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ABSTRACT

Recent controversy in the treatment of communication apprehension and avoidance has centered around whether an individual's communicative difficulties are caused by communicative (skills) deficiency or psychological problems (anxiety). Such debates are not new; arguments about whether to treat communicative difficulties from a communicative or psychological perspective date back to the founding of speech communication as an academic discipline. Although there are effective treatments for dealing with communication apprehension and avoidance, a treatment is needed that is devoid of labels based on (1) the individual perception of the unwilling communicator and his or her problem, and (2) the perception of this problem by a trained observer. People's self-reports may focus on feelings, but still be informative. In addition, observation needs to be employed. If progress in treating communication apprehension and avoidance is to be made, methods of treatment must not rely on labels based on historical assumptions, and individual analysis of communicative problems needs to be used. (HOD)

TREATING COMMUNICATION APPREHENSION AND AVOIDANCE: PAST ROOTS, FUTURE PERSPECTIVES

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ABSTRACT

Recent controversy in the treatment of communication apprehension and avoidance has centered around whether an individual's communicative difficulties are caused by communicative (skills) deficiency or psychological problems (anxiety). Such debates are not new; arguments about whether to treat communicative difficulties from a communicative or a psychological perspective date back to the founding of speech communication as an academic discipline. If progress in treating communication apprehension and avoidance is to be made, methods of treatment must be devoid of labels based on historical assumptions, and individual analysis of communicative problems needs to be employed.

TREATING COMMUNICATION APPREHENSION AND AVOIDANCE: PAST ROOTS, FUTURE PERSPECTIVES

A review of the literature on communication apprehension and avoidance will usually guide the reader to one of two perspectives: treatments[1] based from a psychological standpoint, and treatments based from a communicative viewpoint (Page, 1980). However, such a dichotomy is plagued by the problem of begging the question when labels are employed. If one uses the label of reticence, the problem is seen as stemming from a lack of skills, and rhetoritherapy is the preferred mode of treatment. When communication apprehension is used, the treatment employed is systematic desensitization, since the problem is believed to be caused by high levels of anxiety or apprehension (Kelly, 1982). As Kelly has pointed out, these labels may not always be describing different problems, and the term "communication apprehension and avoidance" has become the current buzz word to refer to people who cannot communicate effectively when the need or desire arises, regardless of casual factors.

In examining treatments from a psychological standpoint (using systematic desensitization) as opposed to treatment procedures from a communicative standpoint (using rhetoritherapy), one finds methods based on semantics that could be placed in either perspective--cognitive restructuring. Though cognitive restructuring has most often been identified with the psychological school, Phillips (1983) claims that it is nothing more than fancy psychological terminology for the rhetorical concept of persuasion. Pedersen (1980) neatly explains how the current mainstay of the psychological approach, systematic

desensitization, can be used via a communicative approach in rhetoritherapy training without any of the formal relaxation procedures of systematic desensitization. Kelly (1982) has claimed that labels that have previously guided treatment programs are not unqiue. The basic assumption is that rhetoritherapy is the "cure" for the reticent, and systematic desensitization is the "cure" for the communication apprehensive. Kelly has further muddied the waters by claiming that "It has not been established empirically that reticent persons perform poorly because of inadequate skills rather than anxiety," and that how one gets labeled may be in fact a result of that person's perception of his or her problem (p. 101).

To place dysfunctional communicators into treatment programs, researchers have relied heavily on a variety of self-report measures. Beginning with Gilkinson's Personal Report of Confidence as a Speaker, or PRCS (1942), Phillips and Erickson's "R" Scale (1964), McCroskey's Personal Report of Communication Apprehension, or PRCA (1970), Burgoon's Unwillingness to Communicate Scale (1976), and ending with Zimbardo's Stanford Shyness Survey (1977), these scales have been the mainstay of identifying problem communicators. Forty years from the development of the PRCS, Kelly, Phillips, and McKinney (1982) claim that these scales are of little value, since they are based on feelings that are not always accurate. Feelings may not motivate choices; a person may be terrified of public speaking, yet realize the necessity of such a skill. Another person may be aware of his or her skill deficiency, but for some reason may not be anxious about it. Finally, the most severe criticism that can be made of these treatment programs is the lack of

strict methodology in follow-up studies documenting their effectiveness over a substantial period (Page, 1980; Glaser, 1981; Kelly, 1984).

The preceding review of some of the problems that beset present-day treatment programs for communication apprehension and avoidance is to demonstrate the recent nature of the awareness of these problems. We are currently at a crossroads in this area; the next ten years will determine whether we will progress in our programs or wallow in terminology while those with communicative problems can only hope that they are in the proper treatment program.

The previous mentioned controversies are not new, they date back to the founding of speech communication as an academic discipline. The debate whether a person has trouble communicating due to psychological problems or skills deficiency has come full circle. Phillips and McCroskey (1982) have burried the hatchet; each admits no one approach is best for treating communication apprehension and avoidance. In fact, these two schools of thought have much in common (Kelly, 1982). In order to understand why this dichotomy persisted at all, an analysis of the historical treatment methods is in order. Finally, suggestions will be made regarding future perspectives of treatments of communication apprehension and avoidance.

Historical Background of Treatment Methods

The belief that dysfunctional communication can be cured from either a psychological or a communicative perspective dates back to the early twentieth century when speech was founded as an academic discipline. Blanton (1915, 1916) was one of the first in the profession

to publish arcicles about the relationship that existed between problem speakers and their psychological states. He believed that voice problems and emotional problems are directly related. Creasy (1919) dealt with stuttering as a psychological problem, and saw it as a failure on the part of the stutterer to sublimate, and that stuttering was an outward sign of an inner psychological conflict. Gray (1924) proposed that emotional problems could cause speech problems and that speech defects were signs of emotional problems. Bryngelson (1928) believed in the psychological approach in dealing with speech problems and felt that it was essential to get at the cause of the speech problem as opposed to treating symptoms. To do this, the speech teacher was to develop a case history for each problem speaker. Morse (1928) advanced this view of "mental hygiene" and saw the need for psychiatric training for speech teachers. He renounced the eloqu-tionary method (which today could be equated with the skills approach) and, as with Bryngelson, saw the need for the understanding of causes rather than symptoms.

Thus, the early approaches to speech problems were from a psychological origin--most likely a result of the heavy influence of psychology on the neophyte discipline of speech. These concerns for problem speakers at the onset were for stutterers and speakers with physiological dysfunctions; however, by the late 1920s these concerns were also for speakers that were suffering from communication apprehension and avoidance, as evidenced in the writings of Bryngelson and Morse. Also in the late 1920s another approach was being advocated: teaching problem speakers the necessary skills to overcome their

communicative problems.

An early advocate of the skills or communicative approach to helping dysfunctional communicators was Howes (1928). He disagreed with the psychological approach, claiming that behavioral aspects of speech is important and the best way to help a poor conversationalist is by teaching conversational skills. Stevens (1928) also advocated a skills as opposed to a psychological approach in treating communicative problems. However, Woolbert (1930) called for the use of psychological means in the teaching of speech, claiming that training in speech is a form of applied psychology. Raubicheck (1930) responded to Woolbert by claiming that there was danger in speech teacher's using the "new technology" of psychology without understanding it, and that speech teachers should not disregard the work of the early eloqutionists.

So, early in the development of the Speech Communication Association the "treatment as psychological" as opposed to "treatment as communicative" battle lines were drawn. On one side were the supporters of the psychological approach who believed that problem speech resulted from emotional disturbances, and that the correct way to cure speech problems was to treat the student's emotional disturbance. On the other side, the behaviorist approach considered that deficient skills caused problem speech, and in order to help troubled speakers, the teacher must mold the proper behavioristic skills associated with good speaking (DeMasi, 1984).

These debates continued in various forms through the next three decades. In the 1930s Murray (1934) pressed the need for "mental

hygiene" which he saw as emotional stability without any trouble with shyness. However, Murray emerged both psychological and communicative approaches for helping students, advocating psychological tests to determine which skills students needed to learn to develop mental hygiene. Bryngelson (1936) continued with his psychologically based plea for speech teachers to focus on causes rather than symptoms of speech problems. Kolberg (1937) argued for an approach that had all the earmarks of an earlier form of Philips' (1977) "rhetoritherapy." Kolberg suggested that the best way to develop conversational skills in students was to (1) have practice conversations in class, (2) compose individual scripts for conversing in different situations, and (3) write a self-analysis paper at the end of the semester analyzing each student's abilities as a conversationalist.

The skills-psychological controversy of the 1930s was nowhere more evident than in the discussion of stage fright. Bryngelson (1936) saw stage fright as a psychologically-based problem. Lomas (1937) offered solutions that were based on communicative training: (1) directing the emotion of stage fright toward delivery, (2) taking the mind off stage fright through the use of props, and (3) preparing adequately. Menchofer (1938) took both a psychological and a communicative approach to "curing" stage fright: preparation via outlines and rehearsals (communicative), and mental attitude via conferences with the instructor to discuss hidden fears and complexes (psychological). Eckert (1939) ended the decade by claiming that the failure of teachers of speech to handle stage fright adequately resulted from treatment of symptoms rather than causes. Eckert believed the causes

of stage fright to be behavioral in nature, and once the causes of stage fright were dealt with, the physical symptoms would disappear. This is an argument that continued over the next forty years, fueled by the rantings of the rhetoritherapists (Phillips, 1977; Phillips and Sokoloff, 1979; Cohen, 1980; Phillips, 1983). Their belief: Ineffective communication resulted from a lack of skills (cause), and once a student has acquired the appropriate skills anxiety will disappear (symptoms).

In the 1940s the communicative-psychological debates continued with the addition of an instrument that was to change forever the research in this area. Gilkinson (1942) developed a paper-and-pencil self-report, the Personal Report of Confidence as a Speaker (PRCS). This was a watershed; from this period on self-report measures of one's perceived communicative ability would eventually dominate the communication apprehension and avoidance literature.

In 1942, Irwin noted the limitations of the psychological approach, and appeared to be advocating the communicative-skills approach when he wrote that it didn't matter if a techer knew a student's past as to why s/he spoke too slowly or too fast, that it was better to teach him to slow down or speed up as needed. Moore (1943) also criticized the psychological school when he claimed that the mental hygiene approach was not sufficient for improving public speaking skills. However, Duncan (1945) exalted the need for psychological methods to improve voice, because he saw speech and personality closely related. Lillywhite (1947) attacked the skills approach and referred to it as "hocus pocus," and advocated language skills and training in

social integration.

Of interest in the 1950s was an article by Dunn (1952) where she further advocated the use of skills for treating communication apprehension and avoidance. She claimed that people do not participate in social groups because they lack the appropriate skills to interact with other people. Clevenger's (1959) landmark article on the synthesis of experimental research in stage fright up to that point made some important distinctions. His claim that how we measure stage fright is how we chose to define it proved to be prophetic, if one considers the reticence/communication apprehension constructs of the 1970s and 1980s. Clevenger also made a distinction among three types of stage fright: audience perceived stage fright--how much stage fright an observer says a speaker has, cognitively experienced stage fright--how much stage fright a self-report measure says a speaker has, and physiological disruption--how much stage fright an instrument says a speaker has based on heart rate or galvanic skin response. (Though Clevenger was using stage fright that refers to public speaking communication apprehension and avoidance, these categories clearly can be transposed to most any situational communication apprehension and avoidance.) Within the next twenty years, speech communication scholars would lose interest in the physiological disruption aspect of stage fright. They would, however, align themselves under audience perceived stage fright which was to evolve into Phillips' reticence school where interviewers determine reticence, and cognitively experienced stage fright, which was to become McCroskey's PRCA method of determining levels of communication apprehension via paper-and-pencil

self-reports.

The preceding review was presented to demonstrate that the debate over which method is best in treating oral communication apprehension and avoidance has been in existence ever since the founding of the speech profession. Current theorists such as Phillips, McCroskey, Zimbardo et al. have been more or less re-inventing the wheel. In the 1960s there is a shift in the psychological school away from neo-Freudian analyses of speech problems to an emphasis on altering inappropriate cognitive states that are believed to be the result of learned helplessness. The communicative-skills school will become more defined, focusing on specific behavioral techniques of successful communicative repertories.

Current Treatment Methods

In the 1960s Paul published Insight vs. Desensitization in Psychotherapy, which was to alter forever the psychological approaches to communication apprehension and avoidance. Mowrer (1965) wrote in Western Speech that stage fright was a psychopathology where the speaker was suffering from intense repressed guilt; the only way to treat a speaker suffering from stage fright was through self-disclosure that would resolve personal guilt and eliminate the fear of there audience. However, once Paul's (1966) work was published, the insight-oriented approach to communication apprehension and avoidance was soon to become an anachronism. Paul's work was concerned with "insight" and "behavioral" approaches to eliminating the fear of public speaking. Specifically, he wanted to see which was more effective in treating

public speaking anxiety: (1) the traditional insight-oriented psychotherapy based on the "disease model" of emotional disturbances, or (2) therapy based on the "learning model" of emotional disturbances via systematic desensitization. Paul's research yielded the conclusion that the learning model approach of systematic desensitization was superior to the disease model of insight-oriented psychotherapy in treating speech anxiety. His conclusion spawned the learning-theory approach to treating communication apprehension and avoidance and a particular construct that still dominates the literature--communication apprehension.

Communication apprehension is a construct advanced by McCroskey (1970, 1977, 1980, 1982) which is the present-day psychological school's conceptualization of communication apprehension and avoidance. It relies on learning theory, the basic premise being that a person cannot communicate effectively due to high levels of anxiety that are learned responses to communicative situations. Systematic desensitization is employed to eliminate this problem. It is based on the premise of reciprocal inhibition (Wolpe, 1958), where an individual is taught progressive relaxation (Jacobson, 1938) while being exposed to a hierarchy of threatening stimuli--the belief being that a relaxation response will inhibit tension and thus eliminate communication apprehension. The basis for this construct is that communication apprehension (CA) is a cognitively experienced state, and once cognitions are altered, behavioral changes will follow.

This research, a direct outgrowth of Paul's (1966) work, has yielded numerous studies documenting the effectiveness of systematic

desensitization in reducing CA (Kondas 1967; Goss, Thompson, and Olds 1974; Sherman, Mulac, and McCann 1974; Curran and Gilbert, 1975; Weissberg 1975; 1977; Weissberg and Lamb 1977; Trussell 1978; and Berger, Richmond, Baldwin, and McCroskey 1984). However, all has not been roses with this approach, and it has come under criticism from a variety of sources. The principle criticism of systematic desensitization is that while it might make an individual relaxed, it does little to produce any behavioral changes (Glaser 1981). Though one study (Goss, Thompson. and Olds, 1974) does demonstrate behavioral support for systematic desensitization for reducing CA, others (Weissberg, 1977; Weissberg and Lamb, 1977; Trussell, 1978) conclude that systematic desensitization produces little behavioral change. Page (1980) makes the clever conclusion that using systematic desensitization for CA may reduce anxiety, but not avoidance of communication, producing at best "relaxed incompetents."

Finally, as Friedr h and Goss (1984) note, how effective systematic desensitization is may be dependent on how an instructor introduces it. This will effect a student's expectations of treatment effectiveness, "which will, in turn, influence the effectiveness of SD as a treatment method" (p. 181).

Whereas communication apprehension is an outgrowth of early psychological approaches to treating communication apprehension and avoidance, reticence is the skills-training school's conceptualization of this problem which may be seen as a descendent of the early work of Howes (1928); Stevens (1 28); Kolberg (1937); and Irwin (1942). Reticence is a behavioral approach which sees faulty communication resulting from

inadequate repertories of rhetorical skills. Though originally anxiety-based (Phillips, 1968), this construct has undergone several revisions (Phillips, 1977; Phillips and Sokoloff, 1979). As opposed to anxiety causing dysfunctional communication, the reticence school now believes that removal of anxiety will do little to help troubled communicators. In fact, Phillips (1980) claims that removal of anxiety may do more harm than good. Phillips' contention is that removal of anxiety will only produce more anxiety if the person is unskilled at the onset. If the person is unskilled, and undergoes systematic desensitization training, s/he may be more apt to try communication, but will receive negative feedback due to his or her lack of skills training leading to an increase in anxiety. Thus, removal of anxiety is useful only when skills are present. However, the major distinction between these two constructs was, and still is, that reticence is viewed from a strict behavioral perspective while CA remains a cognitive construct (McCroskey, 1982).

To treat reticence, Phillips (1977) has developed "rhetoritherapy" which in essence involves no therapy in the clinical sense. According to Phillips (1983), this is the only method on instruction based on the classical principles of rhetoric: inventio, dispositio, elocutio, pronuncito, and memoria, and that "In essence, rhetoritherapy is based on individualized speech skills training program for each individual regardless of physical or mental condition" (Phillips, 1983; p. 13). Included in rhetoritherapy is: (1) understanding how talk alters situations, (2) identifying relevant persons, (3) goal setting, (4) analyzing alternatives in behavior, (5) coherent sequences of talk,

(6) vocabulary and syntax development, (7) developing speech competence, and (8) assessing reponses of others (Cohen, 1980).

As with the CA construct, rhetoritherapy has had its share of critics. The biggest criticism of Phillips' rhetoritherapy training at Penn State is that there is insufficient data to prove its effectiveness (Page, 1980; Glaser, 1981). The most positively reported aspect of skills training as opposed to systematic desensitization is that skills training will produce a behavioral change (Curran, Gilbert, and Little, 1976; Glaser, 1981). A person undergoing rhetoritherapy will most likely not only report improved communicative abilities as noted by Metzger (1974) and Derkivtz (1975), but will actually behaviorally enact those skills.

One major assumption of rhetoritherapy is that anxiety is caused by lack of skills, and the only way to remove anxiety is through skills training. The CA theorists resist this claim. Though McCroskey and Phillips reached an agreement of sorts in 1982, CA researchers continue to doubt the effectiveness of the skills approach. Berger, Richmond, Baldwin, and McCroskey (1984) found that administering systematic desensitization along with a basic communication course was less effective than systematic desensitization alone. They concluded that skills training added to systematic desensitization was of little help. However, a substantial body of research demonstrates skills training is as effective as systematic desensitization in reducing self-reported CA, even without any systematic desensitization training. Weissberg and Lamb (1977) found that while systematic desensitization was effective in reducing general anxiety, speech preparation was more

effective in reducing behavioral aspects of speech anxiety. Trussell (1978) concluded that graduated behavioral rehearsal by itself (which entailed practicing speeches to progressively larger audiences) was just as effective as graduated behavioral rehearsal and systematic desensitization. McKinney (1980) administered the PRCA to six classes of reticent students before and after rhetoritherapy training. He discovered that the skills training method of instruction (rhetoritherapy) will reduce CA as measured by the PRCA even when systematic desensitization is not employed. Bee and More (1982) studied the effects of speech course content on the reduction of CA, and concluded that during a normal course in speech, individual's level of CA decreased, again without systematic desensitization. It is significant to note that in this study it was high CA students who reduced their level of CA after skills training.

Finally, Stacks and Stone (1982) examined how different types of the basic speech course (public speaking, group discussion, and interpersonal) affected CA. Student's levels of CA were reduced for all three courses. What is of special interest is that high CA students in the public speaking course showed a significant decrease in CA though they received no instruction in systematic desensitization. The authors conclude that "simply completing a basic speech course reduces the high communication apprehensive student's fear or anxiety toward communication" (p. 14).

Comfortably nestled between rhetoritherapy and systematic desensitization is the treatment of cognitive restructuring. Cognitive restructuring is an outgrowth of Ellis' (1962) rational emotive therapy

(RET). A concept based on the premise that negative self-verbalizations cause communication apprehension and avoidance. Cognitive therapy assumes that most individuals have the needed skills to perform adequately once negative thoughts about communication are reduced. Cognitive restructuring has been shown to be effective in reducing speech anxiety (Weisberg, 1977; Fremouw and Zitter, 1978), but suffers from the same drawback as systematic desensitization--little or no evidence of behavioral change.

From a psychological standpoint, cognitive restructuring attempts to alter irrational cognitions about communication (Fremouw and Scott, 1979). If a person thinks "I am going to sound stupid" and instead is taught to think "I know my topic better than anyone else; I will sound OK," few would argue that a psychological transformation has not taken place. At face value it would seem that cognitive restructuring is purely a psychological approach to treating communication apprehension and avoidance and it has little to do with the communicative-skills approach. This is not the case.

Phillips (1983) claims that cognitive restructuring is nothing more than a "psychological euphemism" for the rhetorical concept of persuasion. In order for any student to successfully alter his or her cognitions about communicative encounters, the student must be made aware of appropriate talk and persuaded that his or her communication can alter situations.

So, is cognitive restructuring a psychological or a rhetorical approach to treating communication apprehension and avoidance? It certainly is a rhetorical concept. A student must be persuaded to alter

cognitions about communication, but at the same time must undergo the psychological process of actively changing his or her cognitions about communication. Thus, it legitimately falls within the purview of both methodologies. It is the gray area of treatments of communication apprehension and avoidance.

Future Perspectives For Treatment Programs

Hoffman and Sprague (1982) in an article entitled "Survey of Reticence and Communication Apprehension Treatment Programs at U.S. Colleges and Universities," found that of institutions registered with the Speech Communication Association, only 6.1 percent had treatment programs. Fifty-four percent of these programs used a combination of treatment methods (systematic desensitization, cognitive restructuring, and/or rhetoritherapy). The next most popular treatment method was systematic desensitization alone (33.3 percent), followed by rhetoritherapy (9.5 percent).

At face value, these might be optimistic results. Clearly not all students with communication apprehension and avoidance need systematic desensitization; some may lack only required skills. Additionally, not all students with communicative problems are suffering from a lack of skills, so rhetoritherapy may be of little use; they might have the skills but for some reason be apprehensive about communicating as a result of faulty cognitions. Thus, a treatment program that utilizes all methods will probably at some point provide the necessary treatment, but will not be very efficient. However, assumptions like this ignore individual differences in communicative problems, that Kelly, Phillips,

and McKinney (1982) and Glaser (1981) point out, are probably the key to helping those who avoid communication. It is disturbing that the next two largest treatment programs outlined by Hoffman and Sprague assumed that either systematic desensitization or rhetoritherapy were the best treatment procedures. It is doubtful that any one institution will have only those who are either anxious or skill deficient with respect to communication. In addition, there needs to be more of a distinction between those who have difficulty speaking before an audience as a result of either anxiety or skills deficiency, and those who have difficulty in interpersonal communication as a result either one of these problems.

We currently possess effective treatments for dealing with communication apprehension and avoidance, but need to provide the best treatment devoid of labels based on (1) the individual perception of the unwilling communicator of his or her problem, and (2) the perception of this problem by a trained observer. Too little has been written about what a person says about his or her communication problems, this is because we have been told not to focus on feelings since they are not always an accurate predictor of behavior (Kelly, Phillips, and McKinney, 1982). People's self-reports tend to focus on feelings (Pilkonis, 1977; Phillips, 1983), and maybe we are missing something by not listening. This alone may not be totally reliable, but still informative. (Where would the medical profession be if it could not at first focus on a patient's description of his or her symptoms or feelings?) As Kelly (1982) says, "It would make sense to provide treatment directed at the individual's prime concern [feelings]" (p. 111).

In addition, observation needs to be employed. Once we have a correlation between reported feelings and observed behaviors, then the appropriate treatment might be prescribed on an individual basis. Though time-consuming and perhaps not always cost-effective with respect to faculty-student ratio, this I feel, is logically our next step.

Endnote

[1]In using the word "treatments" in the course of this paper, I do not mean to imply a medically oriented "disease" model. I do not believe that communication apprehension and avoidance is a pathological disorder except in a few rare cases where other pathologies interfere with communication (i.e., schizophrenia). In the context of this paper when the word "treat" or "treatments" is employed, it is simply used to mean an act of intervention for the purpose of helping another person.

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