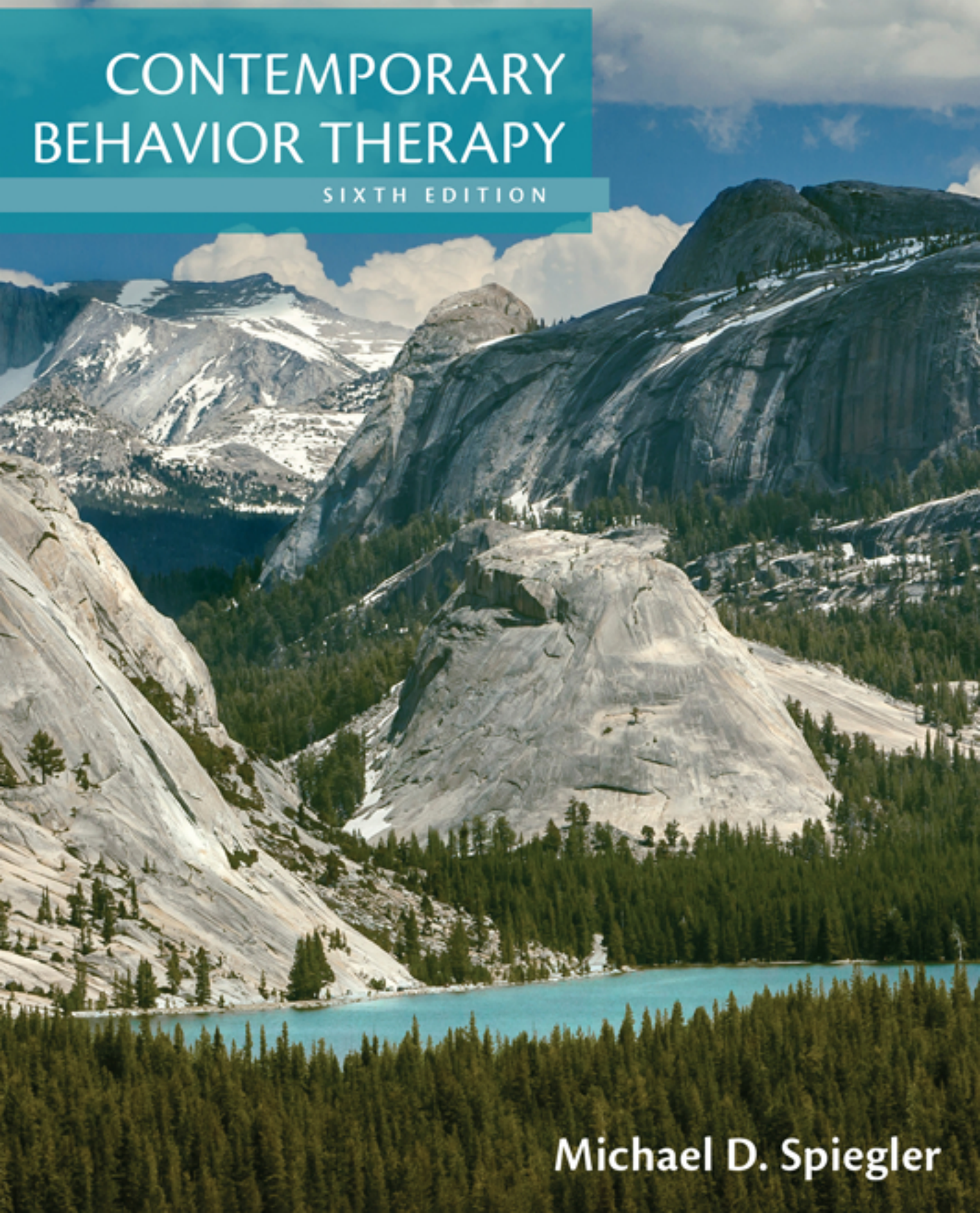
CONTEMPORARY BEHAVIOR THERAPY

SIXTH EDITION



Michael D. Spiegler

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Sixth Edition

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Michael D. Spiegler

Providence College

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Sixth Edition
Michael D. Spiegler

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To my brother and sister

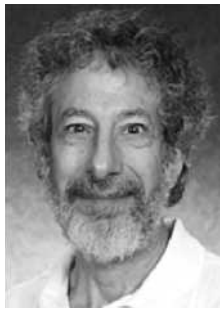
Rick McEwan

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.