced after a 3-year marriage and currently lives alone. In her first session with Dr. Zimmerman, a clinical psychologist with a cognitive orientation, Olivia explains that she feels depressed about being without a partner. The comments she made to Dr. Zimmerman could be summed up in these three beliefs: “I’m no good at relationships,” “Living alone, even for a short time, is intolerable,” and “A lot of my friends are married, but I’m not, so there must be something wrong with me.” After educating Olivia about Beck’s cognitive approach, including the list of common thought distortions, Dr. Zimmerman and Olivia went to work. Together, they attacked the flawed logic in each of Olivia’s beliefs by labeling them as distortions. For example, when Olivia views herself as “no good at relationships,” she’s overgeneralizing from the recent divorce. Living alone may not be her preference, but to call it “intolerable” constitutes magnification. And to blame the divorce on herself—“there’s something wrong with me”—is personalization that is unfounded and unfair. With repeated practice, Olivia developed the ability to identify and oppose her own illogical thoughts and replace them with more logical alternatives. She never became overjoyed about her divorce or the loneliness in her current life—such a reaction would also be illogical—but she was able to lift herself from a state of despair to a state of contentment and mild hopefulness, which made a tremendous difference in her day-to-day life.

Beliefs as Hypotheses

Beck argued that our beliefs are hypotheses, even though we may live our lives as if our beliefs are proven facts. Therefore, a potent way to expose a belief as illogical is to “put it to the test” in real life, just as scientists empirically test their hypotheses in the lab. Beck’s approach to cognitive therapy often includes such personal “experiments,” frequently in the form of homework, designed to bolster or undermine a client’s beliefs (Kuehlwein, 1993; Roth et al., 2002).

As a clinical example, consider Frank, a 45-year-old chain-restaurant manager who has held his job for 15 years but has become increasingly unhappy
If You’ve Seen Attorneys Argue in Court, Then You Understand How Cognitive Therapists Dispute Thought Distortions

“Objection!” In the courtroom, this is how attorneys protest the unsound tactics of opposing counsel. Usually, the purpose of an objection is to interrupt an illogical argument. In other words, as soon as an attorney notices that the opposition is putting forth a logically flawed argument, the appropriate action is to insist that only logically sound statements be allowed in the argument and that any irrational statement be stricken from the record.

In a way, cognitive therapists teach clients to be their own defense attorneys in the “cognitive courtroom” of the mind. Specifically, cognitive therapists train clients to spot illogical thoughts, object to them, and insist that only logical thoughts be allowed. This process implies that there are two opposing voices in each of our minds, just as there are two opposing attorneys in a courtroom. These two voices are represented by the two columns in the cognitive model in which beliefs are articulated—Columns B (Belief) and E (Effective new belief) in Ellis’s ABCDE model. Between them, Column D (Dispute) serves as an objection to the first, illogical voice (B) and an opportunity for the second, logical voice (E) to make a more logical statement.

To illustrate, let’s consider an illogical belief held by Shannon, a 20-year-old college student: “If I fail an exam, I’m stupid.” Or, stated like an accusation from another person, “If you fail an exam, you’re stupid.” If this accusation goes unopposed, as it would in a courtroom with only the prosecuting attorney in attendance, this case may end with the verdict that Shannon is, in fact, stupid. But if Shannon objects to the flawed logic in this belief—in Ellis’s terms, if she Disputes it effectively—Shannon will exonerate herself of the charge of stupidity. In truth, Shannon may be able to use several different Disputes to support her objection—perhaps the test was unfair and many students failed it, or perhaps Shannon wasn’t feeling well on the day of the test, or perhaps Shannon has earned A’s on most of her other tests in college. Any of these objections creates reasonable doubt about the accusation that Shannon is stupid and increases the likelihood that, in her “cognitive courtroom,” she will be found innocent of this charge. As a result, she will avoid a “sentence” of depression. A key to this metaphor, and to cognitive therapy more generally, is that when illogical thoughts cross their minds, individuals feel entitled to defend themselves by objecting and correcting the illogical thoughts rather than simply allowing them to continue unchallenged.
with it. This professional dissatisfaction is the main contributor to the depression for which he seeks therapy. He mentions to Dr. Morris, his cognitively oriented clinical psychologist, that he would like to look for another job, but “I’m sure I wouldn’t be able to get one,” which leaves Frank feeling dejected about the future. One effective strategy that Dr. Morris might employ would involve challenging the logic of Frank’s belief that he would not be employable elsewhere. Using Beck’s Dysfunctional Thought Record (or Ellis’s ABCDE columns), Dr. Morris could try to use words to persuade Frank that his belief is illogical: Perhaps Frank is minimizing his skills and experiences, mind reading when in fact he doesn’t know how prospective employers may evaluate him as an applicant, or engaging in some other cognitive distortion. To accompany this argument, Dr. Morris might also assign Frank some homework that will serve to test his belief. For example, Dr. Morris might ask Frank to create a résumé and highlight the parts of it that would be attractive to an employer (training, years of experience, etc.). Or, Dr. Morris might ask Frank to actually test the market—respond to some want ads and see what kind of response he gets from employers. If these homework assignments result in some feedback inconsistent with Frank’s hypothesis—that is, if his résumé actually looks good, or if prospective employers show interest—the experience will force Frank to abandon the belief that he’s unemployable. And by replacing that belief with the belief that he is indeed attractive to employers, Frank will be more hopeful and less vulnerable to depressive feelings.

Of course, when cognitive therapists encourage clients to test their hypotheses, they are careful to do so in a way that will effectively refute illogical thoughts (Kuehlwein, 1993). If they assign homework that confirms illogical beliefs, the efforts can backfire.

In practice, the approaches of Ellis and Beck overlap quite a bit. Cognitive therapists often incorporate elements of both styles of therapy into their own techniques. Although the terminology that Beck and Ellis use differs somewhat, their therapeutic goals are essentially the same: to identify and critically evaluate illogical thinking and replace it with more rational alternatives that ultimately alleviate psychological symptoms.

**RECENT APPLICATIONS OF COGNITIVE THERAPY**

Although cognitive therapy was originally targeted toward limited types of psychological symptoms, it is now applied almost universally across the range of psychological problems. In fact, it is increasingly used for problems outside the range of traditional mental disorders as well.
Cognitive Therapy for Medical Problems

The relationship between mind and body can strongly influence the way an individual deals with a medical problem. Of particular interest to cognitive therapists are the beliefs that medical patients hold regarding their illness, injury, or condition. How will it affect them? How will their family members respond or cope with it? How well will treatment work? What negative effects might treatment have? Irrational answers to these questions could unnecessarily hinder recovery, and moreover, they could cause excessive worry or despair in the process.

In recent decades, numerous studies have indicated that cognitive therapy can have a significantly beneficial effect on the healing process and the ultimate prognosis of medical patients. For example, Jakes, Hallam, McKenna, and Hinchcliffe (1992) examined the effect of cognitive therapy on patients with tinnitus, an auditory problem involving excessive perception of noises. Some of these patients underwent a brief form of cognitive therapy in which their illogical beliefs about the disease were corrected. Compared with patients who did not receive this cognitive therapy, those who did demonstrated significant improvement regarding their level of distress about tinnitus. Cognitive therapy has been successfully applied to many other medical problems as well, including sexual disorder, spinal cord injuries, and brain injury (Freeman & Greenwood, 1987; Jay, Elliott, Fitzgibbon, Woody, & Siegel, 1995).

As an example of the potential of cognitive therapy to positively influence the lives of medical patients, consider Jackie, a 45-year-old woman recently diagnosed with very early stages of breast cancer. Understandably, Jackie is distressed by the diagnosis, but some of her initial beliefs about the disease are in fact illogical, and these thoughts make her more distraught than she needs to be. For example, Jackie firmly believes “I’m going to die,” “I’ll need chemotherapy, which will be so painful and miserable that I won’t be able to live through it,” and “My family and friends will distance themselves from me if they find out.” Although these may be possibilities, Jackie may be overestimating their likelihood and in the process convincing herself of a worst-case scenario. In cognitive therapy with Dr. Richards, her clinical psychologist, Jackie challenges the validity of these beliefs and learns to identify irrational thoughts and replace them with more rational thoughts. By the end of a brief course of therapy, Jackie remains concerned about her breast cancer but not excessively so. She is realistic rather than pessimistic: “I could die, but the odds are low because it was caught very early and I’m getting good care,” “I may not need chemotherapy, and if I do, it will be very unpleasant but tolerable,” and “I can’t be sure how my family and friends will react, but their past behavior leads me to believe that most will be quite supportive.” These new beliefs—free of catastrophizing,
magnification, mind reading, or other distortions—produce in Jackie a better psychological state and a better medical prognosis as well.

**Cognitive Therapy for Personality Disorders**

Many clinical psychologists view personality disorders as quite distinct from most other disorders for which people might seek treatment. They appear on a different axis (Axis II) of the *DSM*, suggesting that they may be chronic rather than episodic. Also, they are thought to be more pervasive than many Axis I disorders, in that the individual’s entire personality is pathological. As such, for many years, cognitive therapists did not apply their techniques to personality disorders to the same extent that they did to mood disorders, anxiety disorders, and the like.

Since the 1980s, that has changed significantly (Pretzer & Beck, 2004). Cognitive therapists commonly treat personality disorders today, and an increasing body of research is pointing to the efficacy of cognitive approaches with these diagnoses. Sometimes, standard cognitive techniques are modified in some way to better suit clients with personality disorders (e.g., Wessler, 2002). Additionally, of the 10 personality disorders in the *DSM*, some have received more attention from researchers than others. For example, Dialectical Behavior Therapy, which was developed by Marsha Linehan and contains significant cognitive components, has been found effective in the treatment of borderline personality disorder, but many other personality disorders do not have an equally well-established cognitive treatment (Chambless et al., 1998; Linehan, 1993). Regardless of the current amount of empirical outcome research, the underlying goal of correcting illogical thinking remains the same for the treatment of personality disorders as it is for other mental disorders.

Some of the personality disorders are likely to be characterized by particular types of distorted or illogical beliefs. These beliefs may make themselves evident in the therapist-client relationship itself (Pretzer & Beck, 2004). For example, a client with paranoid personality disorder may believe, “If I trust anyone, including my therapist, I’ll get hurt.” A client with obsessive-compulsive personality disorder may believe, “I have to complete the homework my therapist assigns absolutely perfectly every week or my therapist will reject me.” A client with narcissistic personality disorder may believe, “Nothing’s wrong with me at all—I certainly don’t need to be in therapy,” or, “This therapist isn’t good enough for me.” All of these beliefs are not only irrational, but they can impede therapy as well. On the other hand, they can provide the cognitive therapist an in-session example of the kind of distorted thinking that affects other aspects of clients’ lives. Judith Beck (Aaron Beck’s daughter and a leader of the current generation of cognitive therapists) uses the term *hot cognition* to describe these thoughts that arise in the context of the client/therapist interaction (J. S. Beck, 1995).
Quality of Life Therapy

The use of cognitive therapy has spread not only to individuals with medical problems and personality disorders, but to those without diagnosable problems as well. Quality of life therapy (Frisch, 2006) is a recent application of Beck’s cognitive therapy principles to individuals who are experiencing psychological distress that doesn’t meet the criteria for a mental disorder. As such, it is closely aligned with the positive psychology movement (e.g., Linley & Joseph, 2004; Seligman, 2002) and emphasizes the “promotion of human happiness, strengths, and a better quality of life for all” (Frisch, 2006, p. 5).

Quality of life therapy is founded on the notion that thinking logically rather than illogically can enhance anyone’s life, whether or not they qualify for a DSM disorder. People for whom quality of life therapy may be beneficial include not only the general public but also professional groups who may be particularly likely to experience job dissatisfaction or burnout due to job-related illogical beliefs (Frisch, 2006). For example, if teachers of learning-disabled children believe that “I should be able to teach anyone anything,” or hospital personnel believe that “Anything short of a full recovery is a failure,” or salespeople believe that “It’s always my fault if the customer chooses to buy elsewhere,” they are likely to experience unhappiness and decreased job performance. Challenging and revising these thoughts to make them more rational can result in meaningful improvement.
OUTCOME ISSUES

The efficacy of cognitive therapy is strongly supported by a body of empirical evidence that is large and continues to grow. In 2002, Judith Beck stated that over 325 outcome studies had found cognitive therapy efficacious, and the number has certainly increased significantly since that time. The range of psychological disorders for which cognitive therapy works is expansive, including depression, anxiety disorders, bulimia, posttraumatic stress disorder, hypochondriasis, and others (e.g., J. S. Beck, 2002; Prochaska & Norcross, 2007; Roth et al., 2002). And as stated earlier, studies support the use of cognitive therapy for some medical problems and some personality disorders as well.

As a result of its roots in the behavioral movement, cognitive therapists typically emphasize aspects of therapy that facilitate empirical evaluation, such as defining problems in terms that can be overtly measured and observed. If these terms are not blatantly behavioral, they may take the forms of numerical ratings that clients assign to symptoms severity (like depressed mood or anxiety level) both before and after cognitive interventions. So, although a client’s anxiety may rate a 90 on a 0 to 100 scale before therapy, it may drop to 60 after a few sessions, and to 15 by the time therapy is complete. Such objectivity facilitates empirical outcome research designed to determine how well cognitive therapy works.

Box 15.3 Denise in Cognitive Psychotherapy

In the first session with Denise, it was evident that her primary symptoms were depressive, and that the event that precipitated these depressive symptoms was the change in ownership of the restaurant where she works as a chef. More specifically, the new policies of the new owner—a menu over which Denise has no control, and prohibiting her from visiting with customers in the dining room—seemed to have triggered Denise’s depressive symptoms.

I proceeded to treat Denise using a style of cognitive therapy that included aspects of both Ellis’s and Beck’s techniques. First, I educated Denise about the cognitive model by explaining that although sometimes we experience life as if events directly cause feelings, in fact there are automatic thoughts or beliefs that intervene. I used Ellis’s ABCDE model to further illustrate how Denise could understand her experience, and I provided her with a list of Beck’s cognitive distortions to equip her with the tools she would need to dispute her irrational thoughts in column D. Denise had no trouble filling in columns A (Activating event) and C (emotional Consequence) of this model: The implementation of the new restaurant policies was the Activating event, and her
depressive symptoms represented the emotional Consequence. Our next task was to identify the Beliefs (B) that occurred between A and C. This was a bit of a struggle for Denise, but with a bit of exploration and discussion, we identified this powerful thought: “I’m incompetent.” Denise explained that she could think of no other reason why her new boss would bar her from determining the menu or from talking with diners. The boss’ new policies, Denise believed, were motivated by the boss’ desire to prevent Denise’s incompetence from ruining the restaurant’s business.

The next stage in therapy focused on stage D (Dispute), where I encouraged Denise to think critically about her Belief (B) that she was incompetent. I asked a number of questions to facilitate this process, such as “What evidence do you have that you are incompetent?”; “What evidence do you have that you are not incompetent?”; and “How else might we be able to interpret your new boss’ policies?” At first, the notion of challenging her original (illogical) Belief seemed foreign to Denise, and she struggled a bit with this task. But after a few sessions, it became more familiar and comfortable for her. Using homework assignments, I asked Denise to complete a five-column thought journal in which she identified not only Activating events, Beliefs, and emotional Consequences, but Disputes and Effective new beliefs as well. These last two columns represented uncharted territory for Denise, but with time she became quite adept at completing the entire table. Specifically, Denise applied the following thought distortion labels:

- Personalization (Maybe the new boss would have implemented these new policies regardless of the chef who held Denise’s position; if so, Denise need not take them personally.)

- Mental filtering (Denise had been extremely competent as a chef and in other capacities throughout her life, yet she was focusing exclusively on this presumed slight by her new boss.)

- All-or-nothing thinking (Denise may not share her new boss’ preferences, but there were still many things she loved about working as a chef. Just because her job wasn’t perfect, she need not think of it as terrible. Instead, it may fall somewhere in between.)

Individually, any of these disputes was effective enough to negate Denise’s illogical thoughts of incompetence, and in combination they were especially potent. By the end of therapy, Denise was completing column E (Effective new belief) with ease: “I’m not incompetent at all. My new boss’ actions may have little or nothing to do with me personally; I have plenty of evidence that I am a competent person; and even if I don’t like my job as much as I used to, it’s still enjoyable and fulfilling in some ways.” As a result of her Disputes and Effective new beliefs, Denise’s depressive symptoms improved dramatically.
CHAPTER SUMMARY

The primary goal of cognitive therapy, which has become the most commonly practiced single-school approach to psychotherapy among clinical psychologists, is to promote logical thinking. Cognitive therapists accomplish this goal by helping clients recognize and revise cognitions that are illogical or irrational during a course of therapy that is typically brief, structured, and problem focused. Their techniques involve teaching clients about the cognitive model, in which cognitions intervene between events and feelings, and assigning written or behavioral homework to be completed between sessions. Whether using Albert Ellis’s ABCDE model (highlighted by disputing irrational beliefs and replacing them with effective new beliefs) or Aaron Beck’s list of common thought distortions (e.g., all-or-nothing thinking, personalization, magnification/minimization), cognitive therapists enable clients to overcome psychological and behavioral problems by insisting on a logical response to the events of their lives. Although cognitive therapy originally targeted anxiety and mood disorders, it is now applied to most other psychological disorders, including personality disorders and to other issues such as medical problems and minor psychological problems that fall short of diagnostic criteria. A large and increasing body of outcome studies suggests that cognitive therapy is highly efficacious for a wide range of psychological disorders, including mood disorders, anxiety disorders, eating disorders, and others.

KEY TERMS AND NAMES

Aaron Beck  
ABCDE model  
activating event  
Albert Ellis  
all-or-nothing thinking  
automatic thoughts  
belief  
catastrophizing  
cognitions  
cognitive therapy  
cognitive triad  
common thought distortions  
Dialectical Behavior Therapy  
dispute  
Dysfunctional Thought Record  
effective new belief
emotional consequence  mind reading
homework  overgeneralization
hot cognition  personalization
hypotheses  positive psychology
Judith Beck  quality of life therapy
magnification/minimization  Rational Emotive Behavior Therapy (REBT)
Marsha Linehan
mental filtering

CRITICAL THINKING QUESTIONS

1. To what extent do you agree with the fundamental cognitive assumption that illogical or irrational thinking underlies psychological problems?

2. If you were the client, how would you respond to the assignment of homework by your therapist?

3. If you were a clinical psychologist practicing cognitive therapy, which of Albert Ellis’s ABCDE columns would you expect clients to have the most trouble filling in?

4. In your opinion, do any of the common thought distortions that Aaron Beck and his followers defined seem to predispose individuals to particular types of psychological problems (e.g., anxiety, depression, others)?

5. What are the similarities and differences between “hot cognitions” as defined by Judith Beck and the psychodynamic concept of transference?