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The Behavior Therapies, with Special Reference to Modeling and Imitation*

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Ever since I. P. Pavlov and E. L. Thorndike, late in the nineteenth century, enunciated respectively the principles of conditioning and of trial-and-error learning, psychologists, educators, and physicians have been intrigued with the possibility of turning these principles to practical account in the fields of mental hygiene and psychotherapy. Prominent among those who, early in the present century, saw promising potentialities here were John B. Watson (1) and W. H. Burnham (2); but there were many others who gave at least passing attention to this approach, including James (3), Angell (4), Terman (5), and Franz (6).

Interest in learning theory itself was greatly facilitated, during the nineteen thirties and forties, by the work of such men as Clark Hull, Edward Tolman, and B. F. Skinner. And with the advent of World War II, there was also an enormous expansion in clinical psychology. The result was almost inevitable, namely, that efforts should be made to "integrate" these two fields, that is, to use learning principles to give concreteness and rigor to clinical psychology and to use clinical observations and experiences to challenge and stretch the concepts and "laws" of learning.

As Krasner and Ullmann (7) point out in the introduction to their recent book, Research in Behavior Modification, this effort at integration first took the form of attempts "to translate clinical phenomena into terminology acceptable to experimental psychologists" (p. 1). My own 1939 paper, "A Stimulus-Response Analysis of Anxiety and its Role as a Reinforcing Agent," (8), was one of the first efforts along these lines, to be followed by the work of Shaw (9), Shoben (10), Dollard and Miller (11), and others. Here the underlying assumption was that the psychodynamics of Freud represented the ultimate realities and that the language of the

* Presented at the Sixth Guthell Memorial Conference of the Association for the Advancement of Psychotherapy, New York City, October 31, 1965. Some of the material in this paper is adapted from a chapter entitled "Learning Theory and Behavior Therapy" which appears in Wolman's Handbook of Clinical Psychology, McGraw-Hill, New York, 1963.

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learning laboratory made possible a convenient and perhaps more generally
intelligible paraphrase. But as Krasner and Ullman go on to note, a
change has now occurred: "The recent procedures that have led to effec-
tive behavior modifications are direct applications of laboratory data and
principles (12-17; 7, p. 1). In other words, no one is much interested
today in merely restating freudian theory in the vernacular of learning
theory. Instead, the tendency is to approach both the problem of diagnosis
and of treatment in terms of concepts and methods which are indigenous
to the psychology of learning. The purpose of the present paper is there-
fore to review these "direct applications," as opposed to mere "translations,"
and to suggest how they may be given still greater pertinence and scope.

Behavior Therapy Type-I: Desensitization Procedures

In his 1958 book entitled Psychotherapy by Reciprocal Inhibition, Joseph
Wolpe (13) enunciates principles and procedures which will here be taken
as paradigmatic for behavior therapy Type-I. With stark simplicity he
states his thesis thus: "Since neurotic behavior demonstrably originates in
learning, it is only to be expected that its elimination will be a matter of
unlearning" (p. ix). "Most neuroses are basically unadaptive conditioned
anxiety reactions" (p. xi).

Therefore, rational therapy, according to Wolpe, will involve the elimina-
tion of these "unadaptive conditioned anxiety reactions" either by means
of extinction or by counter-conditioning, procedures which Wolpe lumps
together under the rubric of "desensitization." Remarkably enough, Wolpe
refers to this approach as "new." "Nobody else," he says, "tries to treat
patients on the reciprocal inhibition principle" (p. xi). A dozen or so
years ago I recall having heard the Canadian psychologist, Edwin Cameron,
in a lecture at the VA Hospital in North Little Rock, Arkansas, expound
the principle of "desensitization" and give a case history to exemplify its use.
In 1932 Knight Dunlap (18), in a book called Habits, Their Making and
Unmaking, elaborated his concept of "negative practice," which is essen-
tially an extinction procedure. And even earlier, in 1924, William Burnham,
in a widely read book called The Normal Mind (2), set forth the same
point of view as does Wolpe—he even spoke of "inhibition of the inhibi-
tions" (pp. 338 ff.).

The notion that "most neuroses are basically unadaptive conditioned
anxiety reactions," although couched by Wolpe in pavlovian language, is
of course also basic to Freud's whole approach, and thus goes back to the
latter part of the nineteenth century. According to Freud, the potential
neurotic is a person who, as a child, has been exposed to too severe and
unrealistic moral training, as a result of which he acquires fears which
stand in the way of normal impulse gratification and spontaneous, effective
personal functioning. Thus, the essence of neurosis for Freud was inhibition (he even wrote a book entitled *Hemmung, Symptom und Angst, or Inhibition, Symptom, and Anxiety*, the English version of which is called *The Problem of Anxiety* [19]); and therapy, by the same token, was a process of removing inhibitions. Freud, to be sure, often used more poetic and metaphorical language; but this, in brief, was his argument. Although Wolpe uses pavlovian rather than freudian terminology, his presuppositions seem to be almost precisely the same.

Thus, the historical facts do not at all support Wolpe when he says that his approach is "new" and that "nobody else" tries to treat patients on the reciprocal inhibition principle." Both freudian psychoanalysis and rogerian nondirective counseling are predicated on the assumption that the neurotic is suffering from unrealistic fears and that the way to get rid of them is for the therapist (and, hopefully, others) to become "warm, accepting, permissive, nonjudgmental, and nonpunitive," a procedure which is clearly calculated to bring about extinction of unrealistic fears and to produce confidence and spontaneity where there had previously been inhibitions, complexes, and "blocks." We may be duly grateful to Dr. Wolfe for stripping away some of the verbiage of other approaches and for streamlining his treatment procedures. But the underlying ideas, far from being novel, have been "standard equipment" in psychiatry and clinical psychology for more than half a century.

Now we turn to the question of results, the effectiveness of this general approach. By and large, we do not seem to like what we see. Under the sway of this type of thinking, psychotherapy has not unequivocally validated itself (20-23); and its implications and applications in the field of mental hygiene have likewise not led to very gratifying outcomes. In fact, there is some evidence for believing that the great emphasis upon "permissiveness" and unconditional "acceptance" in child rearing which has stemmed from the cognate approach to psychotherapy has, if anything, made matters worse rather than better. Within our society as a whole there seems to have been a pervasive sociopathic drift among our youth, dramatically highlighted by the comment a psychiatrist made to me not long

† Although Wolpe has made use of pavlovian terminology in describing his conception of psychopathology and its alleviation, it should be noted that there is a special set of concepts and practices which flows even more directly from pavlovian theory (especially the esoteric neurologic assumptions of Pavlov). These are what might be called pavlovian diagnostic and treatment procedures proper and are described at some length in a volume recently edited by Cyril M. Franks (16) and entitled *Conditioning Techniques in Clinical Practice and Research*. This line of endeavor, although not wholly unrelated, is somewhat peripheral to what is here referred to as Type-I Behavior Therapy. The interested reader should consult the Franks volume. In purest form pavlovian "psychiatry" is primarily neurologic rather than psychologic.
ago. He said: "Oh for just a few neurotic patients. Everyone I'm seeing nowadays seems to be a sociopath." Having told the parents of this country that the way to keep their children from being neurotic is to go easy on character training, it should not perhaps surprise us—if this advice was as mistaken as it now appears to be—that widespread sociopathy should follow as the fruit of such counsel (24, Chapter 13).

If psychotherapy along the lines just described had been generally satisfactory, it is unlikely that drug therapy would be having its present vogue. But it, too, is predicated on the assumption that the neurotic patient's problem is that he is having emotions which he ought not to have and that the way to make him more comfortable and thus "better" is chemical, rather than psychologic. It is, of course, too early to evaluate the new chemotherapies in any comprehensive way. But there are suggestive straws in the wind. Some persons, both in and out of mental hospitals, tell me that the "pills" just don't "do anything" for them, except produce distressing side effects. Others report relief, which, however, is often followed by the development of faulty judgment, irritability, addictive tendencies, and a kind of generalized personal incompetence. In some instances I have seen suicide attempts made under the influence of protracted drug usage which the persons thus involved later insisted would never have occurred if they had not been "on pills."

Currently, one segment of the medical profession is "enthusiastically" encouraging the use of lysergic acid (LSD) in the treatment of alcoholism and general psychiatric practice (25). When the bromides were introduced more than 60 years ago, extravagant hopes were expressed for them too; and in the intervening years many other chemical, electrical, and surgical interventive measures have come and gone. But none of them has solved the problem—mainly, I suspect, because the problem itself had not been accurately identified. Treatment procedures predicated on a misdiagnosis can hardly be expected to be highly efficacious.§

Wolpe reports that Type-I behavior therapy is 90 per cent effective as he uses it. Admittedly he employs it with a rather narrowly selected range of patients; but even so, this is an impressive level of accomplishment. We can only be grateful that Wolpe and his associates are giving energetic attention to and reviving interest in this type of approach. But even as they understand and apply it, it is, at best, of limited value; and there is perhaps reason to doubt its complete effectiveness even in those cases where it is assumed to be most pertinent. As I have pointed out on other occasions (27, 28), there are theoretical reasons for questioning the validity of Wolpe's interpretation of the nature of neurosis; and it would also be help-

§ For a recent survey of the unauthorized use of medically introduced drugs, as well as narcotics, see the Time-Life Report: The Drug Takers, (28).
few neurotic patients. Everyone I'm seeing is like that. Having told the parents of this unfortunate child that they were not the way to go, but perhaps surprise us—if this advice was not to be—that widespread sociopathy should have been (24, Chapter 13).

Lines just described had been generally satisfied with its present vogue, assumption that the neurotic patient's problem was a chemical, rather than a neuropsychiatric, one. In 1935 B. F. Skinner published a paper (30) in which he drew a fundamental distinction between two kinds of learning, one of which he called respondent conditioning and the other, operant conditioning. The first of these corresponds to conditioning proper or what is sometimes called Pavlovian learning. The other corresponds to what has traditionally been known, especially as a result of the work of Thorndike, as habit formation or trial-and-error learning. Although Skinner, early in his professional career, recognized these two forms of learning, the practical result, as far as he was concerned, was to dismiss so-called respondent conditioning from any further consideration and to concentrate, with extraordinary zest and effectiveness, upon operant conditioning.

Two innovations which came early in Skinner's work were: (a) The development of a standard apparatus for the controlled study of habit formation, now known as the "Skinner box," which involves, essentially, a small compartment in which a rat or other laboratory animal can learn to operate a lever or key as a means of obtaining food; and (b) the development of a type of cumulative recording of this kind of learning which depicts the subject's progressive behavior modification in an unusually meaningful and precisely quantifiable manner. As a result of these two developments, it became possible, for Skinner and the numerous collaborators whom he has attracted, to investigate significant problems in the psychology of learning with very few subjects (rather than the large groups hitherto required for standard statistical purposes) and thus to accumulate a vast quantity of new empirical data and greatly extend our knowledge of the parameters of this type of learning process.

Although Skinner and his followers have thus operated in the empirical tradition of Thorndike, they have revived and stressed the philosophical tenets of radical behaviorism, in the manner of Pavlov and John B. Watson. For them any reference to emotion or any other subjective state or phenomenon is regarded as scientifically quite inadmissible; and they postulate, categorically, that the behavior of living organisms is directly and exclusively a function of what they call environmental or stimulus control. Change the external environment, in the sense of reinforcement contingencies, they...
say, and you change a organism's behavior. They recognize, of course, that species differences, which are determined by heredity, do exist. But they do not recognize, in the domain of psychology, what Dabrowski (31) has recently called the "third factor," namely, the role of the organism itself— or what, as Krechevsky once suggested, the organism "brings to the situation," apart from heredity and environment in the immediate sense of the term.

As a result of the impressive research findings of the Skinnerians and their doctrinaire position, they have aggressively pushed forward into a number of applied fields, prominently including the training of animals for military and commercial purposes and the development of programmed academic learning for human beings, by means of various types of "teaching machines." But these are all background considerations, as far as present purposes are concerned. What is of principal importance for us here is the fact that in the mid-nineteen fifties Skinner and his associates began turning their attention to the possible application of their concepts and methods to the field of psychopathology. Although their claims still outstrip their accomplishments, their work warrants careful consideration.

A book by Skinner entitled Cumulative Record (32), contains a section entitled "The Analysis of Neurotic and Psychotic Behavior," wherein the author reproduces three papers which were published, respectively, in 1953, 1954, and 1955; and it is here that Skinner sets forth the presuppositions for what we are calling behavior therapy Type-II. These presuppositions are two in number:

1. An effective approach to the field of psychopathology must be predicated on the assumption that, practically speaking, there is only stimulus and response, with no intervening variables such as are commonly denoted by the terms thought and feeling. In other words, the organism, in this frame of reference, is essentially "empty," or if there are internal, subjective activities, they are epiphenomenal. As Skinner himself puts this thought, "the individual organism simply reacts to its environment, rather than to some inner experience of that environment" (p. 188).

2. An effective approach to the field of psychopathology, methodologically, will involve selective reinforcement of desirable behavior patterns and extinction of undesirable patterns, according to a procedure which Thorndike called "successive approximation" and Skinner has termed the "explicit shaping of behavior repertoires" (p. 191). Because there are no inner states of any consequence, the concept of "symptom" becomes meaningless. There is only more or less "troublesome or dangerous" behavior, which is subject to change by appropriate structuring of reward contingencies. Says Skinner:
THE BEHAVIOR THERAPIES

By manipulating the event called reinforcement [reward], it is possible to shape up many novel forms of behavior but also to sustain almost any given level of activity for long periods of time. . . . It is reasonable to suppose that such an experimental science will eventually produce a technology capable of modifying and sustaining any given pattern of behavior almost at will" (p. 198).

In the paper which appeared in 1955 ("What Is Psychotic Behavior?") Skinner reported that he and Ogden R. Lindsley had started some research with patients at the Metropolitan State Hospital at Waltham, Massachusetts; and he concluded on the following ebullient note:

In that bright future to which research in psychiatry is now pointing, we must be prepared for the possibility that increasing emphasis will be placed on immediately observable data and that theories of human behavior will have to adjust themselves accordingly. It is not inconceivable that the mental apparatus and all that it implies will be forgotten. It will then be more than a mere working hypothesis to say . . . that psychotic behavior, like all behavior, is part of the world of observable events to which the powerful methods of natural science apply and to the understanding of which they will prove adequate (p. 219).

Five years later, after the collection of approximately 4,500 hours of data from 60 psychotic patients, Lindsley (33) published a paper entitled "Characteristics of the Behavior of Chronic Psychotics as Revealed by Freeweight Conditioning Methods." Despite an expansive introduction, this paper concludes, modestly enough, as follows:

Much of what we have learned from our carefully controlled experiments appears in retrospect to be composed of things that skilled, experienced clinicians "knew" all the time. . . . But remember that we have the advantage of measuring these things automatically in the laboratory (p. 15).

Formerly at a Saskatchewan provincial hospital and now at the State Hospital at Anna, Illinois, Theodoro Ayllon and Associates (34-36) have instituted ward-management programs which use Skinnerian principles in an effort to discourage regressive behavior. At this juncture it appears that the Ayllon approach may be helpful in combating the institutionalizing effects which conventional mental hospitals often have upon patients, but it is not clear that it fathoms or effectively deals with the forms of behavior which precipitate personality crises. Nursing personnel (who were actively involved in Ayllon's procedures) seem to sense this shortcoming when they wonder if anything fundamental happens: "We've changed her behavior. So what? She's still psychotic, isn't she?" In other words, Ayllon's methods seem better designed to facilitate the institutional management of patients (in the sense of circumventing deterioration) than they are to deal with the character defects and faulty interpersonal strategies which cause people to come into mental hospitals in the first place. Although this
is admittedly an accomplishment of no mean order, it is very far from giving us a comprehensive therapeutic approach.

Ulman et al. (37) have explored the possibility of modifying the conversation of schizophrenic patients away from “sick talk” toward more healthy, normal, responsible utterances. The authors’ hypothesis is that in mental hospitals (and in the culture at large), sick talking (that is, complaining, referring to oneself as sick, blaming others, and so forth) commonly gets reinforced, and if one could change patients’ ways of talking, by selective reinforcement, it would have a constructive effect upon their behavior and the course of their careers as “patients.” This investigation, although hardly more than a pilot study as far as empirical findings are concerned, is noteworthy because it focuses on a problem that is a good deal more significant than those upon which other experiments on verbal conditioning have commonly centered.

Work along skinnerian lines with autistic children (Wolf, Mees, and Risley [38], Ferster [39]) and with mental retardates (Bijou & Orlando [40]; Barrett & Lindsley [41]) has also given promising results. But it is to be noted that, in general, the human subjects with whom these methods seem to be applicable are closer to the animal level of functioning than to the more fully evolved, adult human level. Skinner’s methods and concepts developed out of work with animal subjects, so it is not surprising that the whole “operant conditioning” approach is correspondingly limited in its human applicability. However, this approach manifestly has some legitimate uses at the human level and can, I believe, be fairly regarded as usefully complementing the form of behavior therapy which will be discussed in the next section.

Behavior Therapy Type-III: Social Reintegration

As indicated in the preceding section, behavior therapy Type-II has some very real though limited applications, which I see as complementary to, and in no way incompatible with, what I am here calling behavior therapy Type-III. Behavior therapy Type-I and behavior therapy Type-III, on the other hand, are antithetical. And I wish to introduce Type-III therapy by contrasting it with Type-I.

In both of these theoretical frameworks there is an order of phenomenon which, for present purposes at least, will be referred to as “symptoms,” a term which appears at the top of each of the drawings shown in Figure 1.\[5\]

\[5\] It should be pointed out that in Type-II therapy there is a tendency to reject the concept of “symptom” and to see only satisfactory or unsatisfactory behavior. Thus, no underlying emotional component is assumed and the attack is upon the symptom itself. This strategy is in some ways the strength, in other ways the weakness, of the Type-II approach.
Here it is assumed that symptoms are caused by emotional pressures and disturbances which, in the Type-I framework are the "unadaptive conditioned anxiety reactions" of Wolpe and the irrational moral fears and

**Figure 1**

Schematic representation of two conceptions of psychopathology. According to the more conventional of these (diagrammed at the left), the essence of "neurosis" or "mental illness" is an emotional disturbance or disorder which has been produced by inappropriate, irrational behavior on the part of others (parents, teachers, husbands, wives, employers, and so on). The alternative position (depicted on the right) holds that the crux of the problem is not emotional but behavioral. Given the deviant, duplicitous life style of the individual himself, his emotional suffering (insecurity, anxiety, inferiority feelings, guilt) is seen as thoroughly natural, appropriate, normal. The abnormality in the situation consists of the individual's secret deviations from the norms, standards, rules, "values" of his reference group. In the first conceptual scheme, one's own behavior is never seen at "causal," only the behavior of others (which, if one is consistent, must in turn have been caused by others, and so on to an infinite regress). And whatever the individual does, if it is in any way objectionable or "bad," is interpreted as "merely symptomatic of deep, underlying emotional problems." Thus, attention is focused almost exclusively upon emotions, with little or no responsibility accruing to the individual. In the other frame of reference, so-called symptoms (see Fig. 2) arise from emotional discomfort which is appropriate and well "earned," considering what the individual has done in the past, is still doing, and is hiding (a fact denoted by the parentheses). Attention is thus shifted from emotions to conduct and from what others have done to one's own actions.

scruples which, according to Freud, constitute the archaic superego. Now no one would accuse the individual himself of being directly and intentionally responsible for such inappropriate and crippling emotional states or reactions.
They can only have been produced, through conditioning, by the misdirected or malevolent efforts (or perhaps neglect) of others. Hence the term "Others" in Figure 1-a with the arrow pointing to, and thus implying causation of, the "Abnormal Emotions" shown as the middle term in this sequence.

In classic analysis, the therapist is always much interested whenever the patient reports anything about siblings, parents, or other "authority figures" which might be interpreted as having had an untoward, "traumatic" effect upon the individual during his childhood. And if, by chance, the patient says anything about the mistakes or irresponsibilities which he himself has manifested, these tend to be dismissed as reflecting "deep," underlying emotional disorder," that is, they are interpreted as mere symptoms.

Today, many of us have become quite disenchanted with this one-sided view of the matter and have begun to wonder why it is, if others can behave unwisely and irresponsibly toward us, that we ourselves cannot be given the "credit" for a few foolish, irresponsible actions. From time immemorial, human beings have not been held accountable for what others do to them—this, we say, they cannot help; but the very concept of social order is founded on the proposition that individuals can and must be responsible for what they do or fail to do. Thus, we are confronted by the possibility that, by concentrating upon the misbehavior of others as the cause of neurosis in a particular individual, we have seriously missed the mark not only in the matter of treatment but also diagnosis. This is not, of course, to deny the influence that others manifestly have in all our lives; but it does suggest that we are far less likely to be "wrecked," psychologically and emotionally, by what others do to us than by the dishonor and insecurity we bring upon ourselves by our own misconduct and duplicity.

Accordingly, in Figure 1-b, the second arrow, indicating causation, is rotated from its horizontal position in Figure 1-a down into the vertical position and there connected with what I have labeled "Deviant, Abnormal Behavior" on the part of the individual himself. Note that I have hyphenated the word "Ab-normal" to imply, not abnormality in the sense of disease or illness, but deviation from the established norms of the individual's reference group or groups. However, it is not our assumption that such behavior will, of itself, lead to the kinds of emotions and symptoms we associate with psychopathology. A second condition must be met: namely, the deviant behavior must be concealed, a fact indicated in the diagram by the large parentheses. Now the individual comes into a state of chronic insecurity, that is, he becomes vulnerable, first of all, to the possibility of being "found out" and called to account by his reference group; and if he has an active, well-developed conscience, he is also in trouble with it, regardless of whether he is caught or in danger of being.
caught by the external society. This, I suggest, is the essence of what we have previously called a “neurosis” but might better refer to as an “identity crisis” (42) or “sociosis” (43).

Note, in Figure 1-b, that the emotions arising from hidden misbehavior are not labeled “abnormal.” Given a knowledge of the individual’s total life situation, these emotions, however turbulent or painful, are seen as essentially reasonable, normal, and, if responded to in the right way, potentially helpful. What has been off, or “crazy,” is not the individual’s emotions but his conduct, which he has further complicated by the fact of concealment and denial. Thus, the center of emphasis and interest shifts from “Abnormal Emotions,” in Figure 1-a, to “Ab-normal, Deviant Behavior” in Figure 1-b. And if the latter conception is the correct one, it becomes apparent that many of the would-be therapeutic procedures which have been used in the past have been irrelevant, even misleading or actively harmful. On the assumption that the so-called neurotic person is suffering from “wrong” emotions, efforts to eliminate or correct them have often involved medication, electroconvulsive shock, surgical intervention, suggestion, reassurance, extinction procedures, and psychoanalysis. If the real problem lies, not in the area of involuntary “wrong” emotions but in that of deliberate, choice-mediated “wrong” behavior, it is perhaps not surprising that past remedial efforts have not produced satisfactory results.

Now we face the possibility that concrete, specific misbehavior, which has been kept carefully hidden, is the problem; and if this is the case, then the therapy of choice becomes what is here designated as behavior Type-III. Figure 2 represents a combination of Figures 1-a and 1-b, which have been presented as a means of depicting two theories of causation and etiology. Figure 2 will be used in the ensuing discussion of therapeutic strategies.

With Figure 2 before us, we are now in a position to give a functional definition of “symptoms.” As suggested by arrow b-b’, symptoms are the attempts made by the individual to “treat” himself, on the assumption that his problem is wrong emotions. Symptoms, thus conceived, are what Freud called “defense reactions” and Frieda Fromm-Reichmann termed “security operations.” That is to say, they are the individual’s own efforts to make himself feel better without being better, namely, without making any modification in his basic life style and on-going pattern of behavior. (Cf. one psychiatrist’s observation that typically patients “do not ask for change, they seek relief” [44]).

Thus we see that much of the professional “help” which has been given to neurotics in the past has been predicated on the same doubtful assumption as to where the trouble lies that the neurotic himself has been accepting. Both therapist and patient have been concentrating on feelings, emotions.
Combination and elaboration of the two diagrams shown in Figure 1. If, in the conventional frame of reference, the basic problem is an abnormality of emotions which has been produced by others, then "therapy" (a → a') would require some sort of treatment by others which would offset the mistreatment to which the individual has been previously exposed. Oddly, this is precisely what the individual's own symptomatic efforts (b → b') are designed to do—namely, make him feel better, without necessarily being better. Thus, "symptoms" may be defined as an individual's own attempt at self-cure which, like most professional treatment, assumes that the basic problem is wrong emotions, bad "nerves." If, however, the other hypothesis is correct and if the neurotic individual's emotional reactions (considered his ongoing life style) are essentially normal, we see how badly misguided such treatment is. Surely it is suggestive in this connection that, on the average, the apparent effectiveness of professional treatment does not exceed the incidence of "spontaneous remissions" in untreated persons. But if it is really the individual's behavior rather than his emotions which is abnormal, then "therapy," that is, the efforts of others to help him, ought to be directly toward behavior change (c → c'), rather than emotional re-education. And to the extent that this point of view begins to make sense to the suffering person himself, he will then start letting his emotional discomfort motivate him (d → d') to eliminate the questionable behavior and life strategies which have been producing the emotional upset, rather than seeking to eliminate the emotional discomfort directly (b → b'). When an emotionally disturbed person is able to see his predicament in this light, he will actively, independently, effectively set about "curing" himself (through confession and restitution) and will not need protracted treatment from others. Instead of continuing to be weak and needing to "receive," he will become strong and able to give.
And if this is not where the trouble lies, it is in no way surprising that their efforts, jointly or separately, have been about equally ineffective. As is now well known, our best studies of the outcome of traditional forms of psychotherapy show that they roughly match the rate of so-called "spontaneous remission," which is to say, what the individual himself tries to do about his situation, without professional assistance.

If, as now seems likely, the neurotic's problem is not at the level of wrong emotions but of wrong actions which have been systematically concealed, what does therapy or help in this changed frame of reference imply? "Others," as represented at the right in Figure 2, will be involved but in a way very different from that implied by arrow a→a'. The therapist, in this revised frame of reference, will direct attention, not to the patient's emotional discomfort, but to his deviant and duplicious behavior. And how is this best done? Sometimes, by merely suggesting to the neurotic individual that his emotional suffering may reflect unacknowledged and unresolved personal guilt; another can start the process of self-disclosure and self-authentication which will restore the individual's sense of identity and his social integration. But not infrequently, "modeling" of radical honesty by the therapist will be necessary. This procedure is, of course, a radical innovation as far as conventional psychotherapeutic practice is concerned. Typically, the helping person has been expected to play a highly impersonal, professional role; and for a therapist, thus conceived, to disclose anything about himself has been regarded as very bad form. In psychoanalysis such behavior has been condemned on the grounds that it would interfere with the all-important transference; and in rogerian counseling it would be seen as a violation of the tenet of client-centeredness. But neither of these forms of therapy, nor any of their many derivatives, has produced very striking results. And we can now perhaps say why. They have all involved a quite remarkable pedagogical paradox: the therapist never does what he expects the patient to do!

What, in conventional therapy, does the therapist do which, if imitated by the patient, would be particularly therapeutic? The therapist is silent a good deal of the time, and the patient is expected to talk. And when the therapist does speak, it is usually, in psychoanalysis, to make interpretation or, in rogerian counseling, to reflect and hopefully clarify what the client has said. Although we have all seen patients who, in this context, begin mimicking their therapists, such behavior, however reasonable, is not particularly adaptive. If, on the other hand, the therapist exhibits to the patient radical honesty and openness about his own life, its mistakes and its lessons, this is a kind of role with which the patient can readily identify, and to good therapeutic effect.

In Type-III behavior therapy, conditions are deliberately created which
are designed to foster this type of identification: the therapist models the behavior he expects the patient to learn, identification with the therapist is actively encouraged, and acting-like-the-therapist and "getting well" are one and the same process, not antithetical. That is to say, by this process of identification or imitation, the patient begins taking down the parentheses around his life, not just with the therapist but with Significant Others, and begins changing. Moreover, as a result of the therapist calling attention to the area of duplicitous behavior rather than mere emotions, the patient's erstwhile efforts at self-cure, that is, his "symptoms" (a-a'), change into constructive efforts at self-modification at the level of behavior, as shown in Figure 2 by the arrow c-d'. And once the individual comes to understand that here is where his real problem lies, he can take the initiative and manage his own "therapy," with a minimum of further treatment by anyone else.

Elsewhere (45, 28, 46) I have reviewed both clinical and experimental evidence in support of the kind of theory and practice that is involved in behavior therapy Type-III. Here I shall cite two new lines of support. In a series of ingenious researches with children, Albert Bandura (47) has shown the great effectiveness of modeling behavior on the part of a teacher as opposed to the mere rewarding of successive approximations to the desired behavior on the part of the child, without modeling by the teacher. The results of one of Bandura's studies are shown in Figure 3. A few sentences from Bandura's report will suggest the tenor of his own thinking here:

I shall present some research supporting a theory of no-trial learning, a process of response acquisition that is highly prevalent among Homo sapiens, exceedingly efficient and, in cases where errors are dangerous or costly, becomes an indispensable means of transmitting and modifying behavioral repertoires (p. 312).

While operant conditioning [trial-and-error learning] methods are well suited for controlling existing responses, they are often exceedingly laborious and inefficient for development of new behavior repertoires. The fact that a patient and persistent experimenter may eventually develop a novel response in an organism through the method of successive approximations, provided he carefully arranges a benign environment in which errors will not produce fatal consequences, is not proof that this is the manner in which social responses are typically acquired in everyday life (p. 313).

In cases in which a behavioral pattern contains a highly unique combination of elements selected from an almost infinite number of alternatives, the probability of occurrence of the desired response, or even one that has some remote resemblance to it, will be zero. Nor is the successive-approximations shaping procedure likely to be of much aid in altering this probability value. It is highly doubtful, for example, that an experimenter could get a mynah bird to sing a chorus of "Sweet Adeline" during his lifetime by differential reinforcement of the bird's squaws and squawks. Nevertheless, a recent appearance of a gifted mynah bird on television
of identification: the therapist models the therapist but with Significant Others, and the result of the therapist calling attention to the patient's "symptoms" (a-a'), change into a reaction at the level of behavior, as shown. And once the individual comes to understand what is wrong, he can take the initiative and a minimum of further treatment by anyone who reviewed both clinical and experimental of theory and practice that is involved in here I shall cite two new models of support processes with children, Albert Bandura (47) has modeling behavior on the part of a teacher modeling of successive approximations to the de- the child, without modeling by the teacher. The studies are shown in Figure 3. A few will suggest the tenor of his own thinking supporting a theory of no-trial learning, a process that is recently prevalent among Homo sapiens, exceedingly dangerous or costly, becomes an indispensable behavioral repertoires (p. 312).

[Graph: Phases of the Experiment]

Experimental results reported by Bandura (47, p. 315) showing the heuristic value of "modeling" on the part of a teacher. The lack of modeling on the part of conventional psychotherapists may account, in considerable measure, for the common lack of therapeutic benefit (learning, "improvement").
therapy? No attempt will be made here (cf. 45) to answer this question. Suffice it to say that efforts are now being made to correct this oversight of the past.

Although Bandura is critical of what can be accomplished by operant conditioning (trial-and-error) methods in contrast to the modeling-imitation procedure, it is interesting that several investigators who operate within the skinnerian framework are also providing a remarkable form of support for some of the presuppositions of Type-III behavior therapy. As already indicated, it is here assumed that once the patient's attention has been appropriately re-directed from the b-b' type of concern to the d-d' objective, he becomes capable of self-directed change, and thereafter requires very little in the form of therapeutic guidance by others, except as that is forthcoming in the natural, open interaction with the Ordinary Others in one's life (cf. also Dabrowski's concept of "self-education" and "autotherapy" [31]).

A number of investigators who proceed along skinnerian lines have recently become interested in the general problem of self-direction and self-control (49, 50). Here, for example, are some comments which Goldiamond (51) has made on this score:

Psychotherapy and counseling are classical approaches to behavior modification, and considerable attention has been devoted to operant control of events within the session; the verbal behavior of the patient may be affected by contingencies supplied by the therapist (32).

Another procedure involves self-control. This consists in training S to recognize those behaviors of his which he wants to modify. Rather than our telling him to modify them (something which he may have already told himself), he is trained in the experimental analysis of behavior, and also in the variables which maintain it, or which he can recruit to modify it. . . . The weekly therapy sessions then become research conferences, as though between a professor and his research associate on what has to be done next to bring the organism's behavior into line. The S is the acknowledged expert in the content of the field—his own behavior and its ecology—and E brings to bear on the problem his knowledge of procedures and past effects. Eventually, as in a good professional relation, S may become an independent investigator, capable of tending to things on his own (pp. 153-154).

On another occasion (53) I have suggested an analysis of stuttering in the more explicit context of behavior therapy Type-III, and I have also repeatedly suggested (cf. 45) that the way to strengthen will power and self-control is through commitment to a policy of openness with respect to one's life. But it is nonetheless interesting that even Type-II behavior therapists are recognizing the necessity and possibility of teaching "neurotic" individuals to restructure the reinforcement contingencies of their lives so as to bring about, largely under their own direction, marked behavior changes.
To resort to the language of cybernetics, we may thus say that a neurotic is a person who, by deception, has obstructed the “feedback” which would normally occur by way of criticism or correction following openly deviant behavior. All that a “neurotic” person needs to do in this connection to insure radical behavior change is to commit himself to a policy of strict honesty with respect to his behavior. And modeling of the type described in this paper is by all odds the most effective means I know of getting this type of change in personal and interpersonal strategy. Although Goldiamond, in the study cited, does not explicitly speak of modeling and imitation, it is significant that he engages in mental operations and behaviors which he encourages the subject to adopt and makes the whole procedure, as he says, “public knowledge.” Here is education rather than treatment, with the therapist modeling what the patient is supposed to learn, instead of engaging in treatment procedures which the patient is specifically enjoined not to imitate. Only in a situation in which the so-called patient is encouraged to become as much like the so-called therapist as possible can we look for maximally rapid and maximally enduring behavior modification.

CONCLUDING OBSERVATIONS

Today, with increasing urgency, the question is being asked: What is “neurosis”? And there are two major schools of thought concerning the answer. One school holds that “neurosis” is basically an illness, a disorder which calls for treatment; whereas the other maintains that the problem is more akin to ignorance and calls for teaching, instruction, training, persuasion, by others—and initiative, special effort, “study” on the part of the individual himself. The first of these approaches is now commonly referred to as the medical model and the second as the educational, or psychosocial, model.

In one respect, all three types of behavior therapy, as they have been delineated in this paper, presuppose the educational model, that is, they all assume that “neurosis” involves, in one way or another, anomalies of learning; and, by the same token, the elimination of such a condition calls for some form of teaching. According to Wolpe (Type-I behavior therapy), “neurosis” always involves the adventitious (“traumatic”) learning of unrealistic fears; and the preferred means of eliminating them involves teaching the subject to relax and then associating, in imagination, the thing or situation feared with the relaxed state (54). In Type-II (skinnerian) behavior therapy, the assumption is not that the individual has learned false fears but that he has failed to learn effective and socially acceptable overt behavior; and change is sought through altered “reinforcement contingencies,” namely, the structure of rewards and punishments, in the subject's
environment. In Type-III (integrity) therapy the assumption is that the subject has mistakenly ("stupidly") decided that deception, denial, "phoiness" is a good personal strategy; and here the greatest "help" another can give is to encourage, persuade, "inspire" (cf. Jourard, 55) that person, by means of "sharing" and "modeling," to try honesty and openness as an alternative personal strategy.

Thus, all three types of behavior therapy, as they are here conceived, assume that "neurosis" is not really a neurosis, i.e., an "osis" or disorder of the nervous system. The problem is rather that of a structurally normal nervous system functioning in inappropriate ways (cf. Adams, 56).

And what is the criterion of "appropriateness"? By and large, it is social. In Type-III behavior therapy, the problem of "neurosis" involves socially deviant behavior which has been carefully concealed from the persons whom Sullivan has aptly called "the Significant Others." And here the subject's "neurotic" insecurity and fears are assumed to be in the nature of personal guilt and to be quite realistic and "objective." In Type-II behavior therapy, the condition to which therapy is applied is again social. Skinner has already been quoted as saying that, in his frame of reference, the essence of a "symptom" is that it involves behavior that is "troublesome or dangerous," to some one or more human beings. And Wolpe (54) also concedes that "neurotic responses" are often "conditioned to situations involving direct interpersonal relations ... personal relationships ... the mere presence of a particular person" (pp. 169-190). It should be added that for Wolpe this is not invariably the case: "Neurotic responses" may also become conditioned to animals and inanimate objects and situations. Nevertheless, the condition with which all three forms of behavior therapy are concerned is more aptly denoted by the term sociosis (43) than by "neurosis." The latter term is not descriptively accurate and will hopefully be replaced by this other, more meaningful and precise term. (One of the immediate and tangible benefits of such a change in terminology is that it encourages anxious persons to stop saying, to themselves and others, "My nerves are bad," and to say instead, "I am not relating satisfactorily to other people," that is, it encourages such persons to give up what Ullmann has called "sick talk" and to look instead at their past and on-going conduct. And, indirectly, it also has the desirable effect of shifting the emphasis from how a person feels, over which he himself has no direct control, to the realm of concrete, specific, behavioral acts, where self-direction and change are possible (cf. 28).

But there is an even more salient difference between Type-I behavior therapy and the other two types. Wolpe states his philosophy of "neurosis" and its treatment, succinctly, as follows:

The germinal cause of the convocation of this conference is the presence of a
vast problem: how to lift the burden of suffering that neurosis imposes upon humanity. The foremost task of the clinician is always the relief of suffering, and his effectiveness in accomplishing it depends upon the potency of the methods he uses (37, p. 5).

Here there is total disregard of the possibility that “neurotic” suffering may be self-induced, namely, the result of one's own deviant, irresponsible behavior; and if this be the case, then any therapy which sets out to “relieve” this suffering directly—without permitting it, so to say, to do its intended “work”—is open to the criticism of short-circuiting a natural and necessary process of personal growth and improved social integration. And it is at precisely this point that the contrast between the medical model and the educational model of “neurosis” becomes most pointed. Although Wolpe subscribes to the educational model to the extent of agreeing that treatment involves “teaching,” the objective of this teaching, by his own statement, is “relief” (really fear extinction) rather than learning in a positive and constructive sense, namely, “education.”

In a paper entitled “Moral Aspects of Mental Health,” Nathanial S. Lehrman (58) has trenchantly discussed this issue as one which has not, in his judgment, been adequately acknowledged by the psychiatric profession. He says:

There are usually two different aspects to the problems of those coming for psychiatric assistance: the discomforts they experience, and the moral or social conflicts that almost always produce this distress. Although clergymen have recognized and grappled with moral and social conflicts throughout the years, psychiatrists and other mental health professionals tend to avoid them. They usually deny quite explicitly that they have any responsibility to counsel, to give advice, or to judge between people. Their primary orientation is toward the reduction of pain; but, as we have seen, this reduction of pain can occur without regard for either ethical considerations or the rights of others (p. 7).

Since Wolpe, as already indicated, is primarily concerned with “the reduction of pain”—or, as he phrases it, “the relief of suffering”—rather than behavior change in the direction of improved personal and social integration, his approach, in this respect, does not really qualify as behavior therapy. He does not assume that the suffering person needs to change his behavior, as a means of becoming more comfortable. Instead, he assumes that the individual has been mistreated by others, “behaved-against,” and is in no way responsible for his condition. In this respect, Wolpe’s assumption is, of course, basically similar to that underlying classic psychoanalysis. The premises of Type-II and Type-III behavior therapy are manifestly different. Wolpe assumes that “neurosis” represents a learning excess—unrealistic fears which the individual needs to get rid of, be relieved of; whereas the other two forms of behavior therapy both posit a learning deficit, a behavioral...
inadequacy. And here responsibility for change, improvement, "cure" comes back much more directly upon the individual himself. The Skinnerians at first took the position that "treatment," within their context, had to be administered, step by step, by others. But, as already noted, Col- diamond and others are now recognizing the importance of "involving" the other individual as well. And in Type-III therapy, the ability and responsibility of the disturbed individual himself for effecting change is particularly emphasized.

Against the background of this discussion, some additional comments by Lehrman are very much in point:

When moral standards are equated with punitive enforcement, rejection of the latter produces abandonment of the former also. The result of jettisoning moral standards in this way is, of course, moral anarchy. The idea that laws and man are eternally in conflict, and that codes are therefore followed primarily because of fear, is scientifically unsound. The importance of adherence to moral codes from positive devotion is underestimated by both psychiatry and the mental health movement (p. 8).

The net effect of all these denigrating psychological studies is to deny that good really exists, and to imply that individual freedom from anxiety, rather than social usefulness with its accompanying stresses, should be the prime purpose of living (p. 9).

And then, in response to the question, "What is to be done?" Lehrman says:

The present situation in mental health clearly warrants some fundamental revaluations. More attention to the moral codes of psychiatry and mental health might seem preferable to some of the present hoop-la for bigger clinics and more organizations. If the overall medical effectiveness of already existing clinics is dubious, what is the use of new ones? And when they do help individuals, how often do they do so by making immorality more comfortable? (p. 9).

The mental health movement may have some soul-searching of its own to do, in addition to assisting the professionals to reexamine their work . . .

Mental health education may also deserve another look. What are the mental health principles so widely presented to lay groups and community leaders? Do they sometimes include the vague hopelessness and overall defeatism so pervasive in the writings of Freud? Do they include the condoning of selfishness and immorality that sometimes occurs in the clinical practice of his followers? Or is this education primarily based on a more responsible kind of morality? (p. 10).

Because Integrity Therapy explicitly articulates with the concerns here suggested by Lehrman, it is the type in which I, personally, have the greatest interest and investment. But I believe behavior therapy Type-II also has some legitimate complementary, or at least supplementary, uses. The place of Type-I therapy is, however, much less clear. Certainly it is not a universally applicable procedure. Conceivably it is applicable in some in-
the behavior therapies

The remaining possibility is that it is never really indicated and when used merely obscures much fundamental personal and interpersonal considerations. Further experience and empirical evidence are, it seems, the only bases on which such issues can be ultimately decided.

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