

INNOVATIVE PSYCHOTHERAPY AND ITS OUTCOME (1973)

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The evaluation of treatment outcome is multifaceted, since it simultaneously involves the assessment of the efficacy of the procedure, the adequacy of measurement and the sufficiency of the theory from which the treatment has been derived.

One of the most formidable difficulties which continue to plague the field has to do with problems of measurement of the behavioral change. Effective measurement procedures are essential for arriving at repeatable and verifiable observations, identifying precisely the characteristics of therapy behavior and evaluating patient response to treatment. The objectives are fairly clear; investigators continue to aspire to independent, reliable, objective assessment procedures but two classes of difficulty persist. The first is methodological the second conceptual.

Goldstein, Heller and Sechrest (1966) review many of the issues involved in the development and utilization of behavioral measures, reactive measure, instrument decay, statistical regression and the interaction of these factors with one another. These considerations are compelling and failure to provide satisfactory protections against their occurrence has mitigated the findings of a great deal of therapy research. Some of the methodological problems involved in selecting and developing measures of change resulting from counseling and psychotherapy are discussed and illustrated in Volsky et al., (1965).

The conceptual difficulties represent an even greater barrier to satisfactory progress. Experts in the psychometric domain have often complained that their methodological know-how lies awasting in the field of personality measurement, since personality theorists have been singularly unsuccessful in specifying just what it is that one should measure. This failing is perhaps even more true in the field of psychotherapy. Kiesler (1965) argues that most therapy theories remain crude and imprecise and do not permit one to derive concrete measures in any precise way. The variables one chooses to assess, of course, stem directly from the therapeutic objectives. If the therapeutic objectives entail the extensive modification of personality patterns in general (total personality change), then Cattell's (1966) proposal that a broad spectrum of behaviors be measured in a multidimensional way is more appropriate than setting out to assess specific behavioral modifications.

The strategy one should adopt in the face of this problem engages the attention of some writers. Shlien (1966) in reviewing the criterion problem in therapy research, agrees that it stems from the heterogeneity of therapy systems, on the one hand and the heterogeneity of treatment objectives, on the other. His solution would be to move to a level of abstraction sufficiently high to encompass all of the differences, examining very general features that would constitute improvement measures common to all patients and all theoretical persuasions. His, therefore, is one of the few papers which proposes less rather than greater specificity. In general, the more specific and concrete the objectives of treatment that have been stated, the more readily can one devise satisfactory measures to assess the relevant behavior changes. Conversely, the more global, diffuse and abstract, the more difficult to do this.

More often investigators are seeking greater rather than less specification. This has been a hallmark of the group which refer to themselves as behavior therapists. Battle et al., (1966) continue to develop Frank's notion of using the patient's presenting complaints (target complaints) as a criterion for evaluating his response to treatment. They report changes in target complaints after therapeutic intervention to be positively correlated with other outcome criteria and that reliable representations of symptoms and estimates of severity can be gained from trained interviewers. A similar effort is being pursued by Spitzer (1966) who reports on the development of a structured and systematic mental status examination. Its 248 items were constructed on a rational basis and focus on overt behavior, rather than upon underlying and therefore inferential events. It is an instrument which appears to hold some possibilities: interrater reliabilities seem satisfactorily high (over .90), rank order correlations with independent psychiatric ratings of severity of disorder were of the order of .81 and successful discriminations were obtained between patients and non-patients and in-versus outpatients.

Attempts to get at behavioral changes via content analysis of therapy protocols have been discouraging. Marsden (1965) provides a valuable review of the various efforts up to the present time. He emerges with several useful conclusions, reflecting the unsolved problem of the interrelatedness of unit and category selection, the absence of logical or theoretic rationale for the selection of units and the infrequent continued use of content analysis systems. The limitation of all content analysis approaches is that they are examining patient-therapist talking behavior in a therapist's office. The relationship of that behavior to permanent personality or behavior change outside the therapy hour is still unknown. Iker and Harway (1965) are working on ways to apply factor analysis to content analysis and on computer systems to collate and analyze the data they get. Computers can help handle more data but they cannot select the important variables nor can they provide the conceptual framework for understanding results.

There has been a consistent tendency throughout therapy research to concentrate on the “what” of behavior events and a corresponding neglect of other aspects of the same, behavior, viz., attributes such as amplitude, duration and the like. The paper by MacCulloch, Feldman and Pinshoff (1965) represents one of the few studies which examined such attributes. Recordings of response latencies for avoidance patterns to male pictures, in homosexual patients, was one of the measures employed. Interesting, they discovered that these response latencies displayed a regularized learning curve in patients who were said to have improved with treatment and did not do so in those who relapsed or failed to improve.

While the search for more effective measures goes on, investigators continue to fall back upon measures of dubious utility (Muench, 1965; Schmit, Castell and Brown, 1965; Stevens and Astrup, 1965; Volsky et al., 1965). Hain, Butcher and Stevenson (1966) were reduced to making global ratings of global ratings when they had their judge’s work from therapist case summaries. Devising conditions for independent judgments continues to be troublesome. All too frequently, those who are privy to the behavioral changes one wants to assess (e.g., ward attendants) may also know who it is that is undergoing treatment. This seems to have occurred in the Carhuff and Truax (1965) study of the effects of lay counseling. Schmit, Castell and Brown (1965) apparently thought they had arranged for independent judgments but in this instance the ratings were done separately not independently, since one can presume an interaction between the therapist, the psychiatrist in charge of the case and the treatment procedure employed.

By far the majority of investigations hinge upon ratings of the therapy events by the participants themselves. The burden of measurement is often carried by patient self-report devices and by therapist estimates of behavior change. The assertion that the last two people one ought to ask about the results of psychotherapy are the patient and therapist is perhaps too strong. At the same time, it is a useful reminder of the impressive biases which enter into any assessment relying upon observers deeply and personally involved in the consequences. Moreover, the persistent lack of good correspondence between patient self-descriptions and therapist ratings of change, as illustrated in a study by Muench (1965) gives one reason to pause.

Finally, proper assessment of behavior change necessarily entails a subsequent follow-up. Of course, it is troublesome and difficult to engineer. It is nonetheless essential to establish the stability of whatever changes might have been observed; few studies arrange to have this feature added to their investigatory procedure. One is always left with the question of whether the differences are artifactual or genuine and whether they will stand the test of time. The fact that this is not merely an academic issue is illustrated by several studies which undertook follow-up tests at 12- and 18-month intervals. Fiske and Goodman (1965) discovered no group changes,

positive or negative, to have occurred in 69 out of 93 original subjects, although some individuals were found to have made reliable and correlated changes. On the other hand, Gelder and Marks (1965) report that patients in both desensitization and brief reeducative psychotherapy lost ground over a 12-month follow-up and that differences which were present at the point of therapy termination had disappeared by follow-up one year later (Marks and Gelder, 1965). Each of these studies bears testimony to the necessity for follow-up assessment.

In the evaluation of the effectiveness of psychotherapy, appropriate and inappropriate questions continue to be asked. Eysenck moves to the forefront of controversy once again (1965) as he rehearses his 1952 article, this time with citations of more recent empirical investigations. He acknowledges that he overstated the evidence in 1952 but says he did so to stimulate research! He finishes with the same set of convictions, more strongly stated than before, viz., traditional psychotherapeutic approaches persist despite a routine inability to demonstrate their effectiveness. Psychoanalytic approaches are criticized most severely, whereas therapeutic procedures derived from laboratory studies of learning are judged by him to be promising and potentially effective.

Eysenck's article appeared in the *International Journal of Psychiatry*, whose format provides for long articles on critical issues followed by a series of brief discussions. The discussants align themselves for and against the Eysenck theme. One discussion in particular stands out above the rest, that prepared by Hyman and Berger (1965). They argue that the question "Is psychotherapy effective?" is an inappropriate sort of question because it implies a homogeneity of patient and treatment which does not in fact exist. Calling attention to the heterogeneity of theory, techniques, patients presenting problems, therapist proficiencies, treatment goals and the like, they explicitly admonish those who would lump them together and treat them as if they were the same. On the contrary, a more effective set of questions would be cast in the form: Which set of procedures is effective for what set of purposes when applied to what kinds of patients with which sets of problems and practiced by which sort of therapists? Only then can meaningful conclusions concerning efficacy be reached. The same points are echoed by Kiesler (1965), when he argues for the necessity for specifying in very precise terms what variations in therapist behavior are expected to produce what changes in behavior at which points in time and in relation to what different kinds of patient disorder. Kiesler goes on to tackle the notion of spontaneous remission which undergirds much of Eysenck's thinking and subsequent conclusions. Kiesler's reasoning is careful and painstaking, in a deliberate effort to lay the "myth of spontaneous remission" to rest. It is interesting to note that sometimes those persons most vociferous about the shortcomings of the disease analogy for the conceptual understanding of behavior disorder will proceed to borrow a medical

concept and employ it as an explanatory construct. There are the notions in classical conditioning theory of disinhibition and of spontaneous recovery, referring to the reappearance of a previously extinguished response. But there is no construct referring to the spontaneous occurrence of extinction, which would be a direct analogue to spontaneous remission. Moreover, the concept of spontaneous remission is traditionally medical. Finally, it is a negative hypothesis, seeking to explain one unknown with another.

Through psychologists may argue about the value of psychotherapy either in general or in some specific form, they would all agree that research in psychotherapy must go on. It is obvious that if we are ever to attain more certainty about its methods, their possibilities and their limitations, research will be the means through which it has to come. It is less obvious but even more important that therapy affords us one of the best opportunities we have for the study of personality. Many client-centered counselors would point to the research studies through which Rogers' theoretical formulations have been tested and constantly modified as perhaps the major result of more than twenty years of endeavor in the field of therapy (Sundberg and Tyler, 1962).

Research in psychotherapy, can be divided into two large classes; investigation into its outcomes and into its processes. Outcome research answers such questions as: Was the treatment successful? Which of several approaches or techniques works best with a certain type of case? How lasting are its effects? What characteristics in patients encourage us to predict a favorable outcome? What characteristics in therapists tend also to make a favorable outcome more probable?

Process research is concerned with what is happening as therapy proceeds. It is directed to such questions as: In what way do the things the patient says change from interview to interview? How frequently does the patient make remarks indicating anxiety, inferiority feelings, hostile attitudes toward others? What proportion of the patient's remarks in each successive interview have to do with the self? With members of the family? With the therapist? How are the patient's remarks during any one therapy hour related to the therapist's remarks that preceded them? What kinds of remarks are accompanied by physiological indicators of emotion, such as changes in respiratory activity, heart rate or blood pressure?

Outcome studies are designed to produce evidence on the basis of which the effectiveness of psychotherapy can be increased. The process studies are designed to uncover information that will throw light on personality manifestations wherever they occur. Both types are complex and difficult. Outcome studies are concerned with how improvement is related to the characteristics of patients, to the characteristics of therapists or their techniques or to the environment of the patient. One study of physicians who were successful in treatment of schizophrenics, as compared with those

who were not, showed that they were more likely to formulate diagnoses in terms of personal meaning and motivation rather than in terms of psychopathology (Sundberg and Tyler, 1962).

Process studies are concerned with what happens during a single therapeutic session and with changes occurring during a series of sessions. One approach to controlling and limiting the complexity of the situation is to set up experiential situations that simulate therapy with normal subjects. Process studies often analyze the content of transcribed interviews for such variables as the special interpretative techniques of the therapist and indicators of distress in the patient. From some studies like this it appears that interpretations that are moderately close to the patient's own perceptions are best, as opposed to very deep or very superficial interpretations. It has been suggested that experience is more important than the particular theories of the therapists (Sundberg and Tyler, 1962).

Psychotherapists must deal with all aspects of human personality or behavior: faulty habits of thought; misperceptions; emotional upheavals; physiological disruptions which they produce; psychological disruptions produced by physical disease; unfortunate motoric habits such as rituals, tics or functional paralyses, patterns of behavior unacceptable to a subculture (e.g., delinquency); interpersonal discord (e.g., as in family or marital relationships); and troublesome developmental patterns. Virtually no realm of human personality or behavior is immune to disruption or disorganization. There is a growing mass of basic theory and research relevant to each of these response domains and situational contexts. Psychotherapy theorists need to perform a careful inspection of the literature on thinking, concept and attitude formation, motivation and emotion, perception, physiological psychology and social psychology, among other realms, seeking theories and facts which may be translatable into therapeutic application. It is useful to consider the extent to which this is currently taking place.

Generally, psychotherapy aims toward personality growth in the direction of maturity, competence and self-actualization. This usually involves the achievement of one or more of the following specific goals: (Coleman, 1972)

- 1) Increased insight into one's problems and behavior;
- 2) A better delineation of one's self-identity;
- 3) Resolution of handicapping or disabling conflicts;
- 4) Changing of undesirable habits or reaction patterns;
- 5) Improved interpersonal or other competencies;

- 6) The modification of inaccurate assumptions about oneself and one's world;
- 7) The opening of a pathway to a more meaningful and fulfilling existence;

Adherence to a particular point of view can have real utility. It may focus effort and provide a framework within which to interpret findings. It can also lead to dogmatism, selective attention, ignorance and derogation of the work of others. How to maintain its virtues without becoming prey to its liabilities is an old problem in the field of psychotherapy. Signs that the first is shading into the second begin to appear when it is said that no therapy is effective other than one's own, when what has been learned in the past is ignored in the enthusiasm of the present, when a view retains its internal coherence by ignoring external contributions, when new techniques are announced unrecognized as old ones described in new language, when major differences are obscured because a heterogeneity of approaches are referred to with one descriptive label and when a special jargon is developed. This happened with psychoanalysis, some signs of it have appeared among some client-centered proponents and some of it is beginning to occur in the newest movement called behavior therapy.

It seems inappropriate and inaccurate to institutionalize Behavior Therapy into a "school." The term behavior therapy does not refer to a homogenous group. Current approaches stem from a variety of rationales and employ differing techniques. The term itself is somewhat misleading. It developed originally to emphasize a focus on objectively observable aspects of behavior but many in this movement are working with events which are "covert" and implicit, such as imagistic behavior. For some it implies changing behavior without involving awareness or thought but for others in this general stream, those very responses are crucial. Eysenck (1965) recognizes this adversity and refers to the label as a term of convenience only.

It is to be hoped that proponents who have adopted a particular view (e.g., Skinnerian or Hullian) of how learning occurs will not restrict their attention to only those materials which support their own views. For example, proponents of the behavior therapy stream might compare the case reports in Ullman and Krasner (1965) with those of Bellak and Small's *Emergency Psychotherapy and Brief Psychotherapy* (1965). The latter two report on a program of brief psychotherapy provided in a trouble-shooting clinic. They describe the rationale and method and give illustrative case histories as well as some evaluative data about brief psychotherapy. Similarly, a comparison with Glasser's *Reality Therapy* (1965) might be instructive, since he reports on work with chronically delinquent girls (reporting 80% success in getting them functioning again in communities

and out of trouble in six to eight months), chronic male psychotics in a Veterans Administration hospital (discharge rate reported as climbing from two per year in 1961 to 75 per year in 1963, with only three returning), new admissions to a hospital and in private practice. The approaches in the literature are different. Bellak and Small employ psychoanalytic language, Glasser uses a kind of socio-psychological language and the authors in Ullman and Krasner generally use the language of operant, classical or instrumental conditioning. Perhaps, each can profit by examining the work of others.

In seeking to derive procedures from experimental literature, this stream of development is not new. Many of the techniques are not new. What is new is the emphasis placed upon the systematic and detailed analysis of the presenting problem, concrete specification of the objectives to be obtained, selection of procedures (derived frequently from basic literature) in terms of the nature of the problem, orderly and systematic operations to implement the objectives and some efforts to obtain an objective verification of the extent to which goals have been achieved.

The tendency to develop a school has evidently prompted the appearance of critiques of the behavior therapy development. In a careful scholarly article, Breger and McGaugh (1965) call the group to task for blatant deficiencies in conceptualizations concerning learning and the acquisition of disorder, the lack of good correspondence between theory and treatment technique and the dubious methods of empirical validation which are being employed. In a subsequent exchange (Rachman and Eysenck, 1966; Breger and McGaugh, 1955), the critics succeed in sustaining their points in convincing fashion.

Innovations in treatment methods have kept pace with increasing demands for the services of psychologists beyond the field of behavior disorders. Although individual diagnosis and therapy still remain the popular image of the psychologist's activities, current practices in community mental health clinics, schools, hospitals and public institutions have changed. They have moved toward application of the subject matter of psychology to the task of describing, predicting or altering human behavior under many conditions. The consumption of psychological services is no longer the mark of abnormality. Motives for application of psychological principles are as diverse as the methods.

The clinician's changing spheres of action and the wide range of approaches required to handle diverse problems have modified the emphasis of training. Today, a clinician is engaged as much in the analysis of a patient's social environment as in the analysis of thought process, as much in observation of social behaviors as in description of emotions and feelings. The mark of a good clinician is no longer only sensitivity and intuition

capacity for understanding another person; it includes also knowledge and skill in using learned techniques and principles from general psychology applied to particular problems.

How does behavior or personality modification occur? This is a question relevant to all therapies. A variety of proposals is made.

There is a growing emphasis on psychotherapy aimed at limited objectives. Sometimes the justification is economic, sometimes tactical in that long-term treatment is not feasible and sometimes limited objectives are thought to be preferred. Whatever the reasons, there is increasing recognition that most individuals who seek psychotherapy participate for a limited number of sessions and that there is no point in pretending that extensive psychotherapy is typical. A 1965 issue of the *American Journal of Psychiatry* contains four papers on the questions of brief psychotherapy. There is one by Wolberg (1965) and another by Frank (1965), who summarizes characteristics of the approach. Elsewhere in literature are articles on the same topic, by Jacobson et al., (1965) Seagull (1965); Davis (1965); Chafetz (1965). Brief psychotherapy emphasizes rapid rehabilitation of the person to acceptable levels of functioning in society. Efforts are directed toward mobilizing the patient's assets, with a focus on what is working for the patient not just on what is wrong. The goals are circumscribed and more clearly specified. Efforts are made to restore the patient to performance of major social roles. A variety of techniques is used.

These objectives reveal some common ground between "brief psychotherapists" and "behavior therapists." The latter group take a problem-oriented approach. They focus on limited portions of behavior. They try to make their analysis of the problem explicit and concrete and to choose some specific objective, some alternative behavior pattern, to be accomplished or developed. Krasner (1965) acknowledges that the values of the therapist are important considerations since they will influence decisions about what to change and the alternate behaviors to be developed. He identifies the issue but provides no answers. More theoretical and practical attention needs to be given to the question of appropriate goals for therapy, sequential subgoals and their interrelationships.

The therapist must of course, be a master of the techniques and strategy that are the tools for therapy. In addition to a broad knowledge of psychological theory and an understanding of oneself, the therapist is aided by a real understanding of social conditions and their effect on personality development. The therapist, whatever the special bent, must understand the techniques and values of suggestion, reassurance, catharsis, free association and transference, desensitization, reeducation, interpretation synthesis and must know when they can be most effectively used. Such understanding is developed in part from the psychological, cultural and self-studies and in

part from the specific study of all the special techniques. The therapist must also be able to discriminate between functional and physical causation or if unable to do so, must collaborate with someone who can make such discrimination. Since organic changes may result in mental disturbances, the possible organic factors must be understood or the therapist may make the dangerous error of attempting to apply psychological treatment to organic causes. The ability to make this discrimination is also necessary, since one of the most common and swift recourses of the neurotic patient is to physical symptomology. These symptoms must be carefully evaluated in every therapeutic situation.

The objectives of psychotherapy have been stated in many ways but an examination of the terms used often shows differences or psychological theory or method rather than differences in objectives. Thus the objectives may be stated in terms of affective, security or power goals, depending upon which of these factors has been given greater prominence in the psychodynamic theory.

The ultimate goals include the development of understanding, the release of personal resources and continuous growth in social adjustment.

Throughout the history of psychotherapy, desensitization and reeducation have had prominent roles. Most maladjusted individuals react to certain situations or ideas with an exaggerated sensitivity and consequently treatment must result in desensitization to these areas. They also find it difficult to live harmoniously with themselves or others and consequently require reeducation. In fact, all learning and habit formation in the development of normal personalities involve sensitization and desensitization, learning and relearning. In their simplest manifestations then, desensitization and reeducation imply nothing more than that which is involved in the normal process of living.

Since desensitization consists of attempts to enable the patient to be comfortable in the face of situations that have been highly charged and reeducation implies a retaining of one's habits of response, the two processes become inseparable.

The increasing demands of psychological and psychiatric services dictate the techniques and extension of the existing services. Consequently, group techniques have grown in clinical stature and the past decade has witnessed the development of numerous divergent procedures. A most promising variety of short-term therapy is Wolpe's (1958) system of "reciprocal inhibition," by which he achieved the recovery of 188 out of 210 neurotic cases in the average of 34.8 sessions.

A double economy can be achieved by combining the advantages of Wolpe's (1958) expedient clinical procedures with the additional time- and effort-saving properties of group therapy. A paper by Lazarus (1961) describes the adoption of Wolpe's most important therapeutic procedure (the technique of systematic desensitization based on relaxation) to the group treatment of phobic disorders. Of the 18 subjects who were treated by direct group desensitization, 13 recovered in a mean of 20.4 sessions. Follow-up inquires after an average of 9.05 months revealed that 3 of the subjects had relapsed. With a more traditional form of interpretive group psychotherapy applied to 17 subjects, after a mean of 22 therapeutic meetings, it was found that only 2 patients were symptom-free. Both these patients had attended groups in which relaxation was employed as an adjunct to the interpretive procedures. The 15 subjects who were not symptom-free after interpretive group therapy were then treated by group desensitization. After a mean of 10.1 sessions, 10 of them recovered. The very much shorter time required to effect a recovery by desensitization in those patients who had previously received interpretive therapy suggests that the therapeutic relationship and additional nonspecific factors may have facilitated the reciprocal inhibition of neurotic anxieties motivating the phobic symptoms.

Barrett (1969) compared systematic desensitization (SDT) and implosive therapies (IT) for their effectiveness and efficiency in reducing snake phobic behavior in otherwise normal adult humans. SDT and IT *Ss* differed significantly from control *Ss* in posttreatment avoidance of a snake and in change of report discomfort. SDT and IT did not differ in effectiveness. These results held at a 6-month follow-up. IT was more efficient in that treatment was completed at 45% of the time required for SDT. Results were qualified by the finding that SDT had a consistent and continuing effect across *Ss* and across time, whereas IT effect was more variable. The two current learning theory based therapies, applied to reduction of phobic behaviors, call for directly opposed operations. Wolpe's (1958) systematic desensitization therapy and Stampfl's (1961) implosive therapy; in Wolpe's approach, relaxation was used in reciprocal inhibition of small doses of anxiety that may be aroused by a hierarchical arrangement of stimuli. Since relaxation is assumed to inhibit only small amounts of anxiety, a gradual progression through the hierarchy is used. Considerable care is taken to see that *Ss* experience little or no anxiety as they imagine elements of feared stimulus events.

Stampfl's approach is the opposite of Wolpe's. He assumes that extinction of a negative emotional response to objectively neutral stimuli will proceed most rapidly when *Ss* are exposed to a conditioned stimulus (CS) without reinforcement. Use of a gradual approach, for Stampfl, invites a reinstatement of the response to CS in accordance with the conservation of anxiety hypothesis (Solomon, Kamin and Wynne, 1953). Therefore, as Stampfl and Lewis stated, IT therapists attempt to "represent, reinstate or

symbolically reproduce the stimuli (cues) to which the anxiety response has been conditioned, in absence of primary reinforcement.” (p. 499) This is accomplished by instructing *S* to imagine scenes suggested by the therapist until some sign of reduction in the anxiety elicited by the scene occurs. Then scenes that produce even more anxiety are suggested. This process is continued until the scenes suggested by the therapist no longer elicit anxiety.

Findings of this study support the view that IT is an effective, efficient behavior modification technique for use with phobias. Further, the results make more explicit evidence for SDT as an effective technique that has a consistent and continuing effect across *Ss* and across time. Disturbances reported by both SDT and IT *Ss* during imagery, again raise the serious question of what *Ss* actually do following instructions to “imagine a scene.”

In a review of desensitization procedures by Willins (1971), he found that the most popular form of desensitization employs muscle relaxation as an inhibitor of fear or anxiety and according to Wolpe, the states of procedure are: a) training in deep muscle relaxation, b) arranging fear-provoking scenes into a graded hierarchy and c) the instructed imagination of the hierarchy scenes concomitant to a state of muscle relaxation. That recent studies, taken together suggest that of these three above conditions, none are necessary for successful desensitization. Indeed, the only necessary condition appears to be imagination of fear-relevant scenes not necessarily arranged into a hierarchy and not necessarily concomitant to muscle relaxation. Thus, Wilson and Smith (1968) reported success in severely neurotic subjects where treatment consisted of relaxation contiguous to the imagination of free-association scenes that were not organized into a hierarchy. Certainly, individually tailored hierarchies are unnecessary, as Emery and Krumboltz (1967) found no difference in anxiety reduction whether they employed individualized hierarchies or a standard hierarchy developed by the investigators prior to interviewing subjects. Leitenberg, Argas, Barlow and Oliveau (1969) also demonstrated fear reduction using a standard nonindividualized hierarchy for all subjects. Rachman (1968) presented arguments that training in muscle relaxation appears unnecessary, as successful fear reduction has been demonstrated with experimenters who are fairly inexperienced in the technique of muscle relaxation and with subjects who receive only perfunctory relaxation training. Also, Garfield, Darwin, Singer and McBrearty (1967); Cook (1966); and Ritter (1968) reported successes with *in vivo* desensitization where subjects are physically active during treatment sessions. Lazarus (1967) reported successful cases where subjects are instructed to increase muscle activity concomitant to imagining fear-provoking scenes. Davison (1966) demonstrated that muscle relaxation and anxiety are not mutually antagonistic, since anxiety can be experienced while a person is in a state of chemically produced muscle relaxation. Finally, Wolpin and Raines (1966) demonstrated successful fear reduction in a group of subjects who imagined

hierarchy scenes while intentionally tensing their muscles and a third group who received no instructions regarding relaxation and imagined only scenes at the top of the hierarchy with no graded exposure to less fear-provoking scenes. Wolpin also reported successful case studies in which imagination of fear-provoking scenes was used without relaxation training and without arranging them into a graded hierarchy.

The reports of these studies indicate that instructed visualization may also be a sufficient condition for therapeutic gain. The factors, then, for factors operating in the desensitization situation which research evidence indicates are highly influential in affecting the outcome of treatment include: *expectancy* of therapeutic gain, the *social* reinforcing qualities of the therapist, information *feedback* of approximations toward successful fear reduction, training in the *control of attention* and the *vicarious learning* (via instructed imagination) of contingencies of non-avoidance behavior in the fear situation.

Truax and Carkhuff (1965) found that the more the transparency or self-exploration, the greater the positive personality change. They suggest that their findings point to the importance of at least the two variables of client and therapist transparency in a model for psychotherapeutic personality change.

Clinical observations suggest that in successful psychotherapy the patient is indeed involved in a process of self-disclosure and self-exploration a process of coming to verbalize and to know one's beliefs, values, motives, perceptions of others, relationships, fears and life choices. The role of the therapist in both traditional psychotherapy and in counseling has been based upon attempts to facilitate this process. In the terminology of psychoanalytic theory the process would be described as the patient becoming aware of or exploring preconscious and unconscious material upon the perception of reality (Munroe, 1955). For client-centered theory (Rogers, 1955), this "optimal therapy has meant an exploration of increasingly strange and unknown and dangerous feelings in [oneself] . . . thus [one] becomes acquainted with elements of [one's] experiences which have in the past been denied to awareness as too threatening, too damaging to the structure of the self." Jourard (1969) has specified self-disclosure as a central process in personality change and Truax (1961) has for heuristic reasons specified "interpersonal" or "self-exploration" as a sufficient (but not necessary) antecedent for constructive personality change.

There does exist research evidence pointing to the self-exploration or transparency of the therapist as a relevant condition for constructive personality change.

Peres (1947) in a study of group psychotherapy found that successful and unsuccessful group psychotherapy differed in that successful patients in group therapy made significantly more personal references over the course of therapy when compared to unsuccessful patients. In fact, over-all, the benefited patients made almost twice as many personal references as did the non-benefited patients. Braaten (1958) in studying individual therapy found that when he compared early and late interviews from successful and unsuccessful cases, the more successful cases show a greater increase in the amount of self-references, particularly self-disclosures revealing the private self. Using the process scale devised by Walker, Rablen and Rogers (1960) Truax, Tomlinson and van der Veen (1961) presented findings which indicated that more successful patients show more self-exploration and self-disclosure during psychotherapy.

Thus, both clinical and research evidence converge in suggesting the central importance of self-disclosure or transparency of the patient during the therapeutic encounter.

The emphasis on today's psychology appears to be on the innovative, flexible and self-expressive therapist and patient. At least, the patient, to gain any therapeutic value at all must be cognizant that the therapist is a human being with feelings, emotions and understanding. The cognitive abilities of the patient have been too long overlooked. How the patient views the world *is* one's world. If one's emotions or distorted perceptions control one's actions, then one will become a distorted intellectual entity; one's world will change and one will become unable to cope with the stresses of everyday life and living. Once control of one's emotions and a directive effort toward one's cognitive understanding of the processes involved are gained by the therapist, improvement should follow.

All research extols the wisdom of the value of reinforcement for individuals on a personal basis. To reach an individual on one's own level and discover one as a person requires more time than most have to spare. Hence, short-term methods requiring as few sessions as possible are the innovative techniques used most frequently today.

Cognitive behavior and an awareness of one's existence and actions are the goals of perception. To know or to *feel* the whys of behavior are the unreachable goals of the people involved other than the active participant, the client. To reflect on one's feelings, to have them fed back with expert skill and to see them though as through the eyes of another are simply an attempt to take cognizance of the way in which one sees the world or the circumstances with which one is faced. Along the behavioristic approach, the manipulation of the consequent events or consequences of one's actions all require an awareness of and perception of the total situation.

Reinforcement and aversive outcome are naturally controls for most situations which may arise. Through manipulation of these variables, coupled with and earlier awareness of the dynamics involved would seem to be of tremendous benefit to the patient in understanding both oneself and one's relation to one's environment.

Too long has the patient's cognitive and emotional factors or one's awareness of one's perceptions been hidden in the closet of the clinician. Bring them out into the open, let the patient understand the nature of one's problem, desensitize the fears or change the consequences of the activity, label it any way one wishes but let the patient be aware, let the patient understand the dynamics involved in one's behavior and help one to know how to change it or live with it, this is the functional role of both the therapist and therapy ... an achievement few seem to master.

Notes

- 1) Barrett, C. L., "Systematic desensitization versus implosive theory", *Journal of Abnormal Psychology*, 74, 1969, pp. 587-592.
- 2) Battle, C. C., Imber, S. D., Hoehn-Saric, R., Stone, A. R., Nash, C. and Frank, J. D., "Target complaints as criteria of improvement", *American Journal of Psychotherapy*, 20, 1966, pp. 184-192.
- 3) Bellak, L. and Small, L., *Emergency Psychotherapy and Brief Psychotherapy* (New York: Grune and Stratton, 1965).
- 4) Braaten, J. M., *The Movement from Non-self to Self in Client-Centered Psychotherapy* (Chicago: University of Chicago Press, 1958).
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