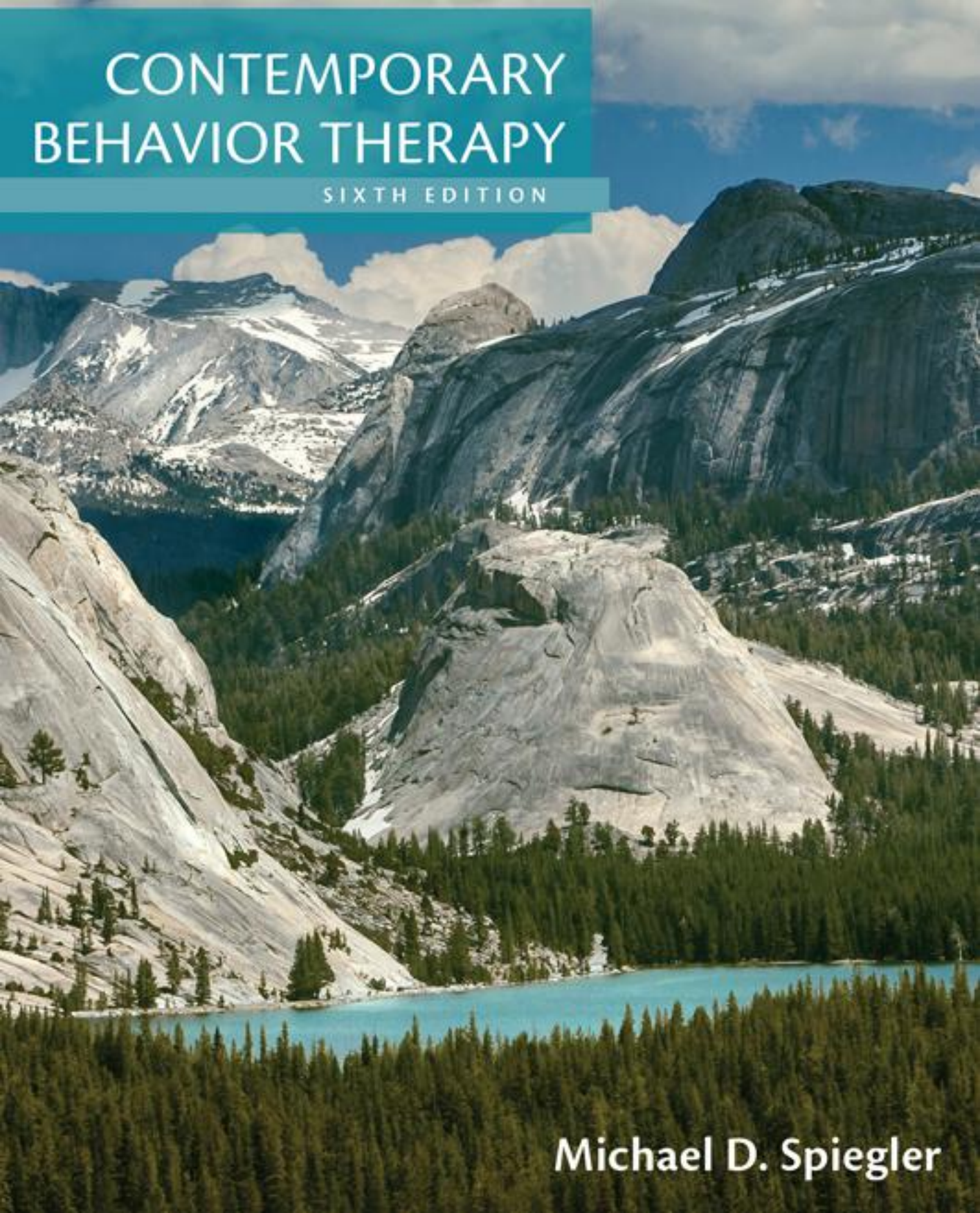
CONTEMPORARY BEHAVIOR THERAPY

SIXTH EDITION



Michael D. Spiegler

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Providence College

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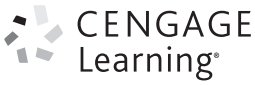

Contemporary Behavior Therapy,
Sixth Edition
Michael D. Spiegler

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To my brother and sister

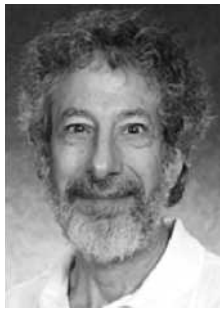
Rick McEwan

my best friend who continues to cover me in many ways, both on and off belay

Myrna Lamb

my dear friend who knew me on levels I could not fathom who has gone void, of course and so cannot read this— but knowing Myrna, I bet she is appreciating yet another tribute to the extraordinary human being she was

About the Author



Michael D. Spiegler (Ph.D., clinical psychology, Vanderbilt University) is professor of psychology at Providence College and was formerly director of the Community Training Center at the Palo Alto VA Hospital and assistant professor of psychology at the University of Texas at Austin. His contributions to behavior therapy include the development of the first skills training program for the treatment of schizophrenia and his pioneering work in film modeling therapy for phobias. His other areas of research include observational learning, anxiety, the treatment of obesity, and active learning. Professor Spiegler is coauthor of *Personality: Strategies and Issues* and *The Community Training Center,* and he is coeditor of *Contemporary Psychotherapies for a Diverse World*. He regularly presents workshops and courses on college textbook writing and is on the governing board of the Text and Academic Authors Association. His nonprofessional passions include his wife and family, flying his Skycatcher, listening to early music, and being in the mountains (especially in those on this book's cover).

Preface

Thank you for reading this preface. Few people read prefaces, so I want to immediately reinforce your extraordinary behavior by answering one of the questions you may be curious about: How is this book different from other behavior therapy textbooks? *Contemporary Behavior Therapy* is simultaneously an introduction for beginning students and a comprehensive, scholarly review and resource for advanced students and professionals. To make this a "teaching book"—one from which students can easily learn—I have written in a casual, inviting style and have employed many pedagogical features, including:

- *Unifying principles and themes* that are initially presented in brief introductory chapters and then illustrated throughout the book
- *A consistent behavioral perspective*, including the use of behavioral principles—such as prompting, shaping, reinforcement, modeling, and behavior rehearsal—to teach behavioral principles and procedures, and the use of behavioral (rather than trait) descriptions of clients' problems
- *Unique conceptual schemes* that organize the currently diverse field of behavior therapy
- *Numerous cases* that are integrated into the text and provide rich detail about the application of behavior therapy to a wide array of disorders
- *Participation Exercises* that provide students with hands-on experience with behavior therapy principles and procedures to promote active learning and that include two new features: greater integration with the text and immediate feedback for those exercises that have answers
- *Broad Strokes* is a new feature that covers concepts related to a number of behavior therapies, such as the use of treatment manuals and the proliferation of the application of acceptance and mindfulness in a number of behavior therapies
- *Many illustrations*—including photographs and cartoons that are functional rather than decorative—present content that is most readily grasped visually
- *Integration of clinical, research, professional, and ethical facets* of behavior therapy to illustrate how they are interwoven in practice

Contemporary Behavior Therapy has been written for readers in a variety of disciplines, and applications and examples are drawn from diverse fields. Readers need no previous background because all of the basic concepts are presented in Chapters 3 and 4. Theoretical, methodological, and professional issues in behavior therapy are set off as In Theory features so that they can be omitted in courses in which their content is not germane.

What makes this book a scholarly review of behavior therapy is its comprehensiveness and critical evaluation. All of the major behavior therapy procedures are discussed, and the latest research findings are presented, synthesized, and

critically evaluated. I have conducted an extensive literature review of more than 3,000 articles, books, and chapters published from 2010 to the spring of 2014, and, of the roughly 2,700 references cited in the book, almost 600 are new.

Since the publication of the previous edition of *Contemporary Behavior Therapy* in 2010, the field of behavior therapy has burgeoned, and the sixth edition of this text has been expanded accordingly. Here is a sampling of what's new to the sixth edition.

- A separate chapter (Chapter 5) is now devoted to behavior therapy research. This chapter includes new discussions of treatment manuals and standards for evidence-based treatment as well as expanded discussion of clinical versus statistical significance and outcome variables.
- Coverage occurs throughout the book of transdiagnostic (unified protocol) behavior therapies, the use of behavioral intervention technology to implement and facilitate many different behavior therapies, and the application of behavior therapy to diverse populations.
- Expanded coverage is given to behavioral activation, functional analytic psychotherapy, and group reinforcement contingencies (Chapter 7); differential reinforcement (Chapter 8); behavioral parent training (Chapter 9); recent developments in virtual reality exposure therapy (Chapter 10); cognitive processing therapy and cognitive therapy for hallucinations and delusions (Chapter 13); and relapse prevention for diverse problems, problem-solving therapy, cognitive-behavioral couple therapy, and prevention of couple relationship problems (Chapter 14).
- Expanded discussion is now provided of relational frame theory and the critical evaluation of acceptance/mindfulness-based behavior therapies (Chapter 15).
- New sections have been added on the crucial issues of dissemination and implementation of evidence-based behavior therapies and the future of behavior therapy (Chapter 18).

As in previous editions, *Contemporary Behavior Therapy* is divided into three parts. Part One presents the fundamental principles of behavior therapy, which are repeatedly illustrated and drawn on in subsequent chapters. Part Two covers all the major behavior therapy procedures used today. Part Three illustrates broader applications of behavior therapy principles and procedures to behavioral medicine and psychological disorders with primary physical characteristics and then presents a final evaluation of and commentary on the present status and future of behavior therapy.

I have written the sixth edition of *Contemporary Behavior Therapy* as a teacher, researcher, and clinician. As a teacher, I have incorporated many pedagogical practices to facilitate learning, including stressing general principles, actively engaging students in learning about behavior therapy, and providing numerous examples and everyday illustrations to which students can relate. As a researcher, I appreciate the importance of empirically validating treatment procedures. Thus, not only have I presented the evidence for the efficacy and effectiveness of behavior therapy procedures by describing numerous studies, but I have also critically evaluated them and discussed their limitations. As a clinician, I find the practice of behavior therapy to be challenging, stimulating, and reinforcing; I have striven to impart that in my writing in the hope of inspiring future behavior therapists.

ACKNOWLEDGMENTS

I wish to express my appreciation to the many people who facilitated the writing of this book and whose contributions enhanced the final product.

I am grateful to Jon-David Hague, my editor, for believing in the book and his behind-the-scenes shepherding of it from start to finish, and to his editorial assistant, Nicole Richards, who always was available to help make things happen.

Over the course of my writing books, I have worked with a dozen and a half copyeditors, including some excellent ones, but Sarah Wales-McGrath tops them all. She clarified my writing (which I thought was clear to begin with!), found errors and inconsistencies, made valuable suggestions, and made the copyediting phase a delight. Thank you Sarah.

I would have had to become a client in behavior therapy to weather the many problems that arose in the production of this book had it not been for the able assistance and caring of Ruth Sakata Corley, my Senior Content Project Manager. Thank you Ruth for being there for me.

Vernon Boes, the Cengage Art Director, is responsible for the excellent design of the book. Vernon is my longtime colleague at Cengage (we first worked together 25 years ago at Brooks-Cole—if you are old enough to remember that imprint). Besides his expertise in the details and esthetics of books design, Vernon is very attentive to the impact the design has on textbook pedagogy, which is important to me. And he patiently went through multiple iterations of the design until we were both pleased with it. Thanks Vernon.

Once again, Rick McEwan provided one of his many stunning photographs for the cover. And this one, an inspiring view of Tenya Lake and the high country of Yosemite from Olmsted Point, has special meaning for me, one that Rick and I share. Thank you Rick.

Victoria Sanborn, my research assistant, performed many tasks that facilitated my writing, including doing most of the work for the large name index. Thank you for all that, Victoria, as well as for your dedication.

I am grateful to my colleague–friends whose knowledge and clear thinking provided me with valuable feedback and advice about how to present complex concepts both simply and accurately: Chris Bloom, Tom Guilmette, Mary O'Keeffe, and George Raymond.

In the spirit of genuine professional collegiality, Dave Barlow, Jonathan Kanter, Alan Kazdin, and Mike Twohig, who are experts in various areas of the field, willingly engaged in email exchanges with me to clarify issues. And many behavior therapists, too numerous to name, promptly responded to my requests for copies of their research. Thanks to all of you.

Yanwei Hu, who, in the course of translating the fifth edition of *Contemporary Behavior Therapy* into Chinese, raised perceptive questions about the accuracy and clarity of some of what I had previously written, which I have made use of in writing this edition. Thank you Yanwei.

I am grateful to Annmarie Mullen, the consummate secretary, who provided assistance in so many ways, as she always does; Diane Wilkes-Smith my Word wizard, who found time-saving shortcuts and solutions to my problems as I wrote; and Brian Marinelli and Will Toner for answering my questions on writing.

For graciously accepting the priority of "the book" for a protracted period, I am most appreciative of and for my family. The joy and nachas I constantly receive from my granddaughter, Amelia Fink, were a source of balance during frenetic periods. Writing this book, and all I do, is partially maintained by the modeling and reinforcement provided by the two people who picked me up from the hospital steps (or at least that's how they explained it to me): my loving and devoted parents, Lillian and Julie Spiegler. And most important, I am grateful, always and forever, for my wife Arlene's total support, understanding, and love as well as "stending" me during the writing of this book.

Michael D. Spiegler

Contents

Case, Participation Exercise, In Theory, and Broad Strokes Features

CASES

PARTICIPATION EXERCISES

IN THEORY FEATURES

BROAD STROKES FEATURES

A Note to Readers

As you journey through this book, you should be aware of several topographical features that will help you learn about behavior therapy and make your reading easier.

- Each chapter begins with an outline of its contents, and I suggest you look it over before starting to read so that you'll have an idea of where you are going.
- References are designated by superscript numbers that correspond to reference notes at the end of each chapter. I've done this to spare you having to jump over APA-style parenthetical references in the text.
- All major behavior therapy terms are printed in **boldface** at the point where they are first formally defined. These terms also are succinctly defined in a comprehensive Glossary of Behavior Therapy Terms at the back of the book.
- Should you be unfamiliar with some of the psychological disorders and problems discussed, there also is a Glossary of Psychological Disorders and Problems at the back of the book.

Four special features are set off from—but integrated with—the main text.

- *Cases* present detailed accounts of behavior therapy in action. The Cases are a continuous part of the text discussion, so you should read them as you come to them and then continue with the main text that follows the Case.
- *Participation Exercises* will give you hands-on experience with behavior therapy principles and procedures. I've written instructions in the text for when to read and complete each Participation Exercise. For those Participation Exercises that have answers, you'll find them at the end of the chapter following the summary. Some of the Participation Exercises require work sheets, which you will find in the Student Resource Manual as well as additional resources to help you learn and study. You can access the Student Resource Manual through Cengagebrain.com. Search for "Spiegler" and then click the following, in order: "Contemporary Behavior Therapy, 6th edition" (be sure it is the sixth edition), "Free Materials" (at bottom), "Access Now" (bottom right), "Student Resource Materials," and finally the "Media" icon. (Note: Specific locations of links on the page may change.)
- *In Theory* features describe theoretical, methodological, and professional issues related to behavior therapy.
- *Broad Strokes* features discuss overarching concepts that relate to a number of behavior therapies.

Finally, tables and figures supplement and complement the text by providing important information and ideas that are most usefully presented in these formats (rather than prose). So look at them carefully when they are referred to in the text. Similarly, spending a moment with photos and cartoons will help you learn and remember the material—that's why I put them there.

In writing the sixth edition of *Contemporary Behavior Therapy*, I have incorporated suggestions from students who have read previous editions. I'd welcome your comments and suggestions. Please write me at spiegler@providence.edu; I promise to respond.

I hope you enjoy reading and learning about behavior therapy—I sure did in the course of writing your textbook.

PART ONE

BASIC PRINCIPLES

Imagine that you are about to enjoy a delicious three-course dinner. Consider each of the three parts of this book as one of the courses. Part One presents the appetizers: the ideas that will prepare your palate for the rest of the dinner. You'll begin with an overview of the field of behavior therapy in Chapter 1, followed in Chapter 2 by a look at the historic events that shaped contemporary behavior therapy. Chapter 3 introduces the behavioral model, the principles that underlie behavior therapy. Chapter 4 explains how the behavioral model is applied to behavior therapy and describes the basic processes involved in implementing behavior therapy. Chapter 5 discusses behavior therapy research. Finally, Chapter 6 describes behavioral assessment, the basic methods behavior therapists use to gather information about clients' problems and measure their progress in therapy.

The first course is about to be served. Bon appétit.

CHAPTER 1

Behavior Therapy:
Introduction

Opening a textbook for the first time is like walking into a psychotherapist's office for the initial visit. Both students and clients arrive with general expectations about what is going to happen. Students assume the author will teach them, just as new clients in psychotherapy expect the therapist will help them with their problems.

Being taught and being helped are all too often passive processes. As a teacher and behavior therapist, I believe that for education and psychotherapy to be most effective, students and clients must actively participate in the process. In behavior therapy, clients are involved in choosing and implementing therapy procedures. In education, students learn best when they are actively engaged. Accordingly, I have written this book in ways that promote active learning.

One way you will actively learn about behavior therapy is through Participation Exercises that provide hands-on experience with the ideas, concepts, and procedures used in behavior therapy. Some Participation Exercises take a very brief time to complete, and you should do them when you come to them in a chapter because they elucidate what you are reading about. Others require a bit more time; it is best to do them before continuing your reading, but you can do them later. Finally, some exercises are more extensive and must be done after you read the chapter; I'll tell you when it would be optimal to complete each Participation Exercise. The first Participation Exercise is one you should complete before you continue reading. It will take just a couple of minutes.

PARTICIPATION EXERCISE 1-1

What Do You Know About Behavior Therapy?

You have no doubt heard about behavior therapy. How accurate is your picture of behavior therapy? This exercise can help answer that question. Read each of the following statements and write down whether you think it is primarily true or primarily false.

1. Behavior therapy is the application of well-established laws of learning.
2. Behavior therapy directly changes symptoms of a disorder.
3. A trusting relationship between client and therapist is not necessary for behavior therapy to be effective.
4. Behavior therapy does not deal with problems of feelings, such as depression and anger.
5. Generally, little verbal interchange takes place between the therapist and client in behavior therapy.
6. The client's cooperation is not necessary for behavior therapy to be successful.
7. Most clients in behavior therapy are treated in fewer than five sessions.
8. Behavior therapy is not applicable to changing mental processes such as thoughts and beliefs.
9. Positive reinforcement works better with children than with adults.
10. Many behavior therapy procedures use painful or aversive treatments.
11. Behavior therapy primarily deals with relatively simple problems, such as phobias (for example, fear of snakes) or undesirable habits (for instance, fingernail biting).

(*continued*)

PARTICIPATION EXERCISE 1-1 (*continued*)

12. Goals for therapy are established by the therapist.
13. The therapist primarily is responsible for the success of therapy.
14. Because behavior therapy treats the symptoms of a disorder and not its underlying cause, once the symptoms are removed, others will develop because the cause of the symptoms has not been treated.

You may have recognized that many of the statements are false. In fact, all of them are predominantly false. They are all myths or misconceptions about behavior therapy, and you will learn why as you read.

TERMINOLOGY AND SCOPE

Behavior therapy also is called *behavior modification* and *cognitive-behavioral therapy* (or *cognitive-behavior therapy*). Behavior therapists occasionally distinguish among the terms, but the distinctions are not standard.[1] *Behavior modification* originally referred to procedures that change the consequences of behaviors (such as reinforcement) and the stimulus conditions that elicit behaviors (such as environmental cues). However, *behavior modification* sometimes has been used as a generic term to refer to *any* procedure that modifies behaviors, including some rather radical procedures ranging from lobotomies to wilderness survival courses,[2] which are unrelated to behavior therapy. The term **cognitive-behavioral** (or **cognitive-behavior**) **therapy** originally referred to treatments that change cognitions (such as thoughts and beliefs) that are influencing psychological problems. Today, *cognitive-behavioral therapy* more broadly refers to therapies that involve both cognitive and overt behavioral interventions or what might be called *traditional behavior therapy.*[3] *Behavior therapy* is the broadest and "purest" term,[4] and I will use it to refer to the entire field of therapy you will be learning about.

The major goal of behavior therapy is to help clients with psychological problems, a goal it shares with other forms of psychotherapy. Examples of psychological problems include anxiety, depression, interpersonal difficulties, sexual dysfunction, stress-related problems, and odd behaviors (such as hearing voices). Psychological problems are personally maladaptive, are generally distressing to clients, may violate social norms, and may be disturbing to other people (for example, parents may be troubled by their child's aggressive acts). Such problems are often referred to as *mental illness, emotional disturbance, psychopathology,* and *abnormal behavior*, each of which has a particular connotation. In this book, I use more neutral terms: *psychological problem, psychological/psychiatric disorder, problem behavior,* and *problem.*

In addition to treating psychological disorders, the principles and procedures of behavior therapy have been harnessed for a variety of purposes, including to improve everyday functioning, such as work productivity and child rearing;[5] to deal with societal problems, such as safety hazards and recycling;[6] to enhance athletic performance;[7] to reduce perfectionism in graduate students;[8] and to prevent and treat the physical and psychological effects of medical disorders.[9]

WHAT IS BEHAVIOR THERAPY?

If the statements in Participation Exercise 1-1 reveal something of what behavior therapy is *not,* then just what is behavior therapy? Unfortunately, no single, agreed-upon definition exists.[10] Behavior therapy is both diverse and evolving, so it is difficult to define concisely.

DEFINING THEMES OF BEHAVIOR THERAPY

Instead of a general definition, I propose four defining themes that are at the core of behavior therapy: scientific, active, present focus, and learning focus.[11] These themes are interrelated and overlap in their influence on the practice of behavior therapy.

Scientific

The essence of behavior therapy is a commitment to a scientific approach that involves *precision* and *empirical evaluation*.[12] All aspects of behavior therapy are defined precisely, including the behaviors targeted for change, treatment goals, and assessment and therapy procedures. Treatment protocols that spell out the details of particular therapy procedures have been developed for a number of behavior therapies.[13] Using such protocols enables therapists to employ the same procedures that have already proven efficacious. As another example of precision, clients' progress is monitored before, during, and after therapy using *quantitative* measurements of the behaviors to be changed.

Conclusions about the effectiveness of behavior therapies are based on the results of empirical research[14] rather than the subjective judgments of therapists or testimonials from satisfied clients.[15] This standard, which behavior therapists have always used, has been highlighted in recent years with the advent of managed care. Managed-care companies are willing to pay only for psychotherapy that has a track record of success with the client's identified psychiatric disorder, and many behavior therapies are on their list of preferred treatments because they are empirically supported.

Active

In behavior therapy, clients engage in specific actions to alleviate their problems. In other words, clients *do* something about their difficulties, rather than just talk about them. Behavior therapy is an *action therapy,* in contrast to a *verbal therapy* (such as psychoanalysis or client-centered therapy). In verbal psychotherapies, the dialogue and relationship between the client and therapist is the major mode through which therapy techniques are implemented. In action therapies, conversations between the client and therapist are predominantly for exchanging information. The therapy itself primarily consists of tasks the client engages in. In therapy sessions, examples would be role-playing problem situations, rehearsing coping skills, and imaging anxiety-evoking situations while actively countering the anxiety with muscle relaxation. Examples of what clients do outside of therapy sessions include monitoring their problem behaviors during the course of their daily activities and practicing applying coping skills.

Specific therapeutic tasks clients perform in their everyday environments, called **homework assignments**, are an integral part of behavior therapy,[16] and compliance with homework often is associated with better outcomes.[17] The logic

for implementing treatment in the client's natural environments is simple: The client's problem is treated where it is occurring, which is in the client's everyday life. "Taking therapy home" makes it more likely that the changes that occur during therapy will transfer to the client's life and continue after therapy has ended.[18] For instance, in the treatment of antisocial behaviors, children and adolescents are taught problem-solving skills in therapy sessions; but the crucial part of the treatment occurs when the clients practice these skills at home.[19] For instance, school interventions that are coordinated with treatment in therapy sessions have proved beneficial for such diverse problems as attention disorders,[20] adolescent depression,[21] disruptive behaviors,[22] bullying,[23] and obesity.[24]

Homework contributes to the efficiency of behavior therapies because it reduces the number of therapy sessions and therapist's time, and it shortens the overall length of treatment. On the down side, clients may consider homework to be onerous, both because of the time required, which can be considerable, and negative associations with homework in school, which may be a reason for calling out-of-session assignments something else, such as "real-life practice." A study titled "No Pain, No Gain: Depressed Clients' Experiences of Cognitive Behavioural Therapy" revealed that clients identified homework as a big challenge.[25]

The term **in vivo** (Latin for "in life") is used to designate therapy procedures that are implemented in the client's natural environment. In vivo therapy can be implemented in one of three ways. First, the therapist may work directly with the client in the client's natural environment. This approach is costly in terms of therapists' time and is therefore used only occasionally. Second, the therapist can train people in the client's life (such as parents, spouses, and teachers) to assist in the treatment, as by administering reinforcers.[26] Third, clients can serve as their own change agents by carrying out therapy procedures on their own with therapist instructions and monitoring.[27] Thus, those responsible for implementing treatment include not only behavior therapists but also other people who serve as *change agents*, including relatives, friends, teachers, and—most important—clients themselves.

Clients' serving as their own change agents illustrates the **self-control approach** commonly used in behavior therapy.[28] Examples of specific behavior therapies that involve self-control are self-monitoring (Chapter 17), self-reinforcement (Chapter 7), and self-instructional training (Chapter 14). Self-control skills are necessary for independent daily functioning, which is why they are target behaviors for people with developmental disabilities.[29]

Self-control approaches have three important advantages. First, being responsible for changes in one's life is personally empowering.[30] Second, clients who are instrumental in changing their own behaviors are more likely to maintain the change. Third, clients who become skilled in dealing with their problems may be able to cope with future problems on their own,[31] which makes a self-control approach cost effective in the long run.

Present Focus

The focus of behavior therapy is in the present. Behavior therapists assume that clients' problems, which occur in the present, are influenced by current conditions. Accordingly, behavioral assessment focuses on the client's current, rather than past, circumstances to find the factors responsible for the client's problems. Then

behavior therapy procedures are employed to change the current factors that are affecting the client's behaviors. This emphasis contrasts with other types of psychotherapy, such as psychoanalytic therapy, which assume that the major influences on clients' problems reside in the past.

Learning Focus

An emphasis on learning is a final theme that defines behavior therapy and distinguishes it from other types of psychotherapy. Learning is important in three different respects. First, the behavioral model holds that many problem behaviors develop, are maintained, and change primarily through learning. Behavior therapists do not believe that *all* behaviors are primarily a function of learning because some behaviors are strongly influenced by heredity and biology. Nonetheless, virtually all behaviors are affected by learning, even if they have biological components.

Second, behavior therapy provides clients with learning experiences in which new (adaptive) behaviors replace old (maladaptive) behaviors. Thus, there is a strong *educational* component in behavior therapy, and behavior therapists often serve as teachers.

Third, the development of some behavior therapies was influenced by basic learning principles, and theories of learning (such as classical and operant conditioning) often are used to explain why behavior therapy procedures work.

COMMON CHARACTERISTICS OF BEHAVIOR THERAPY

In addition to the defining themes in behavior therapy just described, four common characteristics of behavior therapy help distinguish it from other forms of psychotherapy: individualized therapy, stepwise progression, treatment packages, and brevity.

Individualized Therapy

In behavior therapy, standard therapy and assessment procedures are tailored to each client's unique problem, the specific circumstances in which the problem occurs, and the client's personal characteristics.[32] For instance, reinforcement is used to get clients of all ages to engage in adaptive behaviors. However, the specific reinforcer is likely to vary with the client's age as well as a host of other demographic factors, including cultural identification. For example, cream cheese might be a reinforcer for a Jewish-American 3-year-old girl while kimchi—a spicy Korean cabbage dish—might be a reinforcer for a Korean-American girl of the same age.

Stepwise Progression

Behavior therapy often proceeds in a stepwise progression, moving from simple to complex, from easier to harder, or from less threatening to more threatening. For example, a girl who was socially withdrawn was taught—through modeling and reinforcement—to interact with peers in steps: initially playing by herself in the presence of peers, then playing with peers, and finally initiating play with peers. Similarly, a man who was afraid of heights was gradually exposed to higher elevations during treatment, beginning a few feet off the ground and eventually ending on top of a 10-story building.

Treatment Packages

Two or more behavior therapy procedures often are combined in a **treatment package** to increase the effectiveness of the therapy. This practice is analogous to the treatment of many medical problems, such as combining medication, diet, and exercise for cardiovascular disease.

There are two caveats about treatment packages. First, reasoning that more is better, one would expect that the combination of two or more effective treatments would be more beneficial than just one of the treatments. However, that is not always the case.[33] For example, exposure therapy for obsessive-compulsive disorder and social phobia is as effective as combining exposure therapy with cognitive-behavioral therapies, whereas cognitive-behavioral treatment packages are more effective than single treatments for other anxiety disorders.[34] Second, although treatment packages can be more effective than single treatments, combining therapies may lengthen treatment.[35]

Treatment packages are the norm in behavior therapy today. This is important to keep in mind as you begin to read about specific behavior therapies in Chapter 7. To facilitate your learning about behavior therapies, they will be introduced individually. Then, as you become familiar with specific therapies, increasingly you will read about treatment packages made up of the specific therapies.

Brevity

The duration of behavior therapy is relatively brief, generally involving fewer therapy sessions and often less overall time than many other types of therapy. This results, in part, from the use of homework assignments in particular and the self-control approach in general, but it is largely attributable to the potency of the treatments that target the critical factors that are causing the client's problems.

The length of therapy varies considerably with the problem being treated. Usually, the more complex and severe the problem, the longer is the treatment duration. For example, one survey revealed that the average number of hours required to treat specific phobias with behavior therapy was 13.4, compared with 46.4 for obsessive-compulsive disorder (a considerably more complex problem).[36] Treatment duration also varies with the particular behavior therapy used. In general, the majority of behavior therapies require between 8 and 20 therapy sessions,[37] which in relation to many other types of psychotherapies is quite brief.

THE THERAPIST–CLIENT RELATIONSHIP IN BEHAVIOR THERAPY

The relationship between the therapist and the client is important in all forms of psychotherapy,[38] and with some psychotherapies it is paramount. In behavior therapy, the relationship is considered *a necessary but not a sufficient condition* for successful treatment,[39] and the specific behavior therapy techniques are the primary source of treatment effectiveness.[40] Interestingly, clients in behavior therapy may attribute their improvement more to the therapist–client relationship than to the therapy procedures.[41] Nonetheless, from the behavior therapist's perspective, the therapist–client relationship is analogous to the role of anesthesia in surgery.

> Somebody goes . . . for surgery because there are certain procedures that need to be implemented. In order for these procedures to take place, the person must be under anesthesia; the anesthesia facilitates what is really

> important [that is, the surgical procedures]. However, if anything goes wrong with the anesthesia during the surgery, then that becomes the priority. Similarly . . . a good . . . [therapist–client relationship] is necessary and often crucial. Without it you just can't proceed.[42]

Thus, there is no question that the rapport between behavior therapists and their clients impacts the outcome of therapy.[43] In fact, in one study of the effects of the therapeutic relationship on treatment of chronic depression, cognitive-behavioral therapy and brief supportive psychotherapy were compared.[44] The supportive therapy was similar to client-centered therapy in which the therapist–client relationship is considered the primary factor that accounts for its effectiveness. Surprisingly, the therapeutic relationship was more strongly related to outcome with the cognitive-behavioral therapy.

In behavior therapy, the therapist–client relationship facilitates the implementation of specific therapy procedures in a variety of ways, including increasing the client's positive expectations and hope for success; encouraging the client to complete homework assignments that involve risk taking; overcoming obstacles that arise in therapy, including clients' not complying with the treatment; and increasing the potency of the therapist's praise and approval.[45]

Collaboration between the therapist and client is a hallmark of behavior therapy.[46] Behavior therapists share their expertise so that clients become knowledgeable partners in their therapy. Decisions about therapy goals and treatment procedures are made jointly. For instance, behavior therapists provide information about treatment options, describing what each of the appropriate therapies entails and the effectiveness of each (based on research findings). Clients then can decide on the type of treatment that is best suited to their needs and personal preferences.

MANY VARIATIONS OF BEHAVIOR THERAPY

Behavior therapy is not a single technique. There are many different forms of behavior therapy—in other words, many behavior therapies. These therapies are unified by the defining themes and common characteristics you read about earlier. The following examples illustrate the variety of behavior therapy procedures that exist; the chapters in which they are introduced appear in parentheses.

- *Positive reinforcement* (Chapter 7): A fifth-grade girl strongly disliked doing homework and was spending much less time on it than was required because she avoided doing it until shortly before her bedtime. The therapist suggested that her parents have her earn preferred evening activities by spending appropriate time on homework. The girl was allowed to play a favorite computer game, watch a video, have an evening snack, and chat with her grandma only after she had completed her homework.
- *Self-instructional training* (Chapter 14): In a predominantly Latino-American junior high school, students were required to speak English in class. However, many of the first-generation immigrant students often reverted to Spanish because they could express themselves better in their native tongue. They were taught to subvocally say, "Speak only English" to remind themselves each time they raised their hand to speak in class.

- *Modeling* and *behavior rehearsal* (Chapter 12): A woman was intimidated by her boss and consequently was unable to speak to him about problems at work. She learned to express her desires to her boss appropriately by observing her therapist demonstrate effective ways to tell superiors politely yet forcefully about dissatisfactions and personal preferences (modeling). The woman then practiced these behaviors—initially with her therapist and later with other people who were less threatening than her boss—before she attempted to speak with her boss (behavior reversal).
- *Response cost* (Chapter 8): A 7-year-old boy, who was big for his age, frequently bullied smaller children. To decrease the boy's bullying, his teacher instituted a rule specifying that he would miss recess or gym, his favorite school activities, each time he was caught fighting.
- *Stress inoculation training* (Chapter 14): A business executive drank excessively when he arrived home each evening after a frustrating day at the office. To help the man deal with his frustration, the therapist taught him appropriate coping skills, including self-instructions and problem solving. In therapy, the client role-played being in various frustrating situations and practiced applying the coping skills. Then he used the skills in his everyday life whenever he felt frustrated and had the urge to drink.
- *Extinction* and *differential reinforcement of other behaviors* (Chapter 8): On several occasions, a young mother had beaten her 3-year-old son when he had a temper tantrum. The more the mother tried to get her son to stop crying, the angrier she got; eventually, she hit the child. The mother was taught to ignore her son during a temper tantrum (extinction) and to reinforce him with attention when he began engaging in any other behavior (differential reinforcement of other behaviors). This treatment package was designed not only to reduce the frequency and duration of her son's temper tantrums but also to help the mother cope with her frustration and eliminate abusing her child.
- *Systematic desensitization* (Chapter 10): A college student was doing poorly in school because she panicked during examinations. To overcome her test anxiety, the student first was taught muscle relaxation. While relaxed, she visualized increasingly more anxiety-evoking situations (beginning with hearing the announcement that an exam would be given in 2 weeks and ending with being unable to answer an exam question). The objective was to substitute relaxation for the anxiety associated with test situations.
- *Token economy* and *shaping* (Chapters 9 and 7, respectively): A 36-year-old man who was hospitalized for the treatment of schizophrenia was extremely socially withdrawn. He was placed in a token economy program in which he earned tokens (poker chips) for engaging in increasing levels of social interaction. At first, he earned tokens for minimally interacting with others (for instance, asking a nurse for something he wanted) and later, he earned them for extended social interactions (for example, having a conversation with another patient while they worked on a project together) (shaping). The man could exchange the tokens he earned for a variety of reinforcers (such as having a snack and playing pool).
- *Cognitive-behavioral couple therapy* (Chapter 14): A gay couple who had been together for 11 years sought help because of their difficulty resolving conflicts, which arose frequently, and because they believed that they no longer loved each other. For dealing with conflicts, they were taught problem-solving

strategies that involved generating many potential solutions to disagreements and then evaluating them to select the optimal solution. For the couple's second complaint, the therapist instructed each partner to perform several behaviors each day that the other partner considered an indication of caring.

- *Cognitive restructuring* (Chapter 13): A college student avoided going to social functions (which he desperately wanted to do) because he was afraid that he was socially awkward. He learned to substitute positive, reassuring thoughts (such as, "I just need to be myself, and I will fit in") for his habitual negative, self-deprecating thoughts (such as, "I'm going to make a fool of myself"), which lowered his social anxiety and allowed him to attend social functions.
- *Acceptance and Commitment Therapy* (Chapter 15): A college student avoided going to social functions (which he desperately wanted to do) because he was afraid that he was socially awkward. He learned to accept and defuse (separate from) his habitual negative, self-deprecating thoughts (for example, "I'm going to make a fool of myself") by recognizing that they were just thoughts (in other words, "I am having the thought that I will make a fool of myself"), which allowed him to attend social functions while still having his critical thoughts and feeling anxious.

Even from the small sample of behavior therapy procedures just presented, it is clear that many diverse behavior therapies are used to treat a wide array of problems. Also, the same problem can be treated with very different behavioral strategies, as was illustrated in the last two examples in which the college student suffering from social anxiety could be treated by either cognitive restructuring or Acceptance and Commitment Therapy.

Why are there so many different behavior therapies? One advantage of having multiple treatments for the same general problem is that therapies vary in their suitability for specific problems, clients, and circumstances. Clients' preferences make a difference in the success of therapy because clients are more willing to engage in and persevere at a treatment that they believe will work.[47] Also, different therapies may target different aspects of the same problem. In treating anger in children, for example, one study showed that problem-solving therapy and social skills training were both successful in reducing aggression, conduct problems, and the frequency of anger expression.[48] However, problem-solving therapy was more effective in reducing hostile intentions in anger-provoking situations and developing adaptive ways of thinking about conflict situations; in contrast, social skills training was more effective in developing anger control skills. Thus, depending on the nature of a client's specific problem, one therapy might be more suitable than another.

ETHICAL ISSUES IN BEHAVIOR THERAPY

The two major potential ethical issues in behavior therapy are *depriving clients of their rights* and *harming clients*. Throughout the book, I will raise ethical questions in relevant contexts. As you read, be alert for instances where ethical issues could arise. In addition, consider the ways in which behavior therapy protects clients from ethical violations. For example, you have already read about the active role clients play in deciding on their treatment goals and the specific therapy procedures used to achieve them. This practice not only increases the chances

that the treatment will be successful because clients are actively involved in their therapy,[49] it also gives clients freedom of choice, which protects clients' rights.

Ethical violations occasionally occur in behavior therapy, and there are a small number of well-documented incidents. Most involved clients who had little or no power, especially institutionalized individuals such as prison inmates.[50] To help prevent such incidents, behavior therapists developed guidelines for the ethical practice of behavior therapy.[51] Table 1-1 presents examples of the questions that should be answered for each therapy case.

TABLE 1-1
Examples of Ethical Questions That Should Be Answered for Each Therapy Case

A. Have the goals of treatment been adequately considered?
   1. To ensure that the goals are explicit, are they written?
   2. Has the client's understanding of the goals been ensured by having the client restate them orally or in writing?
   3. Have the therapist and client agreed on the goals of therapy?
   4. Will serving the client's immediate interests be contrary to the client's long-term interest?

B. Has the choice of treatment methods been adequately considered?
   1. Does the published literature show the procedure to be the best one available for that problem?
   2. Has the client been told of alternative procedures that might be preferred by the client on the basis of significant differences in discomfort, treatment time, cost, or degree of demonstrated effectiveness?

C. Is the client's participation voluntary?
   1. Have possible sources of coercion on the client's participation been considered?
   2. If treatment is legally mandated, has the available range of treatments and therapists been offered?
   3. Can the client withdraw from treatment without a penalty or financial loss that exceeds actual clinical costs?

D. Has the adequacy of treatment been evaluated?
   1. Have quantitative measures of the problem and its progress been obtained?
   2. Have the measures of the problem and its progress been made available to the client during treatment?

E. Has the confidentiality of the treatment relationship been protected?
   1. Has the client been told who has access to the records?
   2. Are records available only to authorized persons?

F. Is the therapist qualified to provide treatment?
   1. Has the therapist had training or experience in treating problems like the client's?
   2. If deficits exist in the therapist's qualifications, has the client been informed?
   3. If the therapist is not adequately qualified, is the client referred to other therapists or has supervision by a qualified therapist been provided? Is the client informed of the supervisory relation?

Source: Adapted from *Ethical issues for human services*, 1977, pp. v-vi.

Finally, in considering ethical issues related to behavior therapy, bear in mind that the ethical issues that can potentially arise in behavior therapy are relevant to all types of psychotherapies.

PURPOSE OF THIS BOOK

The purpose of this book is to introduce you to contemporary behavior therapy. I'll first present its general principles and then illustrate how they are applied using different behavior therapies to treat clients' problems. Although this book is not intended to teach you to be a behavior therapist, you may be able to apply many of the principles and some of the procedures to deal with minor problems in your everyday life. However, if you develop a psychological problem that seriously affects your life and does not resolve itself quickly, you should seek the help of a professional therapist. You can find guidelines for choosing a behavior therapist in the Appendix.

SUMMARY

1. The basic aim of behavior therapy is to help clients deal with psychological problems. Behavior therapy principles and procedures also are used to modify everyday problems.
2. There is no single, agreed-upon definition of behavior therapy. Behavior therapy can be characterized by four defining themes: scientific, active, present focus, and learning focus.
3. The scientific approach entails precisely defining treatment goals, assessment procedures, and therapy procedures; continuously monitoring clients' progress using quantitative measurements; and evaluating the effectiveness of procedures through controlled research.
4. Behavior therapy is active in that clients do more than just talk about their problems. Clients engage in specific therapeutic tasks in therapy sessions and in the everyday environments where their problems are occurring.
5. Behavior therapy focuses on the present. Current conditions are assumed to influence the clients' present problems, and behavior therapy procedures change these current conditions.
6. In behavior therapy, problem behaviors are assumed to be acquired and/or changeable through learning; therapy therefore focuses on learning. Also, theories of learning often are used to explain why behavior therapies work.
7. Four common characteristics further define behavior therapy. Behavior therapy is individualized for each client, proceeds in a stepwise progression, often involves the combination of two or more therapies in a treatment package, and tends to be relatively brief.
8. In behavior therapy, the therapist–client relationship is considered necessary but not sufficient for successful treatment because it is the specific change techniques used that are most influential in treatment success. Collaboration between the therapist and client, such as in setting goals and choosing therapy procedures, is a hallmark of behavior therapy.

9. Behavior therapy consists of a wide variety of different treatment procedures.
10. As with all psychotherapies, ethical issues can arise in behavior therapy. The two major potential issues are depriving clients of their rights and harming clients. Behavior therapy practices provide for some internal protections against ethical violations.

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CHAPTER 2

Antecedents of Contemporary Behavior Therapy

Behavior therapy has "a long past but a short history."[1] In rudimentary forms, behavior therapy is very old. Humans have been using behavioral principles to modify people's behaviors for thousands of years (such as parents' rewarding children for good behaviors). Although these everyday applications are generally haphazard, they can be effective. However, to treat serious problems, a systematic approach is necessary. The formal, systematic application of behavioral principles to treat psychological problems—that is, behavior therapy—is only about 60 years old.

HISTORICAL PRECURSORS

A number of historical treatments for psychological disorders closely resemble contemporary behavior therapies. For example, Pliny the Elder, a 1st-century C.E. Roman scholar and naturalist, treated drinking problems using the fundamental principle of aversion therapy. He created an aversion to alcohol by putting putrid spiders at the bottom of the problem drinker's glass.[2] Pliny wrote about *Lupus salictarius*—better known as hops, the flavoring and stability ingredient in beer. To pay homage to him, the Russian River Brewing Company named a double India pale ale with a high alcohol content "Pliny the Elder."

An early account of a behavioral activation and cognitive therapy strategy for treating depression is portrayed in a 10th-century Icelandic story.[3] In Egil's saga, a daughter helps her grieving father overcome his severe depression by getting him to engage in sequentially more active behaviors, which results in his feeling better.

At the close of the 18th century, Jean-Marc-Gaspard Itard attempted to socialize the "Wild Boy of Aveyron," a child who grew up without human contact.[4] To teach the boy language and other social behaviors, Itard employed procedures similar to contemporary behavior therapies used to treat children with autism spectrum disorder, including modeling, prompting, shaping, and time-out from positive reinforcement.[5]

In the early 19th century, Alexander Maconochie, a captain in the Royal Navy, was put in charge of a British penal colony located on Norfolk Island, Australia.[6] To rehabilitate the prisoners, Maconochie established a point system that allowed each prisoner to redeem himself by performing appropriate behaviors. In Maconochie's words, "When a man keeps the key of his own prison, he is soon persuaded to fit it into the lock." Despite the apparent success of this early token economy, Maconochie's superiors disapproved of his innovative methods and denigrated their effectiveness.[7] This scenario would be replayed a century and a half later, as you shall see shortly.

An 1845 paper presented to the Royal Academy of Medicine in Paris reported on the treatment of a 30-year-old wine merchant for his obsessional thoughts. François Leuret, a physician, had the man recite song lyrics, behaviors that competed with his disturbing, repetitive thoughts.[8] With a similar problem, Diocletian (Dio) Lewis, a 19th-century physician, described in his book *Chastity or Our Secret Sins* the treatment of a man preoccupied with sexual thoughts by telling the man that sensual ideas are dangerous and that they would startle him when they came to mind. When this occurred, Lewis instructed the man to immediately engage in a competing response, such as thinking about something else or engaging in physical exercise (Lewis was a pioneer in physical education and also invented the beanbag).[9] Lewis and Lauret's procedures are similar to some present-day cognitive-behavioral interventions.

These early harbingers of behavior therapy procedures have only historical significance because they have had no real influence on the development of contemporary behavior therapy.[10]

EARLY EXPERIMENTAL WORK

The inspiration for contemporary behavior therapy came from experimental work on learning carried out at the beginning of the 20th century. Russian physiologist Ivan Pavlov is credited with the first systematic account of what has come to be called *classical* (or *Pavlovian*) *conditioning*.[11] In this form of learning, a neutral stimulus (one that elicits no particular response) is repeatedly paired with a stimulus that naturally elicits a particular response. The result is that eventually, the neutral stimulus alone comes to elicit the response. In Pavlov's well-known experiments with dogs, a neutral stimulus, such as a light or a tone, was paired with food, a stimulus that reflexively produces salivation. After repeated pairings of these two stimuli, the light or tone alone resulted in the dogs' salivation. This classical conditioning process is shown in Figure 2-1 (see page 18).

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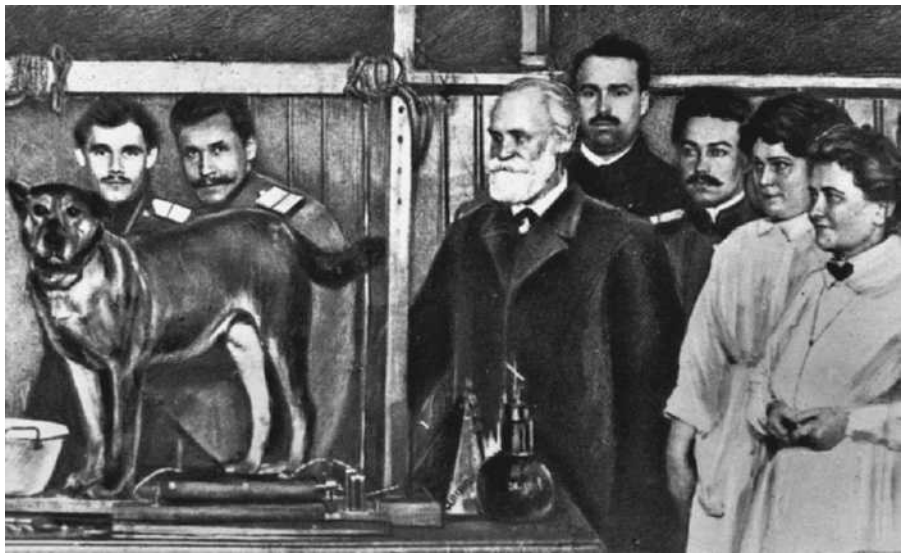
John B. Watson

In addition to his important laboratory experiments with animals, Pavlov wrote about the application of learning procedures to treat psychological disorders.[12] Pavlov's critical contribution to behavior therapy, however, was the influence his work had on John B. Watson, an experimental psychologist at Johns Hopkins University. Watson is the founder of *behaviorism*, the school of psychology on which behavior therapy is largely based. Watson's behaviorism emphasized the importance of objectively studying behaviors by dealing only with directly observable stimuli and responses and rejected mentalistic concepts, such as consciousness, thought, and imagery.[13]



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Pavlov (center) in his lab

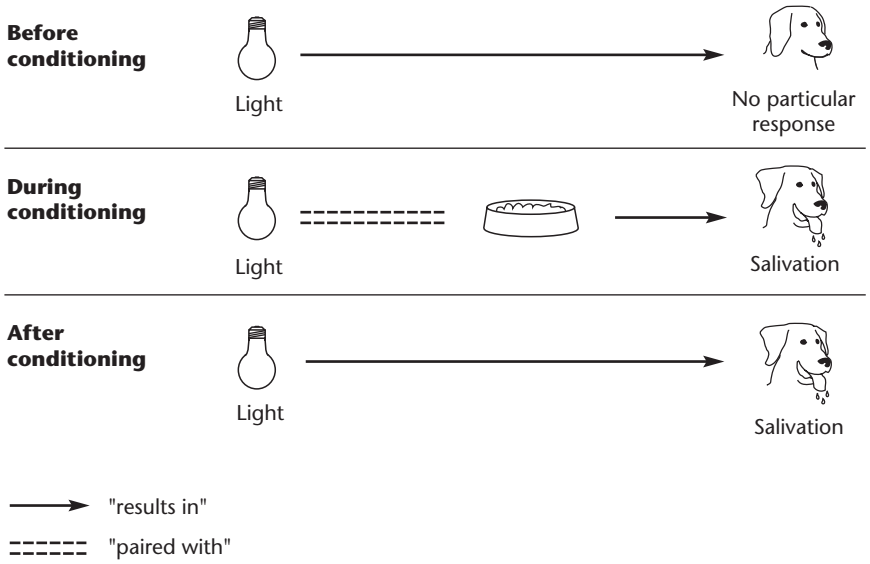

FIGURE 2-1
The learning process Pavlov recognized, which came to be called *classical conditioning*


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Mary Cover Jones

In 1924, Mary Cover Jones, one of Watson's students, successfully treated a 3-year-old boy named Peter, who had an intense fear of rabbits.[14] The therapy consisted of two basic procedures. First, Peter watched other children happily playing with a rabbit. Then Jones gradually exposed Peter to the rabbit. She placed a caged rabbit in the room while Peter was eating a favorite food. The cage was at a sufficient distance so that its presence did not interfere with Peter's eating and did not upset him. Over a number of days, Jones brought the rabbit closer to Peter, always keeping it at a distance that was comfortable for Peter. Jones eventually took the rabbit out of the cage and gradually brought it closer to Peter. Following this treatment, Peter was able to comfortably hold and play with the rabbit. Years later, Jones' two treatment procedures—modeling therapy and in vivo desensitization—were refined and now are widely used behavior therapies for the treatment of fears.

Hobart and Willie Mowrer also were influenced by Pavlov's classical conditioning principles. In 1935, they began a treatment program for nocturnal enuresis (bedwetting) at the New Haven Children's Center.[15] The treatment taught children to awaken when they felt tension in their bladder so that they could go to the toilet to urinate rather than wet the bed. To accomplish this, a special pad under the bed sheet activated a bell when a small amount of urine contacted it.[16] Thus, as soon as a child began to urinate, he or she was awakened by the bell. After bladder tension and awakening were paired a number of times, a full bladder alone woke the child. The bell-and-pad technique proved highly successful and is still used today.


Archives of the History of American Psychology/The University of Akron
Edward Thorndike

At the same time that Pavlov was studying classical conditioning, psychologist Edward Thorndike at Columbia University was investigating the strengthening and weakening of behaviors by systematically changing their consequences (reinforcement and punishment, respectively).[17] This type of learning came to be called *operant* (or *instrumental*) *conditioning*.

Photographer: Special Collections & University Archives, University of Illinois at Chicago Library

Willie & Hobart Mowrer

In a different arena, Edmund Jacobson, a physiologist at the University of Chicago in the 1930s, was experimenting with skeletal muscle relaxation as a treatment for tension associated with a wide array of psychological and physical disorders, including generalized anxiety, phobias, depression, hypertension, colitis, tics, and stuttering.[18] Jacobson's *progressive relaxation* is the basis for the extensive use of muscle relaxation in behavior therapy.

GROWING DISCONTENT WITH PSYCHOANALYSIS

Despite the effectiveness of some early behavior therapy efforts,[19] contemporary behavior therapy did not begin in earnest until the 1950s.[20] The genesis of behavior therapy was influenced to a significant degree by the nature and status of psychoanalysis, the prevailing model of psychotherapy in the 1950s.

Psychoanalysis, originally developed by Sigmund Freud, focuses on exploring clients' early childhood experiences and attempting to uncover unconscious conflicts and desires, which are hypothesized to be the causal factors of psychological disorders. The objective is for clients to gain insight about the origin of their problems. Insight is believed to be the key to change; for this reason, psychoanalysis and similar therapies are called *insight therapies*.

Psychoanalysis was the only major approach to psychotherapy during the first half of the 20th century. However, after World War II, doubts about the usefulness of psychoanalysis as a general treatment method began to mount.

TABLE 2-1
Differences Between Psychoanalysis and Behavior Therapy

	Psychoanalysis	Behavior Therapy
Locus of time	Past	Present
Mode of treatment	Verbal	Action-oriented
Treatment strategy	Indirectly explore client's past and unconscious as related to client's problem	Identify and directly change present maintaining conditions of client's problem
How techniques are applied	Same for all clients	Customized for each client
Length of treatment	Lengthy	Brief
Evidence for effectiveness	Uncontrolled, qualitative case studies	Controlled, quantitative experiments

Courtesy of the University of London British Postgraduate Medical Federation

Hans Eysenck

Because psychoanalysis is such a lengthy process—often requiring years—it could not meet the needs of the large number of veterans who required psychological treatment as a result of the war.

This growing discontent with traditional psychoanalytic psychotherapy received a major impetus from a 1952 retrospective study by British psychologist Hans Eysenck (pronounced EYE-zink).[21] Eysenck investigated the effectiveness of insight therapies by examining records from hospitals and insurance companies. He concluded that people treated by traditional insight psychotherapy were no more likely to improve than those who received no treatment at all. Subsequent reanalysis of Eysenck's data showed that his conclusion was exaggerated.[22] Nonetheless, Eysenck's original conclusion did serve as an impetus for psychotherapists to seriously question the benefits of traditional insight therapies and to seek more effective alternatives. Behavior therapy was a major alternative. The differences between psychoanalysis and behavior therapy are highlighted in Table 2-1.

FORMAL BEGINNINGS OF CONTEMPORARY BEHAVIOR THERAPY

Contemporary behavior therapy formally began in the 1950s simultaneously in the United States and Canada, South Africa, and Great Britain.

Harvard University Archives, call # HUP Skinner, B.F. (9)

B. F. Skinner

DEVELOPMENTS IN NORTH AMERICA

Beginning in the 1930s, psychologist B. F. Skinner at Harvard University began his extensive investigation of operant conditioning with pigeons and rats. Like Pavlov, Skinner speculated about the therapeutic uses of learning principles,[23] but he himself did not carry his ideas to fruition. It remained for his students and followers to apply operant principles to therapy.

In the early 1950s, Ogden Lindsley, then a graduate student working with Skinner, directed a series of studies to determine the feasibility of applying operant conditioning procedures to adults with severe psychiatric disorders.[24] His initial research demonstrated that patients in psychiatric hospitals whose behaviors seemed

Courtesy of University Archives, Spencer Research Library, University of Kansas Libraries

Ogden Lindsley

aimless would consistently perform simple tasks when given meaningful reinforcers. Lindsley's initial investigations could not legitimately be considered therapy. However, they did lead to the development of sophisticated procedures, derived from operant conditioning principles, to treat complex human problems. Incidentally, Lindsley may have been the first to formally use the term *behavior therapy* to describe the systematic use of learning procedures to treat psychological disorders.[25]

In the late 1950s, Teodoro Ayllon (pronounced eye-YONE), at the Saskatchewan Hospital in Canada, performed now-classic demonstrations of the effectiveness of operant principles in modifying severely disturbed behaviors of psychiatric patients.[26] According to psychoanalysis, the dominant approach at the time, the symptoms of psychological disorders are the result of deep-seated, unconscious conflicts that were originally created by complex psychological processes (that often arose from anxiety-inducing or traumatic events in the person's life).[27] Besides having implications for how abnormal behaviors develop, this theory implied that successful treatment had to delve into those conflicts.

To challenge this psychoanalytic notion and to present an alternative and far simpler behavioral account, Ayllon and his colleague Eric Haughton performed a simple demonstration. The demonstration showed that a behavior that might be considered a symptom of a psychiatric disorder could be created simply by reinforcing it and then could be eliminated (treated) simply by withdrawing the reinforcement.[28]

The behavior they chose was *standing while holding a broom in an upright position* (see Figure 2-2). Their subject was a 54-year-old female patient with schizophrenia who had been hospitalized for 23 years and who spent most of her time lying in bed or sitting on a couch.

FIGURE 2-2
Sketch of the patient's stance that Haughton and Ayllon reinforced in their demonstration study

Source: Haughton & Ayllon, 1965, p. 96.

After Ayllon and Haughton had successfully conditioned the woman to engage in the broom-holding behavior, a psychiatrist who was unaware of what they had done made the following comments.

> Her constant and compulsive pacing holding a broom . . . could be seen as a ritualistic procedure, a magical action. When regression conquers the associative process, primitive and archaic forms of thinking control the behavior. Symbolism is a predominant mode of expression of deep-seated unfulfilled desires and instinctual impulses . . . .
>
> Her broom could then be:
>
> 1. a child that gives her love and she gives him in return her devotion;
> 2. a phallic symbol;
> 3. the sceptre of an omnipotent queen.[29]

This explanation is consistent with psychoanalytic theory that postulates complex and deep-rooted causes of behavior. However, the actual cause of the broom-holding behavior was that it had been reinforced. The validity of this simpler and more straightforward explanation was enhanced by demonstrating that the behavior could be eliminated by withholding the reinforcement. As with Lindsley's demonstrations, Ayllon and Haughton's broom-holding demonstration played a role in overcoming the widespread resistance to the behavioral model in the psychiatric community.

In 1961, Ayllon collaborated with Nathan Azrin, another of Skinner's former students, to design the first comprehensive token economy at Anna State Hospital in Illinois.[30] A token economy provides clients with token reinforcers (such