

# Toward the Delineation of Therapeutic Change Principles

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**ABSTRACT:** *There is a growing discontent among therapists of varying orientations. Psychoanalytic, behavioral, and humanistically oriented clinicians are starting to raise serious questions about the limits of their respective approaches and are becoming more open to contributions from other paradigms. This article documents this trend within the field, which resembles a Kuhnian-type crisis, noting some of the political, economic, and social forces apt to affect our likelihood of ever reaching a consensus within the field and presenting an approach to the delineation and study of commonalities across various orientations.*

It has been close to one hundred years since the practice of psychotherapy emerged as a recognized professional activity. Partly as a function of this unofficial anniversary, but more as the result of a growing zeitgeist in the field, the time is ripe for questioning how far we have come and how close we are to achieving a "consensus" (cf. Kuhn, 1970) within the professional community. The thesis developed in this article is that psychotherapy is currently in a state of infancy; anyone desiring therapy nowadays needs to decide which of more than 130 different approaches is likely to be most helpful (Parloff, 1976). It will be argued, however, that the time is rapidly approaching when more than ever before, we have the opportunity to advance the field in the direction of greater maturity.

Before developing this thesis, I might note that my original intent was to have this article published anonymously, but editorial policy prevented this from happening. The reason for wanting the article to appear anonymously was that all of us interested in the field of psychotherapy seem to have a tendency either to read or to ignore articles and books on the basis of our allegiance with the author's theoretical camp. We have all "taken up sides" and have placed far too much emphasis on *who* is correct, not *what* is correct. I wanted to circumvent this tendency, as I believe the message has relevance to therapists of all orientations.

Much of what is included in this article is based on the writings of therapists from psychoanalytic, behavioral, and humanistic orientations. To let them speak for themselves, I have taken the liberty of quoting them liberally. My observation has been that there is a growing discontent among therapists within each orientation and that the need for rapprochement is becoming ever more appropriate. Although it may be possible to delineate commonalities across all theoretical persuasions, formidable pressures nonetheless exist that oppose such integration. Jerome Frank (1976) has astutely noted such barriers by suggesting that "features which are shared by all therapists have been relatively neglected, since little glory derives from showing that the particular method one has mastered with so much effort may be indistinguishable from other methods in its effects" (p. 74). The goal of this article is not to outline these shared features but to suggest what needs to be done to work toward integration.

## *Psychotherapy: Approaching a Crisis*

In reviewing the history of various approaches to therapy, it becomes apparent that therapists have typically operated from within a given theoretical framework, often to the point of being completely blind to alternative conceptualizations and potentially effective intervention procedures. Considering the role schools of therapy have played in the development of the field, Raimy (1976) has observed that these schools "undoubtedly contributed to the enthusiasm and the competitive urge to drive therapists to develop their thinking and their

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techniques, but also imposed limited horizons which clamped their proponents into rigid molds" (p. 225).

Although examples of this are legion, a few may be offered to illustrate the point: Many of Freud's early attempts to introduce psychoanalytic insights and techniques into the profession were initially ignored, if not explicitly rejected, as they did not fit into the generally accepted theoretical framework at the time. Although procedures for progressive relaxation were originally described by Jacobson in 1929, it took nearly thirty years before the therapeutic potential was recognized. At the time it was introduced, it no doubt appeared superficial and mechanistic and did not "fit" with what was deemed to be necessary for effecting therapeutic change. Breger and McGaugh's (1965) criticism of behavior therapy for its exclusive reliance on classical and operant conditioning principles was initially rejected by behavior therapists, although the cogency of their critique is now being acknowledged indirectly by the rapid growth of cognitive behavior therapy. And though intervention procedures for the treatment of sexual dysfunctions were introduced into the literature in the 1950s (Seamans, 1956; Wolpe, 1958), their professional use was not fully explored until Masters and Johnson (1970) presented their suggestions for the direct treatment of sexual difficulties.

Despite our tendency to be suspicious of new ideas, we do eventually process novel information. Within the past several years, an interesting phenomenon seems to be emerging. There appears to be a slight, but clearly growing, trend toward questioning whether or not all the answers may be found within any given school of therapy (e.g., Appelbaum, 1975, 1979; Bergin & Strupp, 1972; Birk & Brinkley-Birk, 1974; Brady, 1968; Burton, 1976; Dewald, 1976; Egan, 1975; Feather & Rhoads, 1972; Ferster, 1974; Frank, 1976; Goldfried & Davison, 1976; Goldstein, 1976; Grinker, 1976; Haley, 1963; Horwitz, 1976; Lazarus, 1977; Lewis, 1972; London, 1972; Marmor, 1971; Martin, 1972; Raimy, 1975, 1976; Ricks, Wandersman, & Poppen, 1976; Segraves & Smith, 1976; Silverman 1974; Wachtel, 1977). We seem to be entering a period of self-examination, with therapists beginning to ask themselves such questions as, Where does our approach fail? What are the limits of our paradigm? Do other approaches have something useful to offer? One gets the impression that therapists are starting to grow somewhat weary of a strict adherence to their theoretical orientation and are becoming more pragmatic. In recent sur-

veys of clinical psychologists within the United States (Garfield & Kurtz, 1976; Kelly, Goldberg, Fiske, & Kilkowski, 1978), between 55% and 58% of those professionals contacted indicated that they did not adhere to any single orientation. This eclecticism may have evolved over a period of time or, in some instances, may reflect an integration of different orientations from the outset of their professional training (e.g., Birk, Note 1).

Kuhn (1970) has observed that scientific revolutions are typically preceded by a period of "crisis," when well-accepted paradigms simply do not work as well as they did before. Such crises are reflected by the "proliferation of competing articulations, the willingness to try anything, the expression of explicit discontent, the recourse to philosophy and to debate over fundamentals" (p. 91). It appears that just as our patients/clients change their perceptions of the world as a result of corrective experiences, we, their therapists, are now becoming more willing to question our particular paradigm as a result of our own corrective experiences. In some cases this may occur because the therapist is successful with an intervention procedure typically associated with another theoretical orientation. In other instances, such changes appear to be the result of personal therapy with a therapist of a different persuasion.

One may argue that the tendency for therapists to look to other approaches for what they may have to offer is nothing new. Indeed, Fiedler (1950) found some thirty years ago that greater similarity was to be found among experienced clinicians of different therapeutic schools than among beginning therapists of varying orientations. Presumably, with increased experience—both clinical and through living itself—more points of commonality emerge. These findings confirm what has frequently been observed among practicing clinicians, namely, that there exists a therapeutic "underground," which may never appear in the literature but which nonetheless reflects those informal, if not unspoken, clinical observations on what tends to work (Klein, Dittman, Parloff, & Gill, 1969; Wachtel, 1977). Although this underground may always have been there, we now seem to be at a point in time when clinicians are starting to acknowledge its existence more openly and are beginning to recognize the contributions from orientations other than their own.

Among psychoanalytically oriented therapists are several instances of this open acknowledgment that other theoretical orientations may have something

valuable to contribute. For example, Dewald (1976) has stated that efforts need to be made toward rapprochement, suggesting that "the articulation of conceptual generalizations regarding the therapeutic process in different treatment modalities hopefully might initiate more objective and dispassionate comparison of similarities and differences" (p. 284). Silverman (1974) has similarly suggested that his psychoanalytic colleagues look toward nonanalytic intervention approaches, adding, "I am convinced that there is much psychoanalysts can learn from these other approaches that can make (unmodified) psychoanalytic treatment more effective" (p. 305). As the result of findings from the Menninger Foundation Psychotherapy Research Project, Horwitz (1974, 1976) has concluded that supportive therapeutic procedures, involving no uncovering, were just as effective as insight-oriented psychoanalytic therapy. Appelbaum (1979), a former colleague of Horwitz at Menninger, has argued that psychoanalytic therapy can learn much from the intervention procedures used by gestalt therapists. In one of his last papers, Alexander (1963) acknowledged the role of learning theory in the full understanding of the therapeutic process, prophesying "the beginnings of a most promising integration of psychoanalytic theory with learning theory, which may lead to unpredictable advances in the theory and practice of the psychotherapies" (p. 448). And in a recent scholarly evaluation of the clinical and theoretical links between psychoanalysis and behavior therapy, Wachtel (1977) has suggested how the two approaches to intervention may effectively be integrated.

Within behavior therapy one sees some similar self-examination and openness to the views of others. A survey recently conducted among leading behavior therapists, asking them to rate the degree to which they were satisfied with their current understanding of human behavior (Mahoney, 1979), revealed a most noteworthy finding. On the basis of a 7-point rating scale, it was found that the average rating was less than 2! One would certainly never have expected that from reading the behavioral literature. Lazarus (1977), one of the pioneers in the development of behavior therapy, has most recently stated his position as follows:

I am opposed to the advancement of psychoanalysis, to the advancement of Gestalt therapy, to the advancement of existential therapy, to the advancement of behavior therapy, or to the advancement of any delimited school of thought. I would like to see an advancement in psychological knowledge, an advancement in the understanding

of human interaction, in the alleviation of suffering, in the know-how of therapeutic intervention. (p. 553)

Davison (1978) and Thoresen (1973) have argued for the possible synthesis of behavioral and humanistic approaches to therapy. And Goldfried and Davison (1976) have appealed to their colleagues to seriously consider a rapprochement by suggesting,

It is time for behavior therapists to stop regarding themselves as an outgroup and instead to enter into serious and hopefully mutually fruitful dialogues with their non-behavioral colleagues. Just as we firmly believe that there is much that behavior therapy can say to clinicians of other orientations, we reject the assumption that the slate should be wiped clean and that therapeutic innovations should be—and even can be—completely novel. (p. 15)

Even among those who are primarily Skinnerian in their behavioral emphasis, one sees efforts to draw on other orientations. Thus Ferster (1974) has argued that behavioral and psychodynamic approaches "are complementary rather than exclusive ways to uncover the actual events of psychopathology and the procedures of therapy" (p. 153). Another example can be found in Baer and Stolz's (1978) recent article in *Behaviorism* on the potential therapeutic effectiveness of est.

Among those who are primarily identified with a humanistic orientation, Landsman (Note 2) has emphasized some of the similarities between humanistic and behaviorally oriented intervention approaches, urging his colleagues to recognize the contribution that behavior therapy may have to offer. He suggests,

If humanists are truly confident that they have much to offer then they ought to welcome what is being offered by the responsible behaviorists—attention to specifics, to details, careful quantification, modesty in claims, demonstrable results. And even beyond this we welcome its challenge, its role as stimulator to make the dreams of humanistic psychology more of the substance of reality, the spur to demonstrate our promises. (p. 15)

Egan has modified his earlier reviews (Egan, 1970, 1973) of the interpersonal growth process by suggesting that there comes a time when the therapist must assist the client in acting differently in the real world (Egan, 1975). The therapist's goal then becomes "collaborating with the client in working out specific action programs; helping the client to act on his new understanding of himself; exploring with the client a wide variety of means for engaging in constructive behavioral change; giving support and direction to action programs" (Egan, 1975, p. 30). Egan goes on to suggest that a useful way of facilitating such direct action is to employ the procedures developed by behavior therapy. In a recent issue of the *Journal of Humanistic Psychol-*

ogy, the editor acknowledged Lazarus's (1977) call for a rapprochement across various therapeutic orientations and urged the readers of the journal to be open to such attempts (Greening, 1978). It will be recalled that it was none other than Maslow (1966) who warned us against becoming too firmly entrenched within a given perspective, observing, "If the only tool you have is a hammer, [you tend] to treat everything as if it were a nail" (pp. 15-16).

### *Rapprochement Through Common Clinical Strategies*

In considering how one might approach the task of looking for points of commonality among different orientations, it might be helpful to conceptualize the therapeutic enterprise as involving various levels of abstraction from what is directly observable. At the highest level of abstraction we have the *theoretical framework* to explain how and why change takes place, as well as an accompanying *philosophical stance* on the nature of human functioning. In the search for commonalities, it is unlikely that we can ever hope to reach common ground at either the theoretical or the philosophical level. Indeed, numerous differences can be found at this level within the psychoanalytic, behavioral, and humanistic orientations. At the lowest level of abstraction, we have the therapeutic *techniques* or clinical *procedures* that are actually employed during the intervention process. Although commonalities across approaches may be found in the realm of specific techniques (e.g., role playing, relaxation training), it is unlikely that such comparisons would reveal much more than trivial points of similarity. I would suggest, however, that the possibility of finding meaningful consensus exists at a level of abstraction somewhere between theory and technique which, for want of a better term, we might call *clinical strategies*. Were these strategies to have a clear empirical foundation, it might be more appropriate to call them *principles* of change. In essence, such strategies function as clinical heuristics that implicitly guide our efforts during the course of therapy. For illustrative purposes, I would like to offer as examples two such strategies that may very well be common to all theoretical orientations: (a) providing the patient/client with new, corrective experiences, and (b) offering the patient/client direct feedback.

Therapists of varying orientations have suggested that one of the essential ingredients of change in the clinical setting involves having the patient/client engage in new, corrective experiences (e.g.,

Gill, cited in Silverman, 1979; Grinker, 1976; Korchin, 1976; Marmor, 1976; Prochaska, 1979; Raimy, 1975; Rotter, 1954; Strupp, 1976; Thor-esen & Coates, 1978). The role that new experiences play in the clinical change process was initially outlined in Alexander and French's (1946) description of the "corrective emotional experience," which suggested that concurrent life experiences could change patients even without their having had insight into the origins of their problems. Alexander and French emphasized the importance of encouraging their patients to engage in previously avoided actions in order to recognize that their fears and misconceptions about such activities were groundless. They even suggested giving homework assignments to patients so that they would act differently between sessions and facilitate such corrective experiences. In an attempt to justify their more liberal, if not seemingly radical, suggestion, they noted that "Freud himself came to the conclusion that in the treatment of some cases, phobias, for example, a time arrives when the analyst must encourage the patient to engage in those activities he avoided in the past" (Alexander & French, 1946, p. 39). The strategy was noted by Fenichel (1941), who made the following clinical observation:

When a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less. (p. 83)

In his analysis of how people change, Wheelis (1973) has suggested, "Personality change follows change in behavior. Since we are what we do, if we want to change what we are we must begin by changing what we do, must undertake a new mode of action" (p. 101). This observation has recently been confirmed by Horwitz's (1974, 1976) report of the Menninger Foundation Psychotherapy Research Project's finding that corrective experiences, provided to patients within the context of supportive therapy, resulted in as much long-lasting therapeutic change as did more traditional psychoanalytic psychotherapy.

In the case of behavior therapy, the same clinical strategy has been employed. Although behavior therapists have tended to place greater emphasis on the observable characteristics of the client's novel behavior patterns, rather than the more subjective experiences, they nonetheless encourage clients to do things in ways they have not tried before. Kanfer and Phillips (1966) refer to this as the "instiga-

tion" aspect of behavior therapy, the objective being to encourage the client to respond differently to various life situations. Clients are taught new ways to deal with various situations through role playing and are urged to try out these new behavior patterns as homework assignments (Goldfried & Davison, 1976; Lazarus, 1971; Wolpe, 1973). Although a variety of different behavior therapy procedures have been used in reducing clients' fears and phobias, several behavior therapists have suggested that the overriding clinical strategy involves having clients expose themselves to the feared situation (Agras, 1967; Bandura, 1969; Marks, 1969; Wilson & Davison, 1971). As stated by Bandura (1969), "Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither avoidance responses nor the anticipated adverse consequences occur" (p. 414). This conclusion is clearly consistent with Fenichel's clinical observations quoted above.

Among humanistically oriented therapists, one sees a similar strong emphasis on having clients experience change through concerted efforts to behave differently. Thus Schutz (1973) has indicated that one of the ground rules of encounter groups involves having clients take risks and attempt to respond differently: "Whatever you are most afraid of is the thing it is most valuable to do" (p. 425). A basic underpinning of gestalt therapy involves the importance of learning through personal experience, going beyond the mere discussion "about" these experiences (Fagan & Shepherd, 1970; Polster & Polster, 1973). One of the ways of furthering this learning is through *directed behavior*, the objective of which is to provide the client with "the opportunity for relevant practice in behaviors he may be avoiding. Through his own discoveries in trying out these behaviors, he will uncover aspects of himself which in their turn will generate further self-discovery" (Polster & Polster, 1973, p. 252).

A second possible clinical strategy that may be common to all therapeutic approaches consists of *direct feedback*, whereby patients/clients are helped to become more aware of what they are doing and not doing, thinking and not thinking, and feeling and not feeling in various situations. One of the first therapists to observe this phenomenon was Reich (1933/1949), who made the following fortuitous observation:

What is added in character-analysis is merely that we isolate the character trait and confront the patient with it

repeatedly until he begins to look at it objectively and to experience it like a painful symptom; thus, the character trait begins to be experienced as a foreign body which the patient wants to get rid of. . . . Surprisingly, the process brings about a change—although only a temporary one—in the personality. (p. 50)

Compare this observation with the more recent serendipitous finding by behavior therapists who, in an attempt to use self-monitoring procedures for assessment purposes, noted that their clients changed merely as a result of observing their own behavior. The typical conclusion reached by behavior therapists is that "when an individual begins paying unusually close attention to one aspect of his behavior, that behavior is likely to change even though no change may be intended or desired (McFall, 1970, p. 140). The similarity to the phenomenon that Reich unexpectedly uncovered is striking. In gestalt and encounter approaches to therapeutic change, considerable emphasis is placed on offering the client feedback, either from the therapist or from other group members. Bugental (1965) has suggested that providing feedback to the client is an essential component in enhancing personal awareness. And one of the procedural cornerstones of nondirective therapy (Rogers, 1951) has involved the therapists' attempts to reflect back to clients their thoughts and feelings.

No doubt there are other clinical strategies that may be common to psychoanalytic, behavioral, and humanistic approaches to therapy. I would like to emphasize, however, that my goal was not to outline all possible commonalities. Instead, it was to illustrate the level of abstraction on which we may need to focus in order to achieve such consensus.

### *Where Do We Go From Here?*

In our attempt to study the effectiveness of our therapeutic procedures, we have expended far too much energy investigating techniques that may not be all that powerful clinically. Far too much time and talent have been spent on the detailed and parametric study of trivial issues. The more recent trend toward comparative therapy research, in which one orientation is pitted against another, similarly has its inherent limitations. To the extent that common elements indeed exist across all approaches to therapy, such a research strategy is likely to undermine any differential effectiveness. Further, if there are inert as well as effective procedures associated with each therapeutic approach studied, such comparative research would not seem to be the most efficient way of uncovering effective

intervention procedures. As noted by Luborsky, Singer, and Luborsky (1975), "everybody has won and all must have prizes" (p. 1003).

On the other hand, it would be naive to conclude that the delineation of commonalities among different approaches to therapy will in itself result in consensus. A likely, although clearly unfortunate, reaction among some might be to conclude that "we're all doing the same thing" and to return complacently to their usual orientation and set of procedures. To be an eclectic is to have a marginal professional identity. By contrast, an identification with a school of therapy is likely to result in some very powerful economic, political, and social supports. After all, without a specific therapeutic orientation, how would we know what journals to subscribe to or which conventions to attend? Krasner (1978), in a candid analysis of the past and future in the behaviorism-humanism dialogue, commented on the factors that contribute to the continuation of varying schools of thought, noting,

In effect, each new slogan and label takes on a full and happy life of its own. I write not as a disinterested historian of this game but rather as a participant-observer with as much guilt (or credit depending on your orientation) as anyone else in the controversy between behaviorism and humanism. (p. 800)

The popularity of a therapy school is often a function of variables having nothing to do with the efficacy of its associated procedures. Among other things, it depends on the charisma, energy level, and longevity of the leader; the number of students trained and where they have been placed; and the spirit of the times. By contrast, there exist certain "timeless truths," consisting of common observations of how people change. These observations date back to early philosophers and are reflected in great works of literature. As suggested throughout this article, these observations have also been noted by most experienced and sensitive clinicians. *To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases.* Although it is clear that a systematic and more objective study of the therapeutic change process is needed to advance our body of knowledge, it would be a grievous error to ignore what has been unsystematically observed by many.

I do not mean to imply that these clinical observations will provide us with all the answers but, rather, that they can offer us an important supple-

ment to, if not a starting point for, other research approaches. Basic research on the origin and maintenance of various psychological disorders is clearly needed as well. I would also like to emphasize that I am not arguing against theory per se, but rather against the very strong temptation to engage in premature speculation. We need to have a clearer consensus on the observable phenomena associated with change before we attempt to theorize about them.

It is presumptuous to expect that any one person will be able to outline a set of common clinical strategies. Inasmuch as there exists a gap between theory and practice, any individual from a given orientation can never really be knowledgeable about the therapeutic underground within other orientations. Moreover, the "I-have-the-answers—come-follow-me" message that would accompany any one person's attempt at integration may only serve to put off one's colleagues, or perhaps even end up in the establishment of yet another school of therapy! What is needed instead is a more cooperative effort. Unfortunately this is not easily achieved. The field of therapy—and certainly other disciplines as well—places too much emphasis on the ownership of ideas, such that we are unwilling to consider the merit of certain notions if they come from those we do not consider to be part of our reference group. Though it would be nice to find cooperative efforts naturally occurring among scientists, it is perhaps more realistic to expect their behavior to reflect the competitiveness inherent in our society at large. Noting how the scientist's early desire to forward a common goal often falls by the wayside, David and Brannon (1976) have observed that "many students are originally attracted to science by [the] image of noncompetitive sharing, only to find a few years later that they are in a system not unlike the competitive world of business they once disdained" (p. 143).

It will be no easy task to get us to set aside our well-established, if not time-honored, practice of setting one approach against another and, instead, to work toward a rapprochement. What may be needed to get us to mobilize our cooperative efforts is *an attack from outside the system itself*. This clearly was the case during World War II, when scientists found themselves working cooperatively toward common goals. In the case of psychotherapy, there is a strong possibility that the attack from outside may come from questions associated with third-party payments. The pressure from governmental agencies and insurance companies—

as well as the growing consumer movement—to have us demonstrate the efficacy of our intervention procedures may very well serve as the necessary impetus for the cooperative effort the field so sorely needs. In a stimulating and challenging account of policymakers' growing interest in the empirical foundations of psychotherapy, Parloff (1979) pointed out that

members of our new audience are raising very pragmatic, prosaic, yet profound questions regarding the efficacy of the wide range of psychosocial interventions currently offered to the public. Clinicians and government officials are experiencing mounting pressures from such not easily disregarded sources as the courts, insurance companies, and national health insurance planners. Third-party payers—ultimately the public—are demanding crisp and informative answers to questions regarding the quality, quantity, durability, safety, and efficiency of psychosocial treatments provided to an ever-widening range of consumers and potential consumers. (p. 297)

My fantasy is that one day we might be able to have a working conference directed toward the goal of developing the field of therapy, not toward the advancement of any given school of thought or of any one individual's career. Parenthetically, it might be noted that Rogers (1963) called for a similar dialogue and search for commonalities some years ago, but the zeitgeist may not have been as hospitable at that time. In the hypothetical conference I am suggesting, the participants would include practicing clinicians of varying theoretical persuasions who would be willing to sit down and outline intervention strategies. Such a dialogue would ultimately need to include the direct observation of what actually occurs during the therapeutic process. These clinicians would not be asked to give up their own particular orientation, but to take steps to work toward some consensus. In breaking set and looking for commonalities, we might even find ourselves more willing to acknowledge the unique contributions that other orientations have to offer. Also present at this conference would be individuals who have been involved in therapy research. Their task would be to guide the discussion in such a way that the strategies outlined can be operationalized and put to empirical test.

It is my hope that the resulting research would address itself to the parametric considerations associated with each potentially robust clinical strategy, as it is not likely that a given strategy would apply to all problems and under all circumstances. This point has been made time and again by therapists of varying persuasions: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific

problem, and under *which* set of circumstances?" (Paul, 1967, p. 111); "The challenging question is not which technique is better than all others, but under what circumstances and for what conditions is the particular technique or particular kind of therapist more suitable than another" (Marmor, 1976, p. 8); and "What kinds of changes are affected by what kinds of techniques applied to what kinds of patients by what kinds of therapists under what kinds of conditions?" (Parloff, 1979, p. 303). Thus, if new, corrective experiences were seen as a common strategy, one would need to investigate the most effective tactic or technique for providing such experiences (e.g., individually, in groups, in imagination, via role playing, face to face), the number and nature of such experiences, the optimal level of emotional arousal needed for change to occur, and the extent to which the particular method of implementing the strategy interacts with other patient/client and therapist variables. On the topic of direct feedback, one might want to study the source of such feedback (e.g., therapist, self, peer, significant other) and how these specific procedures interact with other relevant variables.

Whatever merits there may be to what I have suggested, one needs to be realistic and, again, to recognize that this is by no means an easy path to pursue. Just as patients/clients often find it difficult to develop a new view of the world, so it is difficult for us to relinquish our theoretical paradigms. Kuhn (1970) has documented the reluctance of scientists to undergo a shift in paradigm, noting,

The source of resistance is the assurance that the older paradigm will ultimately solve all its problems, that nature can be shoved into the box the paradigm provides. Inevitably, at times of revolution, that assurance seems stubborn and pigheaded as indeed it sometimes becomes. (pp. 151-152)

Happily, Kuhn goes on to observe,

Though some scientists, particularly the older and more experienced ones, may resist indefinitely, most of them can be reached in one way or another. Conversions will occur a few at a time until, after the last holdouts have died, the whole profession will again be practicing under a single, but now different paradigm. (p. 152)

Clearly, we need to rewrite our textbooks on psychotherapy. In picking up the textbook of the future, we should see in the table of contents *not* a listing of School A, School B, and so on—perhaps ending with the author's attempt at integration—but an outline of the various agreed-upon intervention principles, a specification of varying techniques for implementing each principle, and an indication

of the relative effectiveness of each of these techniques together with their interaction with varying presenting problems and individual differences among patients/clients and therapists. I sense that the time is rapidly approaching when serious, if not painstaking, work on gathering the necessary information for such a text can begin.

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