UNIT 1 BEHAVIOUR MODIFICATION TECHNIQUES

Structure

1.0 INTRODUCTION

In the last few years some writers have used the term *behaviour modification* to refer to almost any practice that alters human behaviour. But this is not the case. More specifically, behaviour modification is not brainwashing or mind control, and behaviour modifiers do not use psychosurgery or electroshock therapy and only occasionally use drugs as a temporary adjunct to a change procedure. Rather, behaviour modification is structured learning in which new skills and other behaviours are learned, undesired reactions and habits are reduced, and the client becomes more motivated for the desired changes. Behaviour modification is experimentally based. The goal of this unit is to describe basic principles of behaviour so that you can learn how environmental events influence human behaviour and to describe behaviour modification procedures so that you learn the strategies by which human behaviour may be changed. In this unit you will learn about behaviour modification, the principles and procedures used to understand and change human behaviour.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour modification;
- Explain the main characteristics of behaviour modification;
- Discuss the historical development of behaviour modification;
- Elucidate the principles of behaviour modification;
- Explain the and procedures of behaviour modification; and
- Analyse the applications of behaviour modification across various settings.

1.2 BEHAVIOUR MODIFICATION

Behaviour modification is the field of psychology concerned with analysing and modifying human behaviour.

Analysing means identifying the functional relationship between environmental events and a particular behaviour to understand the reasons for behaviour or to determine why a person behaved as he or she did.

Modifying means developing and implementing procedures to help people change their behaviour. It involves altering environmental events so as to influence behaviour.

Behaviour modification procedures are developed by professionals and used to change socially significant behaviours, with the goal of improving some aspect of a person's life.

1.2.1 Characteristics of Behaviour Modification

Following are the characteristics of behaviour modification:

1) **Focus on behaviour:** Behaviour modification procedures are designed to change behaviour, not a personal characteristic or trait. Therefore, behaviour modification deemphasises labelling. For example, behaviour modification is not used to change autism (a label); rather, behaviour modification is used to change problem behaviours exhibited by children with autism. Behavioural excesses and deficits are targets for change with behaviour modification procedures.

   In behaviour modification, the behaviour to be modified is called the *target behaviour*.

   A *behavioural excess* is an undesirable target behaviour the person wants to decrease in frequency, duration, or intensity. Smoking is an example of a behavioural excess.

   A *behavioural deficit* is a desirable target behaviour the person wants to increase in frequency, duration, or intensity. Exercise and studying are possible examples of behavioural deficits.

2) **Procedures based on behavioural principles:** Behaviour modification is the application of basic principles originally derived from experimental research with laboratory animals.

   The scientific study of behaviour is called the *experimental analysis of behaviour*, or behaviour analysis.

   The scientific study of human behaviour is called the experimental analysis of human behaviour, or *applied behaviour analysis*.

   Behaviour modification procedures are based on research in applied behaviour analysis that has been conducted for more than 40 years.

3) **Emphasis on current environmental events:** Behaviour modification involves assessing and modifying the current environmental events that are functionally related to the behaviour.

   Human behaviour is controlled by events in the immediate environment, and the goal of behaviour modification is to identify those events. Once these controlling variables have been identified, they are altered to modify the behaviour.

   Successful behaviour modification procedures alter the functional relationships between the behaviour and the controlling variables in the environment to produce a desired change in the behaviour.

   Sometimes labels are mistakenly identified as the causes of behaviour. For example, a person might say that a child with autism engages in problem behaviours (such as screaming, hitting himself, refusal to follow instructions) because the child is autistic. In other words, the person is suggesting that autism causes the child to engage in the behaviour. However, autism is simply a label that describes the pattern of behaviours the child engages in. The label cannot be the cause of the behaviour because the label does not exist as a physical entity or event. The causes of the behaviour must be found in the environment (including the biology of the child).

4) **Precise description of behaviour modification procedures:** Behaviour modification procedures involve specific changes in environmental events that are functionally related to the behaviour.

   For the procedures to be effective each time they are used, the specific changes in environmental events must occur each time. By describing procedures precisely, researchers and other professionals make it more likely that the procedures will be used correctly each time.

5) **Treatment implemented by people in everyday life:** Behaviour modification procedures are developed by professionals or paraprofessionals trained in behaviour modification. However, behaviour modification procedures often are implemented by people such as teachers, parents, job supervisors, or others to help people change their behaviour. People who implement behaviour modification procedures should do so only after sufficient training. Precise descriptions of procedures and professional supervision make it more likely that parents, teachers, and others will implement procedures correctly.

6) **Measurement of behaviour change:** One of the hallmarks of behaviour modification is its emphasis on measuring the behaviour before and after intervention to document the behaviour change resulting from the behaviour modification procedures.

   In addition, ongoing assessment of the behaviour is done well beyond the point of intervention to determine whether the behaviour change is maintained in the long run. If a supervisor is using behaviour modification procedures to increase work productivity (to increase the number of units assembled each day), he or she would record the workers' behaviours for a period before implementing the procedures. The supervisor would then implement the behaviour modification procedures and continue to record the behaviours. This recording would establish whether the number of units assembled increased. If the workers' behaviours changed after the supervisor's intervention, he or she would continue to record the behaviour for a further period. Such long term observation would demonstrate whether the workers continued to assemble units at the increased rate or whether further intervention was necessary.

7) **De-emphasis on past events as causes of behaviour:** As stated earlier, behaviour modification places emphasis on recent environmental events as the causes of behaviour. However, knowledge of the past also provides useful information about environmental events related to the current behaviour. For example, previous learning experiences have been shown to influence current behaviour. Therefore, understanding these learning experiences can be valuable in analysing current behaviour and choosing behaviour modification procedures. Although information on past events is useful, knowledge of current controlling variables is most relevant to developing effective behaviour modification interventions because those variables, unlike past events, can still be changed.

8) **Rejection of hypothetical underlying causes of behaviour:** Although some fields of psychology, such as Freudian psychoanalytic approaches, might be interested in hypothesised underlying causes of behaviour, such as an unresolved Oedipus complex, behaviour modification rejects such

hypothetical explanations of behaviour. Skinner (1974) has called such explanations "explanatory fictions" because they can never be proved or disproved, and thus are unscientific. These supposed underlying causes can never be measured or manipulated to demonstrate a functional relationship to the behaviour they are intended to explain.

1.2.2 Historical Overview of Behaviour Modification

A number of historical events contributed to the development of behaviour modification. Let's briefly consider some important figures, publications, and organisations in the field.

Major Figures

Following are some of the major figures who were instrumental in developing the scientific principles on which behaviour modification is based.

Ivan P. Pavlov (1849–1936) Pavlov conducted experiments that uncovered the basic processes of respondent conditioning. He demonstrated that a reflex (salivation in response to food) could be conditioned to a neutral stimulus. In his experiments, Pavlov presented the neutral stimulus (the sound of a metronome) at the same time that he presented food to a dog. Later, the dog salivated in response to the sound of the metronome alone. Pavlov called this a *conditioned reflex* (Pavlov, 1927).

Edward L. Thorndike (1874–1949) Thorndike's major contribution was the description of the *law of effect*. The law of effect states that a behaviour that produces a favourable effect on the environment is more likely to be repeated in the future. In Thorndike's famous experiment, he put a cat in a cage and set food outside the cage where the cat could see it. To open the cage door, the cat had to hit a lever with its paw. Thorndike showed that the cat learned to hit the lever and open the cage door. Each time it was put into the cage, the cat hit the lever more quickly because that behaviour—hitting the lever—produced a favourable effect on the environment: It allowed the cat to reach the food (Thorndike, 1911).

John B. Watson (1878–1958) In the article "Psychology as the Behaviourist Views It," published in 1913, Watson asserted that observable behaviour was the proper subject matter of psychology, and that all behaviours were controlled by environmental events. In particular, Watson described a stimulus response psychology in which environmental events (stimuli) elicited responses. Watson started the movement in psychology called *behaviourism* (Watson, 1913, 1924).

B. F. Skinner (1904–1990). Skinner expanded the field of behaviourism originally described by Watson. Skinner explained the distinction between respondent conditioning (the conditioned reflexes described by Pavlov and Watson) and operant conditioning, in which the consequence of behaviour controls the future occurrence of the behaviour (as in Thorndike's law of effect). Skinner's research elaborated the basic principles of operant behaviour. In addition to his laboratory research demonstrating basic behavioural principles, Skinner wrote a number of books in which he applied the principles of behaviour analysis to human behaviour. Skinner's work is the foundation of behaviour modification.

Early Behaviour Modification Researchers

After Skinner laid out the principles of operant conditioning, researchers continued to study operant behaviour in the laboratory. In addition, in the 1950s,

researchers began demonstrating behavioural principles and evaluating behaviour modification procedures with people. These early researchers studied the behaviour of children, adults, patients with mental illness and individuals with mental retardation. Since the beginning of behaviour modification research with humans in the 1950s, thousands of studies have established the effectiveness of behaviour modification principles and procedures.

Major Publications and Events

A number of books heavily influenced the development of the behaviour modification field. In addition, scientific journals such as SEAB, Society for the Experimental Analysis of Behaviour; JEAB, Journal of the Experimental Analysis of Behaviour; AABT, Association for Advancement of Behaviour Therapy; JABA, Journal of Applied Behaviour Analysis were developed to publish research in behaviour analysis and behaviour modification, and professional organisations started to support research and professional activity in behaviour analysis and behaviour modification.

1.2.3 Observing and Recording Behaviour

One fundamental aspect of behaviour modification is measuring the behaviour that is targeted for change. Measurement of the target behaviour (or behaviours) in behaviour modification is called behavioural assessment. Behavioural assessment is important for a number of reasons.

Measuring the behaviour before treatment provides information that can help determine whether treatment is necessary.

Behavioural assessment provide information that helps in selecting the best treatment.

Measuring the target behaviour before and after treatment allows determining whether the behaviour changed after the treatment.

There are different methods for behavioural assessment.

1.3 RESPONDENT CONDITIONING AND COUNTERCONDITIONING

1.3.1 Respondent Conditioning

Someone smiling at us produces a pleasant feeling. Pictures of good food may literally cause our mouths to water. In one type of fetishism a man is sexually aroused by the sight of a woman's shoe. A woman with an automobile phobia may become anxious when she sees a car. Why should these stimuli (smiles, pictures of food, women's shoes, and automobiles) elicit these particular responses (a pleased feeling, salivation, sexual arousal, anxiety)? It is not instinctual that these stimuli elicit these responses; hence it probably is learned.

Perhaps one reason a smile now elicits a pleased feeling is that in a person's learning history the stimulus of a smile was associated with other stimuli, such as affection, which produced a pleasant feeling. The stimulus of the image of the food was associated with the stimulus of the taste of the food, with the taste eliciting salivation. Eventually the image of the food came to elicit salivation. Similarly, the sight of a woman's shoe may have been paired with sexually

arousing stimuli such as from masturbation. The image of an automobile may have been paired with an anxiety producing stimulus such as seeing a close relative die in an automobile accident. The learned associations may have been gradually built up over time, as in the case of the smile and affection, or may have followed a single dramatic learning experience, as in the case of the automobile accident.

This type of learning is called *respondent conditioning*, the learning model in which one stimulus, as the result of being paired with a second stimulus, comes to elicit a response it did not elicit just previously. Usually this new response is similar to the response previously elicited only by the second stimulus. In this model the first stimulus is called the *conditioned stimulus* (CS) and the response it comes to elicit is called the *conditioned response* (CR), while the second stimulus is called the *unconditioned stimulus* (UCS) and the response it already elicited is called the *unconditioned response* (UCR). For example take the case of a child who is gradually developing a dislike for school (CS) because the teacher emphasises the use of corporal punishment (UCS), which makes the child anxious and fearful (UCR). This will be the first step for the children to develop school phobias.

Through association of the CS and UCS, the CS comes to provide information about the occurrence of the UCS. The more probable it is the UCS will follow the CS, the stronger the respondent conditioning and the more probable it is the CR will follow the CS. After the CR begins to occur, it may be rewarded or punished, which affects its occurrence. In this sense the CR is often a response the person makes to prepare for the UCS. Respondent conditioning is often called *classical conditioning* and sometimes *Pavlovian conditioning.*

In human behaviour most of the things that are rewarding (e.g., attention, approval, money, good grades) or punishing (e.g., Ostracism, criticism) acquired their affect through respondent conditioning and are called *conditioned reinforcement* and *conditioned punishment.* In respondent conditioning there are two ways of dealing with undesired behaviours: (i) extinction and (ii) counterconditioning.

1.3.2 Extinction

Respondent conditioning is accomplished by establishing a contingency (relationship) between the CS and the UCS

The CS predicts to a certain degree the onset of the UCS.

If we terminate this contingency so that the CS is not associated with the UCS, eventually the CS will no longer elicit the CR.

This process is called *extinction.*

1.3.3 Spontaneous Recovery

If a small child is scratched (UCS) by a cat (CS) and hurt (UCR), then the child may develop a fear (CR) of cats. If the child now onwards encounters cats without anything bad happening, then the fear may extinguish. Sometimes following extinction, the CR may gain in strength over time. This is called spontaneous recovery. However, in practical situations, this is usually minimal; and with further extinction the CR will no longer reappear.

1.3.4 Procedure for Producing Extinction

There are basically two ways of carrying out extinction:

i) gradual and

ii) not gradual.

The gradual approach consists of moving through a sequence of steps, called a *hierarchy,* toward the object or situation that elicits the strongest CR.

The alternative is to bypass most of these intermediate steps and confront the final situation right away.

(Actually these are not two different approaches, but two points on a continuum of how many steps there are until approaching the final situation.)

For example, if a child had a fear of water at the beach, a gradual approach would involve slowly approaching the water, perhaps first playing on the beach 20 feet away from the water, then playing 10 feet away, then at the edge of the water, then putting feet in the water, and so forth.

The non-gradual alternative may be to put or carry the child into the water until the fear extinguishes.

A variation of the non gradual approach involves bombarding the person with the anxiety producing stimuli and / or keeping the person in the anxiety situation without escape. This approach is called *flooding.*

Although extinction is applicable to any respondently conditioned response, it is most used with anxieties and fears. People are continually confronted with situations that elicit some anxiety, such as standing up to the boss, making a presentation before a class, or talking about something personal. If the person can approach and be in the anxiety situation without anything unpleasant happening, then some of the anxiety should extinguish.

1.3.5 Counter Conditioning

Counterconditioning is the reduction of undesired elicited responses by respondently conditioning incompatible responses to the eliciting situations. The first step is to determine the situations that elicit the undesired responses, as for example the sight of spiders may cause excessive anxiety in some people.

The second step is to determine or establish ways to elicit a response incompatible with and dominant to the undesired response, such as some forms of relaxation may be to the spider anxiety.

Finally, the incompatible response is respondently conditioned to the stimuli eliciting the undesired response, as stimuli producing relaxation may be paired with stimuli related to spiders. This counterconditioning is continued until the undesired response that is fear of spiders has been adequately reduced, usually until it no longer occurs.

Counterconditioning is often used to reduce unwanted emotional reactions such as anxiety, anger, or jealousy. Most clinical cases have an anxiety component that needs to be handled in some way. *Desensitisation* is the counterconditioning of anxiety with relaxation.

In other situations, the undesired response is a rewarding, approach response, as occurs in some aspects of alcoholism, drug-addiction, and over-eating. The sight of a bar may elicit a craving for a drink or the taste of one cigarette may lead to smoking another.

In these cases, counterconditioning may involve conditioning in an unpleasant or aversive response to the stimulus situations eliciting the approach response. This is called *aversive counterconditioning*.

It is important in counterconditioning that the incompatible response be dominant to the undesired response. Sometimes this is not a problem. For example, in aversive counterconditioning the aversiveness of electric shock or imagining unpleasant scenes may be dominant to the pleasing effects of having a second piece of cake. However, response dominance is often an issue.

The way to ensure the incompatible response is dominant, is through the use of a hierarchy, similar to the gradual approach of respondent extinction. For example in the case of a person with a fear of spiders, our counterconditioning using relaxation would begin with items low on the hierarchy (such as the word "spider"), work up the hierarchy through intermediate items (such as a picture of a spider), on to items at the top of the hierarchy (such as touching a live spider). The assumption is that the effects of the counterconditioning generalise (carry over to similar stimuli) up the hierarchy, thereby gradually reducing the strength of the undesired response elicited by the various situations.

In the example of the spider anxiety, it may be that at the beginning of treatment the anxiety elicited by a picture of a spider or touching a live spider is dominant to any relaxation we can produce.

But our relaxation is dominant to the anxiety elicited by the word "spider"; so we begin our counterconditioning there.

Now as we countercondition out the anxiety to the word "spider" it is assumed the counterconditioning carries up the hierarchy and reduces somewhat the anxiety to the picture and the live spider.

By the time we get to the picture, our relaxation is dominant to any remaining anxiety, which we can now countercondition out.

And this counterconditioning generalises up the remainder of the hierarchy.

Thus if we choose a hierarchy of related items, have a sufficient number of items in our hierarchy, and do not move through the hierarchy too fast, we can insure that the incompatible response is dominant to the undesired response and Counterconditioning will move in the desired way. This is the approach we take while carrying out systematic desensitisation.

1.4 OPERANT CONDITIONING

This section is concerned with learning and motivational changes based on events that follow behaviour and generally are a result of the behaviour. A worker receives his salary following completion of a certain number of hours of work. A student receives a particular grade on a test as a result of achieving a certain test score. A child is reprimanded for using certain words. In these cases there is some

relationship, called a *contingency,* between the person's behaviour (working a number of hours, achieving a test score, using certain words) and some resultant or *contingent* event (salary, grade, reprimand).

Operant conditioning

This is also called instrumental conditioning. It is the learning model based on the effects on behaviour of contingent events and the learning of the nature of the contingency.

If the contingent event makes it *more* probable that the person will behave in a similar way when in a similar situation, the event is called a *reinforcer.*

1.4.1 Reinforcement and Punishment

Occasionally, when Bobby was put to bed before he wanted, he would cry. His parents dealt with this by reading him a story to quiet him down.

Bobby cried more often when put to bed. In this situation, the parents' reading him a story was reinforcement for Bobby's crying.

On the other hand, if the contingent event makes the behaviour *less* probable, then the event is called a *punisher.*

For a while, Sushila did all her banking at the neighbourhood bank. However, because of poor service there, she gradually shifted most of her business to another bank. Here the poor service is a punishment for using the neighbourhood bank.

Following the behaviour, the contingent event may come on or increase *(positive),* or the contingent event may go off or decrease *(negative).* This produces four combinations:

i) positive reinforcement,

ii) negative reinforcement,

iii) positive punishment, and

iv) negative punishment.

i) Positive reinforcement is an increase in the probability of a behaviour due to an increase in the contingent event. Jane, a new manager in a company, began praising workers for submitting their reports on time. In a couple of weeks, this reinforcement by praise greatly increased on-time reports. Positive reinforcement, when appropriately used, is one of the most powerful of all behaviour change tools.

ii) Negative *reinforcement* is an increase in the probability of behaviour due to a decrease in the contingent event. A person learns to use his relaxation skills to offset anxiety, with the decrease in anxiety being a negative reinforcer. Thus negative reinforcement is based on the decrease of something undesired such as pain or anxiety. Negative reinforcement is not punishment; reinforcement is an increase in the probability of behaviour, while punishment is a decrease.

Negative reinforcement is the basis of *escape conditioning,* learning to escape an aversive situation and being reinforced by the decrease in aversion. Sachin

may learn to leave a neighbour's house when the neighbour gets drunk and obnoxious. Escape conditioning may lead to *avoidance conditioning* in which the person learns to avoid the aversive situation. Sachin may learn to avoid going to his drinking neighbour's house. Many politicians avoid important political issues in which no matter what position they take a moderate number of people will get mad and perhaps later vote against them. Votes and money are two strong reinforcers accounting for much political behaviour.

Positive punishment is a decrease in the probability of behaviour due to an increase in the contingent event. This is what most people mean when they use the word "punishment." If every time Ali tells his algebra teacher he is having trouble keeping up with the class he is then given extra remedial Work, then the extra work may act as a punisher resulting in a decrease in asking for help.

Negative punishment is a decrease in the probability of behaviour due to a decrease in the contingent event. This corresponds to a decrease in something desirable following some behaviour. If every time a person stutters, he briefly turns off a movie he is watching and if this results in a decrease in stuttering, then the offset of the movie is a negative punisher for stuttering.

1.5 OPERANT CONDITIONING PROCEDURES

Now we turn to behaviour change strategies that are based on operant Conditioning. This includes altering the stimulus situations in which behaviours occur *(stimulus control),* getting desirable behaviours to occur and reinforcing them, extinguishing and/or punishing undesired behaviours and reducing the reinforcing effects of events that support undesired behaviours.

1.5.1 Stimulus Control

Operant behaviours do not occur in a vacuum; they occur more in some Situations than others and are triggered by external and internal cues. That is, for all operant behaviours there are stimuli, called *discriminative stimuli* (SD), which tend to cue the response. Discriminative stimuli do not elicit the behaviour, as the CS elicits the CR, but rather set the occasion for the behaviour, making it more or less probable the behaviour will occur. Thus we can often alter operant behaviour by altering discriminative stimuli.

Approach 1: One approach is to remove discriminative stimuli that cue undesired behaviours. As part of a program to reduce smoking we might remove those stimuli that increase the tendency to smoke, such as ashtrays on the table. When trying to lose weight we might change the route from work to home so it does not pass the pastry shop.

Approach 2: A second stimulus control approach, called *narrowing,* involves restricting behaviours to a limited set of stimuli. A person who overeats probably is eating in many situations. This results in many discriminative stimuli (e.g., reading, watching TV, having a drink, socialising) cuing the tendency to eat. To cut back on this, we might restrict the eating to one place and certain times. Or in reducing smoking, we might restrict smoking to when the client is sitting in a particular chair in the basement.

Eliminating cues and narrowing are often combined. For example, in improving study habits an important component is establishing good study areas. If a student sits on the sofa when studying, eating, listening to music, and interacting with friends, then the sofa will cue thoughts, feelings, and behaviour tendencies that may be incompatible with studying. It is preferable to set up an area in which nothing takes place except studying (perhaps a desk in a corner), get out of the area when doing things like daydreaming, and remove from the area stimuli (e.g., pictures, food) that cue behaviours incompatible with studying. Similarly, treatment of insomnia might involve only going to bed when sleepy; leaving the bed when not falling asleep; and not reading, eating, or watching TV when in bed.

Approach 3: A third stimulus control approach involves introducing stimuli that tend to inhibit the undesired behaviour and/or cue behaviours incompatible with the undesired behaviour. A person trying to lose weight might put signs and pictures on the refrigerator door. Or a person who has quit smoking may tell all his friends he has quit. Then the presence of one of his friends may be a stimulus to not smoke.

Because a person's behaviour gets tied into the stimuli and patterns of his daily life, it is often desirable to alter as many of these cues as possible. This *stimulus change* may involve a wide range of things such as rearranging furniture, buying new clothes, painting a wall, eating meals at different times, or joining a new club. Stimulus change is useful in situations such as part of marriage counseling or when a client is ready to significantly alter his life-style.

Similarly, removing a person from his usual life situation until the change program is accomplished is often useful, particularly if coupled with stimulus change of the environment the client returns to.

Stimulus control deals with the antecedent side of operant behaviour; the following sections deal with the consequence side.

1.5.2 Increasing Desirable Behaviours

The most common operant approach consists of reinforcing desirable behaviours. And this should generally be a component of all operant programs, even when the emphasis is on some other approach, such as extinction.

Reinforcement

An important point is that we must identify what actually is reinforcing to the person, not what we expect should be reinforcing to him. A good approach to determine reinforcers is to ask the person what is reinforcing. Similarly, events we may consider not to be reinforcing in fact are. A common example is the teacher who yells at a student as an intended punishment, when really the teacher may be reinforcing the student with attention and/or causing the student to receive social reinforcement from his peers for getting the teacher mad.

Sometimes something will not be reinforcing to the client unless he has had some moderately recent experience with it. Talking on the telephone to a relative may not be reinforcing to a mental patient who has not used the telephone for years. Playing a game may not be reinforcing to an elementary student who is unfamiliar with the game. In these cases, it is often desirable to prime the client

by giving him some free experience with the reinforcer before the operant contingencies are established. This procedure is called *reinforcer sampling* (Ayllon & Azrin, 1968a).

Praise is a common and powerful reinforcer. When appropriately used, it has made dramatic changes in a variety of settings, including elementary classrooms and businesses. Money is another powerful reinforcer already affecting much of our behaviour. Reinforcers for students may include longer recess, opportunity to be the teacher's aide, field trips, dances, or time in a special reward area filled with different things to do. Behaviour modification in business settings and related organisations is also applicable. Potential reinforcers in these settings include recognition and praise, bonuses, equipment and supplies, additional staff, added privileges, participation in decision making, option for overtime, and days and hours off.

A variation of reinforcement is *self-reinforcement,* reinforcement People give themselves. This may be a form of covert verbal reinforcement (e.g., "That was good work.") or a more tangible reinforcer such as buying yourself some treat. Self-reinforcement is often an important part of self control processes in which people reinforce themselves for desired behaviours.

1.5.3 Strategies for Initiating Behaviours

To reinforce desirable behaviour the behaviour must first occur. If a catatonic has not said anything for five years, it would not be an effective approach to wait for him to say something to reinforce his talking. Thus an important part of the operant approach is to use ways to help initiate the behaviours to be reinforced. There are many ways to do this, including shaping, modeling, fading, punishment, and guidance.

Shaping

Shaping, also called *successive approximation,* is the reinforcing of behaviours that gradually approximate the desired behaviour. The key to shaping is the use of successive approximations that are small enough steps so that there is an easy transition from one step to the next. If one is cultivating the ability to meditate for long periods of time, it may not be desirable to start trying to meditate for an hour. An alternative would be to begin at ten minutes and add one minute every other day, gradually shaping meditation for longer periods of time.

Shaping involves starting where the client is; taking small enough steps so the client's behaviour smoothly changes, providing reinforcement and support for the changes, and catching mistakes or problems early because of the small steps. Practitioners often also need to use shaping when trying to change the philosophy or programs of the agency or organisation where they work.

Modeling

Modeling, involves a change in a person's behaviour as a result of observing the behaviour of another person, the model. Thus a way of initiating a behaviour, particularly with a child, is to have the person observe someone doing the desired behaviour and encourage imitation of the behaviour. A client who is learning how to interview for a job may first watch the practitioner model appropriate behaviours in a simulated job interview. Or a teacher who praises one student for good behaviour may find other students imitating this behaviour.

Modeling and shaping combine together well. For example, in *model-reinforcement counseling* the client listens to a tape recording of a counseling interview in which another person is reinforced by a counselor for making a certain class of statements. Then the client is reinforced for making these types of statements. This approach has been used to increase information seeking of high school students engaged in career planning (Krumboltz & Schroeder, 1965) and deliberation and deciding about majors by college students (Wachowiak, 1972).

Fading

Fading involves taking a behaviour that occurs in one situation and getting it to occur in a second situation by gradually changing the first situation into the second. A small child might be relaxed and cooperative at home, but frightened and withdrawn if suddenly put into a strange classroom. This fear can be circumvented if the child is gradually introduced to situations that approximate the classroom. Fading is particularly important when a client learns new behaviours in a restricted environment, such as a clinic, hospital, or half-way house. Taking a person out of such a setting and putting him directly back into his home environment may result in a loss in many of his new behaviours and skills. It is preferable to gradually fade from the therapeutic environment to the home environment. Shaping involves approximations on the response side, while fading involves approximations on the stimulus side.

Punishment

Punishment of one behaviour suppresses that behaviour and results in other behaviours occurring. Perhaps one of these other behaviours is a desirable behaviour that can be reinforced. This is not a particularly efficient or desirable approach in most cases.

Guidance

Guidance consists of physically aiding the person to make some response. Thus as part of contact desensitisation or flooding, the client may be guided to touch a feared object. Guidance may be used to help a client learn a manual skill or help a child who is learning to talk how to form his lips to make specific sounds.

1.5.4 Variables of Reinforcement

Several variables affect the effectiveness of reinforcement. The three most important are amount of reinforcement, delay of reinforcement, and schedule of reinforcement.

Amount of r*einforcement*

This refers to both the quality and quantity of reinforcement. Within limits, and with many exceptions, as the amount of reinforcement is increased, the effect of the reinforcement increases.

Delay of reinforcement

This refers to the amount of time between the person's behaviour and the reinforcement for that behaviour. As a general rule, you get the best results if the reinforcement occurs right after the behaviour. Praising a child for sharing with a friend is generally most effective if the praise occurs right after the sharing

than if it is mentioned later in the day. As the delay of reinforcement increases, the effectiveness of the reinforcement decreases.

Schedule of reinforcement

This refers to the pattern by which reinforcers are related to responses. The primary distinction between schedules of reinforcement is based on whether every correct response is reinforced (continuous reinforcement) or whether only some correct responses are reinforced (intermittent reinforcement). Learning is faster with continuous reinforcement than with intermittent reinforcement, but time to extinction is longer with intermittent reinforcement. Therefore, it is often strategic first to teach the behaviour under continuous reinforcement and then gradually switch to intermittent reinforcement to maintain it.

1.5.5 Facilitating Generalisation and Maintenance

Often an operant program will be established in a specific setting, such as a clinic, hospital, or classroom. Yet we usually want the behaviours and skills supported and acquired in this setting to carry over and be maintained in other settings. The behaviours usually will generalise, to some degree, from our specific setting to other settings; but it is usually desirable to facilitate this carry over.

Fading, discussed earlier, is one way of accomplishing this. Other ways to facilitate generalisation and maintenance of behaviours include the following:

Phase the client off the behaviour change reinforcements onto more "natural" forms of reinforcement.

Thus we start with a specific set of reinforcers and contingencies, as with patients in a hospital or children in a classroom, and gradually switch to the types of reinforcers that should support the behaviours in the everyday environment, as for example the reinforcers such as social approval and self-reinforcement.

A related approach involves gradually exposing the clients to the types of reinforcement contingencies that occur in the natural social environment. This is accomplished by switching from continuous schedules of reinforcement to intermittent schedules and by gradually helping the clients learn to function under long delays of reinforcement.

Finally, we may wish to reprogram the other environments or enlist the help of others to support the newly acquired behaviours. For example, a school counselor and a teacher may set up a program in one classroom that helps a child learn social skills that improve his ability to get along with his peers and experience less conflict in the classroom. To facilitate these skills occurring in settings other than this one classroom, the counselor may talk with the child's parents and his other teachers about ways to support these new behaviours in various settings.

1.5.6 Criticisms

There are many criticisms against programs that use reinforcement, particularly when used in classrooms. For many critics it seems inappropriate to be reinforcing people for something they should be doing; to some critics, this smacks of bribery.

Another common criticism is that people will come to expect rewards for everything they do and will not work otherwise. This may foster greed or teach the person to be bad in order to be rewarded for being good.

Another criticism is based on the fact that some mixed data exist suggesting that in some situations the use of extrinsic reinforcement may reduce intrinsic motivation (Levine & Fasnacht, 1974). That is, reinforcing people for doing something may reduce their motivation to do it when not being reinforced. If children enjoy playing certain games and then we begin reinforcing them for playing the games, when we remove the reinforcement their interest in the games may be less than it was prior to reinforcement.

1.6 CONTINGENCY CONTRACTING

A variation of operant procedures is *contingency contracting,*

This is a program in which the operant contingencies are well specified and clearly understood by everyone involved. These contingencies, reinforcements and punishments that can be expected for different behaviours, are formalised into a contract which is often written. Sometimes the contract is imposed on people; but often the best approach is to negotiate, as much as possible, with all people involved about the nature of the contract. Thus the role of the behaviour modifier is often consultant and negotiator about contracting.

Contingency contracting is powerful in classroom situations. The teacher sets up a contract, perhaps with the help of the counselor, specifying what is expected of the students, academically and non academically, and what reinforcements they may expect for behaving these ways.

Thus the students may be required to bring specified supplies, abide by a list of well specified classroom rules, and turn in their homework completed to a specified degree.

1.6.1 Reinforcement for Contingency

Reinforcements may include opportunity to spend a certain amount of time in a reward area or opportunity to work on a special project.

Ideally the teacher has negotiated all aspects of the contract with the students and all students fully understand the contract.

Consider the contingencies operative in many classrooms below the college level. To cite an example let us say that teachers have a certain amount of material they wish to cover and work they wish completed. For the students the contingent event for completing some work is more work. Hence the students learn to work well below capacity, the teachers push for more to be done, and a certain amount of antagonism develops between teachers and students. Now with contingency contracting the teacher presents the work that needs to be done and asks the students what reinforcements they would like for completing the work and what sort of classroom rules can be established to facilitate this program. This results in the students and teacher working together to establish a mutually satisfactory contract.

Such an approach generally results in a decrease in behaviour problems, an increase in the students liking the classroom setting, and the students doing the work much faster than would be expected.

Most teachers, particularly with younger children, spend most of their time being policemen.

Contingency contracting provides a behaviour management system that frees the teachers to do more teaching.

1.6.2 Consistency in Contingency Contracting

Consistency is a critical aspect of most behaviour change programs, while inconsistency can generate many problems. If a parent or teacher is consistent in dealing with a child, the child can easily learn what contingencies are operative and feels comfortable understanding how part of the world works. Inconsistency, on the other hand, may produce uncertainty, anxiety, tantrums, psychosomatic illness, learned helplessness, and related problems. Children and others also engage in *rule-testing*, the intentional breaking of a rule to determine if the contingency is in effect. If the system is consistent, there will be some rule-testing. If inconsistent, there will be much rule testing. Although consistency is perhaps most important with children, it is also important with others. For example, inconsistency in a business setting may result in a drop in morale, feelings of favoritism, feeling powerless to control events, and not knowing what to expect.

A major strength of contingency contracting is that it teaches and requires people to be consistent. If one person fulfills his part of the contract, the other person must fulfill his part.

All operant conditioning involves reciprocity, a mutual interchange of contingent events, usually reinforcements. For example, in the classroom the teacher reinforces the students for various accomplishments and in turn is reinforced by these accomplishments. Contingency contracting is a way of establishing a level of reciprocity that is most satisfying for the various people involved. Thus it has proved a useful tool in marriage counseling and families in general.

1.6.3 Token Economies

In some contingency contracting programs the client is reinforced with *tokens* (e.g., poker chips, stars or marks on a chart, punch holes in a special card) that can later be exchanged for a choice of reinforcers.

Contingency contracting programs using tokens are called *token economies.* There are now a large number of such programs in a wide variety of settings. The tokens a person earns by completing his part of the contract are eventually exchanged for a choice of reinforcers from a *reinforcement menu.*

By having a large number of items and privileges on this menu the tokens are reinforcing for most of the people most of the time, even though people will buy different things at different times. This reduces problems of a person satiating on any particular reinforcer or continually trying to determine what is currently reinforcing to any person.

Strength of token systems is that they deal with the issue of delay of reinforcement discussed earlier.

The tokens are often easily dispensed and can be given fairly immediately after the desired behaviour. For example, a teacher may walk around a classroom putting checks on each student's small clipboard for appropriate behaviour and accomplishment. These checks are immediately reinforcing, even though they will not be cashed in until later.

They can also be dispensed without greatly disrupting the student's work.

Token systems are often used in home situations. A child may earn tokens every day, which maintains his behaviour, even though his purchased reinforcement does not come until the weekend. Or the child may use some of his tokens for small daily rewards (e.g., staying up an extra half hour) and save others over a period of time for a larger reward (e.g., a new toy).

1.7 DECREASING UNDESIRED BEHAVIOURS

Operant reinforcement strategies are some of the most powerful behaviour change approaches available. Contingency contracting and token economies are ways of formalising these approaches and thus often making them more effective. Now we turn to operant approaches for decreasing undesired behaviours. But remember that in most situations in which you are decreasing one behaviour, you should be reinforcing and increasing another so that desired behaviours are encouraged and the person continues receiving reinforcement.

1.7.1 Extinction

Establishing a contingency between a behaviour and a contingent event is operant conditioning; terminating this contingency is operant *extinction.* Reinforcing a behaviour increases the probability of that behaviour; withholding the reinforcement decreases the probability. A patient in a mental hospital may learn to emit psychotic talk because it gets him extra attention from the staff and other patients. Not reinforcing this type of talk may cause it to extinguish and thus occur less.

However, a person does not learn a simple behaviour to a stimulus, but rather learns a whole hierarchy of behaviours. The behaviour on the top of the hierarchy is the most probable to occur, the second behaviour the next most probable, and on down. The position on the hierarchy and the distance between items on the hierarchy are functions of how many times the behaviours have been reinforced.

If the top behaviour is extinguished, then the second behaviour will occur. And if this behaviour is considered undesirable, it will have to be extinguished.

Thus the problem with the extinction procedure is that considerable time may be spent going through the entire hierarchy or until a desirable behaviour is reached. For this reason the extinction procedure is generally inefficient unless the hierarchy is small, as with many problems with children. It is generally better to emphasise reinforcing a desired behaviour in place of the undesired behaviour.

Another problem is that it may be difficult or undesirable not to attend to some behaviours, such as destructive or disruptive behaviours. Extinction may also have emotional side effects such as frustration, anger, or confusion. These side effects are minimised if we are simultaneously reinforcing alternative behaviours.

1.7.2 Punishment

The most common approach people use to reduce undesired behaviours, particularly in others, is punishment. This consists in applying a contingent event to a behaviour that results in a decrease in the probability of the behaviour. As mentioned earlier, there are two types of punishment, (i) positive punishment and (ii) and negative punishment.

Positive punishment

Positive punishment is a contingent event whose onset or increase, results in a decrease in the probability of the behaviour it is contingent upon. If each time Raghu starts eating his mother's house plants that she shows disapproval and if this disapproval reduces the probability of Raghu eating the plants in the future, then the disapproval is positive punishment. Disapproval, criticism, pain, and fines are common forms of punishment.

As a behaviour change procedure punishment has many disadvantages and possible bad side effects: Punishing an undesirable behaviour does not necessarily result in desirable behaviours.

Punishing a child in a classroom for throwing things during self work time does not necessarily result in the child shifting to working alone.

Perhaps self work behaviours are not in the child's repertoire.

1.7.3 Reactions to Punishment

Punishment may condition in reactions such as fear, anxiety, or hate to the people who administer the punishment or the situations in which it occurs.

Thus children may fear their parents, students may dislike school, criminals may resent society, and workers may not fully cooperate with their foreman.

Related to this is that the person may learn to escape or avoid these people or situations, resulting in such possibilities as a school phobia or an increase in absenteeism from work.

Attempted punishment of an escape or avoidance response may rather increase the strength of the avoidance.

Punishing a child with a fear of the dark for not going into the basement at night alone may actually increase the fear.

The punished person may spend some time making up excuses and passing the blame to others.

The punishing agents may act as models for aggressive behaviour.

Children may model after their parents and learn to hit people when mad.

Workers may model their supervisors and become overcritical of the errors of their subordinates.

Finally, punished people may become generally less flexible and adaptable in their behaviours.

If punishment is to be used, it needs to be applied immediately after the behaviour and applied consistently. The earlier in the response chain the punishment occurs the better, for then it may stop or disrupt a sequence of undesired behaviours.

Punishment should generally be coupled with extinction and reinforcing of alternative behaviours. If possible the punishment should be viewed, by all people involved, as part of a contractual agreement rather than a personal attack.

Punishment is often used more for its disruptive effects than suppressive effects. As part of a self control program a person may wear a rubber band around his wrist which he snaps on the underside of his wrist to disrupt unwanted thoughts or feelings. Also just wearing the rubber band then acts as a reminder about his behaviour.

1.7.4 Overcorrection

Alternative form of punishment is *overcorrection*. In *positive practice overcorrection* the client is required to practice correct behaviours each time an episode of the undesired behaviours occurs. For instance, a child marking on the wall might be required to copy a set of patterns with pencil and paper. In the case of an autistic or hyperactive child who is pounding objects or himself, he would be told of his inappropriate behaviour which would be stopped. Then the child would be given verbal instructions, and physical guidance if necessary, for the overcorrection behaviour; in this case a few minutes of instruction for putting hands at sides, then over head, then straight out, and so forth.

In *restitutional overcorrection* or *restitution,* clients must correct the results of their misbehaviour to a better than normal state. A child who marks on the wall may be required to erase the marks and wash the entire wall as well. A child who turns over chairs may be required to set up those chairs and straighten up the rest of the furniture. Screaming may require a period of exceptional quiet.

1.7.5 Negative Punishment

Negative punishment is a contingent event whose offset or decrease results in a decrease in the behaviour it is contingent on. This generally consists of taking away something that is reinforcing from a person when he misbehaves. The procedure of negative punishment generally also results in positive punishment and/or extinction. In behaviour modification there are two major forms of negative punishmen and these are:

i) response cost and

ii) time out.

Response cost

This refers to the withdrawal or loss of a reinforcement contingent on a behaviour. This may be the loss or fine of tokens in a token system, such as a fine for the use of the wrong words. Response cost has been used to suppress a variety of behaviours such as smoking, overeating, stuttering, psychotic talk, aggressiveness, and tardiness. Possible advantages of response cost are that it may have fewer aversive side effects than positive punishment and it leaves the person in the learning situation, which time out does not.

Time out (or time out from reinforcement)

This refers to the punishment procedure in which the punishment is a period of time during which reinforcement is not available. For example, time out has been an effective punishment procedure in classrooms. If a child misbehaves, he may be sent to spend ten minutes in a time out area, perhaps a screened off corner in the back of the classroom. For time out to be effective the area the client is removed from must be reinforcing to him.

The classroom should be a reinforcing place and being in time out may result in a period of time in which the student cannot earn tokens.

Also the time out area should not be reinforcing. In a home, sending a child to his room may not be a good time out, as the room may be filled with reinforcers. Usually just a few minutes in time out are sufficient and it often gives the punished person a chance to cool off.

1.7.6 Stimulus Satiation

So far in this unit we have discussed two major ways of reducing undesired behaviours, extinction and punishment.

A third way is to reduce the reinforcing effects of the events supporting the undesired behaviour. Aversive counterconditioning is a way to do this.

A related approach *is stimulus satiation* in which the client is flooded with the reinforcer repeatedly until it loses much or all of its reinforcing effect. A child who keeps playing with matches might be sat down with a large number of matches to strike and light. This would be continued until lighting matches lost their reinforcing effect. It is not known how or why stimulus satiation works, but it seems to contain components of aversive counterconditioning and respondent extinction of reinforcing effects.

Stimulus satiation has been used in the treatment of smoking by dramatically increasing the number of cigarettes smoked and/or the rate of smoking the cigarettes. This stimulus satiation produced a significant reduction in smoking with 60 percent of the subjects abstinent at six months.

1.8 AREAS OF APPLICATION

Behaviour modification procedures have been used in many areas to help people change a vast array of problematic behaviours.

1.8.1 Developmental Disabilities

More behaviour modification research has been conducted in the field of developmental disabilities than perhaps any other area. People with developmental disabilities often have serious behavioural deficits, and behaviour modification has been used to teach a variety of functional skills to overcome these deficits. In addition, people with developmental disabilities may exhibit serious problem behaviours such as self-injurious behaviours, aggressive behaviours, and destructive behaviours. A wealth of research in behaviour modification demonstrates that these behaviours often can be controlled or eliminated with behavioural interventions (Barrett, 1986; VanHouten & Axelrod, 1993). Behaviour modification procedures also are used widely in staff training and staff management in the field of developmental disabilities (Reid, Parsons, & Green, 1989).

1.8.2 Mental Illness

Behaviour modification has been used with patients with chronic mental illness to modify such behaviours as daily living skills, social behaviour, aggressive behaviour, treatment compliance, psychotic behaviours, and work skills. One particularly important contribution of behaviour modification was the

development of a motivational procedure for institutional patients called a *token economy* (Ayllon & Azrin, 1968). Token economies are still widely used in a variety of treatment settings.

1.8.3 Education

Great strides have been made in the field of education because of behaviour modification research. Researchers have analysed student–teacher interactions in the classroom, improved teaching methods, and developed procedures for reducing problem behaviours in the classroom (Becker & Carnine, 1981; Madsen, Becker, & Thomas, 1968). Behaviour modification procedures have also been used in higher education to improve instructional techniques, and thus improve student learning.

1.8.4 Rehabilitation

Rehabilitation is the process of helping people regain normal function after an injury or trauma, such as a head injury from an accident or brain damage from a stroke. Behaviour modification is used in rehabilitation to promote compliance with rehabilitation routines such as physical therapy, to teach new skills that can replace skills lost through the injury or trauma, to decrease problem behaviours, to help manage chronic pain, and to improve memory performance.

1.8.5 Community Psychology

Within community psychology, behavioural interventions are designed to influence the behaviour of large numbers of people in ways that benefit everybody. Some targets of behavioural community interventions include reducing littering, increasing recycling, reducing energy consumption, reducing unsafe driving, reducing illegal drug use, increasing the use of seat belts, decreasing illegal parking in spaces for the disabled, and reducing speeding.

1.8.6 Clinical Psychology

In clinical psychology, psychological principles and procedures are applied to help people with personal problems. Typically, clinical psychology involves individual or group therapy conducted by a psychologist. Behaviour modification in clinical psychology, often called *behaviour therapy,* has been applied to the treatment of a wide range of human problems.

1.8.7 Business, Industry and Human Services

The use of behaviour modification in the field of business, industry, and human services is called *organisational behaviour modification* or *organisational behaviour management*. Behaviour modification procedures have been used to improve work performance and job safety and to decrease tardiness, absenteeism, and accidents on the job. In addition, behaviour modification procedures have been used to improve supervisors' performances. The use of behaviour modification in business and industry has resulted in increased productivity and profits for organisations and increased job satisfaction for workers.

1.8.8 Child Management

Numerous applications of behaviour modification to the management of child behaviour exist. Parents and teachers can learn to use behaviour modification

procedures to help children overcome bedwetting, nail-biting, temper tantrums, noncompliance, aggressive behaviours, bad manners, stuttering, and other common problems.

1.8.9 Sports

Behaviour modification is also used widely in the field of sports psychology and are also used to promote health-related behaviours by increasing healthy lifestyle behaviours (such as exercise and proper nutrition) and decreasing unhealthy behaviours (such as smoking, drinking, and overeating).

1.8.10 Medical Problems

Behaviour modification procedures are also used to promote behaviours that have a positive influence on physical or medical problems—such as decreasing frequency and intensity of headaches, lowering blood pressure, and reducing gastrointestinal disturbances —and to increase compliance with medical regimens. Applying behaviour modification to health-related behaviours is called *behavioural medicine* or *health psychology.*

Self Assessment Questions

Multiple choices:

1) "The consequences of behaviour affect their recurrence" is a basic principle of :
   - Respondent conditioning
   - Wolpian conditioning
   - Hullian conditioning
   - Operant conditioning

2) When using desensitisation with a client, first put the client into
   - a heavy state of relaxation
   - a mild tension-arousing scene
   - an intense tension-arousing scene
   - d a scene in which the client can rationally attack the fear

3) Bill, who has a tremendous fear of public speaking, has to take a literature course that requires an oral presentation. Which of the following should be the last tense scene for desensitisation?
   - Bill preparing for his presentation the night before he has to present it
   - Bill registering for the course
   - Bill finding out the course requirements the first day of class
   - Bill talking to his professor about his fears of making the presentation

4) Which statement concerning punishment is NOT correct?
   - Mild punishment is not as effective as the use of positive rewards.
   - Behaviours learned under punishment conditions extinguish quickly.
   - Punishment has longer lasting effects than positive reinforcement.
   - Punishment may result in unforeseen negative emotional consequences.

5) In the extinction process the
   - client is not permitted to behave
   - client is allowed intermittent reinforcement
   - reinforcement is totally eliminated
   - stimulus satiation is an important factor.

6) Having a client repeat a negative behaviour until it becomes aversive is called
   - stimulus satiation
   - drive satiation
   - response satiation
   - reinforcer satiation

7) Behaviour modification programs work best when
   - the individual is not aware of the consequences of his/her behaviour
   - the behaviour selected for modification occur infrequently
   - there are no baseline data
   - none of the above

8) Which of the following is the best example of punishment through satiation to eliminate an undesirable behaviour?
   - Administering an aversive stimulus whenever the client displays an undesirable behaviour
   - Giving the client an overabundance of whatever he or she wants
   - Withdrawing privileges whenever the client's behaviour becomes excessive
   - Allowing the client to do whatever he or she pleases and rewarding him or her only for desirable behaviour.

1.9 LET US SUM UP

Behaviour modification procedures involve analysing and manipulating current environmental events to change behaviour. A behavioural excess or behavioural deficit may be targeted for change with behaviour modification procedures. Behaviour modification procedures are based on behavioural principles derived from scientific research. B. F. Skinner conducted the early scientific research that laid the foundation for behaviour modification.

Behaviour modification procedures often are implemented by people in everyday life. Behaviour is measured before and after the behaviour modification procedures are applied to document the effectiveness of the procedures. Behaviour modification de-emphasises past events and rejects hypothetical underlying causes of behaviour.

Respondent conditioning is the learning model in which a stimulus situation comes to elicit a relatively new response or increase in response because of association with other stimulus situations. Formally, the conditioned stimulus

(CS) comes to elicit the conditioned response (CR) because of the person learning that the CS is associated with (provides information about) the unconditioned stimulus (UCS), which elicits the unconditioned response (UCR).

Respondent conditioning is sometimes used in behaviour modification to establish or strengthen a response, as in the treatment of enuresis. Undesired respondent behaviour is changed by respondent extinction or counterconditioning, both of which may or may not be done gradually with a hierarchy of intermediate steps.

Emphasis of operant conditioning is on changes in the probability of a behaviour in the presence of specific stimuli as a result of events contingent on the behaviour. A reinforcer increases the probability of a behaviour it is contingent on; a punisher decreases the probability.

The contingent event is usually dependent on the behaviour and occurs because of the behaviour. Procedures to get a behaviour to occur to reinforce it include shaping, modeling, fading, punishment, and guidance. Initial learning is usually best when the reinforcer occurs immediately after every example of the correct behaviour (short delay of reinforcement, continuous schedule of reinforcement).

Extinction is the return of the probability of a behaviour toward its initial value (baseline) after the contingent events have been removed. Use of an intermittent schedule of reinforcement increases resistance to extinction.

Punishment as a change procedure should generally be avoided because of undesirable side effects; but it can be used effectively to disrupt or suppress an undesired behaviour while a desired alternative is being strengthened. Positive punishment procedures include administering an aversive event and overcorrection, while negative punishment includes a withdrawal or loss of a reinforcer (response cost) and a period of time during which reinforcers cannot be acquired (time out).

The reinforcing effects of an event can be reduced by aversive counterconditioning or stimulus satiation. Nervous habits can be reduced by negative practice and habit reversal. Contingency contracting is a formalised operant program in which the contingencies are well specified and usually negotiated.

Behaviour modification procedures have been applied successfully to all aspects of human behaviour, including developmental disabilities; mental illness; education and special education; rehabilitation; community psychology; clinical psychology; business, industry, and human services; child management; prevention; sports psychology and health-related behaviours.

1.10 UNIT END QUESTIONS

1) What is the basic definition of human behaviour?

2) Identify eight defining characteristics of behaviour modification?

3) Briefly describe the contributions of Pavlov, Thorndike, Watson, and Skinner to the development of behaviour modification?

4) Discuss in depth the various operant procedures in behaviour modification?

5) Discuss respondent conditioning?

1.11 SUGGESTED READINGS

Baldwin, John and Janice Baldwin. *Behaviour Principles in Everyday Life*. Upper Saddle River, NJ: Prentice-Hall

Martin, Garry and Joseph Pear. *Behaviour Modification: What It Is and How to Do It*. Upper Saddle River, NJ: Prentice-Hall

1.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions

1) d, 2) a, 3). a, 4) c, 5) C, 6) C, 7) d, 8) b

UNIT 2 COGNITIVE BEHAVIOUR THERAPIES (INCLUDING RATIONAL EMOTIVE THERAPY)

Structure

2.0 INTRODUCTION

Cognitive-Behaviour Therapy (CBT) is based on the concept that emotions and behaviours result (primarily, though not exclusively) from cognitive processes; and that it is possible for human beings to modify such processes to achieve different ways of feeling and behaving. There are a number of 'cognitive-behavioural' therapies, which, although developed separately, have many

similarities. This unit will present an approach that combines Rational emotive behaviour therapy (REBT) and Cognitive therapy (CT); incorporating elements of some other approaches as well. The first half of the unit will cover the history of cognitive behaviour therapy, the theory of cognitive behaviour therapy, explanation of dysfunctional thinking and the second half will deal with the steps, process, practice principles and techniques of cognitive behaviour therapy. Lastly we will cover the applications and limitations of cognitive behaviour therapy.

2.1 OBJECTIVES

After reading this unit, you should be able to:

- Know the history and theory and core ideas of cognitive behaviour therapy;
- Discuss the steps, process and treatment principles of cognitive behaviour therapy;
- Describe the different techniques of cognitive behaviour therapy; and
- Describe the applications and limitations of cognitive behaviour therapy.

2.2 HISTORY OF COGNITIVE BEHAVIOUR THERAPY

The 'cognitive' psychotherapies can be said to have begun with Alfred Adler, one of Freud's close associate. Adler disagreed with Freud's idea that the cause of human emotionality was 'unconscious conflicts', arguing that thinking was a more significant factor. Cognitive Behaviour Therapy has its modern origins in the mid 1950's with the work of Albert Ellis, a clinical psychologist. Ellis originally trained in psychoanalysis, but became disillusioned with the slow progress of his clients. He observed that they tended to get better when they changed their ways of thinking about themselves, their problems, and the world. Ellis reasoned that therapy would progress faster if the focus was directly on the client's beliefs, and developed a method now known as Rational Emotive Behaviour Therapy (REBT). Ellis' method and a few others, for example Glasser's 'Reality Therapy' and Berne's 'Transactional Analysis', were initially categorised under the heading of 'Cognitive Psychotherapies'.

The second major cognitive psychotherapy was developed in the 1960's by psychiatrist Aaron Beck; who, like Ellis, was previously a psychoanalyst. Beck called his approach Cognitive Therapy (CT). (Note that because the term 'Cognitive Therapy' is also used to refer to the category of cognitive therapies, which includes REBT and other approaches, it is sometimes necessary to check whether the user is alluding to the general category or to Beck's specific variation).

Since the pioneering work of Ellis and Beck, a number of other cognitive approaches have developed, many as offshoots of REBT or CT. The term 'Cognitive Behaviour Therapy' came into usage around the early 1990's, initially used by behaviourists to describe behaviour therapy with a cognitive flavour. In more recent years, 'CBT' has evolved into a generic term to include the whole range of cognitively oriented psychotherapies. REBT and CT have been joined by such developments as Rational Behaviour Therapy (Maxie Maultsby),

Multimodal Therapy (Arnold Lazarus), Dialectical Behaviour Therapy (Marsha Linehan), Schema Therapy (Jeffrey Young) and expanded by the work of such theorists as Ray DiGiuseppe, Michael Mahoney, Donald Meichenbaum, Paul Salkovskis and many others.

All of these approaches are characterised by their view that cognition is a key determining factor in how human beings feel and behave, and that modifying cognition through the use of cognitive and behavioural techniques can lead to productive change in dysfunctional emotions and behaviours.

Though the various versions or 'brands' of cognitive behavioural therapy (CBT) can be distinguished in terms of certain aspects of the client therapist relationship, the cognitive target for change, the assessment of change, the degree of emphasis placed on the client's self-control, and the degree to which cognitive or behavioural change is the focus, treatment principles common to all cognitive behavioural therapies can be identified.

2.3 THEORY OF CAUSATION

CBT is not just a set of techniques. It also contains comprehensive theories of human behaviour. CBT proposes a 'biopsychosocial' explanation as to how human beings come to feel and act as they do that is, that a combination of biological, psychological, and social factors are involved. The most basic premise is that almost all human emotions and behaviours are the result of what people think, assume or believe (about themselves, other people, and the world in general). It is what people believe about situations they face not the situations themselves that determine how they feel and behave.

Both REBT and CT, however, argue that a person's biology also affects their feelings and behaviours which is an important point, as it is a reminder to the therapist that there are some limitations on how far a person can change.

2.3.1 ABC Model

A useful way to illustrate the role of cognition is with the 'ABC' model. (Originally developed by Albert Ellis, the ABC model has been adapted for more general CBT use). In this framework 'A' represents an event or experience, 'B' represents the beliefs about the A, and 'C' represents the emotions and behaviours that follow from those beliefs. Here is an example of an 'emotional episode', as experienced by a person prone to depression who tends to misinterpret the actions of other people:

A) **Activating event:** Friend passed me in the street without acknowledging me.

B) **Beliefs about A:** He's ignoring me. He doesn't like me.
I'm unacceptable as a friend – so I must be worthless as a person.
For me to be happy and feel worthwhile, people must like me.

C) **Consequence:** Emotions: hurt, depressed.
Behaviours: avoiding people generally.

Note that 'A' doesn't cause 'C': 'A' triggers off 'B'; 'B' then causes 'C'. Also, ABC episodes do not stand alone: they run in chains, with a 'C' often becoming

the 'A' of another episode – we observe our own emotions and behaviours, and react to them. For instance, the person in the example above could observe their avoidance of other people ('A'), interpret this as weak ('B'), and engage in self-downing ('C').

Note, too, that most beliefs are outside conscious awareness. They are habitual or automatic, often consisting of underlying 'rules' about how the world and life should be. With practice, though, people can learn to uncover such subconscious beliefs.

2.4 DYSFUNCTIONAL THINKING

We have seen that what people think determines how they feel. But what types of thinking are problematical for human beings?

To describe a belief as 'irrational' is to say that:

It blocks a person from achieving their goals, creates extreme emotions that persist and which distress and immobilise, and leads to behaviours that harm oneself, others, and one's life in general.

It distorts reality (it is a misinterpretation of what is happening and is not supported by the available evidence);

It contains illogical ways of evaluating oneself, others, and the world.

2.4.1 The Three Levels of Thinking

Human beings appear to think at three levels:

1) Inferences;
2) Evaluations; and
3) Core beliefs.

Every individual has a set of general 'core beliefs' usually subconscious, that determines how they react to life. When an event triggers off a train of thought, what someone *consciously* thinks depends on the core beliefs they *subconsciously* apply to the event.

Let's say that a person holds the *core belief*:

'For me to be happy, my life must be safe and predictable.' Such a belief will lead them to be hypersensitive to any possibility of danger and overestimate the likelihood of things going wrong. Suppose they hear a noise in the night. Their hypersensitivity to danger leads them to *infer* that there is an intruder in the house. They then *evaluate* this possibility as catastrophic and unbearable, which creates feelings of panic.

Here is an example (using the ABC model) to show how it all works:

Your friend phones and asks if you will help her for a project for the rest of the day. You had already planned to catch up with some reading.

You *infer* that: 'If I say no, she will think badly of me.' You *evaluate* your inference: 'I couldn't stand to have her disapprove of me and see me as selfish.' Your

inference and the evaluation that follows are the result of holding the *underlying core belief*: 'To feel OK about myself, I need to be liked, so I must avoid disapproval from any source.'

You feel anxious and say yes.

Cognitive Therapy focuses mainly on inferential-type thinking, helping the client to check out the reality of their beliefs, and has some sophisticated techniques to achieve this empirical aim.

REBT emphasises dealing with evaluative type thinking (in fact, in REBT, the client's inferences are regarded as part of the 'A' rather than the 'B').

When helping clients explore their thinking, REBT practitioners would tend to use strategies that examine the logic behind beliefs (rather than query their empirical validity).

What REBT and CT do share, though, is an ultimate concern with underlying core beliefs.

2.4.2 Two Types of Disturbance

Knowing that there are different levels of thinking does not tell us much about the actual content of that thinking. The various types of CBT have different ideas of what content is important to focus on (though the differences are sometimes a matter of terminology more than anything else).

One way of looking at the content issue that is helpful comes from REBT, which suggests that human beings defeat or 'disturb' themselves in two main ways: (1) by holding irrational beliefs about their 'self' (ego disturbance) and (2) by holding irrational beliefs about their emotional or physical comfort (discomfort disturbance). Frequently, the two go together – people may think irrationally about both their 'selves' and their circumstances – though one or the other will usually be predominant.

2.4.3 Seven Inferential Distortions

In everyday life, events and circumstances trigger off two levels of thinking: inferring and evaluating. At the first level, we make guesses or *inferences* about what is 'going on' – what we think has happened, is happening, or will be happening. Inferences are statements of 'fact' (or at least what we think are the facts – they can be true or false). Inferences that are irrational usually consist of 'distortions of reality' like the following:

1) **Black and white thinking:** This refers to seeing things in extremes, with no middle ground that is either good or bad, perfect versus useless, success or failure, right against wrong, moral versus immoral, and so on. This is also known as all ornothing thinking.

2) **Filtering:** This refers to seeing all that is wrong with oneself or the world, while ignoring any positives.

3) **Over-generalisation:** This refers to building up one thing about oneself or one's circumstances and ending up thinking that it represents the whole situation. For example: 'Everything's going wrong', 'Because of this mistake,

I'm a total failure'. Or, similarly, believing that something which has happened once or twice is happening all the time, or that it will be a never-ending pattern: 'I'll always be a failure', 'No-one will ever want to love me', and the like.

4) **Mind-reading:** This involves making guesses about what other people are thinking, such as: 'She ignored me on purpose', or 'He's mad with me'.

5) **Fortune-telling:** Here this refers to treating beliefs about the future as though they were actual realities rather than mere predictions, for example: 'I'll be depressed forever', 'Things can only get worse'.

6) **Emotional reasoning:** This refers to thinking that because we feel a certain way, this is how it really is: 'I feel like a failure, so I must be one', 'If I'm angry, you must have done something to make me so', and the like.

7) **Personalising:** This means assuming, without evidence, that one is responsible for things that happen: 'I caused the team to fail', 'It must have been me that made her feel bad', and so on.

The seven types of inferential thinking described above have been outlined by Aaron Beck and his associates.

2.4.4 Evaluations

As well as making inferences about things that happen, we go beyond the 'facts' to evaluate them in terms of what they mean to us. Evaluations are sometimes conscious, sometimes beneath awareness. According to REBT, irrational evaluations consist of one or more of the following four types:

i) Demandingness
ii) Awfulising
iii) Discomfort Intolerance
iv) People rating

These four are being discussed below:

i) **Demandingness:** Described colourfully by Ellis as 'musturbation', demandingness refers to the way people use unconditional should and absolutistic musts, believing that certain things must or must not happen, and that certain conditions (for example success, love, or approval) are absolute necessities.

   Demandingness implies certain 'Laws of the Universe' that must be adhered to. Demands can be directed either toward oneself or others. Some REBT theorists see demandingness as the 'core' type of irrational thinking, suggesting that the other three types derive from it.

ii) **Awfulising:** Exaggerating the consequences of past, present or future events; seeing something as awful, terrible, horrible, that is the worst that could happen.

iii) **Discomfort intolerance:** This is often referred to as *'can't-stand-it-itis'*: This is based on the idea that one cannot bear some circumstance or event.

It often follows awfulising, and leads to demands that certain things do not happen.

iv) **People Rating:** People rating refers to the process of evaluating one's entire self (or someone else's). In other words, trying to determine the total value of a person or judging their worth. It represents an overgeneralisation. The person evaluates a specific trait, behaviour or action according to some standard of desirability or worth. Then they apply the evaluation to their total person as for example, 'I did a bad thing, therefore I am a bad person.' People rating can lead to reactions like self downing, depression, defensiveness, grandiosity, hostility, or over concern with approval and disapproval.

2.4.5 Core Beliefs

Guiding a person's inferences and evaluations are their core beliefs. Core beliefs are the underlying, general assumptions and rules that guide how people react to events and circumstances in their lives. They are referred to in the CBT literature by various names: '**schema**'; 'general rules'; 'major beliefs'; 'underlying philosophy', etc. REBT and CT both propose slightly different types of core belief. In this unit we would refer to them as *assumptions* and *rules*.

Assumptions are a person's beliefs about how the world is – how it works, what to watch out for, etc. They reflect the 'inferential' type of thinking. Here are some examples:

My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.

Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.

It is easier to avoid rather than face responsibilities.

Rules are more prescriptive – they go beyond describing what is to emphasise what should be. They are 'evaluative' rather than inferential. Here are some examples:

I need love and approval from those significant to me – and I must avoid disapproval from any source.

To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.

People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.

Things must be the way I want them to be, otherwise life will be unbearable.

I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.

Because they are too much to bear, I must avoid life's difficulties, unpleasantness, and responsibilities.

Everyone needs to depend on someone stronger than themselves.

I should become upset when other people have problems, and feel unhappy when they're sad.

I shouldn't have to feel discomfort and pain – I can't stand them and must avoid them at all costs.

Every problem should have an ideal solution –and it's intolerable when one can't be found.

2.5 STEPS IN COGNITIVE BEHAVIOUR THERAPY

The steps involved in helping clients change can be broadly summarised as follows:

i) Help the client understand that emotions and behaviours are caused by beliefs and thinking. This may consist of a brief explanation (Psychoeducation) followed by assignment of some reading.

ii) Show how the relevant beliefs may be uncovered.

The ABC format is useful here. Using an episode from the client's own recent experience, the therapist notes the 'C', then the 'A'. The client is asked to consider (at 'B'): 'What was I telling myself about 'A', to feel and behave the way I did at 'C'? As the client develops understanding of the nature of irrational thinking, this process of 'filling in the gap' will become easier. Such education may be achieved by reading, direct explanation, and by record-keeping with the therapist's help and as homework between sessions.

iii) Teach the client how to dispute and change the irrational beliefs, replacing them with more rational alternatives.

Again, education will aid the client. The ABC format is extended to include 'D' (Disputing irrational beliefs), 'E' (the desired new Effect – new ways of feeling and behaving), and 'F' (Further Action for the client to take). (Refer to table below)

Table: Rational Self-Analysis

CBT emphasises teaching clients to be their own therapists. A useful technique to aid this is Rational Self-Analysis (Froggatt, 2003) which involves writing down an emotional episode in a structured fashion. Here is an example of such an analysis using the case example described earlier:

A) **Activating Event** (what started things off):

Friend passed me in the street without acknowledging me.

C) **Consequence** (how I reacted):

Feelings: worthless, depressed. Behaviour: avoiding people generally.

B) **Beliefs** (what I thought about the 'A'):

1) He's ignoring me and doesn't like me. (inference)

2) I could end up without friends for ever. (inference) This would be terrible. (evaluation)

3) I'm not acceptable as a friend (inference)- so I must be worthless as a person. (evaluation)

4) To feel worthwhile and be happy, I must be liked and approved by everyone significant to me. (core belief)

E) **New Effect** (how I would prefer to feel/behave):

Disappointed but not depressed.

D) **Disputation** (of old beliefs and developing new rational beliefs to help me achieve the new reaction):

1) How do I know he ignored me on purpose? He may not have seen me. Even if he did ignore me, this doesn't prove he dislikes me – he may have been in a hurry, or perhaps upset or worried in some way.

2) Even if it were true that he disliked me, this doesn't prove I'll never have friends again. And, even this unlikely possibility would be unpleasant rather than a source of 'terror'.

3) There's no proof I'm not acceptable as a friend. But even if I were, this proves nothing about the total 'me', or my 'worthwhileness'. (And, anyway, what does 'worthwhile' mean?).

4) Love and approval are highly desirable. But, they are not absolute necessities. Making them so is not only illogical, but actually screws me up when I think they may not be forthcoming. Better I keep them as preferences rather than demands.

F) **Further Action** (what I'll do to avoid repeating the same irrational/ thoughts reactions):

1) Re-read material on catastrophising and self-rating.

2) Go and see my friend, check out how things really are (at the same time, realistically accepting that I can't be sure of the outcome).

3) Challenge my irrational demand for approval by doing one thing each day (for the next week) that I would normally avoid doing because of fear it may lead to disapproval.

iv) Help the client to get into action.

Acting against irrational beliefs is an essential component of CBT. The client may, for example, dispute the belief that disapproval is intolerable by deliberately doing something to attract it, to discover that they in fact survive. CBT's emphasis on both rethinking and action makes it a powerful tool for change. The action part is often carried out by the client as 'homework'.

2.6 THE PROCESS OF COGNITIVE BEHAVIOUR THERAPY

This section of the unit will deal with the summary of the main components of CBT intervention.

2.6.1 Engage Client

The first step is to build a relationship with the client. This can be achieved using the core conditions of empathy, warmth and respect. Watch for any 'secondary disturbances' about coming for help: self-downing over having the problem or needing assistance; and anxiety about coming to the interview. Finally, possibly the best way to engage a client is to demonstrate to them at an early stage that change is possible and that CBT is able to assist them to achieve this goal.

2.6.2 Assess the Problem, Person and Situation

Assessment will vary from person to person, but following are some of the most common areas that will be assessed as part of a CBT intervention.

- Start with the client's view of what is wrong for them.
- Determine the presence of any related clinical disorders.
- Obtain a personal and social history.
- Assess the severity of the problem.
- Note any relevant personality factors.
- Check for any secondary disturbance: How does the client feel about having this problem?
- Check for any non-psychological causative factors: physical conditions; medications; substance abuse; lifestyle/environmental factors.

2.6.3 Prepare the Client for Therapy

- Clarify treatment goals.
- Assess the client's motivation to change.
- Introduce the basics of CBT, including the biopsychosocial model of causation.
- Discuss approaches to be used and implications of treatment.
- Develop a contract.

2.6.4 Implement the Treatment Programme

Most of the sessions will occur in the implementation phase, using activities like the following:

Analysing specific episodes where the target problems occur, ascertaining the beliefs involved, changing them, and developing relevant homework (known as 'thought recording' or 'rational analysis').

Developing behavioural assignments to reduce fears or modify ways of behaving.

Supplementary strategies and techniques as appropriate, e.g. relaxation training, interpersonal skills training, etc.

2.6.5 Evaluate Progress

Toward the end of the intervention it will be important to check whether improvements are due to significant changes in the client's thinking, or simply to a fortuitous improvement in their external circumstances.

2.6.6 Prepare the Client for Termination

It is usually very important to prepare the client to cope with setbacks. Many people, after a period of wellness, think they are 'cured' for life. Then, when they slip back and discover their old problems are still present to some degree, they tend to despair and are tempted to give up self-help work altogether.

Warn that relapse is likely for many mental health problems and ensure the client knows what to do when their symptoms return.

Discuss their views on asking for help if needed in the future. Deal with any irrational beliefs about coming back, like: 'I should be cured for ever', or: 'The therapist would think I was a failure if I came back for more help'.

2.7 THE TREATMENT PRINCIPLES OF CBT

The basic aim of CBT is to leave clients at the completion of therapy with freedom to choose their emotions, behaviours and lifestyle (within physical, social and economic restraints); and with a method of self observation and personal change that will help them maintain their gains.

Not all unpleasant emotions are seen as dysfunctional. Nor are all pleasant emotions functional. CBT aims not at 'positive thinking'; but rather at realistic thoughts, emotions and behaviours that are in proportion to the events and circumstances an individual experiences.

Developing emotional control does not mean that people are encouraged to become limited in what they feel – quite the opposite. Learning to use cognitive-behavioural strategies helps oneself become open to a wider range of emotions and experiences that in the past they may have been blocked from experiencing.

There is no 'one way' to practice CBT. It is 'selectively eclectic'. Though it has techniques of its own, it also borrows from other approaches and allows practitioners to use their imagination. There are some basic assumptions and principles, but otherwise it can be varied to suit one's own style and client group.

CBT is educative and collaborative. Clients learn the therapy and how to use it on themselves (rather than have it 'done to them'). The therapist provides the training – the client carries it out. There are no hidden agendas – all procedures are clearly explained to the client. Therapist and client together design homework assignments.

The relationship between therapist and client is seen as important, the therapist showing empathy, unconditional acceptance, and encouragement toward the client. In CBT, the relationship exists to facilitate therapeutic work – rather than being the therapy itself. Consequently, the therapist is careful to avoid activities that create dependency or strengthen any 'needs' for approval.

CBT is brief and time-limited. It commonly involves five to thirty sessions over one to eighteen months. The pace of therapy is brisk. A minimum of time is spent on acquiring background and historical information: it is task oriented and focuses on problem-solving in the present.

CBT tends to be anti-moralistic and scientific. Behaviour is viewed as functional or dysfunctional, rather than as good or evil. CBT is based on research and the principles of logic and empiricism, and encourages scientific rather than 'magical' ways of thinking.

Finally, the emphasis is on profound and lasting change in the underlying belief system of the client, rather than simply eliminating the presenting symptoms. The client is left with self-help techniques that enable coping in the long-term future.

2.8 COGNITIVE BEHAVIOURAL TECHNIQUES

There are no techniques that are essential to CBT –one uses whatever works, assuming that the strategy is compatible with CBT theory (the 'selectively eclectic' approach). However, the following are examples of procedures in common use.

2.8.1 Cognitive Techniques

Self-monitoring

Self-monitoring is an important assessment tool. The therapist instructs the patient to observe and record her own behavioural and emotional reactions. As these reactions are distributed throughout the patient's daily life, self-monitoring tends to be employed as a homework assignment. The therapist and patient collaboratively select the target of monitoring (e.g., a symptom, behaviour, or reaction) based upon the patient's goals and presenting problem list. Self-monitoring serves at least three purposes within a course of CBT:

1) it encourages and effectively trains the patient to observe her own reactions in a more scientific manner;
2) it renders a concrete record of the target symptoms and problems; and
3) new problems can become apparent and targeted for future intervention.

Self-monitoring is especially useful in early sessions as a means of assessing the severity or frequency of a particular problem or symptom. However, self-monitoring is equally useful in later sessions as a means of tracking the patient's progress. Examples of self-monitoring include a record of daily activities and corresponding mood; a frequency count of the number of panic attacks per day; a record of the frequency and content of auditory hallucinations; and a food diary in which time, quantity, and type of food eaten are recorded (J. S. Beck, 1995).

Rational analysis

This refers to the analyses of specific episodes to teach client how to uncover and dispute irrational beliefs (as described above). These are usually done in-session at first – as the client gets the idea, they can be done as homework.

Double-standard dispute

If the client is holding a 'should' or is self-downing about their behaviour, ask whether they would globally rate another person (e.g. best friend, therapist, etc.) for doing the same thing, or recommend that person hold their demanding core belief. When they say 'No', help them see that they are holding a double-standard.

This is especially useful with resistant beliefs which the client finds hard to give up.

Catastrophe scale

This is a useful technique to get **awfulising** into perspective. On a whiteboard or sheet of paper, draw a line down one side. Put 100% at the top, 0% at the bottom, and 10% intervals in between. Ask the client to rate whatever it is they are catastrophising about, and insert that item into the chart in the appropriate place. Then, fill in the other levels with items the client thinks apply to those levels.

You might, for example, put 0%: 'Having a quiet cup of coffee at home', 20%: 'Having to do chores when the cricket is on television', 70%: being burgled, 90%: being diagnosed with cancer, 100%: being burned alive, and so on. Finally, have the client progressively alter the position of their feared item on the scale, until it is in perspective in relation to the other items.

Devil's advocate

This is a useful and effective technique (also known as reverse role-playing) which is designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional. It is especially useful when the client now sees the irrationality of a belief, but needs help to consolidate that understanding.

Reframing

This is another strategy for getting bad events into perspective is to re-evaluate them as 'disappointing', 'concerning', or 'uncomfortable' rather than as 'awful' or 'unbearable'. A variation of reframing is to help the client see that even negative events almost always have a positive side to them, listing all the positives the client can think of (Note this needs care so that it does not come across as suggesting that a bad experience is really a 'good' one).

2.8.2 Imagery Techniques

Time projection

This technique is designed to show that one's life and the world in general, continue after a feared or unwanted event has come and gone. Ask the client to visualise the unwanted event occurring, then imagine going forward in time a week, then a month, then six months, then a year, two years, and so on, considering how they will be feeling at each of these points in time. They will thus be able to see that life will go on, even though they may need to make some adjustments.

The 'worst-case' technique

People often try to avoid thinking about worst possible scenarios in case doing so makes them even more anxious. However, it is usually better to help the client identify the worst that could happen. Facing the worst, while initially increasing anxiety, usually leads to a longer-term reduction because

1) the person discovers that the 'worst' would be bearable if it happened, and
2) realises that as it probably won't happen, the more likely consequences will obviously be even more bearable; or

3) if it did happen, they would in most cases still have some control over how things turn out.

The 'blow-up' technique

This is a variation of 'worst-case' imagery, coupled with the use of humour to provide a vivid and memorable experience for the client. It involves asking the client to imagine whatever it is they fear happening, then blow it up out of all proportion till they cannot help but be amused by it. Laughing at fears helps get them under control.

2.8.3 Behavioural Techniques

One of the best ways to check out and modify a belief is to act. Clients can be encouraged to check out the evidence for their fears and to act in ways that disprove them.

Exposure

This is possibly the most common behavioural strategy used in CBT involves clients entering feared situations they would normally avoid. Such 'exposure' is deliberate, planned and carried out using cognitive and other coping skills.

The purposes are to

1) test the validity of one's fears (e.g. that rejection could not be survived);
2) deawfulise them (by seeing that catastrophe does not ensue);
3) develop confidence in one's ability to cope (by successfully managing one's reactions); and
4) increase tolerance for discomfort (by progressively discovering that it is bearable).

Hypothesis testing

In this, there is a variation of exposure, the client

1) writes down what they fear will happen, including the negative consequences they anticipate, then
2) for homework, carries out assignments where they act in the ways they fear will lead to these consequences (to see whether they do in fact occur).

Risk-taking

The purpose is to challenge beliefs that certain behaviours are too dangerous to risk, when reason says that while the outcome is not guaranteed they are worth the chance. For example, if the client has trouble with perfectionism or fear of failure, they might start tasks where there is a chance of failing or not matching their expectations. Or a client who fears rejection might talk to an attractive person at a party or ask someone for a date.

Stimulus control

Sometimes behaviours become conditioned to particular stimuli; for example, difficulty sleeping can create a connection between being in bed and lying awake; or the relief felt when a person vomits after bingeing on food can lead to a connection between bingeing and vomiting. Stimulus control is designed to lengthen the time between the stimulus and the response, so as to weaken the

connection. For example, the person who tends to lie in bed awake would get up if unable to sleep for 20 minutes and stay up till tired. Or the person purging food would increase the time between a binge and the subsequent purging.

Paradoxical behaviour

When a client wishes to change a dysfunctional tendency, encourage them to deliberately behave in a way contradictory to the tendency. Emphasise the importance of not waiting until they 'feel like' doing it: practising the new behaviour – even though it is not spontaneous – will gradually internalise the new habit.

Stepping out of character

This is one common type of paradoxical behaviour. For example, a perfectionist person could deliberately do some things to less than their usual standard; or someone who believes that to care for one self is 'selfish' could indulge in a personal treat each day for a week.

Postponing gratification

This is commonly used to combat low frustration tolerance by deliberately delaying smoking, eating sweets, using alcohol, etc.

2.8.4 Other Strategies

Problem solving

Activity Scheduling

Skills training, e.g. relaxation, social skills.

Reading (self re-education).

Tape recording of interviews for the client to replay at home.

Probably the most important CBT strategy is ***homework***. This includes reading, self-help exercises such as thought recording, and experiential activities. Therapy sessions can be seen as 'training sessions', between which the client tries out and uses what they have learned.

2.9 APPLICATIONS OF CBT

CBT has been successfully used to help people with a range of clinical and non-clinical problems, using a variety of modalities. Typical clinical applications include:

- Depression
- Anxiety disorders, including obsessive compulsive disorder, agoraphobia, specific phobias, generalised anxiety, posttraumatic stress disorder, etc.
- Eating disorders
- Addictions
- Hypochondriasis
- Sexual dysfunction
- Anger management

- Impulse control disorders
- Antisocial behaviour
- Jealousy
- Sexual abuse recovery
- Personality disorders
- Adjustment to chronic health problem, physical disability, or mental disorder
- Pain management
- General stress management
- Child or adolescent behaviour disorders
- Relationship and family problems

The most common use of CBT is with individual clients, but this is followed closely by group work, for which CBT is eminently suited. CBT is also frequently used with couples, and increasingly with families.

2.10 LIMITATIONS AND CONTRAINDICATIONS

It is safe to say that CBT has proved quite versatile, having been successfully applied to a wide spectrum of psychological difficulty. The limits of cognitive therapy have yet to be empirically established. However, several factors may make the cognitive-behavioural approach less effective; in fact, these factors may interfere with the efficacy of any psychotherapeutic approach. Low patient motivation, unless appropriately addressed, can impede progress, especially among patients who hold beliefs that they will suffer significant adverse consequences if they comply with treatment. Patients who have positive beliefs about dysfunctional aspects of their disorder likewise need special intervention. Examples include the schizophrenic patient's grandiose delusion (e.g., one who believes he is being persecuted because he is a great deity) and the anorexic patient's social beliefs (e.g., she is superior to others).

Even when motivation is present, the success of cognitive-behavioural methods can be hampered by mental facility. Severely retarded individuals, for example, might not be capable of the reasoning entailed in cognitive restructuring. Self-monitoring might also prove to be too demanding a task for a person with severe intellectual impairment. Behavioural methods may be more appropriate for these individuals than cognitive strategies. Psychopaths (Lykken, 1995) might also have difficulty with certain cognitive interventions; when performing a goal-directed task, they may be less able to attend to peripheral information or to self-regulate, especially under conditions of neutral motivation (Newman et al., 1997).

Finally, cultural differences may impact efficacy if therapists do not tailor the therapy appropriately. Therapists must understand, for example, how these differences may affect the building of a therapeutic alliance and how patients' cultural beliefs affect their thinking and reactions. Different thinking styles and stylistic preferences must often be accommodated for patients to progress.

Self Assessment Questions 1

1) What does A, B, C represent in the ABC model used to explain the role of cognitions?

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2) What are the two main ways in which human beings disturb themselves?

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3) What are core beliefs?

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4) Name the main components of CBT intervention?

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5) Explain the technique playing "Devil's advocate'?

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2.11 LET US SUM UP

Cognitive behaviour therapy (CBT) is a type of psychotherapeutic treatment that helps patients to understand the thoughts and feelings that influence behaviours. Cognitive behaviour therapy is generally short-term and focused on helping clients deal with a very specific problem. During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behaviour.

The underlying concept behind CBT is that our thoughts and feelings play a fundamental role in our behaviour. For example, a person who spends a lot of time thinking about plane crashes, runway accidents and other air disasters may find themselves avoiding air travel. The goal of cognitive behaviour therapy is to teach patients that while they cannot control every aspect of the world around them, they can take control of how they interpret and deal with things in their environment. Cognitive behaviour therapy has become increasingly popular in recent years with both mental health consumers and treatment professionals. Because CBT is usually a short-term treatment option, it is often more affordable than some other therapeutic options. CBT is also empirically supported and has been shown to effectively help patients overcome a wide variety.

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self help material. There are a number of different approaches to CBT that are regularly used by mental health professionals. These types include Rational Emotive Therapy, Cognitive Therapy and Multimodal Therapy.

Cognitive behaviour therapy has been used to treat people suffering from a wide range of disorders, including anxiety, phobias, depression, addiction and a variety of maladaptive behaviours. CBT is one of the most researched types of therapy, in part because treatment is focused on a highly specific goal and results can be measured relatively easily. Cognitive behaviour therapy is well-suited for people looking for a short-term treatment options that does not necessarily involve pharmacological medication. One of the greatest benefits of CBT is that it helps clients develop coping skills that can be useful both now and in the future.

2.12 UNIT END QUESTIONS

1) Discuss the history and theory of Cognitive behaviour therapy?

2) Discuss in detail dysfunctional thinking with examples?

3) Describe the steps and process of cognitive behaviour therapy?

4) What are the treatment principles of CBT?

5) Describe in detail the various cognitive and behavioural techniques in CBT?

6) Write about the applications and limitations of CBT?

2.13 SUGGESTED READINGS

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). Oxford *Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Gabbard, Glen O. (2009). *Textbook of Psychotherapeutic Treatments*. U.S.A: American Psychiatric Publishing, Inc.

2.14 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) 'A' represents an event or experience, 'B' represents the beliefs about the A, and 'C' represents the emotions and behaviours that follow from those beliefs.

2) The human beings defeat or 'disturb' themselves in two main ways: by holding irrational beliefs about their 'self' (ego disturbance) and by holding irrational beliefs about their emotional or physical comfort (discomfort disturbance).

3) Core beliefs are the underlying, general assumptions and rules that guide how people react to events and circumstances in their lives.

4) The main components of CBT are engaging the client; assessing the problem, person and situation; preparing the client for therapy; implementing the treatment program; evaluating progress and lastly preparing the client for termination.

5) Devil's advocate is a useful and effective technique designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional.

UNIT 3 SOLUTION FOCUSED THERAPY

Structure

3.0 INTRODUCTION

Solution Focused Therapy (SFT) is a form of brief therapy which builds upon clients' strengths by helping them to evoke and construct solutions to their problems. It emphasises the future, more than the past or the present. In a solution focused approach the counsellor and client devote a greater proportion of time to solution construction than to problem exploration. They try to define as clearly as possible what the clients would like to see in their lives. This unit will offer an overview to the general structure of Solution Focused Therapy. These following sections are included in this unit: overview, description and basic tenets of SFT, ingredients of solution focused therapy, the process and treatment principles of SFT, various intervention techniques and applications of solution focused therapy.

3.1 OBJECTIVES

After completing this unit, you should be able to:

- Describe and explain the rationale of solution focused therapy;
- Explain the key ingredients and tenets of solution focused therapy;
- Discuss the practice, issues and treatment principles of SFT; and
- Describe the various interventions and applications of SFT.

3.2 SOLUTION FOCUSED THERAPY (SFT)

The Solution focused approach originated in family therapy. Solution Focused Therapy treatment is based on over twenty years of theoretical development, clinical practice, and empirical research of the family therapists Steve de Shazer, Kim Insoo Berg and colleagues at the Brief Family Therapy Centre in Milwaukee, as well as Bill O'Hanlon, a therapist in Nebraska. The members of the Brief Therapy Practice in London pioneered the method in the United Kingdom.

Solution-Focused Therapy is different in many ways from traditional approaches to treatment. It is a competency-based model, which minimises emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. There is a focus on working from the client's understandings of her/ his concern/situation and what the client might want different. The basic tenets that inform Solution-Focus Therapy are as follows:

It is based on solution building rather than problem solving.

The therapeutic focus should be on the client's desired future rather than on past problems or current conflicts.

Clients are encouraged to increase the frequency of current useful behaviours

No problem happens all the time. There are exceptions that is there are times when the problem could have happened but did not. This can be used by the client and therapist to co construct solutions.

Therapists help clients find alternatives to current undesired patterns of behaviour, cognition, and interaction that are within the clients' repertoire or can be co constructed by therapists and clients as such.

Differing from skill building and behaviour therapy interventions, the model assumes that solution behaviours already exist for clients.

It is asserted that small increments of change lead to large increments of change.

Clients' solutions are not necessarily *directly* related to any identified problem by either the client or the therapist.

The conversational skills required of the therapist to invite the client to build solutions are different from those needed to diagnose and treat client problems.

Solution Focused Therapy differs from traditional treatment in that traditional treatment focuses on exploring problematic feelings, cognitions, behaviours, and/ or interaction, providing interpretations, confrontation, and client education (Corey, 1985). In contrast, SFT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources. Even in cases where the client comes to use outside resources to create solutions, it is the client who takes the lead in defining the nature of those resources and how they would be useful.

3.3 INGREDIENTS OF SOLUTION FOCUSED THERAPY

3.3.1 General Ingredients of Solution Focused Therapy

Most psychotherapy, SFT included, consists of *conversations.* In SFBT there are three main general ingredients to these conversations.

First, there are the overall topics. SFT conversations are centred on client concerns; who and what are important to the clients; a vision of a preferred future; clients' exceptions, strengths, and resources related to that vision; scaling of clients' motivational level and confidence in finding solutions; and ongoing scaling of clients' progress toward reaching the preferred future.

Second, as indicated in the previous section, SF conversations involve a therapeutic process of co-constructing altered or new meanings in clients. This process is set in motion largely by therapists asking SF questions about the topics of conversation identified in the previous paragraph and connecting to and building from the resulting meanings expressed by clients.

Third, therapists use a number of specific responding and questioning techniques that invite clients to co-construct a vision of a preferred future and draw on their past successes, strengths, and resources to make that vision a reality.

3.3.2 Specific Active Ingredients

Some of the major active ingredients in SFT include developing a cooperative therapeutic alliance with the client; creating a solution versus problem focus; the setting of measurable changeable goals; focusing on the future through future-oriented questions and discussions; scaling the ongoing attainment of the goals to get the client's evaluation of the progress made; and focusing the conversation on exceptions to the client's problems, especially those exceptions related to what they want different, and encouraging them to do more of what they did to make the exceptions happen.

3.4 THE PRACTICE OF SOLUTION FOCUSED THERAPY

The goals of the therapy are the goals which clients bring with them, providing they are ethical and legal. The counselor's role is to help clients to begin to move or continue to move in the direction they want.

They do this by helping:

- to identify and utilise to the full the strengths and competencies which the client brings with him;
- to enable the client to recognise and build upon exceptions to the problem, that is, those times when the client is already doing (thinking, feeling) something which is reducing or eliminating the impact of the problem;
- to help the client to focus in clear and specific terms on what they would consider to be solutions to the problem.

The counsellor acknowledges and validates whatever concerns and feelings the client presents, and seeks to develop a rapport, a cooperative 'joining', in which the counsellor offers the client a warm, positive, accepting relationship and the client feels understood and respected.

In SFT, the counsellor shares expertise with the client by adopting a learning position, 'a one-down position', in which the client is encouraged to teach the counsellor about her way of looking at the world. The counsellor matches the language of the client, offers encouragement and genuine compliments and adapts her stance according to what the client finds helpful. The client is respected as being an expert in her own life, while the counsellor has expertise in creating a therapeutic environment.

It is not the usual practice to offer clients a fixed number of sessions. It is more common to consult with the client at the end of a session to hear what she feels about meeting again, and if a further session is necessary, when that should take place.

3.5 FOCAL ISSUE

Solution Focussed therapists (SFT) stress the importance of negotiating a focal or central issue for the work. The clearer and more defined the agenda, the greater the likelihood that the counseling will be efficient and effective.

SFT attends to the problem as presented by the client. The closer the counsellor can keep to the client's agenda, the more likely the client will be motivated to change. It is not always possible to achieve this at the beginning as clients are often confused, anxious, overwhelmed and unsure how counseling can help them.

The priority is to find a common language to describe what the client wants to change and to begin to explore how those changes would affect the client's life. The counsellor needs to find leverage – a solvable problem which the client both wants, and is able, to work upon.

Clients who present with broad, diffuse, and poorly understood problem patterns and who need considerable time to form a trusting alliance are more likely to need an extended period of exploratory work. It is a great advantage when clients can articulate their problem and their goals, but it does not mean that initial vagueness about the future disqualifies them from brief solution focused work. It simply means that the counsellor has to work harder and take longer.

3.6 THE MESSAGE

Near the end of each session, the solution focused counsellor will compliment the client on what he is doing, thinking or saying which is helpful. She may also give him a task to perform. At the end of the first session, clients are usually asked to 'notice between now and the next time we meet, those things you would like to see continue in your life and come back and tell me about them'.

3.7 TREATMENT PRINCIPLES

There are a number of principles which guide solution focused work. They apply both to how the client should approach the problem and to how the counsellor should conduct the counseling.

If it is not broken do not fix it.

SFT emphasises that people have problems, rather than that they are problems. It avoids a view of clients as being sick or damaged and instead looks for what is healthy and functioning in their lives.

Small change can lead to bigger changes.

Change is regarded as constant and unavoidable. Initiating a force for change can have repercussions beyond the original starting point. Experiencing change can restore the person's sense of choice and control in his or her life and encourage the making of further changes.

If it is working keep doing it.

The client is encouraged to keep doing what she has shown she can already do. This constructive behaviour may have started prior to the counseling. Clients may need to continue with a new pattern of behaviour for some time before they feel confident about maintaining it.

If it is not working stop doing it.

Clients in SFT are encouraged to do something different (almost anything) to break the failure cycle. This may run counter to family scripts such as, 'If at first you don't succeed, try, and try again.'

Keep counseling as simple as possible.

There is a danger that the beliefs of the counsellor, particularly if they demand a search for hidden explanations and unconscious factors, will complicate and prolong the relationship.

3.8 INTERVENTIONS

The following interventions are commonly found in solution focused practice. How and when they are used will depend upon the judgment of the therapist.

Pre-session change

When making an appointment, the client is asked to notice whether any changes take place between the time of making the appointment and the first session. Typically, the counsellor will enquire about these changes early on in the first session. By granting recognition to pre-session change, the counsellor can build upon what the client has already begun. The client may present the counsellor with clear clues about strategies, beliefs, values and skills which are transferable into solution construction. This 'flying start' helps to accelerate the process of change and increases the likelihood of the counseling being brief. Positive pre-session change is empowering for the client because the changes have taken place independently of the counsellor and, therefore, the credit belongs solely to the client.

Exception seeking

The counsellor engages the client in seeking exceptions to the problem, that is, those occasions when the problem is not present, or is being managed better. This includes searching for transferable solutions from other areas of the client's life, or past solutions adopted in similar situations.

Competence seeking

The counsellor identifies and affirms the resources, strengths and qualities of the client which can be utilised in solving the problem. Coping mechanisms which the client has previously used are acknowledged and reinforced.

The miracle question

This is a central intervention typically used in a first session, but which may also reappear in subsequent sessions. It aims to identify existing solutions and resources and to clarify the client's goals in realistic terms. It is a future-oriented question which seeks to help the client to describe, as clearly and specifically as possible, what her life will be like, once the problem is solved or is being managed better. The question as devised by Steve de Shazer follows a standard formula:

Imagine when you go to sleep one night, a miracle happens and the problems we've been talking about disappear. As you were asleep, you did not know that a miracle had happened. When you wake up what will be the first signs for you that a miracle has happened?

This imaginary format gives the client permission to rise above negative, limited thinking and to develop a unique picture of the solution. An open expression of what they believe they want can either motivate them further towards achieving their goals, or perhaps help them to realise that they really don't want these changes after all. It can also highlight conflicts between what they themselves want and what other people in their life want for them. The counsellor helps the client to develop answers to the miracle question by active listening, prompting, empathising and therapeutic questioning.

Scaling

The counsellor uses a scale of 0-10 with clients with 10 representing the morning after the miracle and 0 representing the worst the problem has been, or perhaps how the client felt before contacting the counseling service. The purpose of scaling is to help clients to set small identifiable goals, to measure progress and to establish priorities for action. Scaling questions can also assess client motivation and confidence. Scaling is a practical tool which a client can use between sessions. The use of numbers is purely arbitrary - only the client knows what they really mean.

Reframing

Using the technique of reframing, the counsellor helps the client to find other ways of looking at the problem, ones which are at least as valid as any other, but which, in the opinion of the counsellor, increase the chances of the client being able to overcome the problem.

3.9 COMPATIBILITY WITH ADJUNCTIVE THERAPIES

SFT can easily be used as an adjunct to other therapies. One of the original and primary tenets of SFT is that if something is working, do more of it. It is suggested that therapists should encourage their clients to continue with other therapies and approaches that are helpful.

For example, clients are encouraged to continue to take prescribed medication, stay in self help groups if it is helping them to achieve their goals, or begin or continue family therapy.

Finally, it is a misconception that SFT is philosophically opposed to traditional substance abuse treatments. Just the opposite is true. If a client is in traditional treatment or has been in the past and it has helped, he or she is encouraged to continue doing what is working. As such, SFT could be used in addition to or as a component of a comprehensive treatment program.

3.10 TARGET POPULATIONS

SFBT has been found clinically to be helpful in treatment programs in the U.S. for adolescent and adult outpatients (Pichot & Dolan, 2003), and as an adjunct to more intensive inpatient treatment in Europe. SFT is being used to treat the entire range of clinical disorders, and is also being used in educational and business settings.

Meta-analysis and systematic reviews of experimental and quasi-experimental studies indicate that SFT is a promising intervention for youth with externalising behaviour problems and those with school and academic problems, showing medium to large effect sises (Kim, in press; Kim & Franklin, 1997).

While SFBT may be useful as the primary treatment mode for many individuals in outpatient therapy, those with severe psychiatric, medical problems, or unstable living situations will most likely need additional medical, psychological, and social services. In those situations, SFT may be part of a more comprehensive treatment program.

Self Assessment Questions

Multiple Choice Questions:

1) Solution-focused brief therapy is based on:
   - clear diagnostic formulations
   - appreciating the client's resources
   - a detailed description of the client's problem
   - the scientific study of personality.
2) Solution-focused techniques involve:
   - the 'miracle' question
   - paradoxical injunctions
   - careful administration of medication
   - the patient's acceptance of the problem.
3) Solution-focused brief therapy has been effective in the treatment of:
   - drug and alcohol misuse
   - agoraphobia
   - adolescent behavioural problems
   - eating disorders
   - all the above.

4) Solution-focused authors include:
   - de Shazer
   - Rollnick
   - O'Hanlon
   - Both a & c

5) Scaling questions are used to explore:
   - the patient's achievements
   - the patient's description of the symptoms
   - medication requirements
   - Goals of therapy.
   - a & d

3.11 LET US SUM UP

Solution focused brief therapy (SFBT) is often referred to as simply 'solution focused therapy' or 'brief therapy'. It focuses on what clients want to achieve through therapy rather than on the problem(s) that made them to seek help. The approach does not focus on the past, but instead, focuses on the present and future. The therapist/counselor uses respectful curiosity to invite the client to envision their preferred future and then therapist and client start attending to any moves towards it whether these are small increments or large changes. To support this, questions are asked about the client's story, strengths and resources, and about exceptions to the problem.

Solution focused therapists believe that change is constant. By helping people identify the things that they wish to have changed in their life and also to attend to those things that are currently happening that they wish to continue to have happen, SFT therapists help their clients to construct a concrete vision of a *preferred future* for themselves. The SFT therapist then helps the client to identify times in their current life that are closer to this future, and examines what is different on these occasions. By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, the therapists helps the client move towards the preferred future they have identified.

Solution focused work can be seen as a way of working that focuses exclusively or predominantly at two things. 1) Supporting people to explore their preferred futures. 2) Exploring when, where, with whom and how pieces of that preferred future are already happening. While this is often done using a social constructionist perspective the approach is practical and can be achieved with no specific theoretical framework beyond the intention to keep as close as possible to these two things.

3.12 UNIT END QUESTIONS

1) What do you think about the idea that it is preferable to spend more time exploring solutions than understanding problems?

2) Counselling should be as brief as possible so that people can get on with their lives. Discuss.

3) Write about the treatment principles and interventions in SFT?

4) Answer the miracle question in relation to a problem area in your own life and share your observations with a colleague.

3.13 SUGGESTED READINGS

Coren, Alex. (2001). *Short-Term Psychotherapy.* London: Palgrave.

Dewan, Mantosh J., Steenbarger, Brett N., Greenberg, Roger P. (2004). *The Art and Science of Brief Psychotherapies: A Practitioner's Guide.* London: American Psychiatric Publishing, Inc.

Palmer, Stephan. (2000). *Introduction to Counseling and Psychotherapy.* New Delhi: Sage Publications.

3.14 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) b, 2) a, 3) e, 4) d, 5) e

UNIT 4 INTEGRATIVE AND MULTIMODAL THERAPIES

Structure

4.0 INTRODUCTION

A major emphasis of this unit is on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy. Throughout the world, when you ask a psychologist or counsellor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation, you will integrate one or more of the theories presented in this block. This unit explores in detail the integrative and multimodal approach to therapy. The first part of this unit traces the historical development, variables responsible for, the different models and future of integrative approach. The second half of this unit will explore multimodal therapy. This part will cover the development of theory, basic concepts, explanations for development and maintenance of problems, practice, applications and limitations of multimodal therapy.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the foundational aspects and variables responsible for integration;
- Describe the different paths to integration and future of integrative approach;
- Discuss the concept and development of multimodal therapy; and
- Describe the practice, applications and limitations of multimodal therapy.

4.2 DEFINITION OF INTEGRATIVE PSYCHOTHERAPY

Integrative psychotherapy is an attempt to combine concepts and counselling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counselling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients.

According to Norcross (2005):

Psychotherapy integration is characterised by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy. (pp. 3–4).

4.3 HISTORICAL OVERVIEW OF THE INTEGRATIVE MOVEMENT

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients' problems. From Freud's Wednesday evening meetings

on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviourism was introduced to the field, clashes took place between psychoanalysts and behaviourists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy,* was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published *Psychoanalysis and Behaviour Therapy: Toward an Integration*. In 1979, James Prochaska offered a transtheoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp organised an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy.* By 1991, it began publishing the *Journal of Psychotherapy Integration*. As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

4.4 VARIABLES RESPOSIBLE FOR GROWTH OF PSYCHOTHERAPY INTEGRATION

Norcross and Newman (1992) have summarised the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

First, they point out that there was simply a proliferation of separate counselling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation.

Second, they note that practitioners increasingly recognised the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory.

Third, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioural change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement.

Fifth, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments.

Sixth, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fuelled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers' identification of common factors related to successful therapy outcome influenced clinicians' tendency toward psychotherapy integration. Increasingly, therapists began to recognise there were common factors that cut across the various therapeutic schools.

Eighth, the development of professional organisations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.

4.5 DIFFERENT WAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, we might feel more comfortable in thinking about how we might pursue this same avenue. Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

4.5.1 Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many psychologists accept some features of behaviourism, yet they do not attempt to use the theory to explain all aspects of client behaviour. Eclecticism in psychology has been caused by the belief that many factors influence human behaviour; therefore, it is important to examine a client from a number of theoretical perspectives.

4.5.2 Differences between Eclecticism and Psychotherapy Integration

Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counselling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counselling technique, yet not investigate any further why the positive change occurred. In

contrast, an integrative therapist would investigate the how and why of client change. Did the client change because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists.

4.5.3 Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behaviour therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

4.5.4 Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labelled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioural assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single theoretical approach, and over time many gradually incorporate techniques and methods of other approaches. Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

4.5.5 The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers' contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals. Researchers and theorists have transformed Rogers' necessary and sufficient

conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counselling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller, 1999).

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

4.5.6 Multitheoretical Approaches

Recently, therapists have developed multitheoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesise two or more theories at the theoretical level. Instead, there is an effort to "bring some order to the chaotic diversity in the field of psychotherapy and "preserve the valuable insights of major systems of psychotherapy" (Prochaska & DiClemente, 2005, p. 148). *The goal of multitheoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multitheoretical frameworks are (1) the transtheoretical approach by Prochaska and DiClemente, and (2) multitheoretical therapy by Brooks-Harris.

4.5.7 The Transtheoretical Model

The most widely recognised model using a multitheoretical framework has been the transtheoretical model developed by Prochaska and DiClemente (1984, 2005). The transtheoretical model is a model of behavioural change, which has been the basis for developing effective interventions to promote healthy behaviour change. Key constructs are integrated from other counselling theories. The model describes how clients modify problem behaviour or how they develop a positive behaviour. The central organising construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages:

1) precontemplation,
2) contemplation,
3) preparation,
4) action, and
5) maintenance.

In the precontemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The transtheoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labelled behavioural processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness rising ("I remember information people gave me about how to stop smoking") and social liberation ("I find society changing in ways that make it easier for me to be a non-smoker"). The 5 behavioural processes of change range from (6) stimulus control to (8) counter-conditioning ("I do other things with my hands to stop smoking") to (10) self-liberation ("I make commitments not to smoke").

The transtheoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development. The transtheoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasise different stages and levels of change.

4.5.8 Brooks-Harris' Multitheoretical Model

The most recent multitheoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches:

1) cognitive,
2) behavioural,
3) experiential,
4) bio psychosocial,
5) psychodynamic,
6) systemic, and
7) multicultural.

A brief explanation of each of these areas is provided below (table 6.5.2). His framework emphasises at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

Table: Multi Theoretical Psychotherapy

Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts.
Behavioural skills–focal dimension of actions encourage effective client actions to deal with challenges.
Experiential interventions result in adaptive feelings.

Bio psychosocial strategies emphasise biology and adaptive health practices.

Psychodynamic-interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions.

Systemic-constructivist interventions examine the impact of social systems and support adaptive personal narratives.

Multicultural-feminist strategies explore the cultural contexts of clients' issues.

Brooks-Harris presents five principles for psychotherapy integration, which include

1) intentional integration,
2) multidimensional integration,
3) multitheoretical integration,
4) strategy-based integration, and
5) relational integration.

The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualisation, and intervention strategies.

Principle two (multidimensional) proposes that therapists should recognise the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions.

The fourth strategy-based principle states that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled.

The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalogue of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy. To integrate behavioural therapy into one's practice, he suggests some of the following catalogue of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

4.5.9 Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools. For instance, the first stage of helping is labelled *exploration.*

Using Rogers' client-centered therapy as the therapy school of choice, Hill (2004) emphasises the counselling skills of attending, listening, and reflection of feelings.

The second stage is termed *insight,* and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed.

The third stage is termed the *action stage,* and this stage is based largely on cognitive-behavioural techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

4.6 EVIDENCE-BASED THERAPY AND INTEGRATIVE PRACTICE

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

The American Psychological Association (2006, p. 273) conceptualises evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence-based practice emphasises the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favour of Evidence based Practice (EBP) are reasonable.

First, clients have a right to treatments that have been proven to be effective.

Second, managed care requires counsellor accountability in choosing a method of treatment.

Increasingly, counsellors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder.

Helping professionals may be required to answer for using a therapeutic approach with a specific disorder.

4.6.1 Implementation of EBP in Practice

The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun.*

There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration sets standards for reviews of medical, health, and mental health treatments and provides "systematic reviews" of related research by disorder.

Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions.

Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (http://www.guideline.gov/).

This site contains very good information on medication. Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health

http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm).

Activity

Reflection on Therapist Qualities. The purpose of this exercise is to help you identify and assess your own strengths and weaknesses as future therapists and encourage self-reflection and openness in your group. Identify three things about yourself that you believe will assist you in becoming a good therapist. Record these things in your book.

4.7 FUTURE OF PSYCHOTHERAPY SCHOOLS AND THERAPY INTEGRATION

What does the future look like for psychotherapy schools that have been presented in this book?

Norcross, Hedges, and Prochaska (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: cognitive-behaviour therapy, culture-sensitive multicultural counselling, Beck's cognitive therapy, interpersonal therapy, family systems therapy, behaviour therapy, technical eclecticism, solution-focused therapy, and exposure therapies.

Therapy orientations that were predicted to decrease the most included classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy.

The poll also showed how psychotherapy is changing. The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease i.e. Short term is in, and long term on its way out.

Self Assessment Questions

Fill in the Blanks:

a) ———————————— approach to psychotherapy integration involves having a strong grounding in one system of psychotherapy and a willingness to select practices and views from other systems.

b) ———————————— Psychotherapy maintains that thoughts, actions, and feelings interact with one another and are shaped by biological, interpersonal, systemic, and cultural contexts.

c) ———————————— is a psychotherapy model developed by Prochaska and DiClemente that matches a therapist's approach to a client's readiness to change.

d) ———————————— is an integrative approach that advocates using multiple procedures taken from various therapeutic approaches without specific concern from which theories they come.

e) ———————————— Involves the integration of two or more therapies with an emphasis on integrating the underlying constructs associated with each therapeutic system.

4.8 MULTIMODAL THERAPY

Multimodal counselling and therapy is a technically eclectic and systematic approach. The approach is technically eclectic as it uses techniques taken from many different psychological theories and systems, without necessarily being concerned with the validity of the theoretical principles that underpin the different approaches from which it takes its techniques and methods. The techniques and interventions are applied systematically, based on data from client qualities, the counsellor's clinical skills and specific techniques.

The approach uses a unique assessment procedure which focuses on seven different aspects or dimensions (known as modalities) of human personality. Not only is a serious attempt made to tailor the therapy to each client's unique requirements, but the counsellor also endeavours to match his or her inter-personal style and interaction to the individual needs of each client, thereby maximising the therapeutic outcome.

4.9 DEVELOPMENT OF MULTIMODAL THERAPY

During the 1950s Arnold Lazarus, a psychologist undertook his formal clinical training in South Africa. The main focus of his training was underpinned by psychodynamic and person-centred theory and methods. In addition, he attended seminars provided by Joseph Wolpe, a psychologist, thereby learning about conditioning therapies based on Behaviour Therapy. During 1957 he spent several months as an intern at the Marlborough Day Hospital in London, where the orientation was Adlerian.

He believed that no one system of therapy could provide a complete understanding of either human development or condition. In 1958 he became the first psychologist to use the terms 'behaviour therapist' and 'behaviour therapy' in an academic article.

Lazarus conducted follow up enquiries into clients who had received behaviour therapy and found that many had relapsed. However, when clients had used both behaviour and cognitive techniques, more durable results were obtained. In the early 1970s he started advocating a broad but systematic range of cognitive-behavioural techniques and his follow-up enquiries indicated the importance of breadth if therapeutic gains were to be maintained. This led to the development of Multimodal Therapy which places emphasis on seven discrete but interactive dimensions or modalities which encompass all aspects of human personality.

4.10 BASIC CONCEPTS

4.10.1 Modalities

People are essentially biological organisms (neurophysiological/biochemical entities) who behave (act and react), emote (experience emotional responses), sense (respond to olfactory, tactile, gustatory, visual and auditory stimuli), imagine (conjure up sights, sounds and other events in the mind's eye), think (hold beliefs, opinions, attitudes and values), and interact with one another (tolerate, enjoy or endure various interpersonal relationships). These seven aspects or dimensions of human personality are known as modalities. By referring to these seven modalities as Behaviour, Affect, Sensations, Images, Cognitions, Interpersonal and Drugs/biology, the useful acronym and memory aide BASIC I.D. arises from the first letter of each. ('Affect' is a psychological word for emotion and 'cognitions' represent all thoughts, attitudes and beliefs.)

From the multimodal perspective these seven modalities may interact with each other for example an unpleasant image or daydream and a negative thought may trigger a negative emotion such as anxiety or depression. The multimodal approach rests on the assumption that unless the seven modalities are assessed, counselling is likely to overlook significant concerns. Clients are usually troubled by a multitude of specific problems which should be dealt with by a similar multitude of specific interventions or techniques.

For example, a client may suffer from a simple fear of spiders, anxiety about giving presentations at work, sleep disturbances, a lack of exercise and a poor diet. Each problem will probably need a specific intervention to help the client improve his or her condition.

Multimodal therapists have found that individuals tend to prefer some of the BASIC I.D modalities to others. They are referred to as 'imagery reactors' or 'cognitive reactors' or 'sensory reactors' depending upon which modality they favour.

4.10.2 Principle of Parity

In multimodal therapy the counsellor and client are considered equal in their humanity (the principle of parity). However, the counsellor may be more skilled in certain areas in which the client has particular deficits. Therefore it is not automatically assumed that clients know how to deal with their problems and have the requisite skills. The counsellor may need to model or teach the client various skills and strategies to help overcome his or her problem(s). It should be understood that having superior skills in certain areas does not make counsellors superior human beings!

4.10.3 Thresholds

One key assumption made in multimodal therapy is that people have different thresholds for pain, frustration, stress, external and internal stimuli in the form of sound, light, touch, smell and taste. Psychological interventions can be applied by individuals to help modify these thresholds but often the genetic endowment or predisposition has an overriding influence in the final analysis. For example, a client with a low tolerance to pain may be able to use psychological

distraction techniques such as relaxing imagery, but is still likely to need an anaesthetic when receiving minor fillings at the dentist.

4.11 THE DEVELOPMENT AND MAINTENANCE OF PROBLEMS

Problems develop and are maintained for a variety of reasons. Social learning, systems and communication theories all explain some of the ways problems can arise and how they are maintained. Of course, underlying all problems is the biological and genetic dimension which goes to help make up a human being. We will discuss a few additional key factors.

4.11.1 Misinformation

Over a period of time people may learn incorrect assumptions and beliefs about life. For example, the beliefs 'I must perform well otherwise I'm a failure', or 'I'm worthless if my partner leaves me', or 'Life should be easy', may be learnt or imbibed by listening to significant others such as peers, parents or teachers. These beliefs may lead to considerable stress when external life events conflict with them. Couples may also hold on to unhelpful beliefs or myths such as 'If you feel guilty, confess.'

Due to misinterpreting their doctor's advice many people have misunderstood medical and health-related issues such as treatment of cancer or heart disease. Unless the health professionals correct these errors then patient compliance to medical procedures may be hindered or even non-existent.

4.11.2 Missing Information

Unlike the case with misinformation, with missing information people have not learnt the necessary skills, knowledge or methods to either understand or undertake particular activities or recognise specific problems. For example, people may not have in their repertoire of behaviour job interview skills, friendship skills, communication skills, or assertiveness skills etc. They may not realise that a pain in their left arm could signify heart disease and that it might be strongly advisable to have a medical check-up.

4.11.3 Defensive Reactions

People avoid or defend against discomfort, frustration, pain, or negative emotions such as shame, guilt, depression and anxiety. Although it sounds quite natural to avoid fears or the unbearable pain of loss, people do not learn how to conquer them unless they confront them. For example, if a person has a fear of travelling by airplane he or she could easily avoid this mode of transport. However, there might be certain job expectations that require the person to fly across the Atlantic. If the person wanted to keep the job he or she would need to deal with this problem sooner rather than later. According to learning theory the main method of overcoming flying phobia is to experience exposure to flying. Although this can be partially undertaken using the person's imagination, the most effective technique is to fly on the airplane. Initially this might trigger very high levels of anxiety which only gradually subsides or to which the person habituates after an hour or two of exposure to flying. This is no different from the advice given to horse-riders who fall off their horse: 'Get straight back on the horse immediately.'

4.11.4 Lack of Self Acceptance

People tend to link their behaviour skills deficits directly to their totality as a human being. Depending upon the particular belief the person holds, this tends to lead to anxiety, shame, anger or depression. For example, a person may believe, 'If I fail my exam, I'm a total failure as a human being.' A more realistic and logical way of looking at the situation could be, 'If I fail my exam all it proves is that I've got exam skills deficits. I can still accept myself as a fallible human being.' The unhelpful beliefs may have been imbibed from parents and other significant people in the child's life but they may be reinforced and perpetuated by the person constantly re-indoctrinating him or herself on a regular basis throughout adulthood. In multimodal therapy the content of self- defeating or unrealistic beliefs is examined and is replaced by more self-helping and realistic beliefs.

4.12 PSYCHOLOGICAL HEATH

The key issues discussed above and the path to psychological health can be expressed in the form of the BASIC I.D. modalities below:

Behaviour: ceasing unhelpful behaviours; performing wanted behaviours; stopping unnecessary or irrational avoidances; taking effective behaviours to achieve realistic goals.

Affect: admitting, clarifying and accepting feelings; coping or managing unpleasant feelings and enhancing positive feelings; abreaction (i.e., living and recounting painful experiences and emotions).

Sensation: tension release; sensory pleasuring; awareness of positive and negative sensations; improving threshold tolerance to pain and other stimuli.

Imagery: developing helpful coping images; improving self-image; getting in touch with one's imagination.

Cognition: greater awareness of cognitions; improving problem-solving skills; modifying self-defeating, rigid beliefs; enhancing flexible and realistic thinking; increasing self-acceptance; modifying beliefs that exacerbate low thresholds to frustration or pain (for example, 'I can't stand it' to 'I don't like it but I'm living proof that I can stand it'); correcting misinformation and providing accurate missing information.

Interpersonal: non-judgemental acceptance of others; model useful interpersonal skills; dispersing unhealthy collusions; improve assertiveness, communication, social and friendship skills.

Drugs/biology: better nutrition and exercise; substance abuse cessation; alcohol consumption in moderation; medication when indicated for physical or mental disorders.

4.13 PRACTICE OF MULTIMODAL THERAPY

4.13.1 Goals of Multimodal Therapy

The goals of multimodal therapy are to help clients to have a happier life and achieve their own realistic goals. Therefore the goals are tailored to each client.

A philosophy of long-term hedonism as opposed to short-term hedonism is advocated whereby the client may need to decide how much pleasure they may want in the present compared to the sacrifices they may have to make to attain their desires and wishes. For example, to go to college and obtain a good degree may necessitate working reasonably hard for a period of three years and not attending as many parties as previously.

4.13.2 The Relationship between the Therapist and Client

The relationship is underpinned by core therapeutic conditions suggested by Carl Rogers. These core conditions are empathy, congruence and unconditional positive regard. Although a good therapeutic relationship and adequate rapport are usually necessary, multimodal therapists consider that they are often insufficient for effective therapy. The counsellor-client relationship is considered as the soil that enables the strategies and techniques to take root. The experienced multimodal counsellor hopes to offer a lot more by assessing and treating the client's BASIC I.D., endeavouring to 'leave no stone (or modality) unturned'.

Multimodal counsellors often see themselves in a coach/trainer-trainee or teacher-student relationship as opposed to a doctor-patient relationship, thereby encouraging self-change rather than dependency. Therefore the usual approach taken is active-directive where the counsellor provides information, and suggests possible strategies and interventions to help the client manage or overcome specific problems. However, this would depend upon the issues being discussed and the personality characteristics of the client. Flexible interpersonal styles of the counsellor which match client needs can reduce attrition (i.e. premature termination of therapy) and help the therapeutic relationship and alliance. This approach of the therapist is known in multimodal therapy as being an 'authentic chameleon'.

For example, if a client states that she wants, 'A listening ear to help me get over the loss of my partner' then she may consider an active-directive approach as intrusive and possibly offensive. On the other hand, a client who states, 'I would value your comments and opinions on my problems', may become very irritated by a counsellor who only reflects back the client's sentiments and ideas. Others may want a 'tough, no-nonsense' approach and would find a 'warm, gentle' approach not helpful or conducive to client disclosure.

This flexibility in the counsellor's interpersonal therapeutic style underpins effective multimodal therapy. Counsellors are expected to exhibit different aspects of their own personality to help the therapeutic relationship and clients to reach their goals. The term 'bespoke therapy' has been used to describe the custom-made emphasis of the approach.

Activity

Qualities for Effective Therapists. Create your own list of qualities for the effective therapist. Review that list and discuss them with the people in your small group.

4.13.3 The Process of Change

The process of change may commence even before the first therapy session as clients are usually sent details about the approach with some explanation of the

key techniques such as relaxation or thinking skills. Occasionally, therefore, the client has already started using simple self-help techniques before the therapy formally commences. In Britain, included with the details is a client checklist of issues the client may want to discuss with the counsellor at the first meeting. This checklist encourages the client to ask the counsellor relevant questions about the approach, the counsellor's qualifications and training and contractual issues, thereby giving the client more control of the session and therapy.

During the course of therapy, the client's problems are expressed in terms of the seven BASIC I.D modalities and client change occurs as the major different problems are managed or resolved across the entire BASIC I.D. Initially, sessions are often held weekly. As client gains are made, then the sessions are held with longer intervals in between, such as a fortnight or a month. Termination of counselling usually occurs when clients have dealt with the major problems on their modality profile or feel that they can cope with the remaining problems.

As multimodal therapy is technically eclectic, it will use techniques and interventions from a variety of different therapies. Although these are largely based on behaviour therapy, cognitive therapy and rational emotive behaviour therapy, techniques are also taken from other approaches, such as psychodynamic and Gestalt therapy.

4.14 APPLICATION AND LIMITATIONS

Multimodal therapy has been shown to benefit children, adults and older client groups experiencing a wide range of problems. For example, those suffering from anxiety-related disorders such as agoraphobia, panic attacks, phobias, obsessive- compulsive disorders; depression, post-traumatic stress disorder; sexual problems; anorexia nervosa; obesity; enuresis; substance and alcohol abuse; airsickness; schizophrenia.

As counsellors are expected to adjust their interpersonal style to each client, they may encounter fewer relationship difficulties when compared to other less flexible approaches. This flexible approach should lead to a reduced rate of attrition.

However, as with other therapies, multimodal therapy has its failures. Some clients are not prepared to face their fears, challenge their unhelpful thinking, use coping imagery, practise relaxation techniques, become assertive with significant others, etc. Others may have psychiatric disorders or other difficulties that prevent them from engaging in therapy. Some clients are in the pre-contemplative stage where they have not made up their minds to change and take on the responsibility of counselling. They may need to return to counselling at a later stage in their lives.

Self Assessment Questions

Fill in the Blanks:

a) ————————————- is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way.

b) For multimodal therapists, assessment and diagnosis involve a thorough evaluation of the ————.

c) ———————————— category of BASIC I.D includes mental pictures or visualisation.

d) ————————————category of BASIC I.D includes all physical or biological areas, including substance use.

e) In multimodal therapy the major emphasis is on ———————————————.

f) Approach of the therapist in multimodal therapy is known as being an———————————.

4.15 LET US SUM UP

Counselling and psychotherapy are moving toward an integrative approach to psychotherapy. The days of adopting one singular therapy approach and using it for the rest of one's professional development seem to be coming to an end. Psychotherapy integration has become intertwined with the evidence based movement in stressing that various client problems necessitate that the therapist use different solutions. Moreover, increasingly these solutions can be chosen on the basis of empirical outcome research what is known as evidence based studies. One advantage of integrative therapies is that they allow therapists the flexibility to meet the needs of clients who have different presenting issues and who come from a range of cultural contexts.

Psychotherapy integration can take several different paths including assimilative integration, technical eclecticism, common factors integration, and theoretical integration. The movement toward psychotherapy integration encourages therapists to take into consideration the benefits of individual therapeutic approaches. Integrative psychotherapy posits that many treatment methods can be helpful in working with different clients. It is predicted that evidence-based studies will have an important influence on psychotherapy theory integration.

Therapists must understand not only the individual theories so that they can decide for themselves what they feel is appropriate for them, but they also need to establish a multitheoretical or integrative framework from which they can integrate the theories they choose. The framework by Brooks-Harris offers the simplest route to developing your own integrative approach.

Within the next couple of decades, it is predicted that graduate schools will adopt an integrative approach to psychotherapy training because such programs themselves will come under increasing pressure to equip their graduates with therapeutic skills that cross theoretical lines. Ethical guidelines for counsellors and psychologists appear to be headed in the direction of requiring therapists to know evidence-based research (what techniques actually work with what clients with what problems) if they are to exercise an appropriate standard of care for their clients.

Multimodal therapy is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way. It is an open system in which the principle of technical eclecticism encourages the constant introduction of new techniques and the refinement or elimination of existing ones, but never in a random or shotgun manner. The major emphasis is

on flexibility. Multimodal therapists subscribe to no dogma other than the principles of theoretical parsimony and therapeutic effectiveness.

Assessments and interventions are structured around seven modalities summarised by the acronym BASIC I.D. (behaviour, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors). This framework allows the therapist to take into account the uniqueness of each individual and to tailor treatment accordingly. The emphasis is constantly on who or what is best for this individual (couple, family, or group). By assessing significant deficits and excesses across the client's BASIC I.D., thorough coverage of diverse interactive problems is facilitated. The therapist's role and the cadence of client-therapist interaction differ from person to person and even from session to session. Some clients respond best to somewhat austere, formal, businesslike transactions; others require gentle, tender, supportive encouragement.

4.16 UNIT END QUESTIONS

1) What key developments stand out in your mind about the integrative movement in psychotherapy?
2) Thoughts about theory integration date back to the 1930s and 1940s. In your opinion, what took so long for the movement to reach its current status?
3) What theories are you considering integrating into your own personal approach to psychotherapy? Explain why.
4) In what ways does multimodal therapy differ from other forms of therapy?
5) Critically discuss the usefulness of the BASIC I.D. assessment procedures.
6) The practice of multimodal therapy places high demands on the therapist. Discuss.
7) Discuss A. Lazarus's view of the authentic chameleon.

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4.18 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Assimilative integration
2) Multitheoretical Psychotherapy
3) Stages of Change
4) Technical Eclecticism
5) Theoretical Integration.

Self Assessment Questions 2

1) Multimodal therapy
2) BASIC I.D
3) Imagery
4) Drugs and biology
5) Flexibility
6) Authentic chameleon.