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History of the Personal Involvement Taboo

The analyst's role is one for which there is no model in real life.

—A. Hoffer (2000)

For 100 years psychotherapy has been taught in clinical academies and medical schools, administered to patients, and subjected to extensive research, it has generated myriad therapy permutations, been vigorously attacked and arduously defended, changed the life of millions, damaged some, and left still others unaffected. Today, psychotherapy is generally considered by patients to be beneficial and to improve the quality of their lives, particularly if they stay in treatment long enough (Seligman, 1995). Various interpersonal styles are used by therapists, who may be sensitive or callous, gentle or aggressive, empathic or interpersonally detached, humorous or dour, obsessive or hysterical, dominant or submissive, friendly or hostile, conforming or maverick, quiet or boisterous, collaborative or adversarial, and directive or nondirective. Or, therapists may exhibit an admixture of several of these styles or possess attributes that characterize one or both of these polar opposites.

Regardless of the therapist or the type of therapy administered, there is one fixed and inviolate rule for practitioners today; therapists generally inhibit their personal responses to patients because personal involvement with patients is strictly taboo. For years I've listened to clinical graduate students tell me what their supervisors instruct them regarding personal involvement: *Do not become personally involved with your patients!* This proscription is almost always articulated by someone in the audience when I describe the CBASP personal involvement construct and how it is used. This has been true of audiences in the United States as well as abroad.

The history of the personal involvement taboo includes a discussion of several prominent psychotherapy traditions. We begin with Sigmund Freud's psychoanalysis, look at Carl Rogers' person-centered psychotherapy, briefly review more than 50 years of research on the therapeutic alliance, discuss the Kieslerian interpersonal movement in psychotherapy to show how interpersonal research has moved us closer to personal involvement with patients, and, finally, review the work of two personal involvement pioneers who have transcended the taboo and utilized the therapist role in novel ways.

Sigmund Freud (1856–1939)

Sigmund Freud’s “talking cure,” an innovative technique he developed in the early 1900s (Freud, 1938, 1956; Jones, 1953), was created to resolve the psychological problems of his neurological patients. The psychoanalytic method emerged from the physician’s strong belief in the deterministic nature of all mental life. Freud viewed the idiosyncrasies of mental life as causally linked to real past events, which begin to exert their influence upon the patient from birth. During psychoanalysis, patients are guided to make associations between long-forgotten memories and current affective processes. The newly associated connections result in two patient outcomes: (1) released psychic energy, which was now freed for utilization in the present (“to enable him [the patient] to save his mental energy which he is expending upon internal conflicts”, Freud, 1963, p. 248); and (2) a positive, empowering impact on psychosocial functioning (“to make the best of him [the patient] that his inherited capacities will allow and so to make him as efficient and as capable of enjoyment as is possible”, Freud, 1963, p. 248). Freud viewed treatment success as contingent upon a meticulously crafted relationship with each patient. Psychoanalysis required analysts and patients to adhere to stringent guidelines that Freud lucidly prescribed. The patient was taught to do the following:

... treatment is begun by the patient being required to put himself in the position of an attentive and dispassionate self-observer, merely to read off all the time the surface of his consciousness, and on the other hand to make a duty of the most complete candor while on the other not holding back any idea from communication, even if (1) he feels that it is too disagreeable or if (2) he judges that it is nonsensical or (3) too unimportant or (4) irrelevant to what is being looked for. (Freud, 1963, p. 234)

Freud described the analyst’s role using an equally exact prescription. The analyst must regard

... the material produced by the patient’s associations as though it hinted at a hidden meaning and of discovering that meaning from it. Experience soon showed that the attitude which the analytical physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of *easy and impartial attention*, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything that he heard particularly in his memory, and by these means to catch the drift of the patient’s unconscious with his own unconscious. (1963, p. 235)

Because the goals of psychoanalytic treatment required uninterrupted access to the unconscious life of the patient, the analyst’s role necessarily receded into the background. Thus, an early therapist role prescription required analysts to provide a *blank screen* persona. Freud strongly believed that if physicians interacted directly with patients, the pristine unconscious processes would be corrupted and remain inaccessible, thereby compromising the success of the analysis.

Today, many classical psychoanalysts continue to adhere to these rigid, separatist guidelines (Levy, 2000). The most extreme description of a disengaged therapist role comes from Axel Hoffer (2000), who reiterates Freud’s view by saying that “(1) the analyst’s responsibility is to enhance the patient’s capacity for conscious

and unconscious conflict elucidation while, (2) conflict resolution remains both the prerogative and responsibility of the analysand” (p. 37). When it comes to wishing or hoping for salubrious change in the patient, Hoffer warns that such wishes or needs signal only countertransference intrusion. He readily admits that the analyst’s role “is one for which there is no model in real life” (p. 38). By this he means that clinicians must maintain a strict facade of *anonymity* (i.e., neutrality in regard to having power and influence over the patient’s life) and *abstinence* (i.e., prevention of countertransference intrusions in the patient’s life: viz. suggestions, encouragement, even hope that the patient will improve). The classical analytic tradition provides us with the ultimate separatist model of the therapist–patient relationship. Overt interpersonal interaction has been, and remains, *verboten*. Interactions between the players in the session are addressed in this one-person therapy model (Aron, 1996; Balint, 1968) only through the transference interpretations of the analyst.

I once knew an analyst whose waiting room resembled an isolation chamber. The room contained one leather sofa, a large plant, and a dull brown carpet. Two nondescript pictures hung on the walls. The receptionist sat behind a Venetian blind enclosure, containing a small open slit that allowed her to see when patients arrived. She did not speak with patients. The analyst explained that he maintained this environment to prevent interference with patients’ transferences.

One interesting aspect of classical psychoanalysis is seen in its heavy-handed proscriptive approach to the therapist role. Because Freudian theory was never informed by psychology’s century-old experimental learning tradition (e.g., constructs such as *shaping*, *transfer of learning*, *generalization*, *counterconditioning*, and *classical conditioning of emotionality*), Freud’s views of psychopathology as well as those of his followers are based on a 19th-century view of the irrational man and woman who must be “fixed” by the triumphant infusion of rational knowledge. The source of the knowledge is the analyst. Classical psychoanalysis conceptualizes the change task as requiring the patient to remain perceptually and behaviorally disengaged from his or her immediate environment (i.e., disengaged from the direct moment-to-moment responses of the therapist). The analyst keeps the individual’s attention focused solely on his or her inner world—a world devoid of direct environmental influences. The personal involvement taboo between therapists and patients began at the beginning of the 20th century in Freud’s practice of neurology. Time has not changed this proscription.

Carl R. Rogers (1902–1987)

Several years ago, while supervising a second-year clinical psychology graduate student who was having interpersonal difficulties with a chronically depressed adult, the following crisis arose. The patient repeatedly made sarcastic comments about the therapist’s inexperience, calling into question his competence and credibility. These hurtful utterances congealed into an interpersonal roadblock, and the student candidly admitted that he wanted to transfer the case. I suggested that

instead he tell the patient how hurtful the comments were and inquire why the person wanted to hurt him. The student demurred, saying that he could never do this. Explaining himself, he said: "I've always heard that psychotherapists must never disclose personal feelings. The only emotion we are allowed to express is unconditional positive regard." What my trainee unknowingly implicated was Carl Rogers' stand on the personal involvement taboo. We'll briefly discuss how the taboo has been maintained by applied psychology.

Sixty years earlier, Carl Rogers introduced his unique treatment approach to psychology in a paper entitled "Newer Concepts of Psychotherapy" (Rogers, 1940). He presented the paper to the University of Minnesota Chapter of Psi Chi. Psychoanalysis had dominated the mental health field between World Wars I and II. The demands for psychological assessment and psychotherapy for hundreds of thousands of soldiers became enormous during and after World War II (Todd & Bohart, 1999). Applied psychology was ripe for a paradigm shift. Rogers provided the direction and impetus for the shift with his nondirective psychotherapy model. His 1942 book Counseling and Psychotherapy offered the first viable psychological theory and treatment alternative to nonanalytic practitioners. Over the next few years, his perspective influenced the field in another way: It moved clinical psychology from an assessment-dominated profession to a treatment-research-oriented profession (Todd & Bohart, 1999).

When I read Counseling and Psychotherapy (Rogers, 1942), decades ago, I realized that I was witnessing the beginning of a revolution. The innovations Rogers initiated were sweeping and pervasive in the nascent field of applied psychology. He proposed radically new roles for the psychotherapist in a unique treatment approach first known as "nondirective," then "client-centered," and ultimately "person-centered" psychotherapy (Rogers, 1942, 1951, 1959, 1978). During the remainder of this section, his work is referred to as *person-centered psychotherapy*. The major assumptions for the model were derived from his strongly held individual-humanistic social philosophy. An important source of influence was American philosopher and educationalist John Dewey (1916/1997: Democracy and Education). Dewey was an ardent proponent of progressive evolutionary thought that extended back to Darwin. Dewey's evolutionary thought and optimistic view of the human organism characterized the philosophical mood in the United States during the early 20th century. He wrote that under the proper educational conditions, individuals could actualize the innate propensities of life, namely, *individual and societal-collective growth* (Dewey, 1916/1997). Consistent with Dewey's social-philosophical optimism, Rogers argued that psychotherapy "clients" have the innate capacity for self-directed phenomenological change and self-actualization within a therapeutic environment in which the counselor's "vantage point is from the internal frame of reference of the patient himself" (Rogers, 1951, p. 494). A person-centered role requires the therapist to maintain a nonjudgmental, accepting, and empathic attitude toward the patient. This role enactment, he argued, creates an in-session atmosphere that frees the innate growth process of the individual (Prouty, 1994). Rogers' concept of *self-structure* comprises the major treatment focus for person-centered psychotherapy.

The Self

Self-structure (the sense of “I” or “me”) arises from a person’s interactions with his or her environment. Development of the self emerges out of one of the basic needs of all people: to be accepted by others (Rogers, 1951). The evaluations of others, combined with the self-values that accrue, lead directly to the construction of consistent patterns of perceptions that constitute the “I” or “me” (self-structure). Children find pleasure doing many things, and they may be either rewarded or punished by parents for their pleasure-seeking behavior. Punishment received for engaging in pleasurable activities results in an internal conflict between the desire to obtain pleasure and the desire to avoid pain. When the individual is negatively evaluated/rejected by significant others for engaging in certain behaviors, expressing particular emotions, or embracing certain attitudes, these valuations are introjected into the self and become perceived as essential parts of the self. Said another way, parts of my self-system and the associated self-values that result mirror the experiential components that have been negatively evaluated by significant others.

Thus, *interpersonal rejection* is the etiological source for maladjustment in Rogerian theory. If the “true” value (innate worth) of the person is eclipsed by the negative introjected values of significant others, the self becomes a house divided. Psychological maladjustment exists when the person denies awareness of certain negatively valued parts of the self; this denial, in turn, prevents their integration into the self-system. Tension, anxiety, and lowered self-esteem are the prominent signs of maladjustment. The goal of psychotherapy is to enable the client to relinquish the introjected values of others that prevent the individual from becoming his or her real self. As noted above, this goal is accomplished in an environment of prescribed acceptance, wherein the patient progressively discovers that *all* parts of his or her conscious and unconscious self are acceptable to the therapist.

The goal of person-centered therapy is psychological adjustment, defined as a process whereby “the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system—based so largely upon introjections which have been distortedly symbolized—with a continuing valuing process” (Rogers, 1951, p. 522). In summary, Rogerian theory is

... basically phenomenological in character and relies heavily upon the concept of the self as an explanatory concept. It pictures the endpoint of personality development as being a basic congruence between the phenomenal field of experience and the conceptual structure of the self—a situation which, if achieved, would represent freedom from internal strain and anxiety, and freedom from potential strain; which would represent the maximum in realistically oriented adaptation; which would mean the establishment of an individualized value system having considerable identity with the value system of any other equally welladjusted member of the human race. (Rogers, 1951, p. 532)

In Rogers’ (1942) view there were two different kinds of psychotherapy: his *nondirective approach*, which put a high premium on the right of every individual to be psychologically independent and to maintain his or her psychological integrity

(without interference from others); and *directive approaches*, which he described as valuing social conformity and the right of the able to direct and influence the lives of weaker souls.

Taking a moment to describe some of Rogers' unique therapist role prescriptions will further clarify the nature of the person-centered approach. His recommendations for the role may seem strange to some of us who live in a different mental health environment where *directive therapy models* predominate (e.g., Beck, Rush, Shaw, & Emery, 1979; Klerman, Weissman, Rounsaville, & Chevron, 1984; Linehan, 1993; McCullough, 2000; Nay, 2004).

The Rogerian Therapist: A Warm Blank Slate

The major goal of the therapist is to help the patient relinquish his or her defensiveness concerning any feelings, thoughts, behaviors, memories, or attitudes of privacy that lead the person to assume that certain matters should not be openly discussed (Rogers, 1942). The relinquishment occurs when the patient concludes that his or her therapist will not criticize, suggest alternative strategies, or try to order or arrange the flow of the discussion. Such a state of affairs comes about only when the practitioner is completely willing to listen to the patient express any attitude or feeling. Rogers' ultimate goal for the patient is similar to that of the classical analyst who teaches the patient to free associate without fear of censure or evasive intrusion by the doctor. Rogers (1951) writes repeatedly that the person-centered role demands the utmost restraint and discipline on the part of the clinician.

Successful actualization of the person-centered role necessarily flows from Rogers' particular set of humanistic philosophical attitudes, which he encouraged his therapists to embrace (Rogers, 1951); thus, he conjoins a philosophy of life with the therapeutic role. Rogers' philosophy embraces the right of every individual to be psychologically independent and eschews all attitudes that view the clinician as superior to the patient in any way. The clinician must completely accept the patient, unequivocally respect the intrinsic worth of the individual, and trust completely in his or her capacity to achieve insight and constructive self-direction. Complete confidence in the patient's ability to move the flow of treatment in salubrious directions leads Rogers to make the following statement: "The skillful counselor refrains from intruding his own wishes, his own reactions, or biases, into the therapeutic situations" (1942, p. 89). The assumption here is that individual growth occurs autonomously, without any form of guidance input. The person-centered role also requires the clinician to put aside all concerns about diagnosis and personality assessment and instead focus complete attention on perceiving and understanding the patient as he or she understands him- or herself". "Notice how the significant theme of the relationship is, 'we were mostly *me* working together on my situation as I found it.' The two selves have somehow become one while remaining two—'we were *me*' "(Rogers, 1951, p. 38).

Rogers also warns that the clinician must not be passive or indifferent. A detached interpersonal stance will be perceived as rejection. Rather, the clinician should function in an active and engaging manner, repeatedly clarifying feeling

statements that should be delivered in a mirroring way, offered empathically and with a modicum of hesitancy. The clarification statement always contains an implicit question, “Am I right here?” (Rogers, 1951). Crisis moments, when the patient expresses desperate emotions, must not pull the therapist off the empathic–reflective baseline. The *internal anchor* during these crisis moments is always a basic confidence in the forward-moving growth tendencies of the patient. Again, the therapist must have absolute trust in the capacity of the individual to resolve his or her problems and to grow productively in a relationship where unconditional positive regard and acceptance are continually extended.

The treatment task and corresponding therapist role require that therapists endeavor to understand the patient, who is seen as unable to face certain memories and experiences because to admit them would be inconsistent or threatening to the current self-structure. Perceiving the patient’s attitudes, confusions, ambivalences, and emotions with an accepting and safe demeanor paves the way for self-acceptance, whereby the disjointed components of the self can be integrated. When the therapist accepts the patient’s contradictory behaviors as if they were an integral part of the individual, the result is that the person can accept these components as part and parcel of him- or herself.

The core therapist attitudes facilitating self-actualization and self-formative growth within the individual are unconditional positive regard for the patient, extended empathy, and verbal and nonverbal congruence that communicates genuineness on the part of the helper (Rogers, 1959).

Rogers’ Continuing Legacy in Clinical Psychology.

Before discussing the Rogerian legacy in applied psychology, I want to express my deep respect for the life and work of Carl Rogers. In writing this section, I have read or reread most of his books, journal articles, and chapters. Rogers, like all of us, is a product of his age. I examine his contributions to our field by looking back, which is unfair in some ways; however, I take Rogers’ momentous legacy and stamp on contemporary training, research, and practice in clinical psychology very seriously. The conclusions I draw may seem somewhat negative, but my respect for his life and work must never be doubted.

For over 50 years, Rogerian theory has continued to exert significant influence on clinical training, research, and practice. Not all of this influence has been positive. By discussing two negative aspects of his legacy, my intent is to show (1) how practicum supervisors, researchers, and practitioners still define the therapist role in a narrow-band way that results in unrealistic perceptions and behavior; and (2) how psychotherapy training, research, and practice continue to ignore the factor of *patient learning* and, in so doing, preclude experimentation with different didactic approaches that might enhance that learning. Next, I provide a historical review of each negative legacy and then offer personal observations to illustrate how each legacy continues to influence clinical psychology.

1. *Narrow-band definition of therapist role.* The first negative influence Rogers has had on clinical psychology is seen in the unrealistic ways many practitioners

view their role. Rogers argued strongly that therapists and patients must share equal status in the therapeutic dyad. He unwittingly created a role that mimics Hoffer's description of the classical analyst as "one for which there is no model in real life" (2000, p. 38). By neutralizing any perceived power differential between therapists and patients to prevent psychologists from viewing themselves as *stronger*, he created a role for which there is no real-life model. Ironically, and in order to maintain in-session equality, his therapist role can aptly be described as "larger than life." Person-centered therapists were trained to be caring, warm, empathic individuals who offered only unconditional positive regard and acceptance and asked for nothing in return. Rules guided the conduct of person-centered therapists (Rogers, 1942). Interviewers must only *listen*, not display *authority*, not give *advice*, not *argue* or *talk* or *ask questions*, except under certain extenuating circumstances. "It will be very evident that these rules, with their stress on the absence of advice, persuasion, and argument and with their clear emphasis on the fact that the interview is the client's, providing him with an opportunity to talk freely, are in harmony with the non-directive approach" (Rogers, 1942, p. 125). As I try to envision the sort of person who could successfully adhere to these rules, I conclude that the number must be small. It would require Herculean efforts to suppress and ignore any and all feelings, thoughts, and behaviors that might otherwise interfere with the total attention one extends to patients.

Patients, at the outset of treatment, do *not* share equal status with therapists. Role inequality (which has nothing to do with socioeconomic, gender, ethnic, religious, or professional status) stems from the *treatment expertise* and *experience* of the therapist as well as from the seriousness of the patient's *psychological problems*.

The clinical practicum student whom I described at the outset thought he had to match the prototype of the all-accepting practitioner, regardless of the negative behavior displayed by his chronically depressed patient. Because he could not do so, his frustration resulted in a request to transfer the case. There is a more realistic role alternative for clinical practicum trainees as well as for veteran practitioners who treat chronically depressed patients. Disciplined personal involvement (McCullough, 2000) provides therapists with the means to utilize their personal responses to patients as a major change vehicle. (These strategies are discussed in Chapter 5 and 6.)

2. *Absence of patient learning factor.* The second negative Rogerian legacy stems from the fact that patient learning was never an important consideration of person-centered psychotherapy. Consistent with the Rogerian tradition, contemporary psychotherapy as well as practicum training in our academies evince little interest in the patient learning variable. When patient learning is not of major concern to the clinician, psychotherapy becomes simply an "exposure" activity in which patients are exposed to either the person of the therapist or to one or more techniques. The irony is that regardless of the fact that learning issues have been neglected, most patients in psychotherapy actually engage in acquisition-like learning tasks (McCullough, 1984a, 1991, 2000, 2002; McCullough & Carr, 1987). That is, (1) patients are introduced to novel skills they did not have before therapy began (acquisition), (2) they are encouraged to practice these skills (practice to strengthen

novel learning), or (3) they learn new ways to experience themselves (acquisition), their therapists, and others, and (4) are once more encouraged to transfer (practice to strengthen the new learning) this new-found cognitive–emotive-behavioral learning to relationships on the outside. *The crucial question concerning how much of what is taught in psychotherapy is actually learned is rarely addressed.*

I feel that the amount of learning acquired is related to positive treatment outcomes as well as to the maintenance of those positive outcomes during the post-treatment period. We are beginning to obtain in-session and follow-up data that support these assumptions (Manber & McCullough, 2000; Manber et al., 2003; Klein et al., 2003). I always ask the patients I treat what they have learned from previous therapy experiences. Most do not have any idea what I am asking. Going further and inquiring what they did during their previous sessions with other therapists, a few would say only that they talked a lot or that their therapist was nice. Our neglect of learning in the contemporary delivery of psychotherapy aids and abets the notorious enemy of learning: *forgetting*.

I never thought about patient learning until the early 1980s. Participating enthusiastically in the behavior therapy movement during the late 1960s and 1970s (e.g., McCullough, Cornell, McDaniel, & Mueller, 1974; McCullough & Southard, 1972), I made a theoretical shift during 1980 by adding the cognitive variable to my single-case studies with chronically depressed adults. My work was no longer acceptable to the behavior journals, many of which were under the editorship of operant researchers. Cognitive data did not meet the requirements of the operant design space. It was then that I began to ask myself, “What *are* my patients learning?”

It seemed to me that one thing they were acquiring was problem-solving skills, so I began to consider the possibility that acquisition learning was taking place. I knew that acquiring cognitive learning, such as the kind involved in a problem-solving algorithm, was a slow process and required practice to strengthen the fledgling habits (McCullough, 1984c). I wrote two papers describing an acquisition learning proposal for psychotherapy research (McCullough, 1984b, 1984c). What I realized was that I was teaching patients cognitive skills, that they, in turn, acquired, to one degree or another. I also observed that patients who acquired the skills scored better on my outcome measures than those who did not. I began to include the acquisition learning–performance data along with other process and outcome scores when I submitted articles for publication (e.g., McCullough, 1984c; McCullough & Carr, 1987).

I also added one more descriptive component to the acquisition learning proposal. The idea came from Don Kiesler, who suggested that I had described a design that contained two levels of dependent variables. One level reflected the learning acquired over therapy sessions (e.g., McCullough, 1984a, 1984b: learned in-session performance scores were graphed over sessions), and the second level denoted the *generalized treatment effect variables* (i.e., the usual process and outcome dependent variables presented in traditional psychotherapy research) that were informed by the in-session learning. At the time, I argued that an acquisition learning design requires the clinician to operationalize the learning goals, measure the extent of patient learning, and measure the generalized treatment effects of

learning (McCullough, 2000, 2002). The culmination of this research project was reported at an Association for the Advancement of Behavior Therapy (AABT) convention in New Orleans in 2000, when data were presented from the largest clinical trial ever conducted with chronically depressed outpatients ($n = 681$ S; Keller et al., 2000). Manber and McCullough (2000) reviewed the learning data and suggested that among 431 chronically depressed outpatients who received psychotherapy, those who achieved the highest performance scores on the problem-solving algorithm taught during the sessions were the patients who reported significantly better therapeutic outcomes. Additional analyses revealed that proficiency in the use of the problem-solving algorithm predicted treatment outcome independently of medication status and baseline depressive severity (Manber et al., 2003).

The general absence of a learning emphasis in psychotherapy training, research, and practice since Rogers' day has had enormous consequences in our profession. When therapists overlook the factor of patient learning, all that remains on the research playing field are the attitudes therapists hold toward patients, the phenomenological experiences of patients, and the therapist–patient relationship; in short, therapy becomes predominantly an *experiential activity* in which patient phenomenology (or the therapeutic relationship, more than likely) takes center stage. This outcome is exactly what has happened in clinical psychology.

Facilitating a therapeutic relationship is not synonymous with the provision of didactic activity and learning goals. Therapist instruction, skills training, repeated practice of skills in the session and beyond, performance-based feedback, acquisition learning across sessions, transfer of learning from the session to the outside, all taken together, constitute didactic activity. Such activity may be directed toward modifying emotionality, discriminating between those who can help versus hinder the patient, or imparting other verbal and nonverbal skills. Therapist use of personal responses to administer consequences to patients to modify their behavior also falls under the umbrella of didactic activity.

Conclusions. The two ways Rogers has negatively influenced clinical psychology are evident in how we continue to define the therapist role in sterile and unrealistic terms, and in how patient learning continues to be ignored in our training, research, and practice. Both legacies have strengthened and maintained the tradition of the unilateral delivery of psychotherapy, with the direction of in-session flow always running from therapist to patient. Because Rogers' theory precluded the expression of direct and honest therapist responses to patients, bidirectional action was inhibited; hence, the personal involvement taboo was effectively maintained.

Before I discuss ways to overcome these two legacies, another important empirical tradition in clinical psychology that fosters them—the therapeutic alliance research tradition—must be discussed.

Therapeutic Alliance Research Tradition (1936–present)

Recently a colleague and I were discussing the specificity–nonspecificity psychotherapy debate presented in the 2002 spring issue of Clinical Psychology:

Science and Practice. My friend remarked that “everyone knows it’s the therapeutic relationship that really matters, not techniques.” I tried to steer the conversation back to specific disorders and then discuss what techniques might or might not work. My colleague would not budge: for this colleague, the relationship is prepotent regardless of the technique used or the type of disorder treated. I find this view of psychotherapy widespread in our field today, and it is frankly distressing (McCullough, 2002). Taken literally, this approach to therapy suggests that if clinicians are accepting, caring, and empathic, it really doesn’t matter what they do. I have not found this to be true in my practice, nor do I endorse such a view—nor am I alone in this view (e.g., Chambless, 2002).

These widely held beliefs about psychotherapy stem from the therapeutic alliance research tradition that has, for over 50 years, scientifically investigated the helping/working relationship (Zetzel, 1956) existing between therapist and patient. This tradition, following Rogers’ lead, focuses mainly on the experiential dimension of the therapist–patient relationship and the phenomenological status of patients. Alliance researchers have drawn several conclusions about psychotherapy, all of which my colleague above espouses: (1) psychotherapy appears to be more effective than placebo control groups; (2) no one therapy technique has been shown to be more effective than another; and (3) the client variable seems to be the biggest contributor to successful outcome (40% of outcome variance), with the dyadic relationship ranking second (30% of the variance), and specific techniques accounting for only 15% of the variance (Lambert, 1992).

Many researchers in this tradition assume that nonspecific and common factors will always eclipse (in importance) specificity concerns such as technique and psychopathology variables (Lambert, 1992; Lambert & Bergin, 1994; Luborsky, Singer, & Luborsky, 1975; Luborsky et al., 2002; Martin, Garske, & Davis, 2000; Messer & Wampold, 2002; Rosenzweig, 1936; Smith & Glass, 1977). These assumptions and generalizations have led to oversimplified conclusions about alliance effects on treatment outcome (Horvath, 1995; Lambert, 1992; Luborsky, McLellan, & Woody, 1985) and to efficacy studies that compare relatively similar models, such as psychoanalytic and humanistic psychotherapies (Constantino, Castonguay, & Schut, 2002; Horvath, 1994). In contrast to these conclusions, recent studies focusing on specific disorder groups suggest that alliance effects may vary depending on the psychopathology of the disorder (e.g., Barber et al., 1999; Klein et al., 2003).

Briefly sampling some of the therapeutic alliance variables that have been found to contribute to therapeutic outcomes, we find the following: (1) the degree to which the therapist extends unconditional affirmation to the patient (Greenberg, Rice, & Elliott, 1993; Orlinsky & Howard, 1986); (2) various phenomenological characteristics of patients, such as negative attitudes, their degree of passivity versus involvement in the therapeutic process, as well as their ability to bond with therapists (Bordin, 1979, 1994; Safran 1993a, 1993b; Zetzel, 1956, 1966); (3) a correspondence in level of affective intensity and empathic resonance between therapist and patient (or, put another way, a “sense of being on the same wavelength . . . of being fully heard by, and fully hearing, the other person”—Orlinsky & Howard,

1986, p. 344); and (4) several interactional–structural domains involving how therapists and patients approach the therapeutic undertaking: (a) the reciprocal role investment of the dyad, including the quality of the relational *bond* (Goldfried & Davison, 1974, 1994; Greenberg, et al., 1993; Greenson, 1967, 1971; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Safran, 1998; Safran & Segal, 1996; Safran & Muran, 2000); (b) the extent to which both therapist and patient agree on the *goals* of therapy (Bordin, 1979; Greenson, 1967, 1971; Safran & Muran, 2000); and (c) dyadic agreement concerning the specific *tasks* (i.e., what the patient will actually be doing) necessary to achieve the therapeutic goals (Bordin, 1979; Safran & Muran, 2000; Sterba, 1934, 1940). Revising Rogers’ earlier view that the alliance is something the therapist alone establishes (i.e., one-person psychology), contemporary alliance investigators define the alliance as a two-person psychology (Balint, 1968; Ghent, 1989; Mitchell, 1988) or the collaborative product of the therapist-by-patient interaction.

Not surprisingly, the alliance tradition, with its focus on the therapeutic relationship and deemphasis of technique, has proposed few novel systems of psychotherapy. One exception is Sheldon Cashdan’s (1973) interactional psychotherapy model. Methodologically, Cashdan’s proposal was a *stage-process model of treatment* that delineated stage rules for therapist behavior as well as setting patient performance goals for each treatment stage. Interestingly, the CBASP model uses a Cashdan-like methodological stage–process structure in prescribing its own therapist rules and patient performance goals (McCullough, 1984a, 1984b, 1984c, 2000: Chapters 6 and 7). However, Cashdan, in keeping with other alliance researchers, paid no attention to patient learning. Traditional emphases on the importance of the dyadic relationship are currently seen in two recent therapeutic alliance texts receiving outstanding reviews and wide distribution (viz., Norcross, 2002; Safran & Muran, 2000) and in Guest Editor John C. Norcross’s (2002) winter 2001 special issue of *Psychotherapy: Theory/ Research/ Practice/ Training*. Terms such as *teaching* and *learning* are not found in these texts or cited in the indexes, nor do such terms play a significant role in the therapeutic relationship literature discussed in the winter 2001 issue of *Psychotherapy*.

What can we conclude about this august research tradition? (1) The alliance tradition, like the work of Carl Rogers, has emphasized the patient–therapist relationship to such a degree that concerns for patient diagnosis are eclipsed. (2) Because the personal involvement taboo is clearly present in this research tradition, the Freudian–Rogerian rule of maintaining *therapeutic neutrality* characterizes the role of alliance clinicians. (3) Alliance researchers, by concentrating solely on the *quality of the patient–therapist relationship*, have simply replaced Rogers’ emphasis on the *role of the therapist* with the *alliance variable*, which also prescribes therapist neutrality. One possible exception to neutrality occurs in instances of *therapeutic rupture* (Safran & Muran, 1995, 1996, 2000; Safran, Muran, & Samstag, 1994). When conflicts or alliance ruptures arise, clinicians are not required to expose their own personal involvement issues; however, they must be willing to focus on the maladaptive schemas of patients that contribute to relational breakage, remain sensitive to past trauma experiences of the individual that might be

activated in the current relationship, assist patients to recognize their oppositional behaviors, metacommunicate to patients in order to expose their negative interpersonal impacts on the clinician (Kiesler, 1988), and, when therapist behavior has contributed to the rupture, admit and be willing to discuss their sins of commission or omission. However, reading case descriptions illustrating the employment of these reparation strategies (e.g., Safran & Muran, 2000) still leaves one with the impression that the heavy relational focus as well as therapist neutrality are maintained throughout. And surprisingly, (4) in reviewing the alliance research literature, I find it difficult to identify the person of the patient and therapist. Alliance emphases occlude the essential individuality of both participants.

(5) No learning emphases exist in this body of research. Patients are exposed to clinicians who are well trained in constructing and maintaining therapeutic relationships and repairing them when necessary; what patients learn during the process of treatment is neither measured nor discussed. Lastly, (6) there is no question that the therapeutic alliance is a crucial and multifaceted variable in all psychotherapy endeavors, nor can there be any doubt that the quality of the dyadic relationship contributes significant variance to treatment outcome (e.g., Klein et al., 2003). However, the personal neutrality relationship these therapists extend to patients makes Hoffer's (2000) comment about classical psychoanalysis highly applicable to the therapeutic alliance research tradition. This type of psychotherapy can aptly be described as a type of relationship "for which there is no model in real life" (Hoffer, 2000, p. 38).

Nevertheless, this longstanding psychotherapy tradition—which, as noted above, steadfastly maintains the Rogerian legacies in clinical psychology—sets the stage for us to move beyond the personal involvement taboo. The research and writings of interpersonal psychotherapist Donald J. Kiesler, whose work clearly places him within the alliance research tradition, have paved the way toward greater personal involvement and less neutrality on the part of psychotherapists.

Kiesler's Interpersonal Psychotherapy

Kiesler's interpersonal psychotherapy research (Anchin & Kiesler, 1982; Kiesler, 1983, 1988, 1996; Kiesler & Schmidt, 1993; Kiesler & Watkins, 1989) stands solidly within the alliance tradition. His work has added substance to the study of the therapeutic alliance by providing robust empirical support for a two-person psychology (Balint, 1968). Furthermore, he has addressed the patient psychopathology variable (Kiesler, 1986a, 1986b, 1996, 1999; Kiesler, Van Denburg, Sikes-Nova, Larus, & Goldston, 1990) to a greater extent than any other alliance researcher.

Kiesler's interpersonal theory derives from Harry Stack Sullivan's (1954) assumption that observational neutrality in regard to one's own therapeutic administrations is unattainable. Kiesler's theory and subsequent research seriously challenge the one-person psychology of Rogers as well as that of classical psychoanalysis. As noted above, his research focus and behavior modification strategies

clearly position him in the *two-person psychology camp* (e.g., Balint, 1968; Safran and Muran, 2000). Therapists and patients are seen as cocreators (Kiesler, 1983, 1988, 1996) of the therapeutic relationship. By focusing attention on the parameters of the dyadic interaction, Kiesler makes clear that constructs such as *transference* (patient learned expectancies) and *countertransference* (therapist learned expectancies) can only be understood when they are seen as inherent properties of what Greenberg (1995a) terms the “interactive matrix”.

From this perspective, Kiesler shows that the expectancies both interactants bring to, and ultimately act out (verbally and nonverbally), in any therapeutic moment directly inform what happens in that moment. For example, if a therapist is comfortable during moments of intimacy whereas his or her patient is frightened by them, then intimacy, whenever it occurs, becomes a serious interpersonal issue that directly influences what happens during such occasions. The concepts of transference and countertransference are integrated within an interpersonal perspective (Kiesler, 1988, 1996) in a technique called “therapist metacommunication”—which comes close to advocating disciplined personal involvement, as opposed to the unilateral delivery of techniques so characteristic of alliance psychotherapy. In the metacommunication technique, Kiesler (1988, 1996) suggests that the therapist’s personal responses to the patient become the central focus of the session. We turn now to a description of the theory underlying metacommunication, the corresponding notion of complementarity, and a description of the technique itself. Metacommunication is a novel way to respond to patients’ in-session behavior as well as a strategy that takes us closer to personal involvement with patients.

Theory Underlying Metacommunication

For Kiesler, metacommunication occurs when an interaction between therapist and patient becomes the topic of the conversation: “Therapeutic metacommunication or metacommunicative feedback refers to any instance in which the therapist provides to the patient verbal feedback that targets the central, recurrent, and thematic relationship issues occurring between them in their therapy sessions” (Kiesler, 1988, p. 39). With this definition, Kiesler moves us away from Hoffer’s (2000) description of the therapist’s role as having no precedent in daily living. Kiesler’s technique looks more like a real-world interaction and less like the blank-slate persona so descriptive of the Rogerian tradition. He explains further: “The rock-bottom assumption of contemporary interpersonal psychotherapy is that the client–therapist interaction, despite its unique characteristics, is similar in major ways to any other human interaction” (Kiesler, 1996, p. 282).

Building upon the work of Sullivan (1953) and Leary (1957), Kiesler argues that the essential unit of behavior is the *interpersonal act*. Both Sullivan and Leary “assert that any interpersonal act is designed to elicit from a respondent reactions that confirm, reinforce, or validate a person’s self-presentation and that cause that person to repeat similar interpersonal acts” (Kiesler, 1988, p. 8). In the interpersonal act, two parties conjointly behave in the above fashion; therefore, understanding

the outcome of the act is contingent on the interaction of two individuals. Reciprocal or bidirectional influence is seen as always present in any therapist–patient encounter. Therapists are constantly bombarded—emotionally, cognitively and behaviorally—by patient behavior, and the impact evokes both covert and overt reactions from therapists (Kiesler, 1988, 1996): *Covert* reactions remain unspoken, whereas *overt* ones are verbalized or nonverbally communicated. Patients experience similar impacts as well as “pulls” for personal reactions from therapists. In summary, the behavior of each participant continually produces and receives behavioral consequences from the other in an ongoing and reciprocal interactive process (Bandura, 1977).

The interpersonal act (Kiesler 1983, 1988, 1996) couples or blends together two dimensions or motivations: One dimension denotes a *power* stance in relation to the other, whereas the second implicates an *affiliation* position. These motivational properties derive from interpersonal theory, which assumes that the need for control (power, dominance) and the need for affiliation (love, friendliness) underlie all human interaction (Kiesler, 1983, 1996; Leary, 1957). Kiesler (1983, 1985) conceptually and empirically describes the varieties of interpersonal acts in his 1982 formulation of the interpersonal circle, a circumplex design that positions the power control dimension (dominant–submissive) on a vertical axis and the affiliation dimension (friendly–hostile) on the horizontal axis. The interpersonal effects one individual has on another can then be plotted on the circumplex (e.g., Kiesler & Schmidt, 1993) by assigning to each dimension so many units of control and so many units of affiliation. Continued research on the interpersonal circle resulted in an instrument called the Impact Message Inventory (IMI) (Kiesler & Schmidt, 1993). The original four quadrants of the 1982 circle, derived from the intersection of the power and affiliation axes, were divided; the IMI circle now contains eight octants, each representing an interpersonal emotive–cognitive “action tendency” or pull on the recipient of the act (i.e. the *decoder*: receiver of the interpersonal message). The action tendency or pull for feeling a certain way toward the other, thinking a certain way about the other, or wanting to behave in a particular manner with the other results from the behavior of the actor (i.e., the *encoder*: sender of the interpersonal message). Actors are the *encoders*, or perpetrators, of interpersonal impacts. As noted, encoders act in ways to obtain confirmation, reinforcement, and validation of their self-presentation. Another way to say the same thing is to say that we behave interpersonally in ways that tend to validate our self-view. Encoding strategies often represent tacit knowledge (Nisbett & Wilson, 1977; Polanyi, 1968, 1976) that arises from sources lying beyond immediate awareness.

Kiesler's Notion of Complementarity

Recipients (decoders) of interpersonal acts tend to behave in *complementary ways* toward the actors (encoders; Kiesler, 1983, 1988, 1996). Kiesler explains that “our interpersonal actions are designed to invite, pull, elicit, draw, entice, or evoke ‘restricted classes’ of reactions from persons with whom we interact, especially from

significant others” (Kiesler, 1983, p. 198). These “restricted classes” of reactions fall under the rubric of *complementary behavior*—that is, reactions we pull from others are predictable and familiar. When patients enter treatment, they behave in ways that are interpersonally similar to behaviors they enact on the outside. Thus, a patient’s expectancies of the therapist’s reactions will naturally mirror those reactions which the patient has consistently received, as well as come to expect, from significant others. This phenomenon is essentially a *transference expectancy*: Relational response patterns are transferred to the person of the therapist (Hilgard & Bower, 1966). By closely observing the covert interpersonal pulls for complementary reactions from the patient, even though we inhibit any overt reactivity, we can begin to discern and articulate the interpersonal style of the patient. Using the IMI (Kiesler & Schmidt, 1993) to make explicit the interpersonal “stimulus value” of patients (i.e., the salient emotive, cognitive, and behavioral pulls/action tendencies *we* experience when we are with patients) also has definite therapist role implications that are discussed in later chapters. Elaborating Kiesler’s concept of complementarity will further demonstrate the utility of the IMI in clarifying the patient’s stimulus value for the clinician.

Interpersonal complementarity, which is “operationalized” in graphic terms by the two-dimensional interpersonal circle (Kiesler, 1983), “occurs on the basis of (a) reciprocity in respect to the control dimension (dominance pulls submission, submission pulls dominance) and (b) correspondence in regard to the affiliation dimension (hostility pulls hostility, friendliness pulls friendliness)” (Kiesler, 1988, p. 14). The octant version of the interpersonal circle is shown in Figure 2.1. Moving counterclockwise around the circle, we leave the dominant (D) octant and come to the hostile–dominant (H-D) octant, then the hostile (H) octant, and the hostile–submissive (H-S), submissive (S), friendly–submissive (F-S), friendly (F), and friendly–dominant (F-D) octants. Complementarity is actualized when an individual, for example, behaving in a F-D manner, pulls the partner to react from the F-S octant. The reverse is also true: F-S behavior pulls for F-D reactions. On the hostile side of the circle, H-D pulls for H-S behavior, and the reverse. An individual behaving in an H-S manner will evoke reactions from the H-D octant. Interpersonal complementarity does *not* mean that decoders (receivers of the message) will automatically behave in an overt manner toward encoders (senders). The action tendency may remain covert. Regardless of whether the complementary reaction is overtly or covertly expressed, it will be experienced by the decoder (recipient) as a pull or tendency to emote, think, or behave in predictable ways. Kiesler provides prototypical examples of octant behaviors and their complementary action tendency pulls in Figure 2.2. Connotative verbal descriptors adjacent to each octant denote prototypical “characterizations” for that octant. The arrows in Figure 2.2 show the directions of the complementary pulls, indicating how clinicians are naturally inclined to behave. The reader can look at each octant, taking into account its complementary pull, think about one patient he or she has treated recently, and then determine if the complementary descriptor is congruent with the reactions he or she actually experienced with that patient.

Profile Summary Sheet
IMPACT MESSAGE INVENTORY: FORM IIA OCTANT VERSION
 Donald J. Kiesler and James A. Schmidt

Patient _____
 Therapist _____
 Session/Date _____ / _____

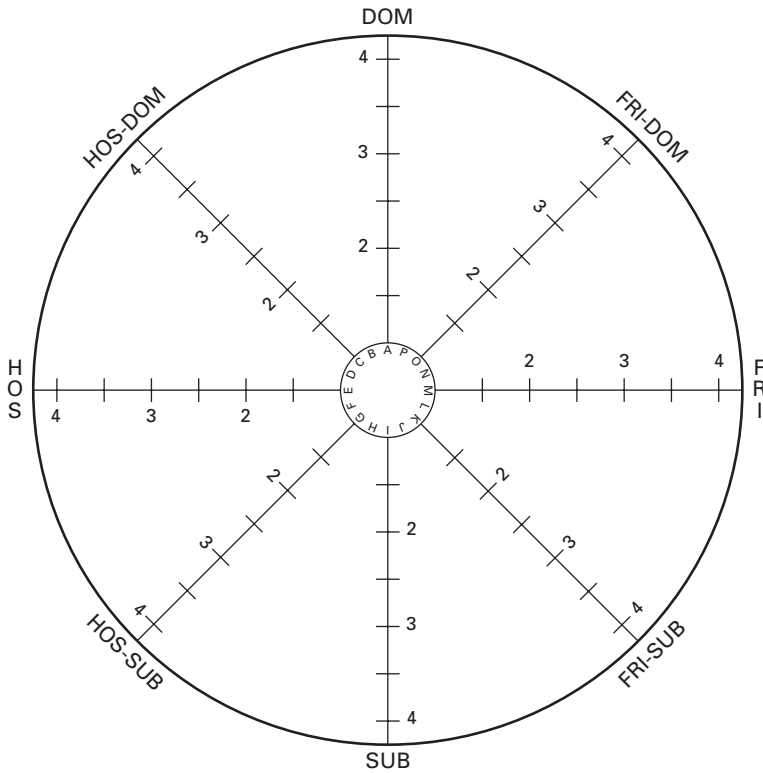


FIGURE 2.1. The octant version of the interpersonal circle. Reproduced by special permission of the publisher, Mind Garden, Inc., 1690 Woodside Road, Suite #202, Redwood City, CA 94061; (650) 261-3500; from the *Impact Message Inventory: Form IIA Octant Scale Version* by Donald J. Kiesler, PhD. Copyright 1993 by Dr. Donald J. Kiesler. All rights reserved. Further reproduction is prohibited without the distributor's written consent.

The Metacommunication Technique

Administration of the metacommunication technique includes several steps. The first step begins when a therapist makes an objective countertransference decision (Epstein & Feiner, 1979) about the patient's prominent interpersonal impact. Said

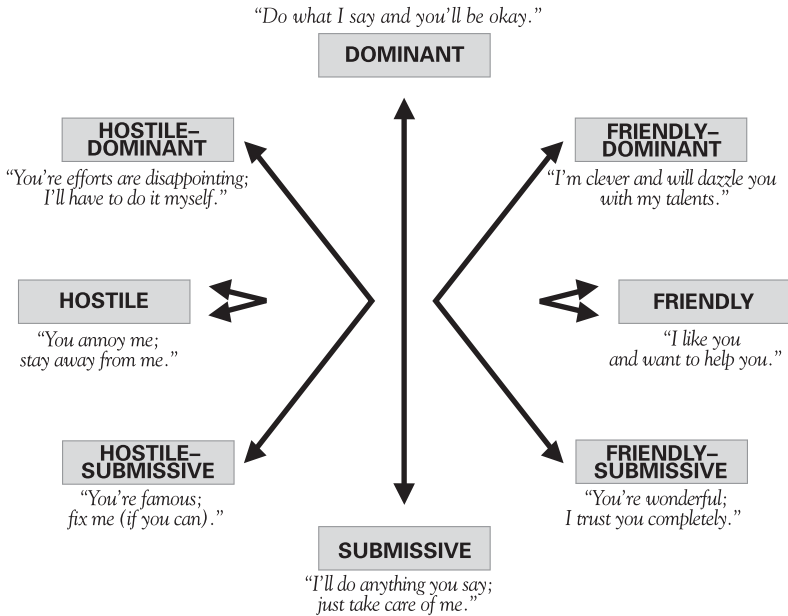


FIGURE 2.2. Octant complementary “pulls” of Kiesler’s interpersonal circle. Reproduced by special permission of the publisher, Mind Garden, Inc., 1690 Woodside Road, Suite #202, Redwood City, CA 94061: (650) 261-3500: from the *Impact Message Inventory: Form IIA Octant Scale Version* by Donald J. Kiesler, PhD. Copyright 1993 by Dr. Donald J. Kiesler. All rights reserved. Further reproduction is prohibited without the distributor’s written consent.

another way, the therapist identifies the evoking style (or pull) of the patient, which was exposed during an interaction. The patient may be duplicitously asking the therapist to tell him or her what to do by enacting submissive behavior (submission pulls for dominance). For example, submissive behavior may be communicated *verbally* in this manner: “I don’t know what to do. You do, so please help me out and tell me.” A *nonverbal* interpersonal act would include breaking into sobs or gazing at the therapist with a helpless expression. Either way, the strong pull is for assistance. Another illustration involves patients who disengage interpersonally or distance themselves (i.e., behave in a hostile–submissive manner, which pulls for a hostile–dominance reaction from the clinician) from some topic or subject whenever they become anxious. Patient avoidance strategies are often frustrating to clinicians, and clinicians might feel like saying something to this effect: “Dammit, if you’re not going to deal with this problem, then why the hell are you sitting here!” This is a hostile–dominance reaction, which would represent a knee-jerk reaction to a hostile–submissive act.

These two examples illustrate how, in step 1, therapists must identify the evoking style of the patient. Both examples denote self-defeating and duplicitous styles.

Kiesler notes that in “assessing the patient, the therapist constantly decodes his or her linguistic and nonverbal messages” (1988, p. 22). The assessment data are derived from the patient’s verbal and nonverbal behavior, the syntactic style of the patient’s speech, and, as illustrated above, from his or her evoking style (Kiesler, 1988). Wisely, Kiesler adds a caveat to the assessment process, warning that objective countertransference assessment is valid only to the degree that the clinician is not threatened (made anxious) by the evoking message, such that he or she has difficulty disengaging from the impact or discussing the impact without distorting it. Noted earlier, problems disengaging from evoking messages arise from unresolved *subjective countertransference* issues.

During step 2, the therapist deliberately disengages from the evoking impact and decides what he or she will do. By not reacting in a complementary way, the therapist breaks into the patient’s maladaptive cycle of interacting with others and offers an *asocial* response (Kiesler, 1988).

Step 3 is taken when the therapist actually responds in an asocial or noncomplementary manner: “The therapist responds to the patient in an asocial or disengaged way whenever the therapist withholds the customary, preferred, or expected complementary response” (Kiesler, 1988, p. 24). By being pulled into unfamiliar (and unexpected) interpersonal territory by an asocial reaction from the therapist, most patients experience a sort of “beneficial uncertainty” (Beier, 1966; Kiesler, 1988)—in short, they are thrown off guard. Making a noncomplementary response in the first case, above, means not acting in a dominant way and telling the patient what to do. In the second example, the therapist does not respond in a hostile-dominant fashion; instead, he or she would metacommunicate something to this effect: “Whenever we encounter something that makes you unsure about what to do, you cry and look longingly toward me. It makes me feel like I ought to provide you with answers.” In a similar vein, metacommunicating to this patient could be done in this way: “It seems like every time we talk about something that makes you nervous or uncomfortable, you withdraw and pull back—you leave the conversation. It makes me feel alone, frustrated, and a little bit silly, wondering why I’m even talking about this stuff.”

The goal of metacommunicative feedback is to reduce the extremes of behaving submissively (in the first case) and disengaging in the face of stress (in the second). By offering these individuals an asocial response, the clinician is attempting to pull both patients toward the “center” of the response circle, away from the extremes. This goal is accomplished by refusing to react with dominance when faced with submission or with a hostile-dominance response in the face of hostile–submissive behavior. Remaining on the friendly side of the circle and assuming a task-focused stance (see McCullough, 2000, Chapter 8) usually constitutes an asocial position on the circle for self-defeating behaviors. A task-focused stance helps patients discuss self-defeating interactive behavior and possible alternative strategies. Kiesler argues that metacommunicative feedback is “one of the most powerful asocial responses in the therapist’s repertoire” (1988, p. 27).

Conclusions

Kiesler is the first alliance psychotherapist in over 50 years to offer a prescribed methodology that moves the therapist beyond the *blank-slate* facade of anonymity and toward more personal disclosure. From the field's inception, psychotherapists have asked patients to be direct, genuine, and honest when they would not and could not reciprocate. Substantive avenues for reciprocal behavior open up in Kieslerian psychotherapy, in which therapists are encouraged to behave like real human beings. Over the years, many patients have seen through our unilateral facade and protested in various ways.

For example, shortly after I had completed my clinical training, one of my patients made a very kind observation late one afternoon when she said, "Dr. McCullough, you look like you're tired." She offered a genuine empathic reaction to an obvious (though unintended) display of fatigue on my part. What I said in return was what I had learned in training: "We're not here to talk about me, we're here to focus on you" (I responded in a hostile-submissive manner). Her reply was almost inaudible but very instructive. She said, "Shit" (she reacted in a hostile-dominant way). I'd pushed her away, acted like a robot, and her reaction was appropriate. I wish she had metacommunicated with me then and there and said something like this: "When I try to be sensitive, you push me away. It makes me feel like you're not a real human being, like you're playing out a role." Kiesler has taken our psychotherapy tradition one step closer to personal involvement with patients. Next, we explore the work of two pioneers in the personal involvement arena, who have broken new ground by successfully transcending the personal involvement taboo.

Personal Involvement Pioneers: Garry Prouty and Kent G. Bailey

Garry Prouty's Pretherapy Method

Prouty (1994) stands within the Rogerian person-centered tradition. Rogers (1942) assumed that the patient's ability to make *psychological contact* was the sine qua non of the therapeutic relationship. Unfortunately, he provided no definition of psychological contact nor offered a description of how it could be learned, if the skill were absent, or restored if lost (Prouty, 1994). Eugene Gendlin, a Rogerian clinical psychologist, mentored Prouty during the latter's clinical training days. Prouty was particularly influenced by Gendlin, who felt that Rogers had overlooked a crucial change variable because of his exclusive focus on therapist attitudes. For Gendlin, the patient's perceptual experience of the therapist's attitudes (i.e., unconditional positive regard, empathy, and congruence), which he called the "experiencing gap," lies between the attitudes and the individual's reception (his or her experience) of them. He shifted the focus of therapeutic change from the therapist to the experiential processes in the patient. The experiential domain, according to Gendlin,

was the critical psychological change variable in person-centered therapy (Van Balen, 1991). In adding the experiencing construct to Rogers' method, he initiated the Rogerian person-centered/experiential movement (Gendlin, 1964, 1968, 1974, 1979; Gendlin & Berlin, 1961).

There was one subject on which Rogers and Gendlin agreed: Both felt that the person-centered method would not work with schizophrenic or retarded psychotic patients. Rogers argued that retarded individuals lacked the necessary introspective skills, and that schizophrenic patients could not generate psychological contact because of their social withdrawal and isolation (Rogers, 1942; Rogers, Gendlin, Kiesler, & Truax, 1967). In a similar vein, Gendlin (1970) reasoned that because schizophrenic patients were perceptually disconnected from the world, they could not sustain social interaction or experience feelings.

Prouty's pretherapy model begins where Rogers and Gendlin stop. The method is designed to *prepare* schizophrenic and retarded psychotic individuals for individual psychotherapy. The pretherapy method concentrates on developing the psychological functions necessary for psychotherapy: reality, affective, and communicational contact (Prouty, 1994). He describes these three contact functions: (1) *reality contact* is the ability to be aware of one's perceptual environment and the people who inhabit it; it is operationalized by the ability to name people, places, and events; (2) *affective contact* is the ability to be aware of one's moods and the changes that occur in feeling shifts; it is operationalized as an expression of bodily or facial affect; (3) *communication contact* is the ability to communicate one's experienced reality with another; it is operationalized as the ability to form socially related words or sentences.

His work is significant for several reasons: (1) his focus on two specific patient populations (regressed schizophrenic and retarded psychotic patients) has enabled us to identify what works for whom; (2) he conducts intensive, single-case research to determine ways to teach contact and experiencing skills to both groups; the intensive study of the single patient provides one of the most effective design procedures with which to develop new therapeutic techniques (McCullough, 1984b); (3) patient learning and measurement of the generalized treatment effects of learning constitute essential parts of his program; (4) his work with these two patient groups indicates that personal involvement (behavioral, emotional, and physical availability to patients) is necessary to administer the methodology. Reading about his methodology reminds me of the work of Eugene Bleuler. He quotes Bleuler, who writes that his "main endeavor was to be close to his patients; working with them, playing and walking with them, even organizing dancing parties with them . . . It was in Rheinau that he realized that schizophrenics could not be "demented" (Bleuler, 1991, pp. 2-3).

Prouty introduces his model by asking a question suggesting that teaching preparatory interpersonal skills will be important. He asks, "What are the necessary *pre-conditions* of a therapeutic relationship?" (1994, p. 36). His answer is a treatment plan designed to teach patients to meet his precondition criteria. As stated above, he assumes that patients who are viable psychotherapy candidates must be able to make reality, affective, and communicational contact with therapists. In

turn, therapists must enact intensely personal, nondirective, verbal, and nonverbal “reflective behaviors” in order to awaken patients’ awareness of these contact functions. Space limitations preclude further description of Prouty’s concepts and methodology, but a presentation of one verbatim case vignette “illustrates contact reflections (on the part of the therapist) resulting in the restoration of the contact functions in a chronic schizophrenic woman” (Prouty, 1994, p. 42):

Case

Dorothy was an older regressed patient on the ward. The therapist could hear specific words within her confused pattern of speech. Reflecting (by repeating word-for-word) the words which could be understood and using bodily movements to mirror (reflect) the body movements of the patient resulted in Dorothy saying a complete sentence after about ten minutes. The example illustrates movement from a pre-expressive communicative state to an expressive style of communication—autism (loss of contact with the world, self, and the other) in this instance gives way to existential contact (contact with the world, self, and the other).

Client: Come with me.

Therapist: Come with me [The patient led me to the corner of the day room. We stood there silently for what seemed to be a very long time. Since I couldn’t communicate with her, I watched her body movements and closely reflected these.]

Client: [The patient put her hand on the wall.] Cold.

Therapist: [I, using body reflections, put my hand on the wall and repeated the word.] Cold.

[She had been holding my hand all along, but when I reflected her, she would tighten her grip. Dorothy began to mumble word fragments. I was careful to reflect only the words I could understand. What she was saying began to make sense.]

Client: I don’t know what this is anymore. [Touching the wall: *reality contact*.] The walls and chairs don’t mean anything anymore. [Existential autism.]

Therapist: [Touching the wall.] You don’t know what this is anymore. The chairs and walls don’t mean anything to you any more.

Client: [The patient began to cry: *affective contact*. After a while she began to talk again. This time she spoke clearly: *communicative contact*.] I don’t like it here. I’m so tired . . . so tired.

Therapist: [As I gently touched her arm, this time it was I who tightened my grip on her hand. I reflected.] You’re tired, so tired.

Client: [The patient smiled and told me to sit in a chair directly in front of her and began to braid my hair.] (Prouty, 1994, pp. 42–43)

Teaching novel contact behaviors to regressed schizophrenic and psychotically retarded patients means that we depart from the mainstream of psychotherapy practice. New therapist roles sometimes emerge during these occasions when old methodologies do not work, and this model is a case in point. The pretherapy model requires practitioners to make themselves available to patients on interpersonal levels not usually encountered in daily practice. For example, physical contact and proximity are often necessary, sessions are sometimes carried out in the home, and the therapist must be able to experience as well as to disclose personal

feelings, thoughts, and concerns that he or she has for the patient. These patients necessitate a therapist's willingness to share in the most horrible dimensions of human experience as well as the ability to tolerate slow and tedious progress.

That Prouty's pretherapy method transcends the personal involvement taboo is not surprising. The reasons why are important. The therapist role prescriptions are informed by the psychological and learning needs of patients. By beginning treatment on the patient's level rather than requiring the patient to fulfill preset psychological and professional criteria, Prouty achieved remarkable results with two populations Rogers and Gendlin had excluded from their purview.

Kent G. Bailey's Kinship Psychotherapy

Bailey is an evolutionary paleopsychologist and psychotherapist (1987, 1988, 1997, 2000, 2002; Ahern & Bailey, 1997; Bailey & Wood, 1998; Bailey, Wood, & Nava, 1992; Gilbert & Bailey, 2000) who introduced a general approach to human behavior called *paleopsychology* (Bailey, 1987) and published the initial article on *kinship psychotherapy* in the late 1980s (Bailey, 1988). He writes that both "empirically and theoretically, the relationship is central to virtually all forms of professional helping and psychological treatment" (Bailey et al., 1992, p. 125). Standing within the alliance tradition, his writings and research illuminate, from a paleopsychological point of view, *why* the personal involvement dimension is so crucial. Bailey assumes that all helping relationships are based on a natural human propensity to form psychological "kinship" or "kinship-like" relationships with significant others.

Two kinship categories are described in Bailey's work: biological and psychological. Biological kinship, although somewhat similar to psychological kinship, differs in significant ways. The former denotes the degree of genetic relationship one shares with another and entails a classification of the other "as family." Psychological kinship, on the other hand, describes "a universal, natural means of interpersonal valuing whereby persons classify others first in terms of in-group versus out-group status . . . and then further in terms of differential value with the respective status. Thus, one may 'love' (value biopsychologically) with differing intensities within the in-group, and 'hate' (disvalue biopsychologically) with differing intensities within the out-group" (Bailey, 1988, p. 133). Psychological kinship feelings and attachments clearly account for the widespread human tendency to include nongenetically related individuals (Bailey's list includes friends, lovers, marital partners, coworkers, adopted children, military buddies, athletic teammates, persons bound by mutual suffering, etc.) into the psychological in-group and classify them "as family" (Bailey, 1988) in a "kin-like" category (Ahern & Bailey, 1997).

According to Bailey, kinship displayed by a psychotherapist would include a long list of attributes or behaviors:

- Strong sensitivity to the patient's need to "be family" (e.g., patient's attempts to deepen the intimacy of dyadic contact)

- Careful monitoring of the sexual transference and countertransference domain so as not to cross the “incest barrier”
- Efforts exerted to increase “bonding” between practitioner and patient
- Avoidance of a “double standard” when ethical or moral issues arise (e.g., not holding one set of rules for his or her family and another for patients)
- Extending of a compassionate and caring style
- Integration of the patient’s biological family into treatment whenever appropriate
- Sensitivity to a minority patient’s racial issues (i.e., sensitive acknowledgment of cultural differences/nuances)
- Behaves authentically (i.e., does not play a “therapist role”)
- Does not overemphasize techniques
- Gears treatment goals to engender “hope, faith and healing.”

Bailey (1988) derives four assumptions from his premise that we universally tend to form psychological kinship relations with nonbiologically related others and, more specifically, with the “helper” in helper–helped relationships. He assumes that (1) patients (helpeds) desire a kinship relationship with psychotherapists (helpers) because they desire to move from an out-group position to in-group status; (2) the desire for kinship varies proportionately to the degree of mental or physical stress/suffering; (3) minority groups are likely to gravitate toward kinship forms of treatment because their life situation includes high levels of stress; and (4) many psychotherapists (helpers) do not recognize or desire psychological kinship relationships with patients. Bailey’s approach represents a clarion call for therapists to recognize how important a role they play in the lives of their patients and then find ways to integrate this recognition into the therapy process.

A case description from Gilbert and Bailey (2000) is presented next to illustrate psychological kinship when it is actualized to a maximum degree. I paraphrase some of the case from Bailey’s description and quote him in other areas.

Case

Jennie was a difficult challenge from the day she entered the office. She was belligerent, argumentative, appeared to be high on drugs, and thought the counseling process was a sham. Her history was sordid: substance abuse, minor brushes with the law, antisocial behavior, and suicide attempts. She was a native of backwoods Alabama and as an infant her “mother had cast her off” to an aunt and uncle. They had raised her in a rigid and unaffectionate manner. Jennie ran away from home as a teenager and was informally adopted by Wanda, a loving but mentally ill older lady. She still feels that Wanda is her “true mother” (i.e., closest psychological kin). During early sessions, Jennie was administered a battery of tests (MMPI [high F: Infrequency scale]) and significant clinical elevations on Scales 2 (Depression scale) and 4 (Psychopathic Deviate scale); Draw-a-Person; TAT [deep longings for love and acceptance]; Rorschach [impulsivity and psychological impoverishment]). The data suggested that she met criteria for borderline personality disorder, moderate, and was probably alcoholic.

When treatment began, the only significant others in Jennie's life were Wanda and the therapist—who came in a very distant second. However, Wanda lived in another city, so Jennie “grabbed on to me as a lifeline” (Gilbert & Bailey, 2000, p. 59). The patient–therapist relationship would prove to be pivotal in the early stages of her therapy. Jennie entered the sessions loud and boisterous, expressing extreme ambivalence about being in the room, and released her rage and anger at the only person in the room—the therapist. Bailey writes that “warm emotionality was low . . . as we struggled to find something to base a relationship on” (p. 59). In terms of kinship status, the relational dynamic was confusing. The patient seemed to perceive the therapist as a potential kinship object and enemy at the same time. Bailey confided that the only emotion he experienced at this point was a deep professional obligation to the patient. Her tirades seemed to be sort of “a test, to see if I really cared.” In the early stages, his “goal was to hold firm and try to win her trust” (2000, p. 59).

During a session in the fourth month of treatment, Jennie became angry over probing questions and ran from the room screaming epithets at the therapist. She returned 20 minutes later looking sheepish, subdued, and trying to figure out how the therapist would react.

At that time, I felt that this was the moment where the relationship would stand or fall. I firmly stated that there was nothing she could do to get me to give up on her, so she might as well just knock it off. Surprisingly, she seemed very pleased with that and promised to be back next week. In retrospect, I can now see that this was the very deep “kinship” affirmation that she had sought all along from others and myself. (Gilbert & Bailey, 2000, p. 59)

The therapeutic bond was affected suddenly and deeply during that session. Subsequently, Jennie began to dress more attractively, made a few new friends, and found employment. At therapy outcome, her MMPI scores on Scales 2 and 4 had dropped significantly, indicating that she was no longer depressed and blaming others less frequently for her problems; however, she was unable to overcome alcoholism. Nevertheless, therapy had helped provide her with a sense of meaning and had terminated the downward spiral of self-destructive behavior. Jennie was accepted into the military shortly thereafter and became one of three female helicopter mechanics in the U.S. Army. Serving 8 years with distinction, she was promoted to sergeant. Following a failed marriage of 1 year, she lapsed back into alcoholism and accepted a medical discharge from the army.

She continues to keep in touch with me and my family, and she will occasionally call or come by my home for a visit. She continues to classify not only me but my wife and daughter as “family,” and we see her as something more than a previous therapy client. This is probably the only true psychological kinship I have developed with a client, and I have been willing to accept the obligations and occasional inconveniences that go with it. (Gilbert & Bailey, 2000, p. 60)

In this instance, a “psychological kinship” or kinlike relationship appeared to bring a degree of relief and psychological improvement into the patient's life.

The psychological kinship role can be thought of as a continuum ranging from *very little* to a *great deal*. From Bailey's point of view, however, kinship issues pervade every nook and cranny of the practice of conventional psychotherapy. The role of both participants in regard to felt kinship or personal involvement will be determined largely by the needs of the patient and the interpersonal capabilities of the clinician.

Summary

In this abbreviated history we have reviewed 100 years of the personal involvement taboo: from the rigid proscription of classical psychoanalysis forbidding personal involvement, to the work of Rogers and the mainstream therapeutic alliance research tradition that have fostered the personal involvement taboo in psychology and psychiatry, to the innovative work of interpersonal psychologist Don Kiesler, who opened the door for therapeutic personal involvement, and concluding with the pioneering work of Prouty and Bailey, who describe methods in which personal involvement can be actively incorporated as an integral part of treatment. Prouty and Bailey have demonstrated that there are obvious degrees of personal involvement and psychological kinship in all varieties of helper–helpee relationships. Some patients need more of a *kinship-like* relationship with therapists than others. Similar variability in the degree of kinship present also occurs in relation to various therapeutic techniques with their respective outcome goals. Some techniques may require therapists to generate personal involvement with patients to achieve therapeutic outcome goals. Others need only a modicum of therapist personal involvement—one that extends no further than having a detached concern for the person's welfare.

In demonstrating that various techniques require differing amounts of therapist neutrality, Prouty and Bailey have also enabled us to transcend our ingrained all-or-none thinking about personal involvement. There is no longer a “one-size fits all,” to borrow a marketing phrase. Our century-old proscription must be revised in light of new data. It is clear that the decision to employ personal involvement with patients depends on complex parameters: (1) the diagnosed disorder; (2) the needs of the patient; (3) the technique being used and the goals of treatment; and (4) the interpersonal capabilities of the clinician. All four domains must be considered as informing sources whenever we speak of therapist personal involvement with patients.

Lastly, I discussed how learning concerns were largely absent during the 20th century in psychotherapy training, research, and practice. The one exception is the behavior therapy movement—which, ironically, never addressed the personal involvement issue. In the chapters that follow, learning issues are presented as salient and as informing therapist choice of personal tactics as well as how case outcomes are evaluated.

Chapter 3 begins by discussing the dangers of overestimating the chronically depressed patient's capabilities. I illustrate how, in overshooting the patient's reach,

we sabotage our teaching efforts. A brief description of the psychopathology of the chronic disorder follows. Once the pathological needs of these patients are understood, it is easier to see why I recommend that CBASP therapists administer disciplined personal involvement with their chronically depressed patients. The final section discusses the interpersonal isolation of this patient population to illustrate why I think disciplined personal involvement is a necessary treatment component.