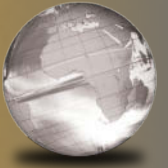


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Abnormal Psychology

SEVENTEENTH EDITION

Jill M. Hooley • James N. Butcher • Matthew K. Nock • Susan Mineka

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may think their perceived defect does not look as bad as it has at other times. However, much more commonly they feel worse after mirror gazing (Veale & Riley, 2001). They frequently engage in excessive grooming behavior, often trying to camouflage their perceived defect through their hairstyle, clothing, or makeup (Sarwer et al., 2004).

The following case illustrates the primary features of this disorder.

Seeing Spots

Steve is a 24-year-old engineer who presented for treatment at the request of his wife. He was recently fired from his job after refusing to go into work for a 2-week period because of his extreme concerns about his appearance. He explains that he could no longer tolerate the enormous birth marks that cover his face, and so he has begun trying to pluck them off his face with nail clippers. This led to noticeable cuts and scabs on his face, which embarrassed him further and prevented him from going to work. Steve's wife reports that although he does have a few very small and hardly noticeable freckles on this face, Steve has never had any significant birth marks or detectable skin discoloration.

Steve explained that ever since he can remember he has "not been thrilled" with the beauty marks on his face, but in the past year that have really bothered him to the point of thinking about them constantly and wishing they were gone. His wife said that Steve spends at least an hour in the mirror each morning and evening looking at the marks, asking her if she really loves him despite their presence, and researching ways to eliminate them via facial plastic surgery, bleaching, or some other cosmetic procedure. His job loss and facial lacerations were enough to push Steve's wife to insist that he see a psychologist for treatment, and Steve has agreed to do so.

DSM-5 Criteria for . . .

Body Dysmorphic Disorder

- A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
- C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Source: Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (Copyright 2013). American Psychiatric Association.

PREVALENCE, AGE OF ONSET, AND GENDER DIFFERENCES Good estimates of the prevalence of BDD are difficult to obtain because of the great secrecy that usually surrounds this disorder. Some leading researchers estimate that it is not a rare disorder, affecting perhaps 1 to 2 percent of the general population and up to 8 percent of people with depression (Buhlmann et al., 2010; Phillips, 2005; Rief et al., 2006). The prevalence seems to be approximately equal in men and women, although the primary body parts that are focused on tend to differ in men and women (Phillips, 2005; Phillips & Diaz, 1997). Men are more likely to obsess about their genitals, body build, and balding, whereas women tend to obsess more about their skin, stomach, breasts, buttocks, hips, and legs (Phillips, Menard, & Fay, 2006). The age of onset is usually in adolescence, when many people start to become preoccupied with their appearance. People with BDD very commonly also have a depressive diagnosis (with most estimates being over 50 percent; Allen & Hollander, 2004), and it can even lead to suicide attempts or death (Neziroglu et al., 2004; Phillips & Menard, 2006). Indeed, of nearly 200 patients with BDD, Phillips and Menard (2006) found that 80 percent reported a history of suicidal ideation, and 28 percent had a history of a suicide attempt. Rates of comorbid social phobia and obsessive-compulsive disorder are also quite substantial, although not as high as for depression (Allen & Hollander, 2004; Coles et al., 2006). Not surprisingly, BDD, like OCD, is often associated with a poor quality of life (IsHak et al., 2012).

Sufferers of BDD commonly make their way into the office of a dermatologist or plastic surgeon, one estimate being that over 75 percent seek nonpsychiatric treatment (Phillips et al., 2001). One study found that 8 percent of those seeking cosmetic medical treatments met criteria for BDD (Crerand et al., 2004), although other studies have estimated this to be as high as 20 percent (Phillips, 2005). An astute doctor will not do the requested procedures and may instead make a referral to a psychologist or psychiatrist. All too often, though, the patient does get what he or she requests—and unfortunately is almost never satisfied with the outcome. Even if they are satisfied with the outcome, such patients still tend to retain their diagnosis of BDD (Tignol et al., 2007).

RELATIONSHIP TO OCD AND EATING DISORDERS People with BDD, like those with OCD, have prominent obsessions, and they engage in a variety of ritualistic behaviors such as reassurance seeking, mirror checking, comparing themselves to others, and camouflage. Moreover, they are even more convinced that their obsessive beliefs are accurate than are people with OCD (Eisen et al., 2003). In addition to these similarities in symptoms, there is overlap in the potential causes. For example, the same neurotransmitter (serotonin) and the same sets of brain structures are implicated in the two disorders (Rauch

et al., 2003; Saxena & Feusner, 2006), and the same kinds of treatments that work for OCD are also the treatments of choice for BDD (Phillips, 2005).

Some researchers have noted similarities between BDD and eating disorders, especially anorexia nervosa. Perhaps the most striking similarities between these disorders are the excessive concern and preoccupation about physical appearance, dissatisfaction with one's body, and a distorted image of certain features of one's body (Allen & Hollander, 2004; Cororve & Gleaves, 2001). It is important to remember, however, that people with BDD look normal and yet are terribly obsessed and distressed about some aspect of their appearance. By contrast, people with anorexia are emaciated and generally satisfied with this aspect of their appearance (Phillips, 2005).

WHY NOW? BDD has existed for centuries and seems to be a universal disorder, occurring in all European countries, the Middle East, China, Japan, and Africa (Phillips, 2005). Why, then, did its examination in the literature begin only recently? One possible reason is that its prevalence may actually have increased in recent years as contemporary Western culture has become increasingly focused on "looks as everything," with billions of dollars spent each year on enhancing appearance through makeup, clothes, plastic surgery, and other means (Fawcett, 2004). A second reason BDD has been understudied is that most people with this condition never seek psychological or psychiatric treatment. Rather, they suffer silently or go to dermatologists or plastic surgeons (Crerand et al., 2004; Phillips, 2001; Tignol et al., 2007). Reasons for this secrecy and shame include worries that others will think they are superficial, silly, or vain and that if they mention their perceived defect, others will notice it and focus more on it. Part of the reason why more people are now seeking treatment is that starting in the past 15 years the disorder has received a good deal of media attention. It has even been discussed on some daily talk shows, where it is sometimes called "imaginary defect disorder." As increasing attention is focused on this disorder, the secrecy and shame often surrounding it should decrease, and more people will seek treatment.

CAUSAL FACTORS: A BIOPSYCHOSOCIAL APPROACH TO BDD Our understanding of what causes BDD is still at a preliminary stage, but recent research seems to suggest that a biopsychosocial approach offers some reasonable hypotheses. First, one recent twin study found that overconcern with a perceived or slight defect in physical appearance is a moderately heritable trait (Monzani et al., 2012). Second, BDD seems to be occurring, at least today, in a sociocultural context that places great value on attractiveness and beauty, and people who develop BDD often hold attractiveness as their primary value. This means that their self-schemas are heavily focused around such ideas as "If my appearance is defective, then I am worthless" (endorsed

by 60 percent in one study) (Buhlmann & Wilhelm, 2004, p. 924). One possibility why this occurs is that, in many cases, people with BDD were reinforced as children for their overall appearance more than for their behavior (Neziroglu et al., 2004). Another possibility is that they were teased or criticized for their appearance, which caused conditioning of disgust, shame, or anxiety to their own image of some part of their body. For example, one study of individuals with BDD found that 56 to 68 percent reported a history of emotional neglect or emotional abuse, and approximately 30 percent reported a history of physical or sexual abuse or physical neglect (Didie et al., 2006).

In addition, substantial empirical evidence now demonstrates that people with BDD show biased attention and interpretation of information relating to attractiveness (Buhlmann & Wilhelm, 2004). They selectively attend to positive or negative words such as *ugly* or *beautiful* more than to other emotional words not related to appearance, and they tend to interpret ambiguous facial expressions as contemptuous or angry more than do controls. When they are shown pictures of their own face that have been manipulated to be more or less symmetrical than in reality, they show a greater discrepancy than controls between judgments of their "actual" face and their "ideal" face. Asked to choose the pictures that best matched their faces, controls' choices were more symmetrical than their real faces, while patients with BDD lacked this bias (Lambrou et al., 2011). Moreover, several fMRI studies have found that patients with BDD showed fundamental differences in visually processing other people's faces relative to controls. Specifically, they showed a bias for extracting local, detailed features rather than the more global or holistic processing of faces seen in controls (Feusner et al., 2007). A second study showed that when patients with BDD are shown a picture of their own face, they demonstrate greater activation than do healthy controls in brain regions associated with inhibitory processes and the rigidity of behavior and thinking (the orbitofrontal cortex and the caudate) (Feusner et al., 2010). Similarly, compared to controls, patients with BDD demonstrate performance deficits on tasks that measure executive functioning (e.g., manipulating information, planning, and organization), which is thought to be guided by prefrontal brain regions (Dunai et al., 2010). Whether or not these factors play a causal role is not yet known, but certainly having such biases and deficits in processing information would, at a minimum, serve to perpetuate the disorder once it has developed.

TREATMENT OF BODY DYSMORPHIC DISORDER The treatments that are effective for BDD are closely related to those used in the effective treatment of OCD. Some evidence indicates that antidepressant medications from the SSRI category often produce moderate improvement in patients with BDD, but many are not helped or show only a modest improvement (Phillips, 2004, 2005; Phillips,

Pagano, & Menard, 2006). However, in some cases showing only limited improvement, it is possible that inadequate doses of the medication were used, thus leading to an underestimation of their true potential effects. In general, it seems that higher doses of these medications are needed to effectively treat BDD relative to OCD (Hadley et al., 2006). In addition, a form of cognitive-behavioral treatment emphasizing exposure and response prevention has been shown to produce marked improvement in 50 to 80 percent of treated patients (Sarwer et al., 2004; Simon, 2002). These treatment approaches focus on getting the patient to identify and change distorted perceptions of his or her body during exposure to anxiety-provoking situations (e.g., when wearing something that highlights rather than disguises the “defect”) and on prevention of checking responses (e.g., mirror checking, reassurance seeking, and repeated examination of the imaginary defect). The treatment gains are generally well maintained at follow-up (Looper & Kirmayer, 2002; Sarwer et al., 2004).

Hoarding Disorder

Hoarding is a condition that had received very little research attention until the past 15 to 20 years. It has been brought into public awareness recently through several TV series such as A&E's *Hoarders* or TLC's *Hoarding: Buried Alive*. Traditionally, hoarding was thought of as one particular symptom of OCD, but this categorization was increasingly questioned (Mataix-Cols et al., 2010) and hoarding was added as a new disorder in *DSM-5*. Compulsive hoarding (as a symptom) occurs in approximately 3 to 5 percent of the adult population, and in 10 to 40 percent of people diagnosed with OCD (Mataix-Cols et al., 2010; Steketee & Frost, 2004). People with hoarding disorder both acquire and fail to discard many possessions that seem useless or of very limited value, in part because of the emotional attachment they develop to their possessions. In addition, their living spaces are extremely cluttered and disorganized to the point of interfering with normal activities that would otherwise occur in those spaces, such as cleaning, cooking, and walking through the house. In severe cases people have literally been buried alive in their own home by their hoarded possessions.

Recent neuroimaging research has found that people diagnosed with OCD who have compulsive hoarding symptoms also show patterns of activation in certain brain areas when their symptoms are provoked. These brain activation patterns are different from those of people diagnosed with OCD who do not have hoarding symptoms (Mataix-Cols et al., 2004, 2010; Pertusa et al., 2010). This has led some to suggest that people with compulsive hoarding may be neurologically distinct from people with OCD (Mataix-Cols et al., 2010; Saxena, 2008). This conclusion would also be consistent with some findings of a relative

lack of responsiveness to the same medications that are often successful in reducing the severity of other forms of OCD and with recent findings that different genes seem to be implicated in OCD without hoarding versus OCD with hoarding (Pertusa et al., 2010; Samuels et al., 2007).

Part of the reason compulsive hoarding has become a focus of significant research attention stems from the realization that, on average, compulsive hoarders are significantly more disabled (both occupationally and socially) than people with OCD but without compulsive hoarding symptoms (Mataix-Cols et al., 2010; Pertusa et al., 2010). They are also at high risk for fire, falling, poor sanitation, and serious health problems (Saxena et al., 2011; Steketee & Frost, 2004). In addition, these individuals have a poorer prognosis for treatment than do people without hoarding symptoms. Notably, although the medications typically used to treat OCD are generally not effective in treating people with compulsive hoarding symptoms, some studies have suggested that one antidepressant can be somewhat effective (Saxena, 2007). Traditional behavioral therapy using exposure and response prevention is also less effective than for traditional OCD (Saxena, 2007), although there are some promising, new intensive and prolonged behavioral treatments that include home visits, which seem to be more effective (2008).

Trichotillomania

Trichotillomania (also known as compulsive hair pulling) has as its primary symptom the urge to pull out one's hair from anywhere on the body (most often the scalp, eyebrows, or arms), resulting in noticeable hair loss. In earlier editions of the *DSM*, trichotillomania was categorized as an impulse-control disorder. However, reflecting its relationship to OCD, in *DSM-5* it is now placed in the obsessive-compulsive and related disorders category. The hair pulling is usually preceded by an increasing sense of tension, followed by pleasure, gratification, or relief when the hair is pulled out. The symptoms must cause clinically significant distress or impairment in some important areas of functioning. It usually occurs when the person is alone (or with immediate family members) and the person often examines the hair root, twirls it off, and sometimes pulls the strand between their teeth and/or eats it. The onset can be in childhood or later, with onset post-puberty being associated with a more severe course (Odlaug & Grant, 2012). Research on trichotillomania is in very early stages and much remains to be learned about this condition.

in review

- Summarize the major symptoms of obsessive-compulsive disorder.
- How have conditioning and cognitive factors been implicated in OCD?

- What are the major biological causal factors for OCD?
- What are the primary symptoms of body dysmorphic disorder, and how are they related to obsessive-compulsive disorder?
- What are the primary symptoms of hoarding disorder and why is it often so debilitating?
- What are the primary symptoms of trichotillomania?

Cultural Perspectives

6.8 Summarize some examples of cultural differences in sources of worry.

Cross-cultural research suggests that although anxiety is a universal emotion, and anxiety disorders probably exist in all human societies, there are some differences in prevalence and in the form in which the different disorders are expressed in different cultures (Barlow, 2002; Good & Kleinman, 1985; Kirmayer et al., 1995). Within the United States, lifetime prevalence rates of several anxiety disorders vary in somewhat surprising ways across different racial and ethnic groups (Breslau et al., 2006). Specifically, lifetime risk for social phobia, generalized anxiety disorder, and panic disorder is somewhat lower among ethnic minority groups than among the non-Hispanic whites.

These differences were slightly larger for people under age 45 and from lower socioeconomic classes. However, once a disorder has developed, the disorders are equally persistent across ethnic groups.

Latin Americans from the Caribbean (especially those from Puerto Rico), and other people from the Caribbean, do show higher rates of a variant of panic disorder called *ataque de nervios* (Guarnaccia et al., 2010; Hinton et al., 2008; Hinton, Lewis-Fernandez, & Pollack, 2009) than do other groups. Most of the symptoms of *ataque de nervios* are the same as in a panic attack, but they may also include bursting into tears, anger, and uncontrollable shouting. Other symptoms can include shakiness, verbal or physical aggression, dissociative experiences, and seizure-like or fainting episodes. Such attacks are often associated with a stressful event relating to the family (e.g., news of a death), and the person may have amnesia for the episode. At least in Puerto Rico, this disorder is quite common in children and adolescents as well, affecting about 9 percent (Guarnaccia et al., 2005). Individuals who experience *ataque de nervios* also seem to be vulnerable to a wider range of other anxiety and mood disorders (Guarnaccia et al., 2010).

Looking at anxiety disorders from a cross-national perspective, one very large study of more than 60,000 people across 14 countries (8 developed and 6 less developed)

The World Around Us

Taijin Kyofusho

Some evidence indicates that the form that certain anxiety disorders take has actually evolved to fit certain cultural patterns (Hinton, Park, et al., 2009). A good example is the Japanese disorder *taijin kyofusho*, which is related to the Western diagnosis of social phobia. Like social phobia, it is a fear of interpersonal relations or of social situations (Kim et al., 2008; Kirmayer, 1991). However, Westerners with social phobia are afraid of social situations where they may be the object of scrutiny or criticism. By contrast, most people with *taijin kyofusho* are concerned about doing something that will embarrass or offend others (Kim et al., 2008). For example, they may fear offending others by blushing, emitting an offensive odor, staring inappropriately into the eyes of another person, or through their perceived physical defects or imagined deformities (which can reach delusional levels; Kim et al., 2008). This fear of bringing shame on others or offending them is what leads to social avoidance (Kleinknecht et al., 1997). Body dysmorphic disorder, described earlier, also commonly occurs in people with *taijin kyofusho* (Nagata et al., 2006).

Kirmayer (1991) and colleagues (1995) have argued that the pattern of symptoms that occurs in *taijin kyofusho* has clearly been shaped by cultural factors. Japanese children are raised to be highly dependent on their mothers and to have a fear of the outside world, especially strangers. As babies and young children,

they are praised for being obedient and docile. A great deal of emphasis is also placed on implicit communication—being able to guess another's thoughts and feelings and being sensitive to them. People who make too much eye contact are likely to be considered aggressive and insensitive, and children are taught to look at the throat of people with whom they are conversing rather than into their eyes. The society is also very hierarchical and structured, and many subtleties in language and facial communication are used to communicate one's response to social status.

At a more general level, cross-cultural researchers have noted that recognition of the cognitive component of most anxiety disorders leads one to expect many cross-cultural variations in the form that different anxiety disorders take. Anxiety disorders can be considered, at least in part, disorders of the interpretive process. Because cultures influence the categories and schemas that we use to interpret our symptoms of distress, there are bound to be significant differences in the form that anxiety disorders take in different cultures (Barlow, 2002; Good & Kleinman, 1985; Kirmayer et al., 1995).

Should different manifestations of anxiety seen in different cultures be considered different disorders, or simply different manifestations of the same underlying condition?

by the World Health Organization (WHO World Mental Health Survey Consortium, 2004) showed that anxiety disorders were the most common category of disorder reported in all but one country (Ukraine). However, reported prevalence rates for all the anxiety disorders combined varied from 2.4 percent (Shanghai, China) to 18.2 percent (United States). Other countries with moderately high rates of reported anxiety disorders were Colombia, France, and Lebanon, and other countries with moderately low rates were China, Japan, Nigeria, and Spain. We now turn to several examples of cultural variants on anxiety disorders that illustrate the range of expressions of anxiety that are exhibited worldwide.

In the Yoruba culture of Nigeria, three primary clusters of symptoms are associated with generalized anxiety: worry, dreams, and bodily complaints. However, the sources of worry are very different than those in Western society; they focus on creating and maintaining a large family and on fertility. Dreams are a major source of anxiety because they are thought to indicate that one may be bewitched. The common somatic complaints are also unusual from a Western standpoint: "I have the feeling of something like water in my brain," "Things like ants keep on creeping in various parts of my brain," and "I am convinced some types of worms are in my head" (Ebigbo, 1982; Good & Kleinman, 1985). Nigerians with this syndrome often have paranoid fears of malevolent attack by witchcraft (Kirmayer et al., 1995). In India also there are many more worries about being possessed by spirits and

about sexual inadequacy than are seen in generalized anxiety in Western cultures (Carstairs & Kapur, 1976; Good & Kleinman, 1985).

Another culture-related syndrome that occurs in places like China and other Southeast Asian countries is *koro*, which for men involves intense, acute fear that the penis is retracting into the body and that when this process is complete the sufferer will die. *Koro* occurs less frequently in women, for whom the fear is that their nipples are retracting and their breasts shrinking. *Koro* tends to occur in epidemics (sometimes referred to as a form of mass hysteria; Sinha, 2011)—especially in cultural minority groups when their survival is threatened—and it is often attributed to either malicious spirits or contaminated food. A variant on this syndrome also occurs in West African nations, where afflicted individuals report shrinking of the penis or breasts (but not retraction), which they fear will lead to loss of sexual functioning and reproductive capacity (but not death). Frequently, another person who was present at the time is blamed and often severely beaten or otherwise punished (Dzokoto & Adams, 2005). They both occur in a cultural context where there are serious concerns about male sexual potency (Barlow, 2002; Kirmayer et al., 1995).

in review

- Discuss the cultural variants of anxiety disorders in Nigeria, China, and India.
-

Unresolved Issues

The Choice of Treatments: Medications or Cognitive-Behavior Therapy?

Many people with anxiety or obsessive-compulsive disorders are unaware of the treatment options that are available to them. They also know little about the pros and cons of different types of treatment. Many mental health professionals are similarly uninformed or lack the training to conduct some of the more specialized treatments. For these reasons they may not recommend referral to what could be a more effective form of treatment. For example, in the United States specialized training in exposure and response prevention treatment for OCD is often not given to therapists in training. Many graduate programs in clinical psychology are also not very scientifically based (Baker et al., 2008).

Some people prefer treatment with medications because they believe it is easier to take pills than to engage in cognitive-behavior therapy (which might be more costly or involve homework assignments). On the other hand, therapy (unlike medications) does not typically lead to unpleasant side effects other than briefly elicited fear or anxiety. Over the longer term,

therapy can also be more cost effective because people treated with medications routinely stay on them indefinitely, but therapy usually has very long-lasting effects that do not wear off with time. Medications sometimes also have limited effectiveness relative to the treatment effects that are seen with properly administered cognitive-behavior therapy.

Finding a well-trained cognitive-behavior therapist, however, is far from easy. And even trained therapists are frequently limited in the range of disorders they have been trained to treat. One solution is to provide therapists in training with proficiency in treating a broader range of disorders. The Association for Psychological Science is trying to improve this situation by developing a new system for accrediting clinical training programs that teach their students well-validated forms of effective treatments. Although progress is being made, the pace of change is much slower than would be desirable.