What *Really* Causes Psychotherapeutic Change?

Albert Ellis and Hans H. Strupp (1997)
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In the Fall, 1967 issue of VOICES: *The Art and Science of Psychotherapy,* the editors have continued and augmented the policy of having most of the major articles discussed by a therapist of a somewhat different persuasion than the writer of the article. This, I think, is an excellent idea: for it gives something of a two-sided approach to each paper. It also leads to interesting results: since in most instances, the discussant tends to conclude that although the therapist reporting on his particular manner of treating phobias (which was the central theme of this issue of the journal) seems to have obtained valid results—his patients probably changed for different reasons than the ones which he emphasizes.

Thus, in his article, *"What Time and Experience Have Taught Me Concerning the Treatment of Phobias,"* O. Spurgeon English notes that "phobic people need considerable pressure in re-training their thinking, their value systems, and in being obliged to make healthy changes in these areas" and stresses the importance of active, directive, educational attacks on phobias. But Richard Felder, in his comments on this article, mainly objects to English's "referring to a person as a case," and strongly implies that much of his effectiveness in treating his phobic patients is because he really sees them "as people for whom he deeply cares."

In a paper on *"Phobic Patients: Treatment with the Learning Theory Approach of Implosive Therapy,"* Thomas J. Stampfl and Donald J. Levis emphasize anxiety-creation, learning theory, and training by homework assignments as the key factors in their therapeutic method. But Paul Z. Frisch, in discussing their article, hypothesizes that the faith of these therapists in their own system as well as their "commitment to a human being" are the real reasons for their success in helping the patient to change.

In her article, *"A Treatment of Phobias: Hydropsychotherapy Technique,"* Lily Wiener stresses that "progressive relaxation in warm water enables one to isolate the phobia and relate it to its source." In his discussion of Ms. Wiener's paper, however, John E. Barnett, Jr. hints that "much more is going on than is actually stated" and that her therapy is effective mainly because "the person of the therapist is made real, 'in charge,' reliable, and willing to share competence and confidence."

In my own paper in this issue of VOICES: *"Phobia Treated with Rational-Emotive Psychotherapy,"* I emphasize a highly active-directive, cognitive rather than relationship approach to a phobic patient; and I state that "this kind of a direct, philosophically-based homework-assigning attack on the phobiac's basic perfectionism works beautifully with some patients and reasonably well with many others who are not reached at all by more passive and historically-centered approaches." In their discussion of my article, R. R. Potash and J. Edward Taylor first note that "although Rational-Emotive Psychotherapy is effective from this account, it is not very rational, nor very emotive, and is probably better called *behavioral therapy;"* and then they give, as the main reason *why* this learning-type therapy works, the theory of Jay Haley that "the paradoxes and inconsistencies of Dr. Ellis' relations to this patient go on and on."

From various comments by practicing therapists on their colleagues' work, it would appear that either many of us are utilizing modes of treatment that we do not sufficiently acknowledge or stress; or many of us are attributing others' therapeutic successes to "real" reasons which are not actually valid. Both these points, of course, may well be partly true. Advocates of a given school of therapy may do much more than they think or say they do; and critics of this school may give their own specious reasons why the school's methods actually work.

The question still remains: What *really* causes psychotherapeutic change? The only honest answer to

this question at the present time is that *no one actually knows,* because the considerable amount of research that would have to be done to give answers has only slightly been started. Let me, as a possible prelude to doing this much needed kind of research, provide a general outline of what might be looked for when it is done.

To determine the main requisites for therapeutic change, it might well be best to look, first, at the basic causes of personality rigidity or "emotional disturbance." Many such causes have been hypothesized by different theorists, from ancient philosophers and theologians to modern biological and social scientists. Most of these, and possibly all, I believe can be subsumed under the following major headings:

1. Perceptual-cognitive factors. People perceive and think about themselves and the world around them in a highly fallible, often unrealistic manner. Their perceptions are biased by their conceptions (e.g., they often see what they think they *should* see), and their cognitions are unduly influenced by their perceptions (e.g., they frequently think that sugar, coffee and tobacco are good for them because they taste good). If people always accurately perceived and thought about themselves and external events, they would truly see and comprehend social reality, and seldom become disturbed. They are biologically disposed as well as sociologically taught to see and think crookedly. Consequently they become unrealistic and make themselves unduly upset.

2. Emotional and motivational factors. Even when people perceive and cognize accurately, they may overreact emotionally and may thereby defeat their own best ends. Thus, they may correctly perceive that a lion is about to attack, and may sanely think, "This beast is dangerous! I'd better get out of here!" But they may overactivate the emotionalizing brain centers and their autonomic nervous system so seriously by the thoughts and perceptions they create that they may freeze with panic rather than heed the impulse to run. Or they may correctly perceive that they have said the wrong thing to another, and may sensibly think, "I'd better apologize." But they may experience, through their trigger-happy central and autonomic nervous systems, such reactions of shame and inadequacy (including physical reactions of blushing and stammering) that they may avoid this other person completely and never approach him again. If people always reacted emotionally with a one-to-one correlation between what they perceived and thought, on the one hand, and what they felt in their gut, on the other hand, then "emotional disturbances" might well not be eliminated (since distortions of perception and thinking could well remain), but they would probably be considerably reduced.

3. Motor and habituation factors. Even when people perceive and cognize accurately, and when their emotional reactions are appropriately related to their perceptual-cognitive apprehension of themselves and the world, they may be overwhelmed by self-defeating motor factors. Thus, they may correctly perceive that they are chain-smoking, believe that this kind of smoking is harmful, and may appropriately fear continuing this behavior. But they may be so habituated to the motions involved in their smoking—lighting the cigarettes, bringing them to their lips, inhaling smoke, tapping away ashes, etc.—that they may find it almost impossible to forego these motions and may foolishly continue to chain-smoke. They may perceive, think and feel that lack of exercise is pernicious, but may find it so hard to change their non-exercising patterns of motor behavior that they rarely or never exercise. If people never were afflicted with dysfunctional motor habits, they would hardly automatically lose all their neuroses (since they could still easily perceive and think erroneously and react with inappropriate emotionality), but they would in all probability become considerably less disturbed in many instances and would more easily be able to overcome their self-defeating activities.

If the foregoing hypothesizing is correct, there are at least three major sources of "emotional disturbance": perceptual-cognitive, emotive and motoric. What is more, there seems to be considerable evidence to support the additional hypothesis that these three factors are interactional or transactional. If an individual perceives and thinks crookedly, he frequently thereby *creates* over- or under-reactive emotionality and *manufactures* self-defeating motor habits. For example: a person who perceives a cat as a dangerous animal and who thinks, "It will be awful if it touches me!" (a) emotes with great fear and (b) habitually runs away whenever he comes in contact with a cat. If an individual over-reacts emotionally, she often *engenders* false perceptions and cognitions as well as dysfunctional motor behavior. Thus: someone who reacts blushingly to her own social errors can (a) easily come to *view* others as dangerous to her welfare, when they really are not and (b) avoid social engagements, when she would be better off going toward them. If an individual is habituated to some self-sabotaging form of motor behavior, he commonly fabricates erroneous perception-cognitions and deliberately *stirs up* over-reacting emotions. For instance: a person who keeps fingering the piano keys wrongly when he is learning to play may easily (a) falsely conclude that he *never* will be able to finger them well and (b) feel thoroughly ashamed of his poor performance.

If what has been said so far has some validity, several important conclusions would seem to follow:

1. There are at least three main methods by which emotional disturbances may be approached. First, a perceptual/cognitive approach may be used, in the course of which individuals are shown that their perceptions and cognitions are mistaken, in that they do not conform to social reality or that they will not bring about the results that the person appears to desire. Thus, it can be demonstrated that a given client does not see people and things as they really are; makes illogical deductions from correct observations or premises; has one set of assumptions that conflict with another of his major sets of assumptions; is really striving for goal A when he thinks he is striving for goal B; has quite unrealistic and perfectionistic aims; etc. This kind of information-giving, cognitive therapy is best exemplified by Adlerian, rational emotive behavioral and various other schools of psychological treatment.

Second, an experiential-emotive therapeutic approach may be used, in the course of which the individual is encouraged to express her feelings more appropriately as she perceives and cognizes what is going on in herself and others. Thus, she may be helped to acknowledge her suppressed feelings of anger toward others; to practice being loving and trusting, even though she at first does not feel that she can be; to concentrate on her own feelings and sensations and to enhance rather than to inhibit them; to engage in intense emotional relationships with her therapists or members of her therapeutic group; etc. This kind of emotive-expressive therapy is best exemplified by Gestalt, basic encounter, psychoanalytic, and various other types of therapy.

Third, a behavioral-motor therapeutic approach may be used, in the course of which the individual is taught to change his overt habit patterns. Thus, a client may be shown relaxation methods during the therapy session; urged to undertake various exercises and actions; be given specific homework assignments to carry out in between sessions; helped with massage, physical encounters with others, or movement therapy; encouraged to paint, draw, act, play a musical instrument; etc. This kind of activity-motor therapy is best exemplified in behavior therapy, sensory awareness, yoga exercises, art therapy, and various other therapeutic modalities.

2. Each of these three main methods of treatment is wittingly or unwittingly carried on with interacting elements of the other two types: and rarely or never is one of them *purely* or *exclusively* practiced. A highly cognitive form of therapy, such as REBT, includes such distinctly emotive elements as the therapist's unconditionally accepting the client with their dysfunctional behavior, encouraging clients to express their

honest feelings for themselves and others, and speaking to the clients in a forceful, down-to-earth, emotionalized manner. REBT also is unusually behavior-motor oriented, in that it stresses the use of concrete homework assignments to individuals and emphasizes their steadily working and practicing their homework.

A forthright experiential-emotive therapeutic approach, such as basic encounter group therapy, is also distinctly cognitive, in that it provides its participants with corrective information about themselves and others and corrects their distorted perceptions and cognitions of the way they and others behave. Behavioral therapy implicitly urges clients to force themselves to speak up and to experiment with behaviors which they have never or rarely tried before; and it encourages them, as a kind of homework assignment, to act outside of therapy along lines similar to those which they have begun to learn in therapy.

A clearcut behavioral approach to psychotherapy, such as Wolpe's desensitization technique, induces the patient to perceptually-cognitively review the hierarchy of his phobias, to convince himself that he can at least temporarily stand thinking about them, and to show himself that they are really not so awful as he originally assumes that they are. The behavior therapist also relates to the client, unconditionally accepts him in spite of his inadequacies, and teaches him how to control his emotional over-reactions.

3. It is highly probable that the three basic approaches to psychotherapy are differentially effective for certain clients most of the time or for certain patients at different times during their lives. Thus, motor-behavior therapy may be almost the only practical method to help some autistic children; certain highly dependent, inadequate individuals may be uniquely helped by relationship-emotive therapy; and informative-cognitive methods may be notably beneficial to bright young people with feelings of alienation or worthlessness.

4. It is likely that the three main types of therapy are correlated with the kinds of improvement that individuals make when they are undertaking psychological treatment. Behavior therapy may be more suitable for symptom-removal than for other types of personality change. Expressive-emotive therapy may help individuals feel better and adjust more adequately to their self-defeating value systems, but may not effect too drastic changes in those systems. Cognitive-oriented therapies may show people how to change their basic ideologies and rid them of their disturbances, but may not necessarily help them to live more fully.

5. It is quite possible that putting the main therapeutic emphasis on one of the three basic approaches and using the other two approaches in a subsidiary manner is most efficient, less time-consuming, and likely to have deeper and longer-lasting effects than putting the main emphasis on one of the other three approaches or of putting equal emphasis on all three approaches. My own prejudices lead me to believe that if the main emphasis is placed on explaining, challenging, and minimizing clients' crooked perceiving and thinking, if a strong
secondary emphasis is placed on giving them specific overt homework assignments of a cognitive-motoric nature to work on, and if a moderate emphasis is placed on working directly with their emotional reactions, maximum therapeutic gain will be made by the great majority of clients. This, however, is only my clinical hunch; and it is exactly this kind of hunch which has to be checked by empirical research.

The main point of the present paper is that hunches and impressions, as well as dogmatic statements, about what *really* causes psychotherapeutic change, continue to proliferate. Every issue of VOICES brings us new authors and discussants who (appropriately enough!) add *their* voices to the general hubbub. Fine! — let us have still more hunches, guesses, and hypotheses. But one of these days, let us also have some facts. It

is hoped that the outline presented here may serve as something of a framework and an incentive for getting such facts. □

Discussion by Hans H. Strupp, Ph.D.

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Let me say first that I thoroughly enjoyed Al Ellis' honest, down-to-earth, and altogether sensible paper. I particularly agree with his statement that at present no one actually knows what really causes psychotherapeutic change, nor do we know why a particular method works well in the hands of one therapist with a particular patient and not with others. Furthermore, each therapist has his successes and failures even when the patients are well selected. At the same time, I am impressed that individual therapists know a great deal more about the psychotherapeutic process than is found in treatises on theory and technique. The trouble is that much of this knowledge is not explicit or very well formalized; hence we have difficulty communicating about it. Kenneth Colby has likened the practice of psychotherapy to the art of wine-making. Actually, he has gone further in asserting that by its very nature psychotherapy can never become a science. Be that as it may; in any event, the process of therapeutic change and our ability to promote it is exceedingly more complex than suggested by our various theories which provide only the crudest guidelines for the practitioner. Nevertheless, to return to Colby's simile, the fact that the art of wine-making cannot be spelled out in textbooks does not mean that some individuals do not know a great deal about it. Moreover, an apprentice can learn much from a master provided he invests the requisite effort. The situation in psychotherapy is not dissimilar: Some therapists indeed know a great deal about psychotherapy and they apply this knowledge every day; they also teach it to their students and their patients. Whether the principles they invoke to explain their operations are the "real" or the most heuristic ones is quite another matter; indeed, as Ellis suggests, there is a strong probability that the isomorphism between theory and practice is typically tenuous and at other times perhaps completely illusory.

Ellis' tripartite approach to psychotherapy strikes me as sound, and I fully agree with his position that all forms of psychotherapy use all three in different combinations. Depending on the patient's problem and other factors, some combinations are undoubtedly more effective than others. Psychoanalytic therapy, with which I happen to be most familiar, is by no means adequately explained by interpretations of resistances and unconscious fantasies or the working through of the transference neurosis. Similarly, other forms of therapy are not restricted to a single form of influence. The analytic therapist, for example, certainly deals prominently with emotional and motivational factors; however, he also deals with the patient's perceptual distortions in terms of the manner in which he construes reality; and finally, as in the case of phobias, he encourages the patient to "test reality," which seems to me synonymous with Ellis' emphasis on practicing new patterns of behavior. What distinguishes analytic therapy is its insistence upon resolving the often disastrous effects of primitive unconscious fantasies upon attitudes and behavior and the belief that the therapeutic influence is mediated most effectively within the context of an affective relationship between patient and therapist. This relationship renders the patient receptive to perceptual-cognitive corrections and fosters a willingness to combat deeply entrenched behavior patterns. This, of course, is an hypothesis whose relative merits have by no means been adequately explored. Personally, I believe it has much to commend it, although in certain instances other methods may be less time-consuming albeit more ephemeral.

Ellis ultimately places his faith in facts and he views systematic research as the "royal road" to the

advancement of knowledge. Few would argue with this position, least of all this writer who has invested a good many years in grappling with the thorny problems facing the investigator. I cannot, in this space, address myself to these issues, but I must call attention to the tremendous difficulties of designing adequate studies in a field where single variables are virtually impossible to manipulate and where complex interactions among variables are the rule. In the present context, how can we hope to assess the relative influence of Ellis' three-way approach if, as may be surmised, each therapist uses all (and probably others)? I am by no means suggesting that the undertaking is impossible in principle, but we should not expect miracles from researchers nor should we become impatient if their work falls short of supplying definitive answers in short order.

Finally, Ellis' contribution is noteworthy for another reason. It exemplifies vividly what I consider to be one of the most important trends in contemporary psychotherapeutic practice and research, namely the gradual (and altogether salutary) erosion of barriers separating the various schools of thought. To be sure, the field is still replete with individuals who extol the unique virtues of their particular approach; but we are also witnessing increasing efforts, on the part of many thoughtful therapists and investigators, to discern common elements in seemingly diverse approaches and to achieve greater specification of those mechanisms which, to a greater or lesser degree, are operative in all forms of psychotherapy. It is fair to say that an article like Ellis' would not have been written twenty-five years ago, particularly by a therapist who himself has pioneered a technique, of whose special merits he understandably was fully convinced. There is today a much greater willingness to examine objectively what other therapists are doing, and to understand their methods and rationale even if their concepts are different from one's own. For example, Franz Alexander, toward the end of his life, saw considerable merit in promoting a rapprochement between psychoanalysis and learning theory; Arnold Lazarus has taken a considerably broader view of behavior therapy than earlier writers; Mowrer (as my colleague Allen Bergin aptly put it) has begun to see some mild virtues in that dastardly Freudian, Joseph Wolpe; and so on. There is no question in my mind that in this way the field is going to advance. No single school of therapy has a monopoly on the truth, and when all is said and done we shall probably find that their basic similarities are more impressive than their alleged differences. Once we succeed in isolating those mechanisms which, in various combinations, achieve a specified therapeutic objective, we shall know a great deal more about psychotherapy and its workings. I have no illusions about the difficulty of this task, which may considerably exceed our lifetime. But I also have no doubt that future generations will regard the school differences in psychotherapy which have dominated our century as quaint, though perhaps inevitable, signposts characteristic of the early stages of a science. □

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