Cognitive Systematic Desensitization: An Innovative Therapeutic Technique with Special Reference to Muslim Patients

M. B. Badri

Abstract

This paper discusses my innovative alterations and my Islamization of Wolpe's systematic desensitization therapy applied during 1965 to treat a Moroccan patient. I have used this technique for the last fifty years; however, this is the first time I have described it in full detail. My main modifications were to (1) ask the patient to speak out loudly when detailing what she was imagining in order to enhance her involvement and her ability to imagine vividly; (2) encourage her to "horizontally" imagine and speak about other scenes of comparable anxiety-provoking instances to facilitate the transfer from clinic to real life. In fact, this turned out to be one of the earliest attempts to transform classical behavior therapy to cognitive therapy. Whenever she reported a great deal of anxiety, I discussed it with her and helped her discover her unconstructive thinking and Islamically change its negative irrationality. In doing so I combined desensitization with behavior rehearsal and spiritual Islamic therapy; (3) ask her to stop talking, instead of raising a finger, whenever she experienced a great deal of anxiety. My combination of the gradual approach of desensitization with cognitive therapy, behavior rehearsal, and spiritual therapy has shown how this combination can be of special relevance when treating Muslim patients.

Malik B. Badri (Ph.D., Leicester) is a Fellow and Chartered Psychologist (C.Psychol.) of the British Psychological Society; Distinguished Professor of Psychology, Ahfad University, Omdurman, Sudan (now on secondment); and holds the Chair of Ibni Khaldun in the International Islamic University, Malaysia. He was awarded an honorary D.Sc. and decorated with Sudan's highest award for academic excellence: the Shahid Zubair medal. He was appointed professor and dean of various universities and served as senior clinical psychologist in Middle Eastern and African hospitals and clinics. He has been active in clinical psychology and counseling since 1962.

Introduction

More than thirty years have passed since the establishment of the International Institute of Islamic Thought. Hundreds of articles have since been written on the historical, philosophical, ideological, and theoretical aspects of Islamization; however, very few scholars have ventured into the practical hands-on aspects of this field.

Many Muslim psychologists and social scientists are now generally convinced about the need to Islamize. Thus they do not need to be convinced about the importance of the Islamization, indigenization, or adaptation of their fields; they need to know how to do it. In this paper, I present an innovative practical study on the Islamization of systematic desensitization therapy. Although I have given a few brief lectures on this topic, this is the first time I have written about it in full detail and have shown its relevance to the practice of Islamized psychotherapy. This study is based on a novel technique I carried out in 1965 while treating a Moroccan female patient by applying major changes to Joseph Wolpe's (d. 1997) systematic desensitization therapy as described in his *Psychotherapy by Reciprocal Inhibition*.[1] The technique was later published in the *Journal of Psychology*.[2]

Although I have been using this therapy with hundreds of patients for the last fifty years, I have now chosen to revisit my first innovative treatment for three main reasons. First, I wish to establish its historical significance as one of the earliest endeavors to transform classical behavior therapy into cognitive therapy. Second, by detailing its practical procedures, I hope that it can help contemporary psychotherapists treating Muslim patients. In pursuit of this goal, I have chosen to detail this particular patient's treatment because her complex complaints and dramatic improvement clearly illustrate the combined effects of my modifications and their Islamized approach.

My third goal, which is related to the earlier one, is to reveal the Islamically oriented behavioral and cognitive therapies I applied in 1965 and was unable to disclose in my article (published in 1967). For my paper to be published in a reputable American journal during the 1960s, I had to avoid talking about spiritual therapy and such religious terms and beliefs as the soul and the acceptance of God's destiny (*qadar*). At that time, and to lesser extent even today, such a religiously oriented approach may be stamped as "unscientific" and unpublishable. The only religious reference I could make was the following:

> To establish rapport and motivate the patient for the course of treatment, it seemed appropriate to make a few interpretations for some of her guilt-provoking incidents. Some of this was done in the light of the Islamic concept of sin forgiveness.[3]

What Is Systematic Desensitization Therapy?

Ever since it was launched by Wolpe in the 1950s, systematic desensitization generally starts by interviewing the patient and explaining the theory and its application. This is followed by training in relaxation and the development of a hierarchy of progressively anxiety-provoking scenes. When patients are fully relaxed with the help of muscular relaxation, deep breathing, mild hypnosis, drugs, or any other method, all of which are supported by the visualization of a relaxing scene from their past experiences, they are asked to silently imagine the least anxiety-provoking scene in the hierarchy. This is repeated until patients report no anxiety and are consequently transferred to the next item in the hierarchy. If patients experience anxiety from this new task, they are to raise their forefinger so that the therapist can bring them back to an earlier item and help them relax again. Later on, the therapist presents the same item until the patients overcome their anxiety and are ready for the next scene.

This therapeutic approach is still being applied. Although its popularity is sharply declining in published works,[4] systematic desensitization continues to be one of the most popular and widely practiced therapeutic techniques in clinics. In the 1960s, this highly successful therapy was followed with the precision of a woman following a recipe from a cookbook; many committed modern behavior therapists still employ it. As I look back at these old days, I feel that my greatest contribution was my refusal to follow those therapists who strictly imprisoned themselves within the stimulus-response paradigm of Ivan Pavlov (d. 1936), Clark Hull (d. 1952), and B. F. Skinner (d. 1990).

Some of the Therapy's Main Inadequacies

Those committed behavior therapists who apply systematic desensitization do not engage with patients about their thinking, consciousness, or inner world. Nor do they deviate from the prescribed Wolpeian technique validated by experimental studies on animals and humans (who behaviorists see as animals with highly developed brains or human machines). An effort is made to cast the patient's problems into a stimulus-response (S-R) paradigm and then treat him/her according to a specific formula of a learning theory, as if he/she were no more than a machine or a hyphen between the "S" and the "R." These were the golden days of classical behavior therapy. It was too authoritatively restricted to the applications of learning by conditioning within the paradigm of radical behaviorism. This was particularly so in England, where behavior therapy first flourished in the in the sixties through the influence of Hans Eysenck, Victor Meyer and Jack Rachman.

When I joined the Department of Psychiatry of Middlesex Hospital's Medical School to study behavior therapy under the guidance of Victor Meyer, I had already read about systematic desensitization and had applied it to a few Sudanese and Lebanese patients, as well as to the Moroccan patient discussed below. Even at that early time I discovered that some of my patients, who had claimed to go through the hierarchy without much anxiety during imagination, did not behave calmly in real-life situations. I discovered later that other behavior therapists complained about the same problem.[5] Furthermore, some patients found it difficult to imagine.[6]

I concluded that the hierarchy was only a sample of the patient's phobic anxiety. Moreover, to follow it rigidly and to expect the patient on his/her own to transfer his/her newly acquired positive learning to novel life-situations viewed as fearful was also unreasonable and did not reflect the best in the theory and practice of the transfer of learning. I also noticed that as the therapy continued, a number of patients who had happily accepted the agreed-upon hierarchy later on discovered that its steps, as regards going from one scene to the next, were too steep. On the other hand, a few others found the hierarchy so finely graded that we wasted a great deal of time in going through it. Additionally, I realized that some patients do not raise their fingers to signal anxiety, although their faces express much fear and agony. At other times, I failed to notice a shyly raised finger. All of this led me to invent a new technique of systematic desensitization that I first applied to our patient in the al-Ghazi Teaching Hospital of the University of Rabat's Neuro-Psychiatric Section. At that time, the hospital was located in Sala, a city close to Rabat. But before I detail my innovations and their Islamic applications, I will give the reader a short report about the patient.

A Brief Case Report

The patient, a twenty-four-year old married woman working as a clerk in a government ministry in Rabat, was first admitted in 1965. She was suffering from an extreme form of social anxiety, depression, hypochondriacal symptoms, a mouth tic, and other phobic anxieties concerning death and blood. She was extremely non-assertive and submissive, particularly with dominant males. She was terrorized by her heartless father and abused by her unemployed husband who was living off her salary. When her boss discovered her weakness, he sexually abused her. Thoroughly guilt-ridden, she strongly believed that Allah had cursed her and would not forgive her sinful sexual behavior, despite the fact that she had been forced into it.

Four months of psychoanalysis, anti-depressant drugs, electro-convulsive therapy, and traditional healing failed to help her; in fact, her condition was apparently becoming worse. Her father and husband decided to take her to a religious healer, but his "therapy" only succeeded in intensifying her feelings of guilt and inadequacy. After her readmission to the hospital, she was referred to me by the senior psychologist who had noticed that she was tearfully responsive to my Islamically oriented discourse with patients on God's mercy and forgiveness of all sins. Those who wish to view the full case history can refer to the original article.[7]

My Innovative Changes

As stated in the case report, the patient was suffering from a number of disorders. I decided to start by treating her extreme social phobia. I thought (correctly, as it turned out) at the time that her depressive mood and other minor symptoms were tributaries of her severe lack of self-confidence, feelings of worthlessness, and severe social anxiety. I initially followed the usual steps of Wolpe's desensitization on the imaginary level[8] by training her in muscular relaxation and other relaxing activities. We agreed on three graded hierarchies that started with easy scenes (e.g., being assertive with children) and "vertically" ending up with confrontational scenes with her husband, father, and boss. I started with her husband's hierarchy, since he was the most aggressive and unkind person in her life.

My main innovative deviation was not to limit myself to the hierarchy's "vertical" approach, as prescribed by Wolpe and as currently practiced, but to ask the patient to "horizontally" imagine instances similar to the one I was counter-conditioning. My second departure was that instead of asking her to imagine a scene for a fixed time, I asked her to loudly speak to me after she had silently imagined ite and describe in detail what she was imagining. I then illustrated what she had verbalized in more vivid detail and encouraged her to imagine and speak about other anxiety-provoking scenes that were, so to speak, horizontally on the same level of anxiety as the scene at hand. Speaking out enhanced her involvement and assured me that she was capable of vivid imagination.

This ability to imagine vividly is of paramount importance to successful desensitization. Many treatments fail because the patient either cannot imagine vividly or feels that the whole process is artificial.[9] Furthermore, the horizontal approach was useful because, as already mentioned, the hierarchy presents a limited sample of anxiety-provoking scenes. Going horizontally helps patients

transfer their learned composure to other situations. So long as she was fully relaxed, I allowed her to digress horizontally from the hierarchy's original scene and speak loudly about what she was imagining. Moreover, going horizontally gave me a better insight into her spiritual agony, ethical and religious conflicts, and self-devaluation.

Unlike behavior therapists who look for a raised finger to signal anxiety, I instructed her to simply stop talking as soon as she felt or anticipated a great deal of anxiety. So I did not need to look for a raised finger. In fact, she changed her tone of voice to signal her anxiety even before she stopped talking.

Sometimes this horizontal digression caused her sudden anxiety, such as when she associated the imagined scene with an incident higher up in the hierarchy. This was beneficial, for after relaxing her and taking her back to the original scene we would discuss what had really caused her to be so anxious. I also used this opportunity to explain its falseness and un-Islamic root. When I devised this horizontal talking technique in the 1960s, I only wanted to facilitate the transfer of learning from clinic to real life. But as I see it now, the actual success of my therapy was also due to my ability to help her speak out and change her negative thought, and to alter her talking monologue in an atmosphere of physical, Islamically spiritual, and psychological relaxation. This was, of course, one of the highly successful cognitive therapeutic techniques that Aaron Beck would develop fully in his *Cognitive Therapy and the Emotional Disorders*.[10] Other pioneers of the cognitive therapeutic revolution followed his lead. But all these innovations came a few years after my paper was published.

Another deviation was that before moving vertically to the next scene in the hierarchy, I used behavior rehearsal and role playing to ensure that she had learned her lesson. The use of behavior rehearsal in a hierarchy that is ranked in increasing complexity was only fully developed in the 1990s,[11] although its forerunner, psychodrama, had been developed during the 1940s.[12] However, its use as part of a novel cognitive systematic desensitization therapy is probably one of my original contributions.

I used to ask her to reimagine the scene and talk loudly and assertively. For example, when I asked her to imagine that her husband was mad at her because she had not prepared his lunch on time and urged her to respond forcefully, she reacted in a weak, apologetic, and defensive manner. So I switched the roles and spoke on her behalf in an aggressive and very loud manner, reminding him that she had to work hard to support him, even though Islam teaches that the man bears full responsibility for supporting the family financially. After returning to our original roles, I asked her to repeat my harsh

words. She did so in a most loud and aggressive manner, cathartically expressing even more degrading information about him. In my later experiences with patients, I found that this behavior rehearsal within this gradual systematization was very helpful, particularly with regard to those patients who suffer from ethical and spiritual conflicts that lead to unwarranted guilt, social phobia, and despair.

My final novelty of the 1960s was the spiritual Islamic approach I embedded in my cognitive desensitization. In revisiting this case, I realize that I was actually functioning as a spiritually oriented cognitive therapist before the downfall of radical behaviorism. I had also unknowingly applied some of the newly developed aspects of the third wave of cognitive behavior therapy: namely, acceptance and mindfulness therapy. In fact, much of what has been recently advocated in this area of acceptance, commitment, mindfulness, and other therapies influenced by ancient Buddhist practice has always been used by ancient and modern traditional Muslim healers. It is sad to say that western psychologists are happy to take long non-stop mental flights to borrow from Buddhism and Hinduism and refuse to land and benefit from nearby Muslim healers.

I have been studying and benefiting from the practices of Muslim traditional healers since the early 1960s. However, I had a good chance for an in-depth study of their spiritual therapies when I was delegated to research their work in Sudan, Saudi Arabia, and Ethiopia. My travels in the late 1970s to these well-known healers was part of a research organized by the World Health Organization's (WHO) Panel on Traditional Medical Practices. I was a member of its experts committee. A summary of this research was published in 1978 in the WHO Technical Report Series 622, titled "The Promotion and Development of Traditional Medicine."

My patient overcame the bitterness of her sexual abuse through this Islamic therapeutic approach. It is a well-known fact that women raped and/or sexually abused feel guilty and blame themselves for failing to do things that could have stopped the abuse. This is often combined with anger at themselves and their abusers. In her case as a religious woman, these emotions were intensified with disgraceful shame, fear of God, and despair at His forgiveness. Whenever she expressed these feelings, I helped her adopt a cognitively positive Islamic line of attack. I supported my therapy with selected Qur'anic verses and hadiths that speak about God's forgiveness and mercy and the acceptance of destiny.

I realized that repeating Q. 3:133-36 and Q. 24:33 while she was fully relaxed was very helpful in reducing or neutralizing her suffering. The first set

of verses urge Muslims to hurry toward God's forgiveness and a paradise as wide as the heavens and Earth. This vast paradise is not only prepared for those who are charitable or suppress their anger and forgive offenders, but also for those who, when they commit something shameful and indecent (*fāḥishah*) or wrong their souls, remember God and ask for forgiveness. The Qur'anic term translated as "indecent" (*fāḥishah*) includes sins of a sexual nature. The verses conclude with the strong words: "And who forgives sins but God?" a firm divine confirmation that only He can and will forgive all of their sins. Paradise is thus waiting for those who sincerely ask for forgiveness, as opposed to those who give up on God's mercy and forgiveness. Listening to these holy verses moved her to tears and a delightful spiritual love for God. For the first time in her painful psychological suffering, she could see a spiritual light in her dark tunnel of hopelessness. This was also helpful in giving her self-confidence and the potential ability to stand up for her rights.

On the other hand, I found Q. 24:33 to be useful with many raped Muslim women, for it exposes those who force their "maids" into prostitution despite the latters' desire to remain chaste. The verse concludes with the loving and comforting words: "But if they are compelled, then Allah is most forgiving and merciful to them." I reminded her that her boss had compelled her and that her inability to resist was caused by her extreme social phobia. Furthermore, Qur'anic verses on accepting God's decree were quite helpful in relieving her depressive mood about her past abuse and exploitation.

I also quoted some of the hadiths that stressed women's rights and the Prophet's teachings about their descent treatment and respect. I reminded her that her soul belongs to God, not to her, and that from the point of view of Islam she does not have the right to humiliate it. I stressed the fact that her excessive fear of people was not Islamic and thus getting rid of it would make her a better and happier Muslim. I believe now that this approach of cognitive and spiritual restructuring and acceptance through spiritual mindfulness was quite helpful, because it came at the right time: during the realistic imagination of vertical or horizontal scenes. Moreover, it helped shorten the time of completing our main hierarchy.

Results

The improvement in her general condition was quite obvious; in fact, it was clearly visible as early as the sixth session. Successfully completing the first hierarchy on her husband greatly reduced the time for the other two hierarchies. This great improvement was confirmed by the clinical observations of

the senior psychologist and by her verbal report. Improvement was also seen in her sleeping and eating patterns, as well as her interest in herself and other patients. After the fifteenth session, she declared that she had overcome her phobia and her hypochondriacal symptoms, and that for the first time since her illness had begun she had an irresistible desire to see her children and return to her home. The treatment ended after the twenty-first session. She informed me later that she had "domesticated" her husband and had no anxiety about facing her boss. Although she was capable of strongly expressing her anger, she preferred to change her job and forget the whole issue. Spiritually, she expressed and overwhelming happiness about her changed conception regarding God's mercy and forgiveness.

When my article first appeared in the *Journal of Psychology*, many renowned behavior therapists considered it a useful therapeutic innovation. Some tried it out; others referred to it in their various publications. For example, Victor Meyer, who originated the exposure and prevention technique in treating obsessive compulsive disorder, was Britain's leading trainer in behavior therapy during the 1960s. He tried out my altered cognitive desensitization therapy on a number of his patients and personally informed me that he found it superior to Wolpe's desensitization therapy. He referred to it in his bestselling *Behaviour Therapy in Clinical Psychiatry*.[13]

He dubbed my new therapeutic technique *behavioral psychotherapy*, for it combines classical behavior therapy with talking therapy. But I now prefer to call it *cognitive systematic desensitization*, because the former term became popular in the Department of Psychiatry of the Middlesex Hospital's Medical School during the late 1960s where I was serving as a clinical assistant. Meyer later used it as a name for his well-known British Association. The term retained its attraction in the 1980s, as can be seen in the titles of various books, among them Herbert Fensterheim's edited *Behavioral Psychotherapy: Basic Principles and Case Studies in an Integrative Clinical Model*[14] and Isaac Marx's *Behavioural Psychotherapy: Maudsley Pocket book of Clinical Management*.[15]

As mentioned above, when it first appeared a number of distinguished authors referred to my new technique. For example, Martin Seligman ("A Learned Helplessness Point of View") and Steven Hollon ("Comparisons and Combinations with Alternative Approaches: Systematic Desensitization") referred to it in *Behavior Therapy for Depression*.[16] Seligman went so far as to say that my study confirmed his view that systematic desensitization is useful for treating depression when it presents itself with anxiety. However, my innovation did not get the coverage it deserved because (1) I did not follow it

up with empirical comparative studies and (2) the rise of the cognitive revolution, with its emphasis on consciousness and thinking, caused classical behavior therapy to fall out of favor. Nevertheless, I believe that my approach's greatest advantage is that its combining of systematic desensitization with cognitive therapy, behavior rehearsal, and psycho-spirituality got the best out of these therapeutic techniques.

Research in desensitization therapy is mainly concerned with such analytical and comparative issues as finding the precise components that make it effective[17] or comparing its efficacy with other therapies.[18] P. J. Lang and A. D. Lazovik found that desensitization that combines relaxation and a graded hierarchy produced improvements that could not be attributed to relaxation, suggestibility, hypnosis, or graded exposure alone. On the other hand, Lars-Goran Ost presented a whole hierarchy of feared scenes in one long session that took several hours.[19]

However, it seems that no research is being conducted on changing the actual structure or the execution of systematic desensitization since its original development by Wolpe in the late 1950s. This stagnation has reduced interest in this particular therapy. In a meticulously written study, McGlynn et al. found that interest in systematic desensitization has greatly declined. The number of articles on desensitization in three major behavior therapy journals, as well as a questionnaire sent to behavior therapists, was used as an indicator. In 1970 there were twenty articles on this topic, about five in 1982, and none in 2000.[20]

According to the McGlynn et al., this sharp decline did not occur because competing therapies had answered the questions that systematic desensitization had failed to answer, but because newer treatments had bypassed or superseded desensitization therapy. In short, its almost complete disappearance can be attributed to the comparatively unchanging practice of its application. Thus my study stands as a singular attempt to change the structure of this therapy. I believe that my drastic alteration of combining gradual desensitization with the benefits of cognitive therapy, behavior rehearsal, and the spiritually oriented approach of the third wave of cognitive behaviroal therapy may give it a new vigor.

Summary

First, asking patients to speak loudly about what they are imagining enables them to take a more active responsibility in therapy; learning by doing. This is particularly helpful to patients who cannot imagine vividly or who feel that imaginative desensitization is artificial. Hearing their own voices may make

the process more realistic. Meyer and Chesser recognized this advantage of our adaptation to classic desensitization therapy:

> Difficulties can arise in achieving a graduated exposure to the hierarchy items if the patient finds it difficult or impossible to imagine them, or experiences no anxiety when imagining them. An attempt can be made to get the patient to use all sense modalities when constructing the image, because some subjects are more proficient in some modalities than others. The patient can be asked to describe the items aloud (Badri, 1967) or pictures or tape recordings if they are found.[21]

Second, our new technique is more efficient in avoiding undue anxiety or anticipated anxiety. In Wolpe's therapy, the patient who is silently imagining an anxiety-provoking scene is instructed to raise his/her finger to signal excessive anxiety. Meyer and Crisp found that this method can be unreliable, for patients do not raise their fingers when they are actually anxious and vice versa.[22] In our method the patient simply stops talking; in fact, the therapist can often recognize anxiety in the patient's voice even before he/she stops talking.

Third, our horizontal approach presents the hierarchy in a variety of similar circumstances. Since the hierarchy presents a limited sample of anxiety-generating scenes, it can only offer the patient limited help in generalizing from the clinic to real-life situations. Exposing the patient to several scenes that generate comparable anxiety is actually a form of practical training in generalization. This horizontal approach can offer the therapist a better chance to reveal their Muslim patients' spiritual anguish and negative beliefs about their relationship with God. Furthermore, this vertical-horizontal technique may be more useful in treating patients suffering from complex phobic disorders or generalized anxiety disorder. As Lang stated, it is hard for such patients to pin down the anxiety-provoking stimuli in a precise hierarchy.[23] In our adaptation, the free expression of imagined scenes at the horizontal level gives such patients a better chance to desensitize their free-floating anxiety.

Fourth, our therapeutic technique inserts cognitive aspects and behavior rehearsal, as well as acceptance and mindfulness therapy, in their appropriate and timely places in the hierarchy. Whenever the patient exposes problems related to these therapies while speaking loudly at the horizontal level, the therapist switches to the appropriate therapeutic practice. Fifth, applying this vertical-horizontal and talking approach may reduce the time needed for systematic desensitization. Sometimes the hierarchy's steps can be too steep or too gradual for the patient. The therapist can easily observe this from the pa-

tient's free horizontal expression at different vertical levels of treatment and readjust the hierarchy accordingly.

Sixth, I found these alterations to Wolpe's desensitization, when supported with Islamic spiritual inspiration, to be very effective in treating Muslim patients. Islam is not a restricted religion of rituals, but a way of life that shapes the very worldview of its believers. Thus, their psychological problems are generally entangled with religious and spiritual aspects. Whether the therapist believes in Islam or not, he/she must take this fact into consideration.

I find that the gradual approach in the hierarchy, when helped by cognitive horizontal free expression, can help many Muslim patients identify their negative thought and religious misunderstandings. These are then corrected in a warm spiritual atmosphere of relaxation. Moreover, I found Islamically oriented behavior rehearsal repeated before the next step to be very useful for those in need of assertiveness training. I have applied this technique in my professional practice for the last fifty years. I realize that in order to confirm its efficacy, I need to carry out controlled comparative experimental researches and compare my results with those of classical systematic desensitization. However, one major limitation of my new techniques is that it requires more skill in applying or comparing it with classical systematic desensitization. I hope to train some of my postgraduate students to carry out this task.

Endnotes

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