Behavior Therapy: Redefining Strengths and Limitations

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This article highlights some of the strengths and limitations that have been associated with the behavioral approach to intervention. For each of behavior therapy's theoretical and empirical contributions, we point out how these very strengths may also paradoxically serve to limit its clinical effectiveness. For the most part, the shortcomings in behavior therapy's strength have come to light as the result of attempts to apply these conceptual and empirical contributions in clinical practice. Included among the "limiting strengths" is the fact that behavior therapy has provided the field with a fine-grained analysis of how individuals react to specific life situations; has been dedicated to the development and study of specific effective techniques; makes use of a skill-training orientation to therapy; focuses on the client's current life situation; has been influential in encouraging psychotherapy outcome research; and has provided various forms of intervention to reduce specific symptomatology. Some of the new avenues, often based on other theoretical orientations, that are being explored by behavior therapy in order to counteract some of its potential clinical limitations are also discussed.

By the end of the 1980s, a growing number of American psychologists involved in clinical and counseling activities identified themselves as behavior therapists or cognitive behavior therapists (Mahoney, 1991; Norcross, Prochaska, & Gallagher, in press).[1] Although a large number of therapists are self-declared eclectics, many claim that cognitive behavior therapy remains

one of their major methods of intervention. Moreover, psychodynamic and experiential therapists alike have been pointing to the behavioral contributions to their own approaches (e.g., Anchin, 1982; Barber & Luborsky, 1991; Bouchard & Derome, 1987; Greenberg, Safran, & Rice, 1989; Landsman, 1974; Messer, 1986; Norcross, 1988; Reid, 1987; Saint-Arnaud, 1987; Strupp, 1983; Wachtel, 1977). It seems fair to say, therefore, that a large percentage of psychotherapists have been directly or indirectly influenced by behavior therapy.

Having won recognition within the larger therapeutic community, behavior therapists have begun to evaluate their own shortcomings (e.g., Franks, 1984; Mahoney, 1980, 1991; Thoresen & Coates, 1978). Whereas behavior therapy was once believed to be successful in nine out of ten cases (Wolpe, 1964), there is now a healthy recognition that our techniques have a more modest impact. Behavior therapy is now also more open about its failures and, much to its credit, has attempted to learn from them (Foa & Emmelkamp, 1983). All this points to what we believe to be a positive trend in our ongoing growth and development.

Despite our self-examination and self-criticism, behavior therapy has remained a major force in psychotherapy. By developing new assessment and treatment procedures, we have broken set with numerous traditions, and in doing so, have provided the field with undeniable contributions. But behavior therapy, like other therapeutic orientations, is imperfect. It is not our purpose here to comprehensively review the status of behavior therapy. Instead, the intent of the present article is to highlight some of the strengths and limitations of the behavioral movement. For each of behavior therapy's contributions, we shall point out, in particular, how these very strengths may also paradoxically serve to limit its clinical effectiveness. Although our focus is on behavior therapy, it should not be concluded that all of these assets and liabilities are unique to this one orientation. Our goal, however, is to offer this evaluation of a system about which we know best. Nor do we wish to foster a uniformity myth, implying that each strength and limitation of behavior therapy reflects a comparable asset or liability that inevitably exists in all clinical situations or disorders. Still, we believe that general and rather global potential limitations of behavior therapy have often followed from its strengths.

Consistent with the experimental roots of behavior therapy, its major contributions have been influenced by basic and applied research, as well as by the theoretical conceptualizations associated with these findings. A point that we would like to underscore, however, is that it has been our attempts as behavior therapists to *apply* behavioral, conceptual and empirical contributions in clinical practice that have highlighted the shortcomings in behavior therapy's strengths. Thus, the limitations may be more in the way we conceptualize and do research than in the way behavior therapy is actually practiced. Fortunately, new avenues are being explored within behavior therapy in order to counteract some of its limitations. As we will point out, these avenues are often based on other theoretical orientations.

Strengths, Limitations and New Directions

Strength #1: Behavior Therapy Characteristically Provides Us with a Fine-Grained Analysis of How Individuals React to Specific Life Situations

Reflecting its well-established experimental roots, behavior therapy approached complex and debilitating human problems by dimensionalizing them so that they could be thought of in terms of *variables*, which may be defined in very specific ways. Bandura's (1986) concept of "reciprocal determinism," for instance, has provided a fine-grained analysis of how behavioral, cognitive, and environmental variables are all mutually influential in understanding human functioning. At a clinical level, the focus on specific determinants of human behavior, rather than on global characteristics of clients, has opened new therapeutic avenues. Thus, instead of concluding that the fearful individual was "not ready to change," behavior therapists created hierarchies of increasingly more anxiety-producing situations that would allow for an ongoing progressive reduction in anxiety. This behavioral emphasis on specificity is much like looking at problematic reactions under a high-magnification microscope. We have encouraged a detailed examination of problematic thoughts, feelings, and behaviors in specific life situations, and a good deal of clinical and research effort has been devoted to developing both methods for the assessment of these molecular interactions and procedures for changing them.

Limitations. Even though this has clearly been one of our strengths, it may also result in a limitation. There is a trade-off involved when we engage in a microscopic analysis; the higher the magnification, the narrower the field of vision. Thus, one of the shortcomings of much of behavior therapy has been its failure to look at *patterns* of behavior — patterns that may span different times and settings in a client's life. This tradition of situational specificity may be readily traced to the early writings of Mischel (1968), who established the behavioral view of personality as one that emphasized what people "did" in various situations, rather than what they "had" more globally. Disavowing such constructs as "traits," "needs," or "motives," Mischel (1969) went on to suggest that "what people do in any situation may be altered radically even by seemingly minor variations in prior experiences or slight modifications in stimulus attributes or in the specific characteristics of the evoking situation" (p. 1016).

In response to this argument against behavioral consistencies, Wachtel (1973) maintained that individuals who are likely to be seen in a clinical context almost by definition manifest behavior patterns that typically do not vary according to situation. Wachtel convincingly argued that it is precisely *because of* their failure to easily alter how they respond to situational changes that their functioning is impaired. It should be noted that in a later formulation of this issue, Mischel and Peake (1982) have suggested that although cross-situational consistency is unlikely, the temporal stability of an individual's prototype characteristics may be found.

New directions. There are a number of ways in which we can become more sensitive to more general patterns in our clients' lives. Wachtel (1977) has suggested that a psychodynamically oriented approach, particularly one that is interpersonal in emphasis, can be valuable in complementing behavior therapy by alerting it to the ways that individual interaction patterns may create problems in clients' lives. Also of relevance in this regard is the clinical-experimental work of Benjamin (1982), which characterizes reciprocal interpersonal relationship patterns along the dimensions of affiliation and control, as they occur both within and outside the context of therapy sessions. Focusing on the same dimensions of affiliation and control, Anchin (1987) has urged behavior therapists to incorporate several constructs and methods developed by interpersonal theorists within their empirical functional analysis of behavior. He argues that such expanded functional analyses would delineate important social factors that are generally disregarded in the current behavioral assessment of the antecedents, consequences, and nature of maladaptive behaviors.

The contributions of a system approach, as reflected in current trends within behavioral marital therapy, may also be viewed as a move to alleviate the microscopic limitation within behavior therapy. By looking at more global patterns of marital interaction — like using a lower magnification microscope with a broader field — we can have a clearer picture of the overall context prior to our use of a fine-grain analysis of the relationship. Enlarging our focus of intervention by addressing the client's interpersonal system may also improve therapeutic effectiveness. A review of the relative merits of individual and/or marital interventions by Jacobson, Holtzworth-Munroe, and Schmaling (1989) has indicated that behavioral marital therapy is as effective as cognitive behavior therapy for the treatment of depressive symptoms and, additionally, has a greater impact on marital satisfaction. As noted by Jacobson et al. (1989), considering the role of marital discord in precipitating and maintaining depression, the improvement of marital communication patterns might significantly reduce the client's relapse. In an attempt to capitalize on the potential synergistic effect of individual and marital interventions, Addis and Jacobson (1991) and Beach, Sandeen, and O'Leary (1990) have proposed theoretical and clinical guidelines to integrate cognitive behavior therapy and behavioral marital therapy for the treatment of depression. As a function of social support and other possible factors, the involvement of the spouse in the treatment of agoraphobia seems to increase the therapeutic effect of behavioral exposure methods (Barlow, 1988). Jacobson et al. (1989) have underscored this point, also reporting studies suggesting that the addition of marital therapy to traditional outpatient treatment can provide an effective treatment for both alcohol-abuse problems and the marital difficulties that are implicated in these problems.

Although behavioral marital therapy addresses important elements of the client's interpersonal system (e.g., the couple's reciprocal use of punishments), its focus of intervention is still perceived by some behavior therapists as too restrictive. Weiss (1980), for instance, has argued that by placing too much emphasis on the response or skill deficits of the partners (e.g., lack of positive reinforcers, communication-skills deficits), behavioral marital therapists have

failed to consider the complex "dynamics" of the marital relationship (e.g., struggle for control, motivation to maintain relationship homeostasis). Such a narrow focus, according to Weiss, may account for problems of noncompliance observed in behavioral marital therapy. In order to deal with couple resistance to change, Weiss has elaborated a "Behavioral Systems Approach" that integrates strategic or systemic techniques (e.g., reframing, paradoxical intention, confusion) with the application of behavioral marital therapy.

Strength #2: Behavior Therapy Has Typically Been Dedicated to Development and Study of Specific Effective Techniques

As behavior therapists, we have at our disposal a wide array of different techniques that we can use when encountering different clinical problems. Because the methods are fairly well specified, they can be readily taught, researched, and perfected. From the early efforts with systematic desensitization and behavior rehearsal to the more current work on exposure, communication training, and cognitive behavioral interventions, a considerable amount of clinical and research attention has been given to the development and study of different behavioral techniques. Behavioral methods of intervention have been subjected to extensive research, and many have been demonstrated to be effective in treating various clinical problems. Here, too, behavior therapy can have two limitations in its strength, in that less attention has been paid to (a) individual client and therapist differences, and (b) the underlying principle of change. Each of these limitations is considered, in turn, below.

Limitation A: Individual differences. With its emphasis on techniques, the behavior therapy literature may lead one to conclude that these methods can be adequately applied to all clients by all therapists. In this respect, we may have inadvertently contributed to maintaining one of the uniformity myths so aptly identified by Kiesler (1966). Consistent with the group comparison methodology that has characterized much of the outcome research on behavior therapy, individual differences have been viewed as "error" or "noise." This tendency to neglect individual differences, as most clinicians well know, can readily undermine the effectiveness of our methods. The tacit assumption that individual differences play a relatively minor role may very well be the result of what we read in the research literature, where, for experimental purposes, subjects are randomly assigned to different treatment procedures. The clinical-research dichotomy is most evident here; we know of no clinical behavior therapist who randomly assigns a client to an intervention.

New directions. This shortcoming has started to change, especially regarding the recognition of clients' individual differences along clinically meaningful dimensions. Clinical researchers, for example, are considering the interaction between the client's locus of control and the therapist's style of intervention. Thus, with highly reactant clients, a directive approach on the part of a therapist is likely to result in behavioral noncompliance (e.g., Beutler & Consoli, 1992; Shoham-Solomon, Avner, & Neeman, 1989). Beck (1983) has written about the sociotropic versus the autonomous client and the specific kinds of life situations that make them prone to depressive reactions. Karoly (1980) has described a number of individual differences in clients that may be rele-

vant at various phases of the therapy process, from the recognition of a problem, to making a commitment to change, to the maintenance of change. Glass and Arnkoff (1982) have argued for matching cognitive behavioral interventions with specific client styles of functioning (e.g., cognitive vs. action-oriented). Following this lead, attention to individual differences in the cognitive behavioral treatment of anxiety disorders has begun to yield promising findings. For example, Michelson (1986) found that agoraphobic clients who received interventions that were designed to address their specific anxiety response profile (e.g., cognitive, behavioral, or physiological) improve more than those whose cognitive behavioral interventions failed to address these individual differences. Preliminary findings by Nelson-Gray (1991) and her research group with unipolar depression similarly support the superiority of cognitive behavioral interventions that match the response class associated with the specific client's depression (e.g., irrational beliefs, social skill deficits, infrequent pleasant activities).

Much less effort has been made to identify specific therapist factors that should guide the selection and administration of particular behavioral interventions. This is noteworthy in light of research reviews pointing out the significant effect of certain therapist variables (e.g., personality, psychological adjustment) on client's improvement or deterioration (Crits-Cristophe et al., 1991; Lambert, 1989). An exception is the recent attention paid to the role of the therapist's personal reactions to the therapeutic relationship, which will be addressed in a later section of this article.

Limitation B: Overlooking principle of change. To the extent that we as behavior therapists think in terms of techniques, we may also at times lose sight of the underlying principle of change reflected in the technique. The failure to look at the underlying principle can, in turn, prevent us from considering and experimenting with techniques that might be even more effective in implementing the change principle. Consider the clinical example of a 35-year-old female therapist whom we saw in treatment. Although she seemed to be clinically competent, she was very unsure of her ability as a therapist, indicating that it had been several years since she worked in a clinical capacity. We suggested that perhaps what was needed was some practice, and we urged her to take the therapist's chair and take the role of the therapist, talking to an imaginary client — a client who was very unsure about her ability to do therapy. She did a good job as therapist in this role-play situation and, in fact, was able to help herself in developing greater confidence in her ability to resume her work therapeutically. The question is, was this a behavioral role-playing technique that we used, or was it a gestalt two-chair exercise? Our own view is that it is less relevant what we label our techniques, and more important that we identify their underlying principle of change. In the example given above, the important principle was to help the client obtain a more realistic vantage point on what she had been construing in a subjective and distorted way.

New directions. Recent contributions have illustrated how techniques derived from different theoretical models can be used to implement the same strategies or processes of change (e.g., Goldfried 1980a; Goldfried & Padawer,

1982; Prochaska & DiClemente, 1984). Moreover, this principle could prob- ably be implemented by any of a number of different methods. Once psy- chotherapists start to think more in terms of principles of change, rather than in terms of the techniques prescribed by their preferred theory, they allow them- selves the option of considering a far greater pool of intervention methods.

In nonbehavioral treatments, numerous clinical procedures have indeed been developed to implement different principles of change that are crucial to be- havior therapy, such as the facilitation of corrective experiences, ongoing reality testing, and, as mentioned above, the provision of a new perspective on self and the world (Brady et al., 1980). Consequently, we may well find that these intervention methods are not inconsistent with a behavioral model of change, and can complement our clinical repertoire (cf. Lazarus, 1981). In addition, some of these interventions may be more effective than the cognitive behavioral techniques we have developed for certain clinical problems. We should, for example, consider using the two-chair gestalt technique when dealing with problematic choices in a client's life, as it has been shown to be more effective than problem-solving techniques (Clarke & Greenberg, 1986).

Strength #3: Behavior Therapy Makes Use of a Skill Training Orientation to Therapy

In rejecting the disease model of psychological problems, behavior therapy has instead adopted an educational model, whereby clients are taught skills for coping with realistic life problems (Goldfried, 1980b). Thus, we serve not as healers, but rather as teachers, trainers, and consultants. As a reaction against early criticism that behavior therapy was undermining the client's autonomy and freedom of choice, we as behavior therapists developed a host of self- regulatory methods that could enable clients to function as their own ther- apists (Goldfried & Merbaum, 1973; Thoresen & Mahoney, 1974). Included among such coping methods have been relaxation, problem solving, cognitive restructuring, and interpersonal communication skills. Not only have these methods been useful within the clinical context, but they also have served as the bases for psychoeducational training programs, thereby reaching a broader population and having more far-reaching applications.

Limitation. Although this skill training emphasis has served us well in dealing with a number of clinical problems (e.g., unassertiveness), it may be limiting at times by fostering a tendency to lapse into a *didactic and overly directive approach* to intervention. In this regard, research findings by Patterson and Forgatch (1985) showed that therapeutic efforts at "teaching" parents to work more effectively with their children resulted in more noncompliance than did attempts at "support" and "facilitation." We have already alluded to the no- tion of psychological reactance and how that is likely to occur with certain individuals for whom there is a high internal locus of control. A clinical ex- ample may serve to illustrate this point a bit more vividly.

Take the case of a 32-year-old, somewhat obsessional male high-school teacher with a number of presenting problems. Should he marry? How well can he handle problems at work? How comfortable is he in social situations? He had been seen in the past by a number of other behavior therapists, all

quite skilled. Although improvements were observed, changes never seemed to be maintained over time. In working with him clinically, we encountered the same problems; changes would occur, but they would not last. It was only after a while that we realized that our didactic approach to teaching assertion, relaxation, and other coping skills was, in fact, responsible not only for our own failure to bring about maintenance, but probably everyone else's as well. By being directive in teaching him coping skills, we were also inadvertently giving him the message that he *needed* directing, thereby unwittingly undermining his own self-efficacy. Once we became aware of the implicit message that was being conveyed by the nature of the therapeutic interaction, it provided a turning point in therapy. Our strategy was to become very nondirective, on the assumption that he already had knowledge of and experience in the use of coping skills, and that his requests for direction and guidance, if satisfied, would only reinforce his lack of independence. Once the therapeutic relationship was based on a more nondirective footing, there was a very discernible positive change in his functioning.

New directions. Although cognitive behavior therapists have written about the importance of the collaborative relationship (e.g., Beck, Rush, Shaw, & Emery, 1979; Goldfried & Davison, 1976), we have been somewhat slow to recognize the inherent complexity and therapeutic value of the working alliance (see Bordin, 1979). Emerging from a psychodynamic tradition, the construct of the working alliance has been shown to predict the client's improvement in behavior and cognitive behavior therapy (see Gaston, 1990; Raue & Goldfried, in press). Interestingly enough, a study of expert therapists (Raue, Castonguay, & Goldfried, in press) found cognitive behavior therapists to be rated significantly higher on an observer measure of the alliance than were psychodynamic therapists. Despite this unexpected finding, it may well be that we as behavior therapists still have a lot to gain from the expertise of other therapists, especially when confronted with potential or actual strains in the therapeutic relationship. Safran, Crocker, McMain, and Murray (1990) have already illustrated the beneficial contributions to cognitive behavior therapy from psychodynamic and humanistic orientations by defining specific signs of alliance ruptures (e.g., expression of negative feelings), as well as the use of several strategies to address such strains (e.g., awareness of one's own feelings; adopting an attitude of "participant-observer").

Systematic efforts to establish and maintain a therapeutic alliance have particularly been emphasized in the cognitive behavioral approach to dealing with personality disorders. Linehan and her colleagues (Koerner & Linehan, 1992; Linehan, 1987), for example, have observed that challenging the irrational beliefs of borderline patients, or encouraging new ways of behaving, unwittingly serves to repeat the invalidating reactions of others that have painfully characterized their early social learning histories. By focusing on how borderline patients need to change, observes Linehan, the behavior therapist faces the danger of sending the latent message that they are deficient. Thus, the first strategy or her "dialectical behavior therapy" consists of establishing an accepting, empathic, and nondirective relationship. It is only after a strong working alliance has been secured with this patient population, and with their

feeling that they have been fully accepted for just the way they are, that more traditional cognitive behavioral techniques are implemented to help them acquire the coping skills that they generally lack.

Strength #4: Behavior Therapy Primarily Focuses on the Client's Current Life Situation

In behavioral interventions, the emphasis is on the "here and now" in the client's life, rather than the "there and then." In our attempt to avoid focusing on early childhood experiences — with the notable exception of dealing with issues of early abuse — we as behavior therapists have dealt primarily with what is going on between sessions in the person's current life. The objective is to provide homework assignments, so that clients can take behavioral risks and have success experiences. As a result of this focus on between-session experiences, behavior therapy has been successful in shortening the course of interventions. However, it may also have kept us from paying sufficient attention to two other distinct arenas: (a) in-session issues and (b) our own reactions to the client. Each of these limitations is considered, in turn, below.

Limitation A: In-session issues. Because of our focus on between-session problems or successes in the client's life, we may at times overlook in-session issues, sometimes to the detriment of therapeutic progress. Take the example of a 53-year-old depressed accountant who had a long history of previous psychodynamic therapy. He came to us because he wanted a more directive approach and something that would focus more on his current life situation. When assertiveness training was presented as a relevant approach in helping him to get better control over his current life and thereby alleviate his depression, the client responded with ambivalence. Although he wanted something that was different from what he had been doing in his past therapy, he continued to emphasize the need to get further insight into the developmental origins of his problem. We explained, however, that the primary focus would be on encouraging more structured types of success experiences. Although the client agreed to the intervention procedures, he resisted following through on homework assignments. The client became increasingly more depressed, and indicated that he was not getting what he wanted from therapy. Precisely because he was so unassertive, he had difficulty in showing his disappointment and anger directly. It was only after the focus was shifted to this in-session issue, and he was encouraged to express his anger toward the therapist more directly, that he finally acknowledged that he could benefit from assertiveness training. From that point on, he became more cooperative in going out and asserting himself in various life situations and started to feel much more empowered in his interpersonal relationships.

New directions. We noted earlier the importance of being mindful of how our directive interventions may at times lead to a client's reactance, as well as the need to maintain a good working alliance. At this point, we suggest that it is important for behavior therapy to acknowledge more generally that the therapeutic relationship can often provide us with a sample of the client's problem. That is, our interaction with clients can reflect a stimulus complex that at times may parallel the kinds of situations clients are having difficulty

with outside the sessions. We hasten to add that we are not suggesting that the therapeutic relationship is always essential for providing the setting in which change occurs. On the other hand, clinical experience has convinced us that the client's reaction to the therapist as a significant other should at times be the essential focus of therapy. As psychodynamic authors have noted for close to a century, clients' emotional reactions to the therapist (such as hostility and ambivalence) provide important cues regarding how they interpret and react to others in their lives (Messer, 1986). Wright and Sabourin (1987) have suggested that in behavior therapy, the exploration of client reactions (emotional, cognitive, and behavioral) toward the therapist can often lead to important benefits, such as the reduction of premature termination, the power struggle over homework assignments, or the minimization of clients' dependence at the end of the treatment.

The exploration of the client's reaction to the therapist has not been a preferred focus of intervention in behavior therapy, presumably because of the Freudian theoretical assumptions underlying the concept of "transference." However, several psychodynamic authors (e.g., Horowitz, 1988; Westen, 1988, 1991) have recently reappraised the transference construct from the perspective of experimental cognitive psychology – an area to which some cognitive behavioral therapists have urged a close link (Goldfried & Robins, 1983; Mahoney, 1980, 1991). Despite our "phobia of transference" (Wright & Sabourin, 1987), systematic efforts have been undertaken by some behavior therapists to use the client's reaction toward the therapist for therapeutic purpose.

For example, Kohlenberg and Tsai (1989, 1991) have proposed a radical behavioral approach to therapy that places a primary focus on the therapeutic interaction. According to this view, the client's ways of relating to the therapist (e.g., being mad at the therapist for not knowing everything) represent *the* best possible source of observation of the client's difficulty, as well as the most salient and effective target of change. Reactions such as "intimacy difficulties, including fears of abandonment, rejection, engulfment; difficulties in expressing feelings; inappropriate affect, hostility, sensitivity to criticism" (Kohlenberg & Tsai, 1989, p. 391) are described as operants or respondents. Kohlenberg maintains that such reactions are nonconsciously triggered by the therapeutic situations (i.e., controlling variables) because they have been learned from functionally similar interpersonal situations in the past (e.g., relationships with punitive and frustrating parents). The tasks of the therapist are to evoke, observe, reinforce, or extinguish the client's problems as they take place within the therapeutic session, to make the client aware of the functional relationship between the problematic behavior and the past and current environmental contingencies, and to provide the appropriate context to enable the client to learn more adaptive ways to behave. Although Kohlenberg interprets the therapeutic relevance of these guidelines from conditioning models, one can hardly fail to see the parallels to psychodynamic theory.

In our own practice (e.g., Goldfried, 1985) we have found it useful to pay attention to clients' perception of and reaction to us, as well as to encourage them to express the feelings generated by our way of interacting with them. These "in vivo" interventions sometimes require a less active or directive attitude, forcing us to maintain more of an observer's than a participant's role

(Sullivan, 1954), so as to gain invaluable information about the clients' contributions to their current relational difficulties. These interventions also permit clients to learn that the expression of feelings to significant others does not necessarily lead to the disastrous consequences that they may have expected (c.f. Alexander & French, 1946).

Limitation B: Our reactions to the client. With our relative inattention to the therapeutic interaction, we as behavior therapists have also often failed to recognize the importance of our own reactions to the client. Henry, Schacht, and Strupp (1990) have shown that clients can evoke therapist hostility (i.e., blaming, ignoring, separating), especially in therapists who are critical toward themselves. Not surprisingly, such reactions were associated with either no change or with actual deterioration. Although these findings were obtained in time-limited dynamic therapy, there is reason to believe that similar phenomena interfere with the conduct of behavior therapy (Raue & Goldfried, in press). As cogently described by Wright and Sabourin (1987), "countertransference" may preclude behavior therapists from attending to important material, may increase the risk of inappropriate punishment, or may lead the therapist to impose treatment goals that may not be in the client's best interest.

New directions. Several behavioral clinicians have recently attempted to demonstrate how the therapist's reaction to the client may serve important therapeutic purposes. As pointed out elsewhere (Goldfried, 1985), these reactions can provide invaluable information about how others in the client's day-to-day life may experience and respond to him or her. A similar observation was made by Kohlenberg and Tsai (1991), who have argued that, from a radical behavioral viewpoint, the appropriate expression of the therapist's private reactions can function as a natural reinforcement for clients, and that the awareness of repeated strong negative (i.e., punitive) reactions should be used as an indication for referral. Other therapists working within the general framework of behavior therapy have similarly begun to explore the use of self-disclosure to challenge clients' distorted perception of others (Arnkoff, 1983) and to prevent or address difficulties in the therapeutic alliance (Safran & Segal, 1990).

Strength #5: Behavior Therapy Has Been Influential in Encouraging Psychotherapy Outcome Research

Perhaps the most significant characteristic of behavior therapy, if not our *raison d'être*, is a commitment to bridge the gap between scientific training and clinical practice (O'Leary & Wilson, 1987). By advocating an objective and controlled evaluation of treatment methods, we not only have provided the field with effective and replicable techniques, but also have forced clinicians of other persuasions to demonstrate empirically their therapeutic effectiveness (c.f. Eysenck, 1952). As shown in Gordon Paul's (1966) landmark study, behavior therapy has developed sophisticated experimental methodologies and, more importantly, has moved the field of behavior change to new directions of research — from the evaluation of the effectiveness of therapy in general to the study of specific interventions for targeted problems. Hence, for O'Leary and Wilson (1987), behavior therapy has brought about a scientific revolution:

> Behavior therapy has radically changed the nature of re-
> search on psychological treatment methods. Both the
> quantity and quality of studies on therapy outcomes have
> increased dramatically. Innovative research strategies allow
> rigorous evaluation of specific techniques applied to par-
> ticular problems, in contrast to inadequate global assess-
> ments of poorly defined procedures applied to heteroge-
> neous problems. (p. 11)

Limitation. The dedication of behavior therapy to the evaluation of psy-
chological interventions has unquestionably been one of its most salient
strengths (see O'Leary, 1984). Nonetheless, our scientific contribution has been
primarily in the area of treatment outcome research. This emphasis has, in
turn, tended to divert research energies away from *process research,* the focus
of which is on studying the mechanisms of change. Consequently, although
behavior therapy has made significant strides in determining whether or not
various behavioral procedures work, we have yet to acquire a clear under-
standing of how they work.

New directions. Process research is hardly a new direction in the field of
psychotherapy. Therapy researchers primarily identified with psychodynamic
or humanistic orientations have conducted an impressive number of studies
on variables such as the clinicians' style, intentions, interpersonal skills, and
involvement (Orlinsky & Howard, 1986). A wealth of empirical data has also
been accumulated about clients' participation in therapy, such as data on their
degree of engagement, initiative, openness, insight, conflict resolution, and
emotional expressiveness (Elliott & James, 1989; Hill, 1990; Orlinsky &
Howard, 1986).

Although process research has provided some substantive and reliable
findings (see Orlinsky & Howard, 1986), it has not yet greatly advanced our
understanding of therapeutic change (Rice & Greenberg, 1984). As cogently
described by Strupp (1973), early process studies have been conducted in a
nonprogrammatic and isolated way. Moreover, some of the phenomena studied
(e.g., frequency of the verbal occurrences) have failed to address the complexity
of clinical reality and, therefore, remain distant from the real concerns of prac-
titioners. Fortunately, a new generation of process researchers has emerged
in recent years (Goldfried, Greenberg, & Marmar, 1990; Greenberg & Pinsof,
1986; Rice & Greenberg, 1984). They have developed innovative, yet rigorous,
research strategies (e.g., task analysis, interpersonal process recall, compre-
hensive process analysis; see Elliott, 1983; Elliott & James, 1989; Goldfried
& Safran, 1986), with the goal of discovering important mechanisms of change
in psychotherapy. Instead of focusing on the general issue of "therapy
process" — including virtually anything that transpired between therapist and
client (e.g., duration of silences) — researchers are now looking more specifically
at the "change process." Their methodologies are based on an intensive and
contextual analysis of significant events that take place in different treatment
phases. Still in its beginning stage, this new path of research has already led
to the identification of recurrent therapist interventions and their impact on

therapeutic change. Thus, Silberschatz, Fretter, and Curtis (1986) have shown that relative to theory-driven transference interpretations, therapists' interpretations that were specifically designed to deal with formulations of the patient's particular issues had more of an in-session impact.

With few exceptions (e.g., Goldfried, 1991; Schindler, Hohenberger-Sieber, & Hahlweg, 1989), behavior therapists have not been involved in the development and application of these new research methodologies. Thus, although behaviorally oriented researchers have been encouraged to study the effectiveness of other orientations (Wolfe, 1983), we may also be advised to consult psychodynamic and experiential therapy researchers on how to assess the significant patterns of interaction that may influence the outcome of our own interventions.

Strength #6: Behavior Therapy Has Provided Various Forms of Intervention to Reduce Specific Symptomatology

Rather than providing the same general approach to every type of psychosocial problem, behavior therapy has developed a variety of interventions directly targeting the client's problem. Guided by the theoretical assumption that the "symptom is the neurosis," behavioral interventions have traditionally focused on the manifest problem (vs. hidden or latent cause) as felt by the client and/or as observed by others. Behavioral methods are aimed at (1) emotions experienced as debilitating and uncontrollable (e.g., panic), (2) overt behaviors that the client wants to get rid of (e.g., compulsive rituals) or acquire (e.g., social skills), and (3) predominant and often explicit modes of thinking that interfere with functioning (e.g., catastrophic thinking). In doing so, we have made significant advances in developing methods for reducing the client's symptomatology.

Limitation. Because of the emphasis on treating problems that may best be characterized by Axis I disorders, behavior therapy has attended less to the *complexity of interpersonal problems* (e.g., personality disorders), instead dealing with explicit and isolated components of client functioning. And although the use of specific behavioral methods in treating symptoms has unquestionably helped to advance the field, it soon became evident that attention needed to be refocused to personality disorders as well, as they were found to undermine the successful treatment of Axis I problems (Mavissakalian & Hamman, 1987; Rush & Shaw, 1983; S. Turner, 1987). Although originally wary of dealing with the construct of personality, we as behavior therapists — like Freud before us — have begun to move from symptomatic treatment to working with more complex personality issues (Lazarus, 1981).

New directions. In addressing the question of personality difficulties, a growing number of cognitive behavior therapists have been inspired by the contributions of nonbehaviorists and have proposed new perspectives on how to conceptualize and treat emotional disorders. As mentioned previously, Linehan (1987) has underscored the importance of the therapist's empathic resonance in the treatment of borderline patients, acknowledging the pertinence of Rogerian and Kohutian models of change. Safran and colleagues (Safran, 1990a, 1990b; Safran & Segal, 1990), relying on the work of Sullivan,

Kiesler, and Bowlby, have enriched cognitive behavior therapists' concept of schema by integrating it with interpersonal and developmental perspectives. Knowledge of the teachings of gestalt therapy has also allowed them to highlight the role of affective processes in the development of psychopathology and adaptive human functioning. Based on the bridge that cognitive psychology has made between cognitive behavior therapy and cognitively oriented psychodynamic therapy, R. Turner (in press) has developed a model of behavior therapy that incorporates dynamic thinking in dealing with a client's interpersonal problems.

Many of our cognitive behavioral theoretical assumptions have also been undergoing a redefinition by a group of therapists referred to as "constructivists" (e.g., Guidano, 1990; Guidano & Liotti, 1983; Mahoney, 1991; Mahoney & Lyddon, 1988). Central to this redefinition is the belief in the individual's active participation in knowing and learning, the role of tacit processes in the perception of self and others, and the importance of emotional processes and interpersonal relationships throughout one's development. Guided by these assumptions, constructivists have developed treatments that focus on clients' history and unconscious knowing processes, and that recognize the importance of human subjectivity, intentionality, sense of identity, search for meaning, and the need for integrity. Constructivists' clinical practice is characterized by the expression and exploration of emotions, the acquisition of insights, and the establishment of a safe, caring, intense relationship that facilitates the exploration of self. Moreover, constructivists have emphasized the role of irrationality in human adaptation, the protective function of resistance, and the learning opportunities provided by relapse and regression (Mahoney 1991; Mahoney & Lyddon, 1988).

Clinicians operating within the more traditional cognitive behavioral framework have also been progressively more sensitive to the implicit intrapersonal and interpersonal aspects involved in severe psychological disorders (Beck, Freeman & Associates, 1990; Pretzer & Fleming, 1989; Young & Swift, 1988). Young and Swift (1988), for example, have identified tacit and enduring maladaptive schemas at the roots of various personality disorders. These schemas, such as "defectiveness/unlovability" and "incompetence/failure," are believed to have resulted from dysfunctional relationship patterns during childhood. In Beck and associates' cognitive therapy for personality disorders, similar basic assumptions (e.g., "I am powerless and vulnerable," "I am inherently unacceptable") are the focus of the treatment, as well as the client's weak sense of identity. Among the clinical issues emphasized in this approach are the patient's "transference" and difficulty with trust and intimacy and the therapist's frequent strong emotional reactions to the patient and need to set clear limits with regard to the patient's demands and behaviors (Beck et al., 1990).

In many respects, these recent efforts within cognitive behavior therapy have begun to integrate some of the suggestions proposed by Messer (1986) regarding how we can benefit from psychoanalytic therapy. For Messer, behavior therapy may find it helpful to foster the exploration, regulation, and integration of the client's inner reality (e.g., conflicts, emotions). Our clients may also benefit from an increased awareness of the origins of their problems in past conflic-

tual relationships, thereby fostering the understandability of their irrational thoughts and schemas. Behavior therapists, according to Messer, may also overcome treatment resistance by being alert to the private reactions that emerge for both participants within the therapeutic interaction.

Like Messer, our contention is that behavior therapy could become more comprehensive, flexible, and ultimately more effective if we went beyond attempts to solely or immediately plan to reduce symptomatology, modify actions, and correct false beliefs. The helpfulness of other strategies and interventions will clearly have to be judged empirically. In the meantime, their theoretical and anecdotical support at least deserve our serious consideration.

Conclusion

In noting the strengths and then highlighting the associated potential shortcomings of behavior therapy, it would be misleading to conclude that we are worse off than are adherents to other orientations. Indeed, over the years, we have developed a number of innovative, systematic procedures for dealings with a wide variety of clinical problems. Behavioral interventions have provided important breakthroughs in the treatment of anxiety disorders, have given impetus to the development of the field of behavioral medicine, and have made inroads in the treatment of a variety of problems in children. In addition, our advocacy of methodological behaviorism has underscored the need to specify one's clinical methods, and to subject them to empirical tests of accountability.

Not only have these tests confirmed that behavior therapy can provide some powerful interventions for certain clinical problems, but they also have imposed new methodological standards on the field. Other orientations, particularly psychodynamic approaches to therapy, have been influenced by our methodological behaviorism, as witnessed by the large number of therapy manuals involving short-term dynamic therapy that have been published (e.g., Klerman, Rounsaville, Chevron, & Weissman, 1984; Luborsky, 1984; Strupp & Binder, 1984). Experiential therapists have been less eager to submit their therapeutic claims to empirical verification. Despite the pioneering efforts of Rogers and his associates (see Mitchell, Bozarth, & Krauft, 1977; Truax & Mitchell, 1971), and with the more recent notable exceptions of Beutler and his colleagues (e.g., Beutler et al., 1991), Greenberg and his research group (e.g., Greenberg & Webster, 1982), and Mahrer and his associates (e.g., Mahrer & Nadler, 1986), there is relatively little in the way of research currently going on in this area. In fact, Wolfe (1983), of the National Institute of Mental Health, has announced that because there is a need for more empirical work on certain experiential procedures, behaviorally oriented researchers should be encouraged to apply for funding to study the effectiveness of such methods.

The clinical and methodological strengths of behavior therapy, however, do not make us a "species" apart. All therapeutic orientations have limitations and blind spots. We have suggested that each of the unique strengths of the behavioral approach to therapy carries with it a potential concomitant weakness: Our fine-grained analysis of how individuals react to specific life situations has often tended to obscure the more general patterns of functioning

within social systems. Our focus on developing and refining therapeutic techniques has caused us to attend less to individual client and therapist differences and general principles of change. Our adoption of an educational rather than a disease model, in which the emphasis is on teaching coping skills for dealing with life problems, has carried with it the risk of using an overly didactic and directive approach to intervention. Our emphasis on the client's ongoing, current life situation outside of therapy has diverted much of our attention away from potentially important issues within the therapy session itself. Our dedication to the demonstration of therapeutic efficacy through controlled outcome investigations has kept us in some situations from deploying our research efforts in process research. And our development of effective methods for reducing symptomatology has led many of us to pay less attention to the complexity of clients' interpersonal problems.

Recognizing such potential shortcomings makes us strong believers that behavior therapy can learn from other approaches, even in the treatment of disorders for which we have come to be identified as the "experts." Over a decade ago, Barlow and Wolfe (1981) reported on the deliberations of a state-of-the-art conference on the behavioral management of anxiety disorders. With phobias, one of the types of problem with which behavior therapy is particularly effective, Barlow and Wolfe indicated that exposure procedures have been successful 75% of the time. However, if one takes into account those individuals who refuse to participate in the therapy, as well as those people who drop out prematurely, this rate shrinks to 49% (Barlow & Wolfe, 1981). Although some would argue that this success rate will increase as we continue to learn more about the parameters of exposure methods, we would maintain that a potentially more effective approach is to consider the possibility that perspectives based on other orientations may help us as behavior therapists to assist our clients to accept the therapy that we offer, and to remain long enough in order to change. Clearly, this applies not only in the treatment of anxiety disorders, but also in the treatment of other types of clinical problems as well.

There is another important point that we would like to underscore. The strengths and concomitant potential limitations of behavior therapy have, for the most part, been based on our theory and research findings. As students of behavior therapy all too well know, however, the theoretical and research literature does not always faithfully depict what goes on in clinical practice (c.f. Goldfried & Davison, 1976; Lazarus & Davison, 1971). For example, a survey of behavior therapists who all obtained their doctorates from the same university (Stony Brook) revealed the not too surprising finding that those who were primarily clinicians were more likely to have gone beyond the behavioral model than were those who worked within an academic setting (Friedling, Goldfried, & Stricker, 1984).

What practicing behavior therapists have known as part of their clinical "underground" (Wachtel, 1977) is now being fed back to create a reevaluation of the model as a whole. Such a reevaluation does not imply a repudiation of the basic empirical, conceptual, and clinical tenets of behavior therapy. We have argued elsewhere (Goldfried, Castonguay, & Safran, 1992) that the cognitive behavioral approach, as well as the other major orientations, will

maintain its predominant position in the future landscape of psychotherapy. Although we believe that behavior therapy can maintain its integrity and contact with its roots, we are also convinced that its development may be enriched by incorporating theoretical and clinical contributions of other forms of psychotherapy. We are in total agreement with Kendall's (1982) Eriksonian developmental analysis of behavior therapy, in which he suggests that as a result of industry and hard work, behavior therapy has achieved a firm identity and is now ready to become intimate with other orientations. It is our belief that such integration could well lead to a better understanding and treatment of many of the problems we are likely to encounter clinically.

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