CHAPTER NINE

Behavior Therapy

B. F. SKINNER (1904–1990) reported that he was brought up in a warm, stable family environment.* As he was growing up, Skinner was greatly interested in building all sorts of things, an interest that followed him throughout his professional life. He received his PhD in psychology from Harvard University in 1931 and eventually returned to Harvard after teaching in several universities. He had two daughters, one of whom is an educational psychologist and the other an artist.

Skinner was a prominent spokesperson for behaviorism and can be considered the father of the behavioral approach to psychology. Skinner championed radical behaviorism, which places primary emphasis on the effects of environment on behavior. Skinner was also a determinist; he did not believe that humans had free choice. He acknowledged that feelings and thoughts exist, but he denied that they *caused* our actions. Instead, he stressed the cause-and-effect links between objective, observable environmental conditions and behavior. Skinner maintained that too much attention had been given to internal states of mind and motives, which cannot be observed and changed directly, and that too little focus had been given to environmental factors that can be directly observed and changed. He was extremely interested in the concept of reinforcement, which he applied to his own life. For example, after working for many hours, he would go into his constructed cocoon (like a tent), put on headphones, and listen to classical music (Frank Dattilio, personal communication, December 9, 2006).

Most of Skinner's work was of an experimental nature in the laboratory, but others have applied his ideas to teaching, managing human problems, and social planning. *Science and Human Behavior* (Skinner, 1953) best illustrates how Skinner thought behavioral concepts could be applied to every domain of human behavior. In *Walden II* (1948) Skinner describes a utopian community in which his ideas, derived from the laboratory, are applied to social issues. His 1971 book, *Beyond Freedom and Dignity*, addressed the need for drastic changes if our society was to survive. Skinner believed that science and technology held the promise for a better future.

*This biography is based largely on Nye's (2000) discussion of B. F. Skinner's radical behaviorism.

Courtesy, Dr. Albert Bandura, Stanford University, Palo Alto, CA

ALBERT BANDURA (b. 1925) was born near Alberta, Canada; he was the youngest of six children in a family of Eastern European descent. Bandura spent his elementary and high school years in the one school in town, which was short of teachers and resources. These meager educational resources proved to be an asset rather than a liability as Bandura early on learned the skills of self-directedness, which would later become one of his research themes. He earned his PhD in clinical psychology from the University of Iowa in 1952, and a year later he joined the faculty at Stanford University. Bandura and his colleagues did pioneering work in the area of social modeling and demonstrated that modeling is a powerful process that explains diverse forms of learning (see Bandura 1971a, 1971b; Bandura & Walters, 1963). In his research programs at Stanford University, Bandura and his colleagues explored social learning theory and the prominent role of observational learning and social modeling in human motivation, thought, and action. By the mid-1980s Bandura had renamed his theoretical approach *social cognitive theory*, which shed light on how we function as self-organizing, proactive, self-reflective, and self-regulating beings (see Bandura, 1986). This notion that we are not simply reactive organisms shaped by environmental forces or driven by inner impulses represented a dramatic shift in the development of behavior therapy. Bandura broadened the scope of behavior therapy by exploring the inner cognitive-affective forces that motivate human behavior.

There are some existential qualities inherent in Bandura's social cognitive theory. Bandura has produced a wealth of empirical evidence that demonstrates the life choices we have in all aspects of our lives. In *Self-Efficacy: The Exercise of Control* (Bandura, 1997), Bandura shows the comprehensive applications of his theory of self-efficacy to areas such as human development, psychology, psychiatry, education, medicine and health, athletics, business, social and political change, and international affairs.

Bandura has concentrated on four areas of research: (1) the power of psychological modeling in shaping thought, emotion, and action; (2) the mechanisms of human agency, or the ways people influence their own motivation and behavior through choice; (3) people's perceptions of their efficacy to exercise influence over the events that affect their lives; and (4) how stress reactions and depressions are caused. Bandura has created one of the few megatheories that still thrive at the beginning of the 21st century. He has shown that people need a sense of self-efficacy and resilience to create a successful life and to meet the inevitable obstacles and adversities they encounter.

To date Bandura has written nine books, many of which have been translated into various languages. In 2004 he received the Outstanding Lifetime Contribution to Psychology Award from the American Psychological Association. In his early 80s, Bandura continues to teach and do research at Stanford University and to travel throughout the world. He still makes time for hiking, opera, being with his family, and wine tasting in the Napa and Sonoma valleys.

This biography is based largely on Pajares's (2004) discussion of Bandura's life and work

Introduction

Behavior therapy practitioners focus on observable behavior, current determinants of behavior, learning experiences that promote change, tailoring treatment strategies to individual clients, and rigorous assessment and evaluation (Kazdin, 2001; Wilson, 2008). Behavior therapy has been used to treat a wide range of psychological disorders with different client populations (Wilson, 2008). Anxiety disorders, depression, substance abuse, eating disorders, domestic violence, sexual problems, pain management, and hypertension have all been successfully treated using this approach. Behavioral procedures are used in the fields of developmental disabilities, mental illness, education and special education, community psychology, clinical psychology, rehabilitation, business, self-management, sports psychology, health-related behaviors, and gerontology (Miltenberger, 2008).

Historical Background

The behavioral approach had its origin in the 1950s and early 1960s, and it was a radical departure from the dominant psychoanalytic perspective. The behavior therapy movement differed from other therapeutic approaches in its application of principles of classical and operant conditioning (which will be explained shortly) to the treatment of a variety of problem behaviors. Today, it is difficult to find a consensus on the definition of behavior therapy because the field has grown, become more complex, and is marked by a diversity of views. Indeed, as behavior therapy has evolved and developed, it has increasingly overlapped in some ways with other psychotherapeutic approaches (Wilson, 2008). The discussion presented here is based on Spiegler and Guevremont's (2003) historical sketch of behavior therapy.

Traditional behavior therapy arose simultaneously in the United States, South Africa, and Great Britain in the 1950s. In spite of harsh criticism and resistance from psychoanalytic psychotherapists, the approach survived. Its focus was on demonstrating that behavioral conditioning techniques were effective and were a viable alternative to psychoanalytic therapy.

In the 1960s Albert Bandura developed social learning theory, which combined classical and operant conditioning with observational learning. Bandura made cognition a legitimate focus for behavior therapy. During the 1960s a number of cognitive behavioral approaches sprang up, and they still have a significant impact on therapeutic practice (see Chapter 10).

Contemporary behavior therapy emerged as a major force in psychology during the 1970s, and it had a significant impact on education, psychology, psychotherapy, psychiatry, and social work. Behavioral techniques were expanded to provide solutions for business, industry, and child-rearing problems as well. Known as the "first wave" in the behavioral field, behavior therapy techniques were viewed as the treatment of choice for many psychological problems.

The 1980s were characterized by a search for new horizons in concepts and methods that went beyond traditional learning theory. Behavior therapists continued to subject their methods to empirical scrutiny and to consider the impact of the practice of therapy on both their clients and the larger society. Increased attention was given to the role of emotions in therapeutic change, as well as to the role of biological factors in psychological disorders. Two of the most significant developments in the field were (1) the continued emergence of cognitive behavior therapy as a major force and (2) the application of behavioral techniques to the prevention and treatment of health-related disorders.

By the late 1990s the Association for Behavioral and Cognitive Therapies (ABCT) (formerly known as the Association for Advancement of Behavior Therapy) claimed a membership of about 4,300. The current description of ABCT is "a membership organization of more than 4,500 mental health professionals and students who are interested in empirically based behavior therapy or cognitive behavior therapy." This name change and description reveals the current thinking of integrating behavioral and cognitive therapies. Cognitive therapy is considered to be the "second wave" of the behavioral tradition.

By the early 2000s, the "third wave" of the behavioral tradition emerged, enlarging the scope of research and practice. This newest development includes dialectical behavior therapy, mindfulness-based stress reduction, mindfulness-based cognitive therapy, and acceptance and commitment therapy.

Four Areas of Development

Contemporary behavior therapy can be understood by considering four major areas of development: (1) classical conditioning, (2) operant conditioning, (3) social learning theory, and (4) cognitive behavior therapy.

Classical conditioning (respondent conditioning) refers to what happens prior to learning that creates a response through pairing. A key figure in this area is Ivan Pavlov who illustrated classical conditioning through experiments with dogs. Placing food in a dog's mouth leads to salivation, which is respondent behavior. When food is repeatedly presented with some originally neutral stimulus (something that does not elicit a particular response), such as the sound of a bell, the dog will eventually salivate to the sound of the bell alone. However, if a bell is sounded repeatedly but not paired again with food, the salivation response will eventually diminish and become extinct. An example

of a procedure that is based on the classical conditioning model is Joseph Wolpe's systematic desensitization, which is described later in this chapter. This technique illustrates how principles of learning derived from the experimental laboratory can be applied clinically. Desensitization can be applied to people who, through classical conditioning, developed an intense fear of flying after having a frightening experience while flying.

Most of the significant responses we make in everyday life are examples of operant behaviors, such as reading, writing, driving a car, and eating with utensils. **Operant conditioning** involves a type of learning in which behaviors are influenced mainly by the consequences that follow them. If the environmental changes brought about by the behavior are reinforcing—that is, if they provide some reward to the organism or eliminate aversive stimuli—the chances are increased that the behavior will occur again. If the environmental changes produce no reinforcement or produce aversive stimuli, the chances are lessened that the behavior will recur. Positive and negative reinforcement, punishment, and extinction techniques, described later in this chapter, illustrate how operant conditioning in applied settings can be instrumental in developing prosocial and adaptive behaviors. Operant techniques are used by behavioral practitioners in parent education programs and with weight management programs.

The behaviorists of both the classical and operant conditioning models excluded any reference to mediational concepts, such as the role of thinking processes, attitudes, and values. This focus is perhaps due to a reaction against the insight-oriented psychodynamic approaches. The **social learning approach** (or the social-cognitive approach), developed by Albert Bandura and Richard Walters (1963), is interactional, interdisciplinary, and multimodal (Bandura, 1977, 1982). Social learning and cognitive theory involves a triadic reciprocal interaction among the environment, personal factors (beliefs, preferences, expectations, self-perceptions, and interpretations), and individual behavior. In the social-cognitive approach the environmental events on behavior are mainly determined by cognitive processes governing how environmental influences are perceived by an individual and how these events are interpreted (Wilson, 2008). A basic assumption is that people are capable of self-directed behavior change. For Bandura (1982, 1997), self-efficacy is the individual's belief or expectation that he or she can master a situation and bring about desired change. An example of social learning is how people can develop effective social skills after they are in contact with other people who effectively model interpersonal skills.

Cognitive behavior therapy and social learning theory now represent the mainstream of contemporary behavior therapy. Since the early 1970s, the behavioral movement has conceded a legitimate place to thinking, even to the extent of giving cognitive factors a central role in understanding and treating emotional and behavioral problems. By the mid-1970s *cognitive behavior therapy* had replaced *behavior therapy* as the accepted designation and the field began emphasizing the interaction among affective, behavioral, and cognitive dimensions (Lazarus, 2003; Wilson, 2008). A good example of this more integrative approach is multimodal therapy, which is discussed later in this chapter. Many techniques, particularly those developed within the last three decades,

emphasize cognitive processes that involve private events such as the client's self-talk as mediators of behavior change (see Bandura, 1969, 1986; Beck, 1976; Beck & Weishaar, 2008).

The former distinction between behavior therapy and cognitive behavior therapy is far less of one now than it used to be, and in reality, is much more blended in theory, practice, and research (Sherry Cormier, personal communication, November 20, 2006). This chapter goes beyond the pure or traditional behavioral perspective and deals mainly with the applied aspects of this model. Chapter 10 is devoted to the cognitive behavioral approaches, which focus on changing clients' cognitions (thoughts and beliefs) that maintain psychological problems.

Key Concepts

View of Human Nature

Modern behavior therapy is grounded on a scientific view of human behavior that implies a systematic and structured approach to counseling. This view does not rest on a deterministic assumption that humans are a mere product of their sociocultural conditioning. Rather, the current view is that the person is the producer *and* the product of his or her environment.

The current trend in behavior therapy is toward developing procedures that actually give control to clients and thus increase their range of freedom. Behavior therapy aims to increase people's skills so that they have more options for responding. By overcoming debilitating behaviors that restrict choices, people are freer to select from possibilities that were not available earlier, increasing individual freedom (Kazdin, 1978, 2001). It is possible to make a case for using behavioral methods to attain humanistic ends (Kazdin, 2001; Watson & Tharp, 2007).

Basic Characteristics and Assumptions

Six key characteristics of behavior therapy are described below.

1. Behavior therapy is based on the principles and procedures of the scientific method. Experimentally derived principles of learning are systematically applied to help people change their maladaptive behaviors. The distinguishing characteristic of behavioral practitioners is their systematic adherence to precision and to empirical evaluation. Behavior therapists state treatment goals in concrete objective terms to make replication of their interventions possible. Treatment goals are agreed upon by the client and the therapist. Throughout the course of therapy, the therapist assesses problem behaviors and the conditions that are maintaining them. Research methods are used to evaluate the effectiveness of both assessment and treatment procedures. Therapeutic techniques employed must have demonstrated effectiveness. In short, behavioral concepts and procedures are stated explicitly, tested empirically, and revised continually.
2. Behavior therapy deals with the client's current problems and the factors influencing them, as opposed to an analysis of possible historical determinants.

Emphasis is on specific factors that influence present functioning and what factors can be used to modify performance. At times understanding of the past may offer useful information about environmental events related to present behavior. Behavior therapists look to the current environmental events that maintain problem behaviors and help clients produce behavior change by changing environmental events, through a process called *functional assessment*, or what Wolpe (1990) referred to as a "behavioral analysis."

3. Clients involved in behavior therapy are expected to assume an active role by engaging in specific actions to deal with their problems. Rather than simply talking about their condition, they are required to *do* something to bring about change. Clients monitor their behaviors both during and outside the therapy sessions, learn and practice coping skills, and role-play new behavior. Therapeutic tasks that clients carry out in daily life, or homework assignments, are a basic part of this approach. Behavior therapy is an action-oriented and an educational approach, and learning is viewed as being at the core of therapy. Clients learn new and adaptive behaviors to replace old and maladaptive behaviors.
4. This approach assumes that change can take place without insight into underlying dynamics. Behavior therapists operate on the premise that changes in behavior can occur prior to or simultaneously with understanding of oneself, and that behavioral changes may well lead to an increased level of self-understanding. While it is true that insight and understanding about the contingencies that exacerbate one's problems can supply motivation to change, knowing that one has a problem and knowing *how* to change it are two different things (Martell, 2007).
5. The focus is on assessing overt and covert behavior directly, identifying the problem, and evaluating change. There is direct assessment of the target problem through observation or self-monitoring. Therapists also assess their clients' cultures as part of their social environments, including social support networks relating to target behaviors (Tanaka-Matsumi, Higginbotham, & Chang, 2002). Critical to behavioral approaches is the careful assessment and evaluation of the interventions used to determine whether the behavior change resulted from the procedure.
6. Behavioral treatment interventions are individually tailored to specific problems experienced by clients. Several therapy techniques may be used to treat an individual client's problems. An important question that serves as a guide for this choice is: "*What* treatment, by *whom,* is the most effective for *this* individual with *that* specific problem and under *which* set of circumstances?" (Paul, 1967, p. 111).

The Therapeutic Process

Therapeutic Goals

Goals occupy a place of central importance in behavior therapy. The general goals of behavior therapy are to increase personal choice and to create new conditions for learning. The client, with the help of the therapist, defines specific

treatment goals at the outset of the therapeutic process. Although assessment and treatment occur together, a formal assessment takes place prior to treatment to determine behaviors that are targets of change. Continual assessment throughout therapy determines the degree to which identified goals are being met. It is important to devise a way to measure progress toward goals based on empirical validation.

Contemporary behavior therapy stresses clients' active role in deciding about their treatment. The therapist assists clients in formulating specific measurable goals. Goals must be clear, concrete, understood, and agreed on by the client and the counselor. The counselor and client discuss the behaviors associated with the goals, the circumstances required for change, the nature of subgoals, and a plan of action to work toward these goals. This process of determining therapeutic goals entails a negotiation between client and counselor that results in a contract that guides the course of therapy. Behavior therapists and clients alter goals throughout the therapeutic process as needed.

Therapist's Function and Role

Behavior therapists conduct a thorough **functional assessment** (or **behavioral analysis**) to identify the maintaining conditions by systematically gathering information about situational antecedents, the dimensions of the problem behavior, and the consequences of the problem. This is known as the **ABC model,** which addresses antecedents, behaviors, and consequences. This model of behavior suggests that *behavior* (B) is influenced by some particular events that precede it, called *antecedents* (A), and by certain events that follow it called *consequences* (C). **Antecedent events** are ones that cue or elicit a certain behavior. For example, with a client who has trouble going to sleep, listening to a relaxation tape may serve as a cue for sleep induction. Turning off the lights and removing the television from the bedroom may elicit sleep behaviors as well. **Consequences** are events that maintain a behavior in some way either by increasing or decreasing it. For example, a client may be more likely to return to counseling after the counselor offers verbal praise or encouragement for having come in or having completed some homework. A client may be less likely to return after the counselor is consistently late to sessions. In doing an **assessment interview,** the therapist's task is to identify the particular antecedent and consequent events that influence or are functionally related to an individual's behavior (Cormier, Nurius, & Osborn, 2009).

Behaviorally oriented practitioners tend to be active and directive and to function as consultants and problem solvers. They pay close attention to the clues given by clients, and they are willing to follow their clinical hunches. Behavioral practitioners must possess skills, sensitivity, and clinical acumen (Wilson, 2008). They use some techniques common to other approaches, such as summarizing, reflection, clarification, and open-ended questioning. However, behavioral clinicians perform other functions as well (Miltenberger, 2008; Spiegler & Guevremont, 2003):

- Based on a comprehensive functional assessment, the therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals.

- The behavioral clinician uses strategies that have research support for use with a particular kind of problem. These strategies are used to promote generalization and maintenance of behavior change. A number of these strategies are described later in this chapter.
- The clinician evaluates the success of the change plan by measuring progress toward the goals throughout the duration of treatment. Outcome measures are given to the client at the beginning of treatment (called a baseline) and collected again periodically during and after treatment to determine if the strategy and treatment plan are working. If not, adjustments are made in the strategies being used.
- A key task of the therapist is to conduct follow-up assessments to see whether the changes are durable over time. Clients learn how to identify and cope with potential setbacks. The emphasis is on helping clients maintain changes over time and acquire behavioral and cognitive coping skills to prevent relapses.

Let's examine how a behavior therapist might perform these functions. A client comes to therapy to reduce her anxiety, which is preventing her from leaving the house. The therapist is likely to begin with a specific analysis of the nature of her anxiety. The therapist will ask how she experiences the anxiety of leaving her house, including what she actually *does* in these situations. Systematically, the therapist gathers information about this anxiety. When did the problem begin? In what situations does it arise? What does she do at these times? What are her feelings and thoughts in these situations? Who is present when she experiences anxiety? What does she do to reduce the anxiety? How do her present fears interfere with living effectively? After this assessment, specific behavioral goals will be developed, and strategies such as relaxation training, systematic desensitization, and exposure therapy will be designed to help the client reduce her anxiety to a manageable level. The therapist will get a commitment from her to work toward the specified goals, and the two of them will evaluate her progress toward meeting these goals throughout the duration of therapy.

Client's Experience in Therapy

One of the unique contributions of behavior therapy is that it provides the therapist with a well-defined system of procedures to employ. Both therapist and client have clearly defined roles, and the importance of client awareness and participation in the therapeutic process is stressed. Behavior therapy is characterized by an active role for both therapist and client. A large part of the therapist's role is to teach concrete skills through the provision of instructions, modeling, and performance feedback. The client engages in behavioral rehearsal with feedback until skills are well learned and generally receives active homework assignments (such as self-monitoring of problem behaviors) to complete between therapy sessions. Martell (2007) emphasized that changes clients make in therapy must be translated into their daily lives; clients must continue working on the changes begun in the therapy office throughout the week. Clients must be motivated to change and are expected to cooperate in

carrying out therapeutic activities, both during therapy sessions and in everyday life. If clients are not involved in this way, the chances are slim that therapy will be successful. However, if clients are not motivated, another behavioral strategy that has considerable empirical support is motivational interviewing. This strategy involves honoring the client's resistance in such a way that his or her motivation to change is increased over time (Cormier et al., 2009).

Clients are encouraged to experiment for the purpose of enlarging their repertoire of adaptive behaviors. Counseling is not complete unless actions follow verbalizations. Indeed, it is only when the transfer of changes is made from the sessions to everyday life and when the effects of therapy are extended beyond termination that treatment can be considered successful (Granvold & Wodarski, 1994). Clients are as aware as the therapist is regarding when the goals have been accomplished and it is appropriate to terminate treatment. It is clear that clients are expected to do more than merely gather insights; they need to be willing to make changes and to continue implementing new behavior once formal treatment has ended.

Relationship Between Therapist and Client

Clinical and research evidence suggests that a therapeutic relationship, even in the context of a behavioral orientation, can contribute significantly to the process of behavior change (Granvold & Wodarski, 1994). Most behavioral practitioners stress the value of establishing a collaborative working relationship (J. Beck, 2005). For example, Lazarus (2008) believes a flexible repertoire of relationship styles, plus a wide range of techniques, enhances treatment outcomes. He emphasizes the need for therapeutic flexibility and versatility above all else. Lazarus contends that the cadence of client–therapist interaction differs from individual to individual and even from session to session. The skilled behavior therapist conceptualizes problems behaviorally and makes use of the client–therapist relationship in facilitating change.

As you will recall, the experiential therapies (existential therapy, person-centered therapy, and Gestalt therapy) place primary emphasis on the nature of the engagement between counselor and client. In contrast, most behavioral practitioners contend that factors such as warmth, empathy, authenticity, permissiveness, and acceptance are necessary, but not sufficient, for behavior change to occur. The client–therapist relationship is a foundation on which therapeutic strategies are built to help clients change in the direction they wish. However, behavior therapists assume that clients make progress primarily because of the specific behavioral techniques used rather than because of the relationship with the therapist.

Application: Therapeutic Techniques and Procedures

A strength of the behavioral approaches is the development of specific therapeutic procedures that must be shown to be effective through objective means. The results of behavioral interventions become clear because therapists receive continual direct feedback from their clients. A hallmark of the behavioral approaches is that the therapeutic techniques are empirically supported and

evidence-based practice is highly valued. To its credit, the effectiveness of behavior therapy (and cognitive behavior therapy) has been researched with different populations and a wide array of disorders.

According to Arnold Lazarus (1989, 1992b, 1996b, 1997a, 2005, 2008), a pioneer in contemporary clinical behavior therapy, behavioral practitioners can incorporate into their treatment plans any technique that can be demonstrated to effectively change behavior. Lazarus advocates the use of diverse techniques, regardless of their theoretical origin. It is clear that behavior therapists do not have to restrict themselves only to methods derived from learning theory. Likewise, behavioral techniques can be incorporated into other approaches. This is illustrated later in this chapter in the sections on the integration of behavioral and psychoanalytic techniques and, as well, by the incorporation of mindfulness and acceptance-based approaches into the practice of behavior therapy.

The therapeutic procedures used by behavior therapists are specifically designed for a particular client rather than being randomly selected from a "bag of techniques." Therapists are often quite creative in their interventions. In the following sections I describe a range of behavioral techniques available to the practitioner: applied behavioral analysis, relaxation training, systematic desensitization, exposure therapies, eye movement desensitization and reprocessing, social skills training, self-modification programs and self-directed behavior, multimodal therapy, and mindfulness and acceptance-based approaches. These techniques do not encompass the full spectrum of behavioral procedures, but they do represent a sample of the approaches used in contemporary behavior therapy.

Applied Behavioral Analysis: Operant Conditioning Techniques

This section describes a few key principles of operant conditioning: positive reinforcement, negative reinforcement, extinction, positive punishment, and negative punishment. For a detailed treatment of the wide range of operant conditioning methods that are part of contemporary behavior modification, I highly recommend Kazdin (2001) and Miltenberger (2008).

In applied behavior analysis, operant conditioning techniques and methods of assessment and evaluation are applied to a wide range of problems in many different settings (Kazdin, 2001). The most important contribution of applied behavior analysis is that it offers a functional approach to understanding clients' problems and addresses these problems by changing antecedents and consequences (the ABC model).

Behaviorists believe we respond in predictable ways because of the gains we experience (positive reinforcement) or because of the need to escape or avoid unpleasant consequences (negative reinforcement). Once clients' goals have been assessed, specific behaviors are targeted. The goal of reinforcement, whether positive or negative, is to increase the target behavior. **Positive reinforcement** involves the *addition* of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behavior. The stimulus that follows the behavior is the positive reinforcer. For example, a child earns excellent grades and is praised for studying by her parents. If she values this praise, it is likely that she will have an investment in studying in the

future. When the goal of a program is to decrease or eliminate undesirable behaviors, positive reinforcement is often used to increase the frequency of more desirable behaviors, which replace undesirable behaviors.

Negative reinforcement involves the *escape* from or the avoidance of aversive (unpleasant) stimuli. The individual is motivated to exhibit a desired behavior to avoid the unpleasant condition. For example, a friend of mine does not appreciate waking up to the shrill sound of an alarm clock. She has trained herself to wake up a few minutes before the alarm sounds to avoid the aversive stimulus of the alarm buzzer.

Another operant method of changing behavior is **extinction,** which refers to withholding reinforcement from a previously reinforced response. In applied settings, extinction can be used for behaviors that have been maintained by positive reinforcement or negative reinforcement. For example, in the case of children who display temper tantrums, parents often reinforce this behavior by the attention they give to it. An approach to dealing with problematic behavior is to eliminate the connection between a certain behavior (tantrums) and positive reinforcement (attention). Doing so can decrease or eliminate such behaviors through the *extinction process.* It should be noted that extinction might well have negative side effects, such as anger and aggression. Extinction can reduce or eliminate certain behaviors, but extinction does not replace those responses that have been extinguished. For this reason, extinction is most often used in behavior modification programs in conjunction with various reinforcement strategies (Kazdin, 2001).

Another way behavior is controlled is through **punishment,** sometimes referred to as aversive control, in which the consequences of a certain behavior result in a decrease of that behavior. The goal of reinforcement is to *increase target behavior,* but the goal of punishment is to *decrease target behavior.* Miltenberger (2008) describes two kinds of punishment that may occur as a consequence of behavior: positive punishment and negative punishment. In **positive punishment** an aversive stimulus is *added* after the behavior to decrease the frequency of a behavior (such as withholding a treat from a child for misbehavior or reprimanding a student for acting out in class). In **negative punishment** a reinforcing stimulus is *removed* following the behavior to decrease the frequency of a target behavior (such as deducting money from a worker's salary for missing time at work, or taking television time away from a child for misbehavior). In both kinds of punishment, the behavior is less likely to occur in the future. These four operant procedures form the basis of behavior therapy programs for parent skills training and are also used in the self-management procedures that are discussed later in this chapter.

Skinner (1948) believed punishment had limited value in changing behavior and was often an undesirable way to modify behavior. He opposed using aversive control or punishment, and recommended substituting positive reinforcement. The key principle in the applied behavior analysis approach is to use the least aversive means possible to change behavior, and positive reinforcement is known to be the most powerful change agent. Skinner believed in the value of analyzing environmental factors for both the causes and remedies for behavior problems and contended that the greatest benefits to the individual

and to society occur by using systematic positive reinforcement as a route to behavior control (Nye, 2000).

In everyday life, punishment is often used as a means of getting revenge or expressing frustration. However, as Kazdin (2001) has noted, "punishment in everyday life is not likely to teach lessons or suppress intolerable behavior because of the specific punishments that are used and how they are applied" (p. 231). Even in those cases when punishment suppresses undesirable responses, punishment does not result in teaching desirable behaviors. Punishment should be used only after nonaversive approaches have been implemented and found to be ineffective in changing problematic behavior (Kazdin, 2001; Miltenberger, 2008). It is essential that reinforcement be used as a way to develop appropriate behaviors that replace the behaviors that are suppressed.

Relaxation Training and Related Methods

Relaxation training has become increasingly popular as a method of teaching people to cope with the stresses produced by daily living. It is aimed at achieving muscle and mental relaxation and is easily learned. After clients learn the basics of relaxation procedures, it is essential that they practice these exercises daily to obtain maximum results.

Jacobson (1938) is credited with initially developing the progressive muscle relaxation procedure. It has since been refined and modified, and relaxation procedures are frequently used in combination with a number of other behavioral techniques. These include systematic desensitization, assertion training, self-management programs, audiotape recordings of guided relaxation procedures, computer simulation programs, biofeedback-induced relaxation, hypnosis, meditation, and autogenic training (teaching control of bodily and imaginal functions through autosuggestion).

Relaxation training involves several components that typically require from 4 to 8 hours of instruction. Clients are given a set of instructions that teaches them to relax. They assume a passive and relaxed position in a quiet environment while alternately contracting and relaxing muscles. This progressive muscle relaxation is explicitly taught to the client by the therapist. Deep and regular breathing is also associated with producing relaxation. At the same time clients learn to mentally "let go," perhaps by focusing on pleasant thoughts or images. Clients are instructed to actually feel and experience the tension building up, to notice their muscles getting tighter and study this tension, and to hold and fully experience the tension. Also, it is useful for clients to experience the difference between a tense and a relaxed state. The client is then taught how to relax all the muscles while visualizing the various parts of the body, with emphasis on the facial muscles. The arm muscles are relaxed first, followed by the head, the neck and shoulders, the back, abdomen, and thorax, and then the lower limbs. Relaxation becomes a well-learned response, which can become a habitual pattern if practiced daily for about 25 minutes each day.

For an exercise of the phases of the progressive muscle relaxation procedure that you can apply to yourself, see *Student Manual for Theory and Practice of Counseling and Psychotherapy* (Corey, 2009b). For an excellent audiotape demonstration of progressive muscle relaxation, see Dattilio (2006).

Relaxation procedures have been applied to a variety of clinical problems, either as a separate technique or in conjunction with related methods. The most common use has been with problems related to stress and anxiety, which are often manifested in psychosomatic symptoms. Some other ailments for which relaxation training is helpful include asthma, headache, hypertension, insomnia, irritable bowel syndrome, and panic disorder (Cormier et al., 2009).

Systematic Desensitization

Systematic desensitization, which is based on the principle of classical conditioning, is a basic behavioral procedure developed by Joseph Wolpe, one of the pioneers of behavior therapy. Clients imagine successively more anxiety-arousing situations at the same time that they engage in a behavior that competes with anxiety. Gradually, or systematically, clients become less sensitive (desensitized) to the anxiety-arousing situation. This procedure can be considered a form of exposure therapy because clients are required to expose themselves to anxiety-arousing images as a way to reduce anxiety.

Systematic desensitization is an empirically researched behavior therapy procedure that is time consuming, yet it is clearly an effective and efficient treatment of anxiety-related disorders, particularly in the area of specific phobias (Cormier et al., 2009; McNeil & Kyle, 2009; Spiegler & Guevremont, 2003). Before implementing the desensitization procedure, the therapist conducts an initial interview to identify specific information about the anxiety and to gather relevant background information about the client. This interview, which may last several sessions, gives the therapist a good understanding of who the client is. The therapist questions the client about the particular circumstances that elicit the conditioned fears. For instance, under what circumstances does the client feel anxious? If the client is anxious in social situations, does the anxiety vary with the number of people present? Is the client more anxious with women or men? The client is asked to begin a self-monitoring process consisting of observing and recording situations during the week that elicit anxiety responses. Some therapists also administer a questionnaire to gather additional data about situations leading to anxiety.

If the decision is made to use the desensitization procedure, the therapist gives the client a rationale for the procedure and briefly describes what is involved. McNeil and Kyle (2009) describe several steps in the use of systematic desensitization: (1) relaxation training, (2) development of the anxiety hierarchy, and (3) systematic desensitization proper.

The steps in *relaxation training,* which were described earlier, are presented to the client. The therapist uses a very quiet, soft, and pleasant voice to teach progressive muscular relaxation. The client is asked to create imagery of previously relaxing situations, such as sitting by a lake or wandering through a beautiful field. It is important that the client reach a state of calm and peacefulness. The client is instructed to practice relaxation both as a part of the desensitization procedure and also outside the session on a daily basis.

The therapist then works with the client to develop an *anxiety hierarchy* for each of the identified areas. Stimuli that elicit anxiety in a particular area, such as rejection, jealousy, criticism, disapproval, or any phobia, are analyzed. The

therapist constructs a ranked list of situations that elicit increasing degrees of anxiety or avoidance. The hierarchy is arranged in order from the worst situation the client can imagine down to the situation that evokes the least anxiety. If it has been determined that the client has anxiety related to fear of rejection, for example, the highest anxiety-producing situation might be rejection by the spouse, next, rejection by a close friend, and then rejection by a coworker. The least disturbing situation might be a stranger's indifference toward the client at a party.

Desensitization does not begin until several sessions after the initial interview has been completed. Enough time is allowed for clients to learn relaxation in therapy sessions, to practice it at home, and to construct their anxiety hierarchy. The desensitization process begins with the client reaching complete relaxation with eyes closed. A neutral scene is presented, and the client is asked to imagine it. If the client remains relaxed, he or she is asked to imagine the least anxiety-arousing scene on the hierarchy of situations that has been developed. The therapist moves progressively up the hierarchy until the client signals that he or she is experiencing anxiety, at which time the scene is terminated. Relaxation is then induced again, and the scene is reintroduced again until little anxiety is experienced to it. Treatment ends when the client is able to remain in a relaxed state while imagining the scene that was formerly the most disturbing and anxiety-producing. The core of systematic desensitization is repeated exposure in the imagination to anxiety-evoking situations without experiencing any negative consequences.

Homework and follow-up are essential components of successful desensitization. Clients can practice selected relaxation procedures daily, at which time they visualize scenes completed in the previous session. Gradually, they also expose themselves to daily-life situations as a further way to manage their anxieties. Clients tend to benefit the most when they have a variety of ways to cope with anxiety-arousing situations that they can continue to use once therapy has ended McNeil and Kyle (2009).

Systematic desensitization is an appropriate technique for treating phobias, but it is a misconception that it can be applied only to the treatment of anxiety. It has also been used to treat a variety of conditions beside anxiety, including anger, asthmatic attacks, insomnia, motion sickness, nightmares, and sleepwalking (Spiegler, 2008). Historically, desensitization probably has the longest track record of any behavioral technique in dealing with fears, and its positive results have been documented repeatedly McNeil and Kyle (2009). Systematic desensitization is often acceptable to clients because they are gradually and symbolically exposed to anxiety-evoking situations. A safeguard is that clients are in control of the process by going at their own pace and terminating exposure when they begin to experience more anxiety than they want to tolerate (Spiegler & Guevremont, 2003).

In Vivo Exposure and Flooding

Exposure therapies are designed to treat fears and other negative emotional responses by introducing clients, under carefully controlled conditions, to the situations that contributed to such problems. Exposure is a key process in treating

a wide range of problems associated with fear and anxiety. Exposure therapy involves systematic confrontation with a feared stimulus, either through imagination or in vivo (live). Whatever the route used, exposure involves contact by clients and what they find fearful (McNeil & Kyle, 2009). Desensitization is one type of exposure therapy, but there are others. Two variations of traditional systematic desensitization are in vivo exposure and flooding.

IN VIVO EXPOSURE **In vivo exposure** involves client exposure to the actual anxiety-evoking events rather than simply imagining these situations. Live exposure has been a cornerstone of behavior therapy for decades (Hazlett-Stevens & Craske, 2003). Together, the therapist and the client generate a hierarchy of situations for the client to encounter in ascending order of difficulty. Clients engage in brief and graduated series of exposures to feared events. Clients can terminate exposure if they experience a high level of anxiety. As is the case with systematic desensitization, clients learn competing responses involving muscular relaxation. In some cases the therapist may accompany clients as they encounter feared situations. For example, a therapist could go with clients in an elevator if they had phobias of using elevators. Of course, when this kind of out-of-office procedure is used, matters of safety and appropriate ethical boundaries are always considered. People who have extreme fears of certain animals could be exposed to these animals in real life in a safe setting with a therapist. Self-managed in vivo exposure—a procedure in which clients expose themselves to anxiety-evoking events on their own—is an alternative when it is not practical for a therapist to be with clients in real-life situations.

FLOODING Another form of exposure therapy is **flooding**, which refers to either in vivo or imaginal exposure to anxiety-evoking stimuli for a prolonged period of time. As is characteristic of all exposure therapies, even though the client experiences anxiety during the exposure, the feared consequences do not occur.

In vivo flooding consists of intense and prolonged exposure to the actual anxiety-producing stimuli. Remaining exposed to feared stimuli for a prolonged period without engaging in any anxiety-reducing behaviors allows the anxiety to decrease on its own. Generally, highly fearful clients tend to curb their anxiety through the use of maladaptive behaviors. In flooding, clients are prevented from engaging in their usual maladaptive responses to anxiety-arousing situations. In vivo flooding tends to reduce anxiety rapidly.

Imaginal flooding is based on similar principles and follows the same procedures except the exposure occurs in the client's imagination instead of in daily life. An advantage of using imaginal flooding over in vivo flooding is that there are no restrictions on the nature of the anxiety-arousing situations that can be treated. In vivo exposure to actual traumatic events (airplane crash, rape, fire, flood) is often not possible nor is it appropriate for both ethical and practical reasons. Imaginal flooding can re-create the circumstances of the trauma in a way that does not bring about adverse consequences to the client. Survivors of an airplane crash, for example, may suffer from a range of debilitating symptoms. They are likely to have nightmares and flashbacks to the disaster, they may

avoid travel by air or have anxiety about travel by any means, and they probably have a variety of distressing symptoms such as guilt, anxiety, and depression. Flooding is frequently used in the behavioral treatment for anxiety-related disorders, phobias, obsessive-compulsive disorder, posttraumatic stress disorder, and agoraphobia.

Prolonged and intense exposure can be both an effective and efficient way to reduce clients' anxiety. However, because of the discomfort associated with prolonged and intense exposure, some clients may not elect these exposure treatments. It is important for the behavior therapist to work with the client to create motivation and readiness for exposure. From an ethical perspective, clients should have adequate information about prolonged and intense exposure therapy before agreeing to participate. It is important that they understand that anxiety will be induced as a way to reduce it. Clients need to make informed decisions after considering the pros and cons of subjecting themselves to temporarily stressful aspects of treatment.

Research consistently indicates that exposure therapy can reduce the client's degree of fear and anxiety (Tryon, 2005). The repeated success of exposure therapy in treating various disorders has resulted in exposure being used as a part of most behavioral and cognitive behavioral treatments for anxiety disorders (McNeil & Kyle, 2009). Spiegler and Guevremont (2003) conclude that exposure therapies are the single most potent behavioral procedures available for anxiety-related disorders, and they can have long-lasting effects. However, they add, using exposure as a sole treatment procedure is not always sufficient. In cases involving severe and multifaceted disorders, more than one behavioral intervention is often required. Increasingly, imaginal and in vivo exposure are being used in combination, which fits with the trend in behavior therapy to use treatment packages as a way to enhance the effectiveness of therapy.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a form of exposure therapy that involves imaginal flooding, cognitive restructuring, and the use of rapid, rhythmic eye movements and other bilateral stimulation to treat clients who have experienced traumatic stress. Developed by Francine Shapiro (2001), this therapeutic procedure draws from a wide range of behavioral interventions. Designed to assist clients in dealing with posttraumatic stress disorders, (EMDR has been applied to a variety of populations including children, couples, sexual abuse victims, combat veterans, victims of crime, rape survivors, accident victims, and individuals dealing with anxiety, panic, depression, grief, addictions, and phobias.

Shapiro (2001) emphasized the importance of the safety and welfare of the client when using this approach. EMDR may appear simple to some, but the ethical use of the procedure demands training and clinical supervision. Because of the powerful reactions from clients, it is essential that practitioners know how to safely and effectively manage these occurrences. Therapists should not use this procedure unless they receive proper training and supervision from an authorized EMDR instructor. A more complete discussion of this behavioral procedure can be found in Shapiro (2001, 2002a).

There is some controversy whether the eye movements themselves create change, or the application of cognitive techniques paired with eye movements act as change agents. The empirical support for EMDR has been mixed, which makes it difficult to draw firm conclusions about the success or failure of this intervention (McNeil & Kyle, 2009). In writing about the future of EMDR, Prochaska and Norcross (2007) make several predictions: increasing numbers of practitioners will receive training in EMDR; outcome research will shed light on EMDR's effectiveness compared to other current therapies for trauma; and further research and practice will provide a sense of its effectiveness with disorders besides posttraumatic stress disorder.

Social Skills Training

Social skills training is a broad category that deals with an individual's ability to interact effectively with others in various social situations; it is used to correct deficits clients have in interpersonal competencies (Spiegler, 2008). *Social skills* involve being able to communicate with others in a way that is both appropriate and effective. Individuals who experience psychosocial problems that are partly caused by interpersonal difficulties are good candidates for social skills training. Some of the desirable aspects of this training are that it has a very broad base of applicability and it can easily be tailored to suit the particular needs of individual clients (Segrin, 2003). Social skills training includes psychoeducation, modeling, reinforcement, behavioral rehearsal, role playing, and feedback (Antony & Roemer, 2003). Another popular variation of social skills training is **anger management training,** which is designed for individuals who have trouble with aggressive behavior. *Assertion training,* which is described next, is for people who lack assertive skills.

ASSERTION TRAINING One specialized form of social skills training that has gained increasing popularity is teaching people how to be assertive in a variety of social situations. Many people have difficulty feeling that it is appropriate or right to assert themselves. People who lack social skills frequently experience interpersonal difficulties at home, at work, at school, and during leisure time. Assertion training can be useful for those (1) who have difficulty expressing anger or irritation, (2) who have difficulty saying no, (3) who are overly polite and allow others to take advantage of them, (4) who find it difficult to express affection and other positive responses, (5) who feel they do not have a right to express their thoughts, beliefs, and feelings, or (6) who have social phobias.

The basic assumption underlying **assertion training** is that people have the right (but not the obligation) to express themselves. One goal of assertion training is to increase people's behavioral repertoire so that they can make the *choice* of whether to behave assertively in certain situations. It is important that clients replace maladaptive social skills with new skills. Another goal is teaching people to express themselves in ways that reflect sensitivity to the feelings and rights of others. Assertion does not mean aggression; truly assertive people do not stand up for their rights at all costs, ignoring the feelings of others.

Assertion training is based on the principles of social learning theory and incorporates many social skills training methods. Generally, the therapist both

teaches and models desired behaviors the client wants to acquire. These behaviors are practiced in the therapy office and then enacted in everyday life. Most assertion training programs focus on clients' negative self-statements, self-defeating beliefs, and faulty thinking. People often behave in unassertive ways because they don't think they have a right to state a viewpoint or ask for what they want or deserve. Thus their thinking leads to passive behavior. Effective assertion training programs do more than give people skills and techniques for dealing with difficult situations. These programs challenge people's beliefs that accompany their lack of assertiveness and teach them to make constructive self-statements and to adopt a new set of beliefs that will result in assertive behavior.

Assertion training is often conducted in groups. When a group format is used, the modeling and instructions are presented to the entire group, and members rehearse behavioral skills in role-playing situations. After the rehearsal, the member is given feedback that consists of reinforcing the correct aspects of the behavior and instructions on how to improve the behavior. Each member engages in further rehearsals of assertive behaviors until the skills are performed adequately in a variety of simulated situations (Miltenberger, 2008).

Because assertion training is based on Western notions of the value of assertiveness, it may not be suited for clients with a cultural background that places more emphasis on harmony than on being assertive. This approach is not a panacea, but it can be an effective treatment for clients who have skill deficits in assertive behavior or for individuals who experience difficulties in their interpersonal relationships. Although counselors can adapt this form of social skills training procedures to suit their own style, it is important to include behavioral rehearsal and continual assessment as basic aspects of the program. If you are interested in learning more assertion training, consult *Your Perfect Right: A Guide to Assertive Behavior* (Alberti & Emmons, 2008).

Self-Modification Programs and Self-Directed Behavior

For some time there has been a trend toward "giving psychology away." This involves psychologists being willing to share their knowledge so that "consumers" can increasingly lead self-directed lives and not be dependent on experts to deal with their problems. Psychologists who share this perspective are primarily concerned with teaching people the skills they will need to manage their own lives effectively. An advantage of self-modification (or self-management) techniques is that treatment can be extended to the public in ways that cannot be done with traditional approaches to therapy. Another advantage is that costs are minimal. Because clients have a direct role in their own treatment, techniques aimed at self-change tend to increase involvement and commitment to their treatment.

Self-modification strategies include self-monitoring, self-reward, self-contracting, stimulus control, and self-as-model. The basic idea of self-modification assessments and interventions is that change can be brought about by teaching people to use coping skills in problematic situations. Generalization and maintenance of the outcomes are enhanced by encouraging clients to accept the responsibility for carrying out these strategies in daily life.

In self-modification programs people make decisions concerning specific behaviors they want to control or change. People frequently discover that a major reason that they do not attain their goals is the lack of certain skills or unrealistic expectations of change. Hope can be a therapeutic factor that leads to change, but unrealistic hope can pave the way for a pattern of failures in a self-change program. A self-directed approach can provide the guidelines for change and a plan that will lead to change.

For people to succeed in such a program, a careful analysis of the context of the behavior pattern is essential, and people must be willing to follow some basic steps such as those provided by Watson and Tharp (2007):

1. *Selecting goals.* Goals should be established one at a time, and they should be measurable, attainable, positive, and significant for the person. It is essential that expectations be realistic.
2. *Translating goals into target behaviors.* Identify behaviors targeted for change. Once targets for change are selected, anticipate obstacles and think of ways to negotiate them.
3. *Self-monitoring.* Deliberately and systematically observe your own behavior, and keep a *behavioral diary,* recording the behavior along with comments about the relevant antecedent cues and consequences.
4. *Working out a plan for change.* Devise an action program to bring about actual change. Various plans for the same goal can be designed, each of which can be effective. Some type of self-reinforcement system is necessary in this plan because reinforcement is the cornerstone of modern behavior therapy. Self-reinforcement is a temporary strategy used until the new behaviors have been implemented in everyday life. Take steps to ensure that the gains made will be maintained.
5. *Evaluating an action plan.* Evaluate the plan for change to determine whether goals are being achieved, and adjust and revise the plan as other ways to meet goals are learned. Evaluation is an ongoing process rather than a one-time occurrence, and self-change is a lifelong practice.

Many people who develop some kind of self-modification program encounter repeated failure, a situation Polivy and Herman (2002) refer to as the "false hope syndrome," which is characterized by unrealistic expectations regarding the likely speed, amount, ease, and consequences of self-change attempts. Self-change efforts are frequently doomed to failure from the outset by these unrealistic expectations, but individuals often continue to try and try in the hope that they will eventually succeed in changing a behavioral pattern. Many people interpret their failures to change as the result of inadequate effort or getting involved in the wrong program.

Self-modification strategies have been successfully applied to many populations and problems, a few of which include coping with panic attacks, helping children to cope with fear of the dark, increasing creative productivity, managing anxiety in social situations, encouraging speaking in front of a class, increasing exercise, control of smoking, and dealing with depression (Watson & Tharp, 2007). Research on self-modification has been conducted in a wide variety of health problems, a few of which include arthritis, asthma, cancer, cardiac

disease, substance abuse, diabetes, headaches, vision loss, nutrition, and self-health care (Cormier et al., 2009).

Multimodal Therapy: Clinical Behavior Therapy

Multimodal therapy is a comprehensive, systematic, holistic approach to behavior therapy developed by Arnold Lazarus (1976, 1986, 1987, 1989, 1992a, 1992b, 1997a, 2005, 2008). It is grounded in social learning and cognitive theory and applies diverse behavioral techniques to a wide range of problems. This approach serves as a major link between some behavioral principles and the cognitive behavioral approach that has largely replaced traditional behavioral therapy.

Multimodal therapy is an open system that encourages *technical eclecticism.* New techniques are constantly being introduced and existing techniques refined, but they are never used in a shotgun manner. Multimodal therapists take great pains to determine precisely what relationship and what treatment strategies will work best with each client and under which particular circumstances. The underlying assumption of this approach is that because individuals are troubled by a variety of specific problems it is appropriate that a multitude of treatment strategies be used in bringing about change. Therapeutic flexibility and versatility, along with breadth over depth, are highly valued, and multimodal therapists are constantly adjusting their procedures to achieve the client's goals. Therapists need to decide when and how to be challenging or supportive, cold or warm, formal or informal, and tough or tender (Lazarus, 1997a, 2008).

Multimodal therapists tend to be very active during therapist sessions, functioning as trainers, educators, consultants, and role models. They provide information, instruction, and feedback as well as modeling assertive behaviors. They offer constructive criticism and suggestions, positive reinforcements, and are appropriately self-disclosing.

Lazarus (2008) contends: "Multimodal therapists subscribe to no dogma other than the principles of theoretical parsimony and therapeutic effectiveness" (p. 396). Techniques are borrowed from many other therapy systems. They recognize that many clients come to therapy needing to learn skills, and they are willing to teach, coach, train, model, and direct their clients. Multimodal therapists typically function directively by providing information, instruction, and reactions. They challenge self-defeating beliefs, offer constructive feedback, provide positive reinforcement, and are appropriately self-disclosing. It is essential that therapists start where the client is and then move into other productive areas for exploration. Failure to apprehend the client's situation can easily leave the client feeling alienated and misunderstood (Lazarus, 2000).

THE BASIC I.D. The essence of Lazarus's multimodal approach is the premise that the complex personality of human beings can be divided into seven major areas of functioning: B = behavior; A = affective responses; S = sensations; I = images; C = cognitions; I = interpersonal relationships; and D = drugs, biological functions, nutrition, and exercise (Lazarus, 1989, 1992a, 1992b, 1997a, 1997b, 2000, 2006, 2008). Although these modalities are interactive, they can be considered discrete functions.

TABLE 9.1 The BASIC I.D. Assessment Process

Modality	*Behaviors*	*Questions to Ask*
Behavior	Overt behaviors, including acts, habits, and reactions that are observable and measurable	What would you like to change? How active are you? What would you like to start doing? What would you like to stop doing? What are some of your main strengths? What specific behaviors keep you from getting what you want?
Affect	Emotions, moods, and strong feelings	What emotions do you experience most often? What makes you laugh? What makes you cry? What makes you sad, mad, glad, scared? What emotions are problematic for you?
Sensation	Basic senses of touch, taste, smell, sight, and hearing	Do you suffer from unpleasant sensations, such as pains, aches, dizziness, and so forth? What do you particularly like or dislike in the way of seeing, smelling, hearing, touching, and tasting?
Imagery	How we picture ourselves, including memories, dreams, and fantasies	What are some bothersome recurring dreams and vivid memories? Do you have a vivid imagination? How do you view your body? How do you see yourself now? How would you like to be able to see yourself in the future?
Cognition	Insights, philosophies, ideas, opinions, self-talk, and judgments that constitute one's fundamental values, attitudes, and beliefs	What are some ways in which you meet your intellectual needs? How do your thoughts affect your emotions? What are the values and beliefs you most cherish? What are some negative things you say to yourself? What are some of your central faulty beliefs? What are the main 'shoulds,' 'oughts,' and 'musts' in your life? How do they get in the way of effective living?
Interpersonal relationship	Interactions with other people	How much of a social being are you? To what degree do you desire intimacy with others?

(continues)

TABLE 9.1 The BASIC I.D. Assessment Process *(continued)*

Modality	*Behaviors*	*Questions to Ask*
Interpersonal relationship (*continued*)		What do you expect from the significant people in your life? What do they expect from you? Are there any relationships with others that you would hope to change? If so, what kinds of changes do you want?
Drugs/biology	Drugs, and nutritional habits, and exercise patterns	Are you healthy and health conscious? Do you have any concerns about your health? Do you take any prescribed drugs? What are your habits pertaining to diet, exercise, and physical fitness?

Multimodal therapy begins with a comprehensive assessment of the seven modalities of human functioning and the interaction among them. A complete assessment and treatment program must account for each modality of the **BASIC I.D.**, which is the cognitive map linking each aspect of personality. Table 9.1 outlines this process using questions Lazarus typically asks (1989, 1997a, 2000, 2008).

A major premise of multimodal therapy is that *breadth* is often more important than *depth.* The more coping responses a client learns in therapy, the less are the chances for a relapse (Lazarus, 1996a, 2008; Lazarus & Lazarus, 2002). Therapists identify one specific issue from each aspect of the BASIC I.D. framework as a target for change and teach clients a range of techniques they can use to combat faulty thinking, to learn to relax in stressful situations, and to acquire effective interpersonal skills. Clients can then apply these skills to a broad range of problems in their everyday lives.

The preliminary investigation of the BASIC I.D. framework brings out some central and significant themes that can then be productively explored using a detailed life-history questionnaire. (See Lazarus and Lazarus, 1991, for the multimodal life-history inventory.) Once the main profile of a person's BASIC I.D. has been established, the next step consists of an examination of the interactions among the different modalities. For an illustration of how Dr. Lazarus applies the BASIC I.D. assessment model to the case of Ruth, along with examples of various techniques he uses, see *Case Approach to Counseling and Psychotherapy* (Corey, 2009a, chap. 7).

Mindfulness and Acceptance-Based Cognitive Behavior Therapy

Over the last decade, the "third wave" of behavior therapy has evolved, which has resulted in an expansion of the behavioral tradition. Newer facets of cognitive behavior therapy have emerged that emphasize considerations that were considered off limits for behavior therapists until recently, including mindfulness, acceptance, the therapeutic relationship, spirituality, values, meditation,

being in the present moment, and emotional expression (Hayes, Follette, & Linehan, 2004). Mindfulness is a process that involves becoming increasingly observant and aware of external and internal stimuli in the present moment and adopting an open attitude toward accepting what is rather than judging the current situation (Kabat-Zinn, 1994; Segal, Williams, & Teasdale, 2002). The essence of mindfulness is becoming aware of one's mind from one moment to the next, with gentle acceptance (Germer, Siegel, & Fulton, 2005). In mindfulness practice clients train themselves to focus on their present experience. Acceptance is a process involving receiving one's present experience without judgment or preference, but with curiosity and kindness, and striving for full awareness of the present moment (Germer, 2005b). The mindfulness and acceptance approaches are good avenues for the integration of spirituality in the counseling process.

The four major approaches in the recent development of the behavioral tradition include (1) *dialectical behavior therapy* (Linehan, 1993a, 1993b), which has become a recognized treatment for borderline personality disorder; (2) *mindfulness-based stress reduction* (Kabat-Zinn, 1990), which involves an 8- to 10-week group program applying mindfulness techniques to coping with stress and promoting physical and psychological health; (3) *mindfulness-based cognitive therapy* (Segal et al., 2002), which is aimed primarily at treating depression; and (4) *acceptance and commitment therapy* (Hayes, Strosahl, & Houts, 2005; Hayes, Strosahl, & Wilson, 1999), which is based on encouraging clients to accept, rather than attempt to control or change, unpleasant sensations. It should be noted that all four of these approaches are based on empirical data, a hallmark of the behavioral tradition.

DIALECTICAL BEHAVIOR THERAPY (DBT) Developed to help clients regulate emotions and behavior associated with depression, this paradoxical treatment helps clients to accept their emotions as well as to change their emotional experience (Morgan, 2005). The practice of acceptance involves being in the present moment, seeing reality as it is without distortions, without judgment, without evaluation, and without trying to hang on to an experience or to get rid of it. It involves entering fully into activities of the present moment without separating oneself from ongoing events and interactions.

Formulated by Linehan (1993a, 1993b), **DBT** is a promising blend of behavioral and psychoanalytic techniques for treating borderline personality disorders. Like analytic therapy, DBT emphasizes the importance of the psychotherapeutic relationship, validation of the client, the etiologic importance of the client having experienced an "invalidating environment" as a child, and confrontation of resistance. The main components of DBT are affect regulation, distress tolerance, improvement in interpersonal relationships, and mindfulness training. DBT employs behavioral techniques, including a form of exposure therapy in which the client learns to tolerate painful emotions without enacting self-destructive behaviors. DBT integrates its cognitive behaviorism not only with analytic concepts but also with the mindfulness training of "Eastern psychological and spiritual practices (primarily Zen practice)" (Linehan, 1993b, p. 6).

DBT skills training is not a "quick fix" approach. It generally involves a minimum of one year of treatment and includes both individual therapy and

skills training done in a group. DBT requires a behavioral contract. To competently practice DBT, it is essential to obtain training in this approach.

MINDFULNESS-BASED STRESS REDUCTION (MBSR) The skills taught in the **MBSR** program include sitting meditation and mindful yoga, which are aimed at cultivating mindfulness. The program includes a body scan meditation that helps clients to observe all the sensations in their body. This attitude of mindfulness is encouraged in every aspect of daily life including standing, walking, and eating. Those who are involved in the program are encouraged to practice formal mindfulness meditation for 45 minutes daily. The MBSR program is mainly designed to teach participants to relate to external and internal sources of stress in constructive ways. The program aims to teach people how to live more fully in the present rather than ruminating about the past or being overly concerned about the future.

ACCEPTANCE AND COMMITMENT THERAPY (ACT) Another mindfulness-based approach is **acceptance and commitment therapy** (Hayes et al., 1999, 2005), which involves fully accepting present experience and mindfully letting go of obstacles. In this approach "acceptance is not merely tolerance—rather it is the active nonjudgmental embracing of experience in the here and now" (Hayes, 2004, p. 32). Acceptance is a stance or posture from which to conduct therapy and from which a client can conduct life (Hayes & Pankey, 2003) that provides an alternative to contemporary forms of cognitive behavioral therapy (Eifert & Forsyth, 2005). In contrast to the cognitive behavioral approaches discussed in Chapter 10, where cognition is challenged or disputed, in ACT the cognition is accepted. Clients learn how to accept the thoughts and feelings they may have been trying to deny. Hayes has found that challenging maladaptive cognitions actually strengthens rather than reduces these cognitions. The goal of ACT is to allow for increased psychological flexibility. Values are a basic part of the therapeutic process, and ACT practitioners might ask clients "What do you want your life to stand for?"

In addition to acceptance, commitment to action is essential. *Commitment* involves making mindful decisions about what is important in life and what the person is willing to do to live a valued life (Wilson, 2008). ACT makes use of concrete homework and behavioral exercises as a way to create larger patterns of effective action that will help clients live by their values (Hayes, 2004). For example, one form of homework given to clients is asking them to write down life goals or things they value in various aspects of their lives. The focus of ACT is allowing experience to come and go while pursuing a meaningful life. According to Hayes and Pankey (2003), "there is a growing evidence base that acceptance skills are central to psychological well-being and can increase the impact of psychotherapy with a broad variety of clients" (p. 8).

ACT is an effective form of therapy (Eifert & Forsyth, 2005) that continues to influence the practice of behavior therapy. Germer (2005a) suggests "mindfulness might become a construct that draws clinical theory, research, and practice closer together, and helps integrate the private and professional lives of therapists" (p. 11). According to Wilson (2008), ACT emphasizes common processes

across clinical disorders, which makes it easier to learn basic treatment skills. Practitioners can then implement basic principles in diverse and creative ways.

For a more in-depth discussion of the role of mindfulness in psychotherapeutic practice, two highly recommended readings are *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* (Hayes et al., 2004) and *Mindfulness and Psychotherapy* (Germer et al., 2005).

Integrating Behavioral Techniques With Contemporary Psychoanalytic Approaches

Certain aspects of behavior therapy can be combined with a number of other therapeutic approaches. For example, behavioral and cognitive behavioral techniques can be combined with the conceptual framework of contemporary psychoanalytic therapies (see Chapter 4). Morgan and MacMillan (1999) developed a three-phase integrated counseling model based on theoretical constructs of object-relations and attachment theory that incorporates behavioral techniques.

In the first phase, object-relations theory serves as the conceptual basis for the assessment and relationship-building process. What children learn from early interactions with parents clearly affects personality development and may result in problematic adult relationships. For meaningful assessment to occur, it is essential that the counselor is able to hear the stories of their clients, to grasp their phenomenological world, and to establish rapport with them. During this phase, therapists provide a supportive holding environment that offers a safe place for clients to recall and explore painful earlier memories. At this phase counseling includes an exploration of clients' feelings regarding past and present circumstances and thought patterns that influence the clients' interpretation of the world.

In the second phase, the aim is to link insights gleaned from the initial assessment phase to the present to create an understanding of how early relational patterns are related to present difficulties. This insight often enables clients to acknowledge and express painful memories, feelings, and thoughts. As clients are able to process previously repressed and dissociated memories and feelings in counseling, cognitive changes in perception of self and others often occur. Both experiential and cognitive techniques are utilized in the second phase. As clients engage in the process of cognitively restructuring life situations, they acquire new and adaptive ways of thinking, feeling, and coping.

In the third and final phase of treatment, behavioral techniques with goal setting and homework assignments are emphasized to maximize change. This is the action phase, a time for clients to attempt new behaviors based on the insight, understanding, and cognitive restructuring achieved in the prior phases of counseling. Clients take action, which leads to empowerment.

According to Morgan and MacMillan (1999), there is increasing support in the literature that integrating contemporary psychodynamic theory with behavioral and cognitive behavioral techniques can lead to observable, constructive client changes. Establishing clear goals for each of the three phases of their integrative model provides an efficient framework within which to structure

the counseling interventions. Morgan and MacMillan claim that if these treatment goals are well defined it is possible to work through all three phases in a reasonable amount of time. Adapting the conceptual foundation of psychoanalytic thinking to relatively brief therapy makes this approach useful in time-limited therapy.

Application to Group Counseling

Group-based behavioral approaches emphasize teaching clients self-management skills and a range of new coping behaviors, as well as how to restructure their thoughts. Clients can learn to use these techniques to control their lives, deal effectively with present and future problems, and function well after they complete their group experience. Many groups are designed primarily to increase the client's degree of control and freedom in specific aspects of daily life.

Group leaders who function within a behavioral framework may develop techniques from diverse theoretical viewpoints. Behavioral practitioners make use of a brief, active, directive, structured, collaborative, psychoeducational model of therapy that relies on empirical validation of its concepts and techniques. The leader follows the progress of group members through the ongoing collection of data before, during, and after all interventions. Such an approach provides both the group leader and the members with continuous feedback about therapeutic progress. Today, many groups in community agencies demand this kind of accountability.

Behavioral group therapy has some unique characteristics that set it apart from most of the other group approaches. The distinguishing characteristic of behavioral practitioners is their systematic adherence to specification and measurement. The specific unique characteristics of behavioral group therapy include (1) conducting a behavioral assessment, (2) precisely spelling out collaborative treatment goals, (3) formulating a specific treatment procedure appropriate to a particular problem, and (4) objectively evaluating the outcomes of therapy. Behavioral therapists tend to utilize short-term, time-limited interventions aimed at efficiently and effectively solving problems and assisting members in developing new skills.

Behavioral group leaders assume the role of teacher and encourage members to learn and practice skills in the group that they can apply to everyday living. Group leaders are expected to assume an active, directive, and supportive role in the group and to apply their knowledge of behavioral principles and skills to the resolution of problems. Group leaders model active participation and collaboration by their involvement with members in creating an agenda, designing homework, and teaching skills and new behaviors. Group leaders carefully observe and assess behavior to determine the conditions that are related to certain problems and the conditions that will facilitate change. Members in behavioral groups identify specific skills that they lack or would like to enhance. Assertiveness and social skills training fit well into a group format (Wilson, 2008). Relaxation procedures, behavioral rehearsal, modeling, coaching, meditation, and mindfulness techniques are often incorporated in behavioral groups. Most of the other techniques described earlier in this chapter can be applied to group work.

There are many different types of groups with a behavioral twist, or groups that blend both behavioral and cognitive methods for specific populations. Structured groups, with a psychoeducational focus, are especially popular in various settings today. At least five general approaches can be applied to the practice of behavioral groups: (1) social skills training groups, (2) psychoeducational groups with specific themes, (3) stress management groups, (4) multimodal group therapy, and (5) mindfulness and acceptance-based behavior therapy in groups.

For a more detailed discussion of cognitive behavioral approaches to groups, see Corey (2008, chap. 13).

Behavior Therapy From a Multicultural Perspective 

Strengths From a Diversity Perspective

Behavior therapy has some clear advantages over many other theories in counseling culturally diverse clients. Because of their cultural and ethnic backgrounds, some clients hold values that are contrary to the free expression of feelings and the sharing of personal concerns. Behavioral counseling does not generally place emphasis on experiencing catharsis. Rather, it stresses changing specific behaviors and developing problem-solving skills. Some potential strengths of the behavioral approaches in working with diverse client populations include its specificity, task orientation, focus on objectivity, focus on cognition and behavior, action orientation, dealing with the present more than the past, emphasis on brief interventions, teaching coping strategies, and problem-solving orientation. The attention given to transfer of learning and the principles and strategies for maintaining new behavior in daily life are crucial. Clients who are looking for action plans and specific behavioral change are likely to cooperate with this approach because they can see that it offers them concrete methods for dealing with their problems of living.

Behavior therapy focuses on environmental conditions that contribute to a client's problems. Social and political influences can play a significant role in the lives of people of color through discriminatory practices and economic problems, and the behavioral approach takes into consideration the social and cultural dimensions of the client's life. Behavior therapy is based on an experimental analysis of behavior in the client's own social environment and gives special attention to a number of specific conditions: the client's cultural conception of problem behaviors, establishing specific therapeutic goals, arranging conditions to increase the client's expectation of successful therapeutic outcomes, and employing appropriate social influence agents (Tanaka-Matsumi et al., 2002). The foundation of ethical practice involves a therapist's familiarity with the client's culture, as well as the competent application of this knowledge in formulating assessment, diagnostic, and treatment strategies.

The behavioral approach has moved beyond treating clients for a specific symptom or behavioral problem. Instead, it stresses a thorough assessment of the person's life circumstances to ascertain not only what conditions give rise

to the client's problems but also whether the target behavior is amenable to change and whether such a change is likely to lead to a significant improvement in the client's total life situation.

In designing a change program for clients from diverse backgrounds, effective behavioral practitioners conduct a functional analysis of the problem situation. This assessment includes the cultural context in which the problem behavior occurs, the consequences both to the client and to the client's sociocultural environment, the resources within the environment that can promote change, and the impact that change is likely to have on others in the client's surroundings. Assessment methods should be chosen with the client's cultural background in mind (Spiegler & Guevremont, 2003; Tanaka-Matsumi et al., 2002). Counselors must be knowledgeable as well as open and sensitive to issues such as these: What is considered normal and abnormal behavior in the client's culture? What are the client's culturally based conceptions of his or her problems? What kind of information about the client is essential in making an accurate assessment?

Shortcomings From a Diversity Perspective

According to Spiegler and Guevremont (2003), a future challenge for behavior therapists is to develop empirically based recommendations for how behavior therapy can optimally serve culturally diverse clients. Although behavior therapy is sensitive to differences among clients in a broad sense, behavior therapists need to become more responsive to *specific* issues pertaining to all forms of diversity. Because race, gender, ethnicity, and sexual orientation are critical variables that influence the process and outcome of therapy, it is essential that behavior therapists pay greater attention to these factors than they often do. For example, some African American clients are slow to trust a European American therapist, which may be a response to having experienced racism. However, a culturally insensitive therapist may misinterpret this "cultural paranoia" as clinical paranoia (Ridley, 1995).

Some behavioral counselors may focus on using a variety of techniques in narrowly treating specific behavioral problems. Instead of viewing clients in the context of their sociocultural environment, these practitioners concentrate too much on problems within the individual. In doing so they may overlook significant issues in the lives of clients. Such practitioners are not likely to bring about beneficial changes for their clients.

The fact that behavioral interventions often work well raises an interesting issue in multicultural counseling. When clients make significant personal changes, it is very likely that others in their environment will react to them differently. Before deciding too quickly on goals for therapy, the counselor and client need to discuss the challenges inherent in change. It is essential for therapists to conduct a thorough assessment of the interpersonal and cultural dimensions of the problem. Clients should be helped in assessing the possible consequences of some of their newly acquired social skills. Once goals are determined and therapy is under way, clients should have opportunities to talk about the problems they encounter as they become different people in their home and work settings.

Behavior Therapy Applied to the Case of Stan

In Stan's case many specific and interrelated problems can be identified through a functional assessment. *Behaviorally*, he is defensive, avoids eye contact, speaks hesitantly, uses alcohol excessively, has a poor sleep pattern, and displays various avoidance behaviors. In the *emotional* area, Stan has a number of specific problems, some of which include anxiety, panic attacks, depression, fear of criticism and rejection, feeling worthless and stupid, and feeling isolated and alienated. He experiences a range of physiological complaints such as dizziness, heart palpitations, and headaches. *Cognitively,* he worries about death and dying, has many self-defeating thoughts and beliefs, is governed by categorical imperatives ("shoulds," "oughts," "musts"), engages in fatalistic thinking, and compares himself negatively with others. In the *interpersonal* area, Stan is unassertive, has an unsatisfactory relationship with his parents, has few friends, is afraid of contact with women and fears intimacy, and feels socially inferior.

After completing this assessment, Stan's therapist focuses on helping him define the specific areas where he would like to make changes. Before developing a treatment plan, the therapist helps Stan understand the purposes of his behavior. The therapist then educates Stan about how the therapy sessions (and his work outside of the sessions) can help him reach his goals. Early during treatment the therapist helps Stan translate some of his general goals into concrete and measurable ones. When Stan says "I want to feel better about myself," the therapist helps him define more specific goals. When he says "I want to get rid of my inferiority complex," she replies: "What are some situations in which you feel inferior?" "What do you actually do that leads to feelings of inferiority?" Stan's concrete aims include his desire to function without drugs or alcohol. She asks him to keep a record of when he drinks and what events lead to drinking.

Stan indicates that he does not want to feel apologetic for his existence. The therapist introduces behavioral skills training because he has trouble talking with his boss and coworkers. She demonstrates specific skills that he can use in approaching them more directly and confidently. This procedure includes modeling, role playing, and behavior rehearsal. He then tries more effective behaviors with his therapist, who plays the role of the boss and then gives feedback on how strong or apologetic he seemed.

Stan's anxiety about women can also be explored using behavior rehearsal. The therapist plays the role of a woman Stan wants to date. He practices being the way he would like to be with his date and says the things to his therapist that he might be afraid to say to his date. During this rehearsal, Stan can explore his fears, get feedback on the effects of his behavior, and experiment with more assertive behavior.

In vivo exposure is appropriate in working with Stan's fear of failing. Before using in vivo exposure, the therapist first explains the procedure to Stan and gets his informed consent. To create readiness for exposure, he first learns relaxation procedures during the sessions and then practices them daily at home. Next, he lists his specific fears relating to failure, and he then generates a hierarchy of fear items. Stan identifies his greatest fear as sexual impotence with a woman. The least fearful situation he identifies is being with a female student for whom he does not feel an attraction. The therapist first does some systematic desensitization on Stan's hierarchy before moving into in vivo exposure. Stan begins repeated, systematic exposure to items that he finds frightening, beginning at the bottom of the fear hierarchy. He continues with repeated exposure to the next fear hierarchy item when exposure to the previous item generates only mild fear. Part of the process involves exposure exercises for practice in various situations away from the therapy office.

The goal of therapy is to help Stan modify the behavior that results in his feelings of guilt and anxiety. By learning more appropriate coping behaviors, eliminating unrealistic anxiety and guilt, and acquiring more adaptive responses, Stan's presenting symptoms decrease, and he reports a greater degree of satisfaction.

(continues)

Follow-Up: You Continue as Stan's Behavior Therapist *(continued)*

Use these questions to help you think about how you would work with Stan using a behavioral approach:

- How would you collaboratively work with Stan in identifying specific behavioral goals to give a direction to your therapy?
- What behavioral techniques might be most appropriate in helping Stan with his problems?
- Stan indicates that he does not want to feel apologetic for his existence. How might you help him translate this wish into a specific behavioral goal? What behavioral techniques might you draw on in helping him in this area?
- What homework assignments are you likely to suggest for Stan?

See the online and DVD program, *Theory in Practice: The Case of Stan* (Session 7 on behavior therapy), for a demonstration of my approach to counseling Stan from this perspective. This session involves collaboratively working on homework and behavior rehearsals to experiment with assertive behavior.

Summary and Evaluation

Behavior therapy is diverse with respect not only to basic concepts but also to techniques that can be applied in coping with specific problems with a diverse range of clients. The behavioral movement includes four major areas of development: classical conditioning, operant conditioning, social learning theory, and increasing attention to the cognitive factors influencing behavior (see Chapter 10). A unique characteristic of behavior therapy is its strict reliance on the principles of the scientific method. Concepts and procedures are stated explicitly, tested empirically, and revised continually. Treatment and assessment are interrelated and occur simultaneously. Research is considered to be a basic aspect of the approach, and therapeutic techniques are continually refined.

A cornerstone of behavior therapy is identifying specific goals at the outset of the therapeutic process. In helping clients achieve their goals, behavior therapists typically assume an active and directive role. Although the client generally determines *what* behavior will be changed, the therapist typically determines *how* this behavior can best be modified. In designing a treatment plan, behavior therapists employ techniques and procedures from a wide variety of therapeutic systems and apply them to the unique needs of each client.

Contemporary behavior therapy places emphasis on the interplay between the individual and the environment. Behavioral strategies can be used to attain both individual goals and societal goals. Because cognitive factors have a place in the practice of behavior therapy, techniques from this approach can be used to attain humanistic ends. It is clear that bridges can connect humanistic and behavioral therapies, especially with the current focus of attention on self-directed approaches and also with the incorporation of mindfulness and acceptance-based approaches into behavioral practice.

Contributions of Behavior Therapy

Behavior therapy challenges us to reconsider our global approach to counseling. Some may assume they know what a client means by the statement, "I feel unloved; life has no meaning." A humanist might nod in acceptance to such a statement, but the behaviorist will retort: "Who specifically do you feel is not loving you?" "What is going on in your life to make you think it has no meaning?" "What are some specific things you might be doing that contribute to the state you are in?" "What would you most like to change?" The specificity of the behavioral approaches helps clients translate unclear goals into concrete plans of action, and it helps both the counselor and the client to keep these plans clearly in focus. Ledley and colleagues (2005) state that therapists can help clients to learn about the contingencies that maintain their problematic thoughts and behaviors and then teach them ways to make the changes they want. Techniques such as role playing, behavioral rehearsal, coaching, guided practice, modeling, feedback, learning by successive approximations, mindfulness skills, and homework assignments can be included in any therapist's repertoire, regardless of theoretical orientation.

An advantage behavior therapists have is the wide variety of specific behavioral techniques at their disposal. Because behavior therapy stresses *doing,* as opposed to merely talking about problems and gathering insights, practitioners use many behavioral strategies to assist clients in formulating a plan of action for changing behavior. The basic therapeutic conditions stressed by person-centered therapists—active listening, accurate empathy, positive regard, genuineness, respect, and immediacy—need to be integrated in a behavioral framework.

Behavioral techniques have been extended to more areas of human functioning than have any of the other therapeutic approaches (Kazdin, 2001). Behavior therapy is deeply enmeshed in medicine, geriatrics, pediatrics, rehabilitation programs, and stress management. This approach has made significant contributions to health psychology, especially in helping people maintain a healthy lifestyle.

A major contribution of behavior therapy is its emphasis on research into and assessment of treatment outcomes. It is up to practitioners to demonstrate that therapy is working. If progress is not being made, therapists look carefully at the original analysis and treatment plan. Of all the therapies presented in this book, this approach and its techniques have been subjected to the most empirical research. Behavioral practitioners are put to the test of identifying specific interventions that have been demonstrated to be effective. For example, with respect to some of the newer forms of behavior therapy, a review of outcome research showed empirical support for these forms of integrative therapies: dialectical behavior therapy, acceptance and commitment therapy, mindfulness-based cognitive therapy, and EMDR (Schottenbauer, Glass, & Arnkoff, 2005).

Behavior therapists use empirically tested techniques, assuring that clients are receiving both effective and relatively brief treatment. Behavioral interventions have been subjected to more rigorous evaluation than those of any other forms of psychological treatment (Wilson, 2008). Evidence-based therapies (EBT) are a hallmark of both behavior therapy and cognitive behavior therapy. Lazarus (2006) states that multimodal therapists are comfortable with the call for evidence-based

treatments, and Cummings (2002) believes evidence-based therapies will be mandatory for third-party reimbursement in the future: "EBT's are defensible both legally and morally. The court often looks to research studies to find its answers. This emphasis on the use of empirically tested procedures fits well with the requirements of managed care mental health programs. Restricting payments to EBT's would reduce much of what managed care regards as run-away, questionable or needlessly long-term psychotherapy" (p. 4).

To their credit, behavior therapists are willing to examine the effectiveness of their procedures in terms of the generalizability, meaningfulness, and durability of change. Most studies show that behavior therapy methods are more effective than no treatment. Moreover, a number of behavioral procedures are currently the best treatment strategies available for a range of specific problems. There has been considerable research done in the areas of generalized anxiety disorders, depression, obsessive-compulsive disorders, panic disorder, and phobias. Compared with alternative approaches, behavioral techniques have generally been shown to be at least as effective and frequently more effective in changing target behaviors (Kazdin, 2001; Spiegler & Guevremont, 2003).

A strength of the multimodal approach is its brevity. Comprehensive brief therapy involves correcting faulty beliefs, problematic behaviors, unpleasant feelings, bothersome images, stressful relationships, negative sensations, and possible biochemical imbalances. Multimodal therapists believe that the more clients learn in therapy the less likely it is that old problems will reoccur. They view enduring change as a function of combined strategies and modalities.

Another strength of the behavioral approaches is the emphasis on ethical accountability. Behavior therapy is ethically neutral in that it does not dictate whose behavior or what behavior should be changed. At least in cases of voluntary counseling, the behavioral practitioner only specifies *how* to change those behaviors the client targets for change. Clients have a good deal of control and freedom in deciding *what* the goals of therapy will be.

Behavior therapists address ethical issues by stating that therapy is basically an education process (Tanaka-Matsumi et al., 2002). At the outset of behavior therapy clients learn about the nature of counseling, the procedures that may be employed, and the benefits and risks. Clients are given information about the specific therapy procedures appropriate for their particular problems. An essential feature of behavior therapy involves the collaboration between therapist and client. Not only do clients decide on the therapy goals, but they also participate in the choice of techniques that will be used in dealing with their problems. With this information clients become informed, fully enfranchised partners in the therapeutic venture.

Limitations and Criticisms of Behavior Therapy

Behavior therapy has been criticized for a variety of reasons. Let's examine five common criticisms and misconceptions people often have about behavior therapy, together with my reactions.

1. *Behavior therapy may change behaviors, but it does not change feelings.* Some critics argue that feelings must change before behavior can change. Behavioral practitioners hold that empirical evidence has not shown that feelings must be

changed first, and behavioral clinicians do in actual practice deal with feelings as an overall part of the treatment process. A general criticism of both the behavioral and the cognitive approaches is that clients are not encouraged to experience their emotions. In concentrating on how clients are behaving or thinking, some behavior therapists tend to play down the working through of emotional issues. Generally, I favor initially focusing on what clients are feeling and then working with the behavioral and cognitive dimensions.

2. *Behavior therapy ignores the important relational factors in therapy.* The charge is often made that the importance of the relationship between client and therapist is discounted in behavior therapy. Although behavior therapists do not place primary weight on the relationship variable, they do acknowledge that a good working relationship with clients is a basic foundation necessary for the effective use of techniques. They work on establishing rapport with their clients, and Lazarus (1996b) states, "The relationship is the soil that enables the techniques to take root" (p. 61).
3. *Behavior therapy does not provide insight.* If this assertion is indeed true, behavior therapists would probably respond that insight is not a necessary requisite for behavior change. A change in behavior often leads to a change in understanding or to insight, and often it leads to emotional changes.
4. *Behavior therapy treats symptoms rather than causes.* The psychoanalytic assumption is that early traumatic events are at the root of present dysfunction. Behavior therapists may acknowledge that deviant responses have historical origins, but they contend that history is seldom important in the maintenance of current problems. However, behavior therapists emphasize changing current environmental circumstances to change behavior.

Related to this criticism is the notion that, unless historical causes of present behavior are therapeutically explored, new symptoms will soon take the place of those that were "cured." Behaviorists rebut this assertion on both theoretical and empirical grounds. They contend that behavior therapy directly changes the maintaining conditions, which are the causes of problem behaviors (symptoms). Furthermore, they assert that there is no empirical evidence that symptom substitution occurs after behavior therapy has successfully eliminated unwanted behavior because they have changed the conditions that give rise to those behaviors (Kazdin & Wilson, 1978; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Spiegler & Guevremont, 2003).

5. *Behavior therapy involves control and manipulation by the therapist.* All therapists have a power relationship with the client and thus have control. Behavior therapists are just clearer with their clients about this role (Miltenberger, 2008). Kazdin (2001) believes no issues of control and manipulation are associated with behavioral strategies that are not also raised by other therapeutic approaches. Kazdin maintains that behavior therapy does not embrace particular goals or argue for a particular lifestyle, nor does it have an agenda for changing society.

Surely, in all therapeutic approaches there is control by the therapist, who hopes to change behavior in some way. This does not mean, however, that clients are helpless victims at the mercy of the whims and values of the therapist. Contemporary behavior therapists employ techniques aimed at increased

self-direction and self-modification, which are skills clients actually learn in the therapy process.

Where to Go From Here

In the *CD-ROM for Integrative Counseling,* Session 8 ("Behavioral Focus in Counseling"), I demonstrate a behavioral way to assist Ruth in developing an exercise program. It is crucial that Ruth makes her own decisions about specific behavioral goals she wants to pursue. This applies to my attempts to work with her in developing methods of relaxation, increasing her self-efficacy, and designing an exercise plan.

Because the literature in this field is so extensive and diverse, it is not possible in one brief survey chapter to present a comprehensive, in-depth discussion of behavioral techniques. I hope you will be challenged to examine any misconceptions you may hold about behavior therapy and be stimulated to do some further reading of selected sources.

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If you have an interest in further training in behavior therapy, the Association for Behavioral and Cognitive Therapies (ABCT) is an excellent resource. ABCT (formerly AABT) is a membership organization of more than 4,500 mental health professionals and students who are interested in behavior therapy, cognitive behavior therapy, behavioral assessment, and applied behavioral analysis. Full and associate memberships are $199 and include one journal subscription (to either *Behavior Therapy* or *Cognitive and Behavioral Practice*), and a subscription to the *Behavior Therapist* (a newsletter with feature articles, training updates, and association news). Membership also includes reduced registration and continuing education course fees for ABCT's annual convention held in November, which features workshops, master clinician programs, symposia, and other educational presentations. Student memberships are $49. Members receive discounts on all ABCT publications, some of which are:

- *Directory of Graduate Training in Behavior Therapy and Experimental-Clinical Psychology* is an excellent source for students and job seekers who want information on programs with an emphasis on behavioral training.
- *Directory of Psychology Internships: Programs Offering Behavioral Training* describes training programs having a behavioral component.
- *Behavior Therapy* is an international quarterly journal focusing on original experimental and clinical research, theory, and practice.
- *Cognitive and Behavioral Practice* is a quarterly journal that features clinically oriented articles.

Recommended Supplementary Readings

Contemporary Behavior Therapy (Spiegler & Guevremont, 2003) is a comprehensive and up-to-date treatment of basic principles and applications of the behavior therapies, as well as a fine discussion of ethical issues. Specific chapters deal with procedures that can be usefully applied to a range of client populations: behavioral assessment, modeling therapy, systematic desensitization, exposure therapies, cognitive restructuring, and cognitive coping skills.

Interviewing and Change Strategies for Helpers: Fundamental Skills and Cognitive Behavioral Interventions (Cormier, Nurius, & Osborn, 2009) is a comprehensive and clearly written textbook dealing with training experiences and skill development. Its excellent documentation offers practitioners a wealth of material on a variety of topics, such as assessment procedures, selection of goals, development of appropriate treatment programs, and methods of evaluating outcomes.

Cognitive Behavior Therapy: Applying Empirically Supported Techniques in Your Practice (O'Donohue, Fisher, & Hayes, 2003) is a useful collection of short chapters describing empirically supported techniques for working with a wide range of presenting problems.

Behavior Modification: Principles and Procedures (Miltenberger, 2008) is an excellent resource for learning more about basic principles such as reinforcement, extinction, punishment, and procedures to establish new behavior.

Behavior Modification in Applied Settings (Kazdin, 2001) offers a contemporary look at behavior modification principles that are derived from operant conditioning and describes how techniques can be applied in clinical, home, school, and work settings.

Self-Directed Behavior: Self-Modification for Personal Adjustment (Watson & Tharp, 2007) provides readers with specific steps for carrying out self-modification programs. The authors deal with selecting a goal, developing a plan, keeping progress notes, and recognizing and coping with obstacles to following through with a self-directed program.

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