

Science AMA Series: I'm Andrea Bonior, Ph.D., talking about clinical psychology. AMA!

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Abstract

Hi Reddit! I'm Andrea Bonior, Ph.D., a licensed clinical psychologist on the faculty of Georgetown University in Washington, DC. I treat adults with anxiety disorders and depression, using mostly cognitive-behavioral psychotherapy techniques, and I have taught Abnormal Psychology to undergrads for a decade. I have special expertise in friendships and social connections, which I blog about for Psychology Today, and my book *Psychology: Essential Thinkers, Classic Theories, and How They Inform Your World* was just released last week. I've also written the less reverent *Baggage Check* mental health advice column for the Washington Post Express for nearly twelve years. And now we've started: welcome! Ask me anything! Edited: Happily, I've just gotten permission from my publisher: If you're interested in checking out *Psychology: Essential Thinkers, Classic Theories, and How they Inform Your World*, I'm making advance review copies exclusively available to the first 100 redditors to sign up below for free, in exchange for honest and unbiased reviews. Many thanks— I would love to hear what you think of it! Thank you so much for the fantastic questions. This was a truly great experience. You can always keep up with my work at (www.drandreabonior.com), and again if you are interested in a free review copy of the book in exchange for an honest and unbiased review, please leave your name and my publisher will get it to you. My best to all of you!

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ANDREA_BONIOR [R/SCIENCE](#)

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Thank you so much for the fantastic questions. This was a truly great experience. You can always keep up with my work at (www.drandreabonior.com), and again if you are interested in a free review copy of the book in exchange for an honest and unbiased review, please leave your name and my publisher will get it to you. My best to all of you!

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Hi Andrea. Do you think it's possible to be suicidal and not have a mental illness? With the exception of people suffering from a terminal illness wanting to end their pain, does being suicidal automatically make someone mentally ill?

[Cactoblastis](#)

This is a very interesting question, and a matter of some debate. The short answer, in my opinion, is it is absolutely possible to be suicidal and not have a mental illness. Now, the majority of people who die by suicide are indeed suffering from a psychological disorder, commonly depression or bipolar disorder, but also possibly any number of disorders where there is severe distress. But the evidence shows us that the actual in-the-moment decision to end one's life by suicide can be more spontaneous than we might think (which is what is sadly missing from the discourse about the dangers of firearms). Someone who is completely thrown by a bad breakup, gets angry and scared and panicky, then drinks a bunch of alcohol and finds a gun and, sadly, takes their own life, is not necessarily mentally ill. And unfortunately, those cases are not rare, especially among young males. We also see suicides among people who have suddenly experienced a great deal of public shame, guilt, or humiliation, and the drastic change in their mindset in a relatively short period of time is striking. Now, if we are talking about people with chronic suicidal ideation, who have made plans to end their own lives for long periods of time, or multiple attempts, and are existing in a severe state of agitation and hopelessness, often they would be diagnosable with depression or something else. I think one of the most important things to remember, though, is whether technically diagnosable or not, the majority of people who die by suicide were not in any kind of psychological treatment at the time of their death. As a community, I believe we desperately need to do better to get these folks help!



Hi Andrea! I'm a student studying psychology. what do you say to those who dont think psychology is fit to be a "science" ?

[hotelartwork](#)

I actually think it's really important to scrutinize ourselves, and to take these criticisms seriously and look at them. In what ways are we not meeting the standards of scientific inquiry? There's been a particular concern lately about the inability to replicate some well-known studies in psychology, and so these questions are indeed being asked at this very moment. But I also think there's a misunderstanding often about research techniques—people in other sciences might assume it's more theoretical conjecture than it really is. Psychological research that appears in peer-reviewed journals is subject to the same empirical scrutiny as in any other discipline. Statistical analyses are sophisticated and rigorous, with the same concern about power and effect size and degrees of freedom and significance that you'd see in any scientific discipline that crunches numbers for analyses. No doubt, though, the scientific community as a whole has reason to be concerned with bias and skewed data—peer-reviewed journals of the “harder” sciences have not been immune to this either. And there's always the ‘file-drawer’ problem in that research that shows no statistically significant results gets ignored and goes unpublished, when arguably those results are extremely important as well. (Ironically, studying the psychological factors at play in some of those problems is also the domain of psychology!) I think we do a respectable job, but we need to keep fighting for rigor. Because as sciences go, our field is the one trying—just like biology and chemistry—to keep people healthy and alive. What could be more important to be doing research on? So let's keep going for higher standards.

Good afternoon Dr. Bonior,

have you come across cases/patients you simply couldn't help out of their problems? Not questioning your knowledge and expertise obviously, but surely there are people who are just too “far gone” to get out of it, no matter who would try to help them? At which point would you 'give up', so to speak, or would you refer them to someone else for a new attempt?

[heywoodu](#)

I'd like to say I'd never “give up” on a patient, per se, but I also have a professional responsibility to understand my limits and acknowledge when I might not be the best practitioner for them. I truly believe in the field enough that I think there is always reason for someone to keep trying, whether it is with a different style of therapist, or the addition of medication or other medical interventions or even an entirely different type of therapy. I am lucky that in my private practice right now, I have long since had the luxury of being able to take patients that I know align well with my training and expertise, and through consultation and screening and assessment beforehand, we both have a plan and a rationale for the work we'll be doing, and why we are a good fit to work together, as we begin. So we avoid the poor fit problem for the most part. In past workplaces, I would be matched with a client because of schedule availability or other logistical factors—and in that case, it occasionally became clear early on that someone with a different speciality—or even just a different style—would be better for that client. I feel strongly that I owe it to clients and potential clients to help them get better above all else—even if I'm not the one to be their therapist. In terms of the “too far gone” question, I can't say I believe that either. Even in the most severe and chronic depression cases, I think there is always hope— we have such a variety of treatments and providers, and the possibility of another intervention or medication is always around the corner. Some talented practitioners even specialize in these types of seemingly intractable cases and see some life-changing successes with them.

How much of depression is triggered by the environment and how much by chemical imbalance in the brain?

[silverpony24](#)

This may very well vary by person. For people who are heavily genetically predisposed to depression, it could be that even some of the smallest triggers—feeling unattractive and uninteresting at parties, not progressing at work, stalling out in dating-- could set depressive symptomology in motion. For others, it might take a much higher level of an environmental trigger (like the loss of a loved one, a terrible breakup, or a medical setback, for example) to set off the depression because neurochemically, they are not as predisposed. There's even some indication that depression might be somewhat more heritable in females—meaning that environmental triggers may matter more for males. But keep in mind that when I say environmental triggers, I am also including some things that are more internal, just not genetic—ways of interpreting the world, hypersensitivity to threat, beliefs involving learned helplessness, etc.—that might be environmentally taught and absorbed (by parents, for instance.) Interestingly enough, in some cases our genetics might predispose us not only to depression or other psych disorders, but also to be more likely to seek out the environmental triggers that can set those disorders in motion in the first place. We call this the reciprocal gene-environment model. It's like, for example, inheriting a genetic predisposition to substance abuse (in terms of the way the substances affect your body physiologically) alongside the inheritance of personality factors that might make you, for example, an easily bored daredevil, more likely to go and seek out drugs or alcohol at a very young age—which in turn puts you at higher risk for problems later on. So you're inheriting not just the predisposition to the disorder but also the higher likelihood of seeking out triggers for it. I call this the double-whammy!

Hi Andrea,

The replication crisis in psychology is big news at the moment, but most of the discussion seems to be focused on findings from social psychology. Do you have any opinions on whether abnormal and clinical psychology are likely to suffer from failures to replicate to a similar extent, and the consequences for the field if they do?

[Burnage](#)

Great question. This has certainly been a matter of concern, because arguably the research in clinical psych is even more crucial—in its immediate applicability, at least—to people's health, so the stakes might be even higher. I do think some of the same problems could apply to clinical psychology as well, because we have the same basic challenges of the human factors that go into desperately wanting your research to work out and wanting it to show what you want it to show, rushing results, and how that could end up making you (even unconsciously) more likely to nudge it in certain directions or ignore certain confounds (or contradictory findings.) We may even have additional challenges, like how with psychotherapy treatment studies it is not as easy to create a double-blind experiment as it is with medication (it's one thing to give a study participant a placebo pill and not know it's the placebo, it's another thing to practice placebo talk therapy and not be aware that you're doing it.... sort of impossible, unless the therapist goes into a dissociative state!) I really think, like I answered in another question, that the answer is more rigor, more hard questions, more scrutiny—not shying away from it because it's embarrassing or jeopardizes theories or findings that we've held dear. The good thing is, in terms of some of the most widely applicable findings—about the efficacy of Cognitive-Behavioral Therapy, for instance—we're not just looking at one major groundbreaking experiment, but rather a variety of meta-analyses that offer a decent amount of generalizability. So in order for the basic tenets of clinical psychology to be shaken up too much, there would have to be far graver and more systematic flaws in the research than some of the ones that are currently being wrestled with in social psychology-- at least in my opinion.

If we know someone with depression, what's the best thing we can do to help them? (Assuming they are getting the required medical help already)

[Jesmasterzero](#)

I love that you are thinking along these lines. I'd say this: Don't disappear, even when they are being a difficult friend. Know that depression can also mean irritability, impatience, lack of interest and not wanting to do things—all the things that can make it hard to be around someone. Don't take it personally. Listen. Don't pretend (or even believe) that you know how they feel. Know that social support matters in helping them get better and yet, because of the depression, some of their friends will drift away, so they need you more than ever. Ask them what they need or what they would like to hear. Know that their mood can change, and they can seem themselves one day and be further down the next. Keep hanging in there and checking in, even when they isolate themselves. Emphasize that you care about them unconditionally, as a whole person, and don't create standards for them to meet other than being who they are. Familiarize yourself with warning signs of suicidal behavior, and keep a good dialogue about their continuing to be in treatment. Be patient and don't put your own timeline on them. It's amazing how intuitive some of these things are, and yet how easy it is to let them fall by the wayside when someone is sinking in to a depression. So it's so good for you to be mindful of the issue!

A lot of people from the online community have said that they've used online games as a way to cope with depression. What are your thoughts on this?

[BlueLuxuria](#)

It's interesting. When an individual person finds something that helps them feel better and manage their depression, it's hard not to love that! But I also wonder if it is sometimes at odds with a larger, more whole-person approach to treatment. Feeling better in the moment while gaming is great. But if that creates a scenario where it's their only coping mechanism, it can cut off other areas of their life—making depression worse in the long run. Relying on any one thing in life for coping is often a little risky. For instance, if physical activity, in-person interactions, or even fresh air (which all can help counteract depressive symptomology) fall by the wayside because of gaming, or if someone becomes less and less motivated (or able) to seek employment because of time spent online, obviously that can cause problems later on, and gets in the way of overall healing. There was recently a discussion about this in the Washington Post, taking into account some (correlational) economic research and projections: the concern is that unemployment among young men might not be as unhappy an experience because of video games. Of course, it sounds great that they're less unhappy, but it's concerning in terms of the larger picture of the trajectory of their lives if they don't care as much about eventually becoming employed. [gaming and mood and unemployment](#) I think the bottom line question is: do I feel like I am on a path toward feeling better and being where I want to be in life? If online gaming is part of that process, that's wonderful. If online gaming is a temporary balm that is actually stalling that overall process, then that could be a reason for concern.

Hi Dr Bonoir

What do you think of EMDR as a treatment for non PTSD related depression (or just as a treatment in general?).

[Shikatanai](#)

The good thing about EMDR (Eye Movement Desensitization and Reprocessing) is it has some research support as to efficacy and there's no indication that it is harmful. The bad thing is that we're

not exactly sure of the mechanism of why it might work, so it's hard to know for sure that the actual eye movement patterns are what are making the difference, as opposed to some of the other therapeutic aspects of it (which look similar to other types of non-EMDR cognitive-behavioral therapy). As you probably know, most of the ways that it has been used and studied have been in PTSD cases, so admittedly I'm not familiar with a great deal of research that looks at it in cases of depression that are not related to trauma. I do think, though, that even if someone's traumatic history doesn't rise to the level of a true PTSD diagnosis, there might be many complicated ways that past trauma can be interwoven with depression-- and depressive thought patterns can look similar to PTSD ones in some ways too-- so if EMDR is good for trauma, it makes sense that it could be somewhat helpful for depression as well.

With the numbers of suicides of young people growing in the Pacific Northwest and elsewhere, what can be done on a broad scale to address the issue?

[Cljsajll](#)

Suicide prevention is something I'm passionate about, and though I don't specialize in it anymore, I did a lot of work earlier in my career on broader-based suicide prevention programs. I think there are several major challenges at play. One is that few people see how big the problem is (three suicides for every two homicides in this country!) and they don't think it will happen to their child, because it is scary to think about. So it's not discussed. There's also the mentality that if someone is set in a suicidal mindset, there is no going back (which is wholly inaccurate.) So there's not much dialogue about prevention as an actual public health issue, which pains me. There is still a big stigma about mental health issues in general, even if it's improving somewhat. What you are referring to in the Pacific Northwest I assume is the particular set of pressures that seem to accompany children of very high-achieving and highly educated families— some publicized cases in the Silicon Valley area lately-- but the suicide problem is by no means limited to that demographic. In my ideal world, we would focus more on mental health by training pediatricians and general practitioners to make it a more standard part of their care and assessment (some of them do this already, quite wonderfully), increase outreach and dialogue to parents and students and teachers in order to decrease the stigma of expressing concerns and getting help, bulk up emergency resources for suicide prevention (like crisis response teams, websites that are places of refuge and help, hospital units and hotlines). Also, for parents to truly face and understand some of the dangers that lurk in our medicine cabinets and firearm cases could do some good as well.

Hi Andrea.

What do you think about the relationship between psychiatry and psychology?

Do you think psychiatry's focus on using pharmacological or electromagnetic interventions detracts at all from the therapy process? By this I mean, that by putting the focus on external treatments (mainly medication, but also ECT/TMS) it can undermine the importance of making behavioral changes?

Thanks for the AMA!

[GodCunt](#)

In an ideal world, psychiatrists and psychologists work hand-in-hand, singing happily to each other as we guide our clients toward the best possible mental health outcomes. Unfortunately, anecdotally I see with some frequency that the med focus of (the vast majority of) psychiatrists can be at odds with the overall outcome picture. Someone might even contact a psychiatrist not knowing the difference, assuming that they will get some semblance of talk therapy to work through some depressive

symptoms or a complicated family history, and what they get is a very cut-and-dried med check asking about allergies and liver function and ending with a prescription-- and not even a referral to a therapist. Medication can definitely be an important part of treatment for some people, especially in the case of severe depression, or disorders where there seems to be a strong genetic history. But I really worry about medication-only as a default treatment for depression, which often is not just the psychiatrists but general practitioners perpetuating as well. A good amount of research shows that with depression, medication combined with cognitive-behavioral therapy works better—and lasts longer—than medication alone. Medication-alone robs people of the tools to change the behavior, relationship and thought patterns that are keeping the depression going. What I sometimes see in clients who have done medication-only for years is that they believe that only the meds can make them better, so there's a learned helplessness factor at play as well. This is not to say that I want them automatically off their meds by any stretch. But in order to truly make some behavioral changes that will help lessen the depression, they are going to need to feel active and autonomous in their ability to address thought patterns, relationships, and behaviors that make the depression better or worse. And if they believe that the only thing that makes their depression better or worse is a pill, then that can be a big mental barrier to break through-- creating an additional hurdle to making permanent behavior changes.

Hi Dr. Bonior, which technique do you use to treat someone with social anxiety/ avoidant personality disorder?

[Eason1018](#)

Social Anxiety Disorder can really run the gamut—from people who are more panicky in traditional performance situations (public speaking, etc.) to people who are, say, completely paralyzed by the unstructured chit-chat that might await them on an elevator. Now, when you get into Avoidant Personality Disorder, you're typically looking at something more ingrained and more severe—it's gone on for a longer period of time and become really a defining feature of their lives. Still, interventions like systematic desensitization can help. That would involve working up a hierarchy of anxiety-producing situations, but gradually, and with the support (when applicable) of the therapist. So, putting yourself in the situation of the chit-chat over and over again to desensitize yourself to it, while perhaps using some calming behavioral techniques, for instance. With Avoidant Personality Disorder there are often long-ingrained negative messages about self-worth and rejection, so for those it is helpful to understand where those messages came from and try to work on countering them-- and diffusing the automatic thoughts that pop up. Sometimes depression is in there too, which would lend itself well to some behavioral activation-- even things like exercise and sunlight.

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Thanks!!

Do you think that the use of solitary confinement as a punishment in prison is ethical?

[Super_Whack](#)

I am strongly against solitary confinement, as a social scientist who sees the abject psychological harm it can cause. I am not an ethicist or an expert in criminal justice by any stretch, but I can't imagine how the extreme and scientifically established distress that solitary confinement causes does not qualify as cruel and unusual punishment. The data is pretty clear that we suffer inordinately when we are not allowed social interaction over periods of time. Again, I don't pretend to have any perfect answers about how to handle some of the biggest challenges involving the most aggressive offenders within the prison population, but I do know what I believe is *not* the answer.

What is your perspective on the Ego?

[AwakenedRobot](#)

Admittedly, I am not a Freudian, though revisiting and researching the nitty-gritty of his work for my latest book was fascinating. I find that post-Freud, many different theorists use the word ego in many different ways, so to me there's not one sole concept of it—not sure exactly which one you had in mind. I do think there are parts of psychoanalytic theory that can be helpful in understanding just how motivated we are by unconscious feelings, fears, desires, etc. In an ideal world, our ego works to negotiate these desires in healthy ways and gain insight into ourselves. Interestingly enough, some cognitive psych research (like implicit bias, for instance—which we all need to be thinking about these days as it relates to race) has returned to a focus on the unconscious as well, though in a much more empirical and quantifiable way.

Hi Andrea! My son (age 10) and I (in my 30s) were both diagnosed with ADD. What advice could you give for starting this journey together? What can I do, as a parent and as an ADD mother, to help my son to be as successful in his development as possible? Thank you!!

[epic_allison](#)

Well, that's great that you both are presumably on the track of feeling empowered by a diagnosis that feels right to you, and hopefully on the road to an effective treatment regimen. I of course can't give direct medical advice in this forum, but I think one of the most important things you can do from the outset is to understand that ADD symptoms may manifest very differently in a 10 year-old boy than in a 30-something-woman. So don't make assumptions that he'll "look" like you, whether in terms of his treatment or his symptoms. Let your own experiences help you empathize with him rather than make you assume you know exactly what he's all about. Maybe it makes sense for you to have the same treatment providers, but maybe not. Know the ways that your own ADD might influence your relationship patterns, whether he had ADD or not. Understand how it might influence your mood, or your ability to follow through, or your organization-- and how you can make goals to counteract that. And don't forget to think of him as not only his own person separate from you, but his own person separate from the ADD! It is really encouraging that you are thinking about these things!

Hi Dr. Bonior! What are your main goals in treating anxiety disorders with CBT? Any tips on how to unleash therapy's full potential as a patient?

[hhebee](#)

Anxiety disorders can be complex because on the one hand, we've got some great empirically-validated treatments for them that are pretty straightforward. And yet, I fully believe that no person's disorder exists in a vacuum. So my goal is always not only to treat the disorder itself—let's say someone has a high level of generalized anxiety—but also look for the ripple effects within their lives. So on the one hand, we're doing the relatively straightforward work of challenging and diffusing those

intrusive thoughts, increasing mindfulness, strengthening healthy coping mechanisms, activating positive behaviors—but all the while, we have to ask, how has this affected their family relationships? Their job? What might have had a role in bringing this on in the first place? So it can be a juggling act. I always want them to end up better than before—which of course sounds like a no-brainer, but every once in a while someone starts to get better within the disorder you're treating, but it starts to implode what they're used to in their marriage or other areas of life. So you work with the whole picture, and sometimes that takes a little more than traditional, manualized CBT techniques. As for being a patient, be open to it. Do the work. Ask the hard questions of yourself; look at the difficult thoughts. Be straight with your therapist. Give it time and keep at it!

What do you think of the current state of treatments for mental illness? Where are we headed? Is Cognitive Behavior Therapy pinnacle of treatment?

[Adamworks](#)

I'd like to think that the pinnacle of treatment is something we haven't reached yet. I think the current state of treatment for many disorders is quite good, although barriers to treatment access can be a big problem. But as many gains as I believe CBT has made in treating some disorders, I think there is always room for more. I am currently very interested in new directions like Acceptance and Commitment Therapy and the role of mindfulness—sort of a new conceptualization of accepting and diffusing negative intrusive thoughts, rather than getting locked into permanent fights with them. Also, I wonder how technology is going to influence the delivery of services. Apps for social anxiety interventions, for instance—or therapy on demand through Skype. There are certainly some questions and some concerns about these directions, but I think there is a lot that is worthy of exploration!

As a blogger yourself, what is your opinion on "pop psychology" articles?

[theruminatingpenguin](#)

Honestly, I am sure there are some people who would accuse me of peddling pop psychology, especially when I write self-helpy articles about relationships (some admittedly looking suspiciously like listicles!) and the fact that my first book had a hot pink cover! So I don't want to pretend that I meet a higher standard than anyone else who might get criticized for this. But: I think psychological advice should be grounded in science, full stop. People like me who are both in academia and in practice are privy to the flaws of both sides-- practitioners who haven't read a new journal article in years, or professors doing research who have no idea how it would actually apply in the real world. With psychology, some of it can be intuitive-- especially about living life in healthy ways. So you have some talented people who naturally "get" how to motivate people to live better lives. That doesn't have to be horrible, unless they are pretending that their advice is backed by data and it isn't. I try my hardest to ground my writing in research, but also, having seen clients for seventeen years, there's a level of instinct there about what is helpful and what isn't. Sometimes I wonder, though, is that instinct enough if I can't point to a particular study to back this particular point up? I think we always need to try, though.

What methods do you use to bridge cultural gaps with clients?

How do you see technology such as neural networks and artificial intelligence impacting the future of therapy?

[LakeSuper_eyore](#)

Practicing in the Washington, DC, area, cultural "competence" (I put quotes there, because I don't think it can ever completely be reached, but rather is a process) is something I think about a lot. I think continued training goes a long way-- as part of my licensure requirements I go to a lot of seminars and discussions by people who have expertise and familiarity with a wide variety of different populations and how they may feel in different treatment protocols. But culture can encompass many things, even things we don't think of-- so I think being as open as possible, and as aware as possible of my blind spots, and how much there is to learn-- is helpful. But also not assuming, on the other hand, that someone is absolutely different from anyone else either, just because of culture. I'm really interested in what the future holds for technology's impact on therapy. On the one hand, I tend to be scared of its implications-- my husband can tell you that the idea of the Singularity sometimes keeps me up at night-- but on the other hand, I believe there are enough of us heavily invested in improving mental health outcomes that some of us (with far more tech expertise than me!) are going to do some amazing things.

Hi Dr. Bonior, is it plausible that gender fluidity is a type of personality disorder? For example, a male claiming that he is a female in a male's body. Thanks!

[AstronautApe](#)

If we are talking about true cases of an individual experiencing gender dysphoria—or feeling that they don't conform to either gender—I really don't feel it has much to do with any type of personality dysfunction. Now, if we are talking about someone *pretending* to have those feelings for reasons that aren't genuine—to attention-seek, or shock one's parents, or whatever—then I imagine there could be a personality component at play. But there's no indication that the concept of gender non-conformity or gender dysphoria have anything to do with personality pathology. For what it's worth, personality disorders are quite controversial themselves—not everyone agrees that they hold together as a valid construct, conceptually. But none of the ones that do exist as of now in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) have any particular overlap with issues surrounding gender dysphoria.

What are your thoughts on transpersonal psychology as a potential fourth wave? I think society is at a state where SFBT is in more demand than anything touching towards existential or transpersonal to take off.

Thoughts?

[SpottedPaws](#)

Within the psychology field itself, the fourth wave as I tend to think of it is going to involve new directions in CBT, specifically the role of mindfulness and the research we're seeing in treatments such as Acceptance and Commitment Therapy. Of course, I'm biased! I think there is room for the more spiritual bent of transpersonal psychology within people's individual beliefs and well-being, but I don't see the research moving in that direction. I think society is at an interesting point, though. Because on the one hand, you are absolutely right in that solution-focused treatments, and brief ones at that, are in favor—because, in our culture of "busy," who thinks they have the time for anything else? On the other hand, we may have a more mainstream interest in spirituality and some of the older questions about meaning and transcendental experiences seem to be coming back. I could see mindfulness as a bridge between the two vastly different worlds of CBT and more spiritual experiences. But I don't see transpersonal psychology itself taking a prominent place in the new direction of the scientific literature, at least in the near future.