Module 71

Behavior, Cognitive, and Group Therapies

Module Learning Objectives

71-1 Explain how the basic assumption of behavior therapy differs from those of psychodynamic and humanistic therapies, and describe the techniques used in exposure therapies and aversive conditioning.

71-2 State the main premise of therapy based on operant conditioning principles, and describe the views of its proponents and critics.

71-3 Discuss the goals and techniques of cognitive therapy and of cognitive-behavioral therapy.

71-4 Discuss the aims and techniques of group and family therapy.

Behavior Therapies

71-1 How does the basic assumption of behavior therapy differ from those of psychodynamic and humanistic therapies? What techniques are used in exposure therapies and aversive conditioning?

The insight therapies assume that many psychological problems diminish as self-awareness grows. Psychodynamic therapies expect problems to subside as people gain insight into their unresolved and unconscious tensions. Humanistic therapies expect problems to diminish as people get in touch with their feelings. Proponents of behavior therapy, however, doubt the healing power of self-awareness. (You can become aware of why you are highly anxious during tests and still be anxious.) They assume that problem behaviors are the problems, and the application of learning principles can eliminate them. Rather than delving deeply below the surface, looking for inner causes, therapies using behavioral techniques view maladaptive symptoms—such as phobias or sexual dysfunctions—as learned behaviors that can be replaced by constructive behaviors.

Classic Conditioning Techniques

One cluster of behavior therapies derives from principles developed in Ivan Pavlov's early twentieth-century conditioning experiments (Module 26). As Pavlov and others showed, we learn various behaviors and emotions through classical conditioning. Could maladaptive symptoms be examples of conditioned responses? If so, might reconditioning be a solution? Learning theorist O.H. Mowrer thought so and developed a successful conditioning therapy for chronic bed-wetters. The child sleeps on a liquid-sensitive pad connected to an alarm. Moisture on the pad triggers the alarm, waking the child. With sufficient repetition, this association of bladder relaxation with waking up stops the bed-wetting. In three out of four cases the treatment is effective, and the success provides a boost to the child's self-image (Christophersen & Edwards, 1992; Houts et al., 1994).

Another example: If a claustrophobic fear of elevators is a learned aversion to the stimulus of being in a confined space, then might one unlearn that association by undergoing another round of conditioning to replace the fear response? Counterconditioning pairs the trigger stimulus (in this case, the enclosed space of the elevator) with a new response (relaxation) that is incompatible with fear. Indeed, behavior therapists have successfully counterconditioned people with such fears. Two specific counterconditioning techniques—exposure therapy and aversive conditioning—replace unwanted responses.

EXPOSURE THERAPIES

Picture this scene reported in 1924 by psychologist Mary Cover Jones: Three-year-old Peter sat petrified of rabbits and other furry objects. Jones planned to replace Peter's fear of rabbits with a conditioned response incompatible with fear. Her strategy is to associate the fear-evoking rabbit with the pleasurable, relaxed response associated with eating. As Peter begins his mid-afternoon snack, Jones introduces a caged rabbit on the other side of the huge room. Peter, eagerly munching away on his crackers and drinking his milk, barely notices. On succeeding days, she gradually moves the rabbit closer and closer. Within two months, Peter is tolerating the rabbit in his lap, even striking it while he eats. Moreover, his fear of other furry objects subsides as well, having been counteracted, or replaced, by a relaxed state that cannot coexist with fear (Fisher, 1984; Jones, 1924).

Unfortunately for those who might have been helped by her counterconditioning procedures, Jones' story of Peter and the rabbit did not immediately become part of psychology's lore. It was more than 50 years later that psychiatrist Joseph Wolpe (1958; Wolpe & Flaud, 1997) refined Jones' technique into what are now the most widely used types of behavior therapies: exposure therapies, which expose people to what they normally avoid or escape (behaviors that get reinforced by reduced anxiety). Exposure therapies have them face their fears and thus overcome their fear of the fear response. The goal is not to habituate to the sound of a train passing their new apartment, so with repeated exposure, can they become less anxiously responsive to things that once terrified them (Rosa-Alcázar et al., 2008; Wolinsky-Taylor et al., 2008).

One widely used exposure therapy is systematic desensitization. Wolpe assumed, as did Jones, that you cannot be simultaneously anxious and relaxed. Therefore, if you can repeatedly relax when facing anxiety-provoking stimuli, you can gradually eliminate your anxiety. The trick is to proceed gradually. Let's see how this might work with social anxiety disorder. Imagine yourself afraid of public speaking. A therapist might first ask for your help in constructing a hierarchy of anxiety-triggering speaking situations. Your list might range from mildly anxiety-provoking situations, perhaps speaking up in a small group of friends, to panic-provoking situations, such as having to address a large audience. Next, using progressive relaxation, the therapist would train you to relax one muscle group after another, until you achieve a blissful state of complete relaxation and comfort. Then the therapist would ask you to imagine, with your eyes closed, a mildly anxiety-arousing situation: You are having coffee with a group of friends and are trying to decide whether to speak up. If imagining the scene causes you to feel any anxiety, you would signal your tension by tightening your finger, and the therapist would instruct you to switch off the mental image and go back to deep relaxation. This imagined scene is repeatedly paired with relaxation until you feel no trace of anxiety.

The therapist would progress up the constructed anxiety hierarchy, using the relaxed state to desensitize you to each imagined situation. After several sessions, you move to actual situations and practice what you had only imagined before, beginning with relatively easy tasks and gradually moving to more anxious ones. Conquering your anxiety in an actual situation, not just in your imagination, raises your self-confidence (Fox & Kozak, 1986; Williams, 1987). Eventually, you may even become a confident public speaker.
When an anxiety-arousing situation is too expensive, difficult, or embarrassing to re-create, virtual reality exposure therapy offers an efficient middle ground. Wearing a head-mounted display unit that projects a three-dimensional virtual world, you would view a lifelike series of scenes that would be tailored to your particular fear and shift as your head turned. Experiments led by several research teams have treated many different people with many different fears—flying, heights, particular animals, and public speaking (Phares & Rizzo, 2008). People who fear flying, for example, can peer out a virtual window of a simulated plane, feel vibrations, and hear the engine roar as the plane taxis down the runway and takes off. In studies comparing control groups with people experiencing virtual reality exposure therapy, the therapy has provided greater relief from real-life fear (Hoffman, 2004; Krijn et al., 2004).

Developments in virtual reality therapy suggest the likelihood of increasingly sophisticated simulated worlds in which people, using avatars (computer representations of themselves), try out new behaviors in virtual environments (Gorini, 2007). For example, someone with social anxiety disorder might visit virtual parties or group discussions, which others join over time.

**AVERSIVE CONDITIONING**

In systematic desensitization, the goal is substituting a positive (relaxed) response for a negative (fearful) response to a harmless stimulus. In aversive conditioning, the goal is substituting a negative (aversive) response for a positive response to a harmful stimulus (such as alcohol). Thus, aversive conditioning is the reverse of systematic desensitization—it seeks to condition an aversion to something the person should avoid.

The procedure is simple: It associates the unwanted behavior with unpleasant feelings. To treat nail biting, one can paint the fingernails with a nasty-tasting nail polish (Barkerd, 1997). To treat alcohol use disorder, an aversion therapist offers the client an appealing drink laced with a drug that produces severe nausea. By linking alcohol with violent nausea (recall the taste-aversion experiments with rats and coyotes in Module 29), the therapist seeks to transform the person's reaction to alcohol from positive to negative (FIGURE 71.1).

**Figure 71.1**

Aversion therapy for alcohol use disorder. After repeatedly imbibing an alcoholic drink mixed with a drug that produces severe nausea, some people with a history of alcohol use disorder develop at least a temporary conditioned aversion to alcohol. (Remember: US is an unconditional stimulus, UR is the conditioned response, CS is the conditioned stimulus, and CR is conditioned response.)

Does aversive conditioning work? In the short run it may. Arthur Wens and Carol Menustik (1983) studied 685 patients with alcohol use disorder who completed an aversion therapy program at a Portland, Oregon, hospital. One year later, after returning for several booster treatments of alcohol-sickness pairings, 63 percent were still successfully abstaining. But after two years, only 33 percent had remained abstinent.

The problem is that cognition influences conditioning. People know that outside the therapist's office they can drink without fear of nausea. Their ability to discriminate between the aversive conditioning situation and all other situations can limit the treatment's effectiveness. Thus, therapists often use aversive conditioning in combination with other treatments.

**Operant Conditioning**

71.2

What is the main premise of therapy based on operant conditioning principles, and what are the views of its proponents and critics?

Pioneering researcher B. F. Skinner helped us understand the basic concept in operant conditioning (Modules 27 and 28) that voluntary behaviors are strongly shaped by their consequences. Knowing this, today's therapists can practice behavior modification—reinforcing desired behaviors and withholding reinforcement for undesired behaviors. Using operant conditioning to solve specific behavior problems has raised hopes for some otherwise hopeless cases. Children with intellectual disabilities have been taught to care for themselves. Socially withdrawn children with autism spectrum disorder (ASD) have learned to interact. People with schizophrenia have been helped to behave more rationally in their hospital ward. In such cases, therapists use positive reinforcers to shape behavior in a step-by-step manner, rewarding closer and closer approximations of the desired behavior.

In extreme cases, treatment must be intensive. One study worked with 19 withdrawn, stubborn 3-year-olds with ASD. Each participated in a 2-year program in which their parents spent 40 hours a week attempting to shape their behavior (Lovaas, 1987). The combination of positively reinforcing desired behaviors, and ignoring or punishing aggressive and self-abusive behaviors, worked wonders for some. By first grade, 9 of the 19 children were functioning successfully in school and exhibiting normal intelligence. In a group of 16 comparable children not undergoing this effortful treatment, only one showed similar improvement. (Ensuring studies suggested that positive reinforcement without punishment was most effective.)

Rewards used to modify behavior vary. For some people, the reinforcing power of attention or praise is sufficient. Others require concrete rewards, such as food. In institutional settings, therapists may create a token economy. When people display appropriate behavior, such as getting out of bed, washing, dressing, eating, talking coherently, cleaning up their rooms, or playing cooperatively, they receive a token or plastic coin as a positive reinforcer. Later, they can exchange their accumulated tokens for various rewards, such as candy, TV time, trips to town, or better living quarters. Token economies are commonly applied in various settings (homes, classrooms, hospitals, institutions for juvenile offenders) and among members of various populations (including disturbed children and people with schizophrenia and other mental disabilities).

Critics of behavior modification express two concerns. The first is practical: How durable are the behaviors? Will people become so dependent on extrinsic rewards that the appropriate behaviors will stop when the reinforcers stop? Proponents of behavior modification believe the behaviors will endure if therapists use the tokens by shifting them toward other, real-life rewards, such as social approval. They also point out that the appropriate behaviors themselves can be intrinsically rewarding. For example, as a withdrawn person becomes more socially competent, the intrinsic satisfactions of social interaction may help the person maintain the behavior.
The second concern is ethical: Is it right for one human to control another’s behavior? Those who set up token economies deprive people of something they desire and decide which behaviors to reinforce. To critics, this whole process has an authoritarian taint. Advocates reply that some patients request the therapy. Moreover, control already exists: rewards and punishers are already maintaining destructive behavior patterns. So why not reinforce adaptive behavior instead? Treatment with positive rewards is more humane than being institution-ized or punished, advocates argue, and the right to effective treatment and an improved life justifies temporary deprivation.

Cognitive Therapies

71-3 What are the goals and techniques of cognitive therapy and of cognitive-behavioral therapy?

We have seen how behavior therapies treat specific fears and problem behaviors. But how do they deal with major depression? Or with generalized anxiety disorder, in which anxiety has no focus and developing a hierarchy of anxiety-triggering situations is difficult? Therapists treating these less clearly defined psychological problems have had help from the same cognitive revolution that has profoundly changed other areas of psychology during the last half-century.

The cognitive therapies assume that our thinking colors our feelings (FIGURE 71.2). Between the event and our response lies the mind. Self-blaming and overgeneralized explanations of bad events are often an (integral) part of the vicious cycle of depression (see Module 67). The depressed person interprets a suggestion as criticism, disagreement as dislike, praise as flattery, friendliness as pity. Ruminating on such thoughts sustains the negative thinking. If such thinking patterns can be learned, then surely they can be replaced. Cognitive therapists therefore try in various ways to teach people new, more constructive ways of thinking. If people are miserable, they can be helped to change their minds.

**Cognitive therapy** is a form of therapy that teaches people new, more adaptive ways of thinking, based on the assumptions that thoughts intervene between events and our emotional reactions. It is based on the idea that thoughts can influence behavior, by changing our thinking we can change our behavior. It is a form of therapy that helps people to identify and change negative or unhelpful patterns of thinking. It is based on the idea that thoughts can influence behavior, by changing our thinking we can change our behavior.

Rational-Emotive Behavior Therapy

According to Albert Ellis (1962, 1987, 1993), the creator of rational-emotive behavior therapy (REBT), many problems arise from irrational thinking. For example, he described a disturbed woman and suggested how therapy might challenge her illogical, self-defeating assumptions (Ellis, 2011, pp. 198-199):

- [Bel] does not merely believe it is undesirable if her lover rejects her. She tends to believe, also, that (a) it is awful, (b) she cannot stand it, (c) she should not, must not be rejected; (d) she will never be accepted by any desirable partner; (e) she is a worthless person because one lover has rejected her; and (f) she deserves to be rejected for being so worthless. Such common covert hypotheses are illogical, unrealistic, and destructive. They can be easily elicited and demolished by any scientist worth his or her salt.

Change people’s thinking by revealing the “absurdity” of their self-defeating ideas, the sharp-tongued Ellis believed, and you will change their self-defeating feelings and enable healthier behaviors.

Aaron Beck’s Therapy for Depression

Cognitive therapist Aaron Beck also believes that changing people’s thinking can change their functioning, though he has a gentler approach. Originally trained in Peruvian techniques, Beck analyzed the dreams of depressed people. He found recurring negative themes of loss, rejection, and abandonment that extended into their waking thoughts. Such negativity even extends into therapy, as clients recall and rehearse their failings and worst impulses (Kelly, 2000). With cognitive therapy, Beck and his colleagues (1979) have sought to reverse clients’ catastrophizing beliefs about themselves, their situations, and their futures. Gentle questioning seeks to reveal irrational thinking, and then to persuade people to remove the dark glasses through which they view life (Beck et al., 1979, pp. 145-146):

- **Client:** I agree with the descriptions of me but I guess I don’t agree that the way I think makes me depressed.
  - **Beck:** How do you understand it?
- **Client:** I get depressed when things go wrong. Like when I fail a test.
  - **Beck:** How can failing a test make you depressed?
- **Client:** Well, if I fail I’ll never get into law school.
  - **Beck:** So failing the test means a lot to you. But if failing a test could drive people into clinical depression, wouldn’t you expect everyone who failed the test to have a depression? ... Did everyone who failed get depressed enough to require treatment?
- **Client:** No, but it depends on how important the test was to the person.
  - **Beck:** Right, and who decides the importance?
- **Client:** I do.
  - **Beck:** And so, what we have to examine is your way of viewing the test (or the way that you think about the test) and how it affects your chances of getting into law school. Do you agree?
- **Client:** Right.
  - **Beck:** Do you agree that the way you interpret the results of the test will affect you? You might feel depressed, you might have trouble sleeping, not feel like eating, and you might even wonder if you should drop out of the course.
- **Client:** I have been thinking that I wasn’t going to make it. Yes, I agree.
  - **Beck:** Now what did failing mean?
Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT), a widely practiced integrative therapy, aims not only to alter the way people think (cognitive therapy), but also to alter the way they act (behavior therapy). It seeks to make people aware of their irrational negative thinking, to replace it with new ways of thinking, and to practice the more positive approach in everyday settings. Behavioral change is typically addressed first, followed by sessions on cognitive change; the therapy concludes with a focus on maintaining both and preventing relapses. Anxiety and mood disorders share a common problem: emotion regulation (Al-Akss and Nicolle-Hoeksema, 2010). An effective CBT program for these emotional disorders training people both to replace their catastrophizing thinking with more realistic appraisals, and, as homework, to practice behaviors that are incompatible with their problem (Kazantzis et al., 2010, 2011; Moses & Barlow, 2006). A person might, for example, keep a log of daily situations associated with negative and positive emotions, and engage more in activities that lead them to feeling good. Or those who fear social situations might be assigned to practice approaching people.

CBT may also be useful with obsessive-compulsive disorder. In one study, people learned to prevent their compulsive behaviors by relabeling their obsessive thoughts (Schwartz et al., 1996). Feeling the urge to wash their hands again, they would simply tell themselves, "I'm having a compulsive urge," and attribute it to their brain's abnormal activity, as previously viewed in their PET scans. Instead of giving in to the urge, they would then spend 15 minutes in an enjoyable, alternative behavior, such as practicing an instrument, taking a walk, or gardening. This helped "unstick" the brain by shifting attention and engaging other brain areas. For two to three months, the weekly therapy sessions continued, with relapsing and relapsing patients returning. By the study's end, most participants' symptoms had diminished and their PET scans revealed normalized brain activity. Many other studies confirm CBT's effectiveness for those with anxiety, depression, or anorexia nervosa (Cocin et al., 2008; Mitte, 2005; Norton & Price, 2007). Studies have also found that cognitive-behavioral skills can be effectively taught and therapy conducted over the Internet (Saraz et al., 2008; Kessler et al., 2009; Marks & Cavanaugh, 2009; Strosi, 2011).

Group and Family Therapies

What are the aims and benefits of group and family therapy?

Group Therapy

Except for traditional psychoanalysis, most therapies may also occur in small groups. Group therapy does not provide the same degree of therapist involvement with each client. However, it offers benefits:

- It saves therapists' time and clients' money, often with no less effectiveness than individual therapy (Fahmian & Burlingame, 1994).
- It offers a social laboratory for exploring social behaviors and developing social skills. Therapists frequently suggest group therapy for people experiencing frequent conflicts or whose behavior distresses others. For up to 90 minutes weekly, the therapist guides people's interactions as they discuss issues and try out new behaviors.

Table 71.1 Selected Cognitive Therapy Techniques

<table>
<thead>
<tr>
<th>Aim of Technique</th>
<th>Technique</th>
<th>Therapists' Directives</th>
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</thead>
<tbody>
<tr>
<td>Reveal beliefs</td>
<td>Question your interpretations</td>
<td>Explore your beliefs, revealing faulty assumptions such as &quot;I must be loved by everyone.&quot;</td>
</tr>
<tr>
<td>Risk thoughts and emotions</td>
<td>Gain perspective by running your thoughts and emotions from mildly to extremely upsetting.</td>
<td></td>
</tr>
<tr>
<td>Test beliefs</td>
<td>Examine consequences</td>
<td>Explore difficult situations, assessing possible consequences and challenging faulty reasoning.</td>
</tr>
<tr>
<td>Decatastrophize thinking</td>
<td>Work through the actual worst-case consequences of the situation you face (it is often not as bad as imagined). Then determine how to cope with the real situation you face.</td>
<td></td>
</tr>
<tr>
<td>Change beliefs</td>
<td>Take appropriate responsibility</td>
<td>Challenge total self-blame and negative thinking, noting aspects for which you may be truly responsible, as well as aspects that aren't your responsibility.</td>
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<tr>
<td>Resist extremes</td>
<td>Develop new ways of thinking and feeling to replace maladaptive habits. For example, change from thinking &quot;I am a total failure&quot; to &quot;I got a failing grade on that paper, and I can make these changes to succeed next time.&quot;</td>
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</table>
It enables people to see that others share their problems. It can be a relief to discover that you are not alone—to learn that others, despite their composure, experience some of the same troublesome feelings and behaviors.

It provides feedback as clients try out new ways of behaving. Hearing that you look poised, even though you feel anxious and self-conscious, can be very reassuring.

**Family Therapy**

One special type of group interaction, family therapy, assumes that no person is an island. We live and grow in relation to others, especially our families. We struggle to differentiate ourselves from our families, but also need to connect with them emotionally. Some of our problem behavior arises from the tension between these two tendencies, which can create family stress.

Unlike most psychotherapy, which focuses on what happens inside the person's own skin, family therapists work with multiple family members to heal relationships and to mobilize family resources. They tend to view the family as a system in which each person's actions trigger reactions from others, and they help family members discover their role within their family's social system. A child's rebellion, for example, affects and is affected by other family tensions. Therapists also attempt—usually with some success, research suggests—to open up communication within the family or to help family members discover new ways of preventing or resolving conflicts (Hazeltine et al., 1987; Shadish et al., 1993).

**Self-Help Groups**

Many people also participate in self-help and support groups (Baum, 1988). One analysis of online support groups and more than 14,000 self-help groups reported that most support groups focus on stigmatized or hard-to-treat illnesses (Dawson et al., 2000). AIDS patients, for example, are 250 times more likely than hypertensin patients to be in support groups. Those struggling with anorexia and alcohol use disorders often join groups; those with migraines and ulcers usually do not. People with hearing loss have national organizations with local chapters; people with vision loss more often cope on their own.

The grandparent of support groups, Alcoholics Anonymous (AA), reports having more than 2 million members in 114,000 groups worldwide. Its famous 12-step program, emulated by many other self-help groups, asks members to admit their powerlessness, to seek help from a higher power and from one another, and (the 12th step) to take the message to others in need of it. In one eight-year, $27 million investigation, AA participants reduced their drinking sharply, although so did those assigned to cognitive-behavioral therapy or to "motivational therapy" (Project Match, 1997). Other studies have similarly found that 12-step programs such as AA have helped reduce alcohol use disorder comparably with other treatment interventions (Fert et al., 2006; Moos & Moos, 2005). The more meetings members attend, the greater their alcohol abstinence (Moon & Moon, 2006). In one study of 2300 veterans who sought treatment for alcohol use disorder, a high level of AA involvement was followed by diminished alcohol problems (McKellar et al., 2003).

In an individualistic age, with more and more people living alone or feeling isolated, the popularity of support groups—for the addicted, the bereaved, the divorced, or simply those seeking fellowship and growth—seems to reflect a longing for community and connectedness. More than 100 million Americans belong to small religious, interest, or self-help groups that meet regularly—and 9 in 10 report that group members "support each other emotionally" (Gallup, 1994).

For a synopsis of the modern forms of psychotherapy we've been discussing, see TABLE 71.2.

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**Table 71.2: Comparing Modern Psychotherapies**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Presumed Problem</th>
<th>Therapy Aim</th>
<th>Therapy Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>Unconscious conflicts from childhood experiences</td>
<td>Reduce anxiety through self-insight.</td>
<td>Interpret patients' memories and feelings</td>
</tr>
<tr>
<td>Client-centered</td>
<td>Bunker to self-understanding and self-acceptance</td>
<td>Enable growth via unconditional positive regard, genuineness, and empathy</td>
<td>Listen actively and reflect clients' feelings</td>
</tr>
<tr>
<td>Behavior</td>
<td>Dysfunctional behaviors</td>
<td>Relieve adaptive behaviors; extinguish problem ones.</td>
<td>Use classical conditioning (via exposure or aversion therapy) or operant conditioning (as in token economies)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Negative, self-defeating thinking</td>
<td>Promote healthier thinking and self-talk.</td>
<td>Train people to dispute negative thoughts and attributions</td>
</tr>
<tr>
<td>Cognitive-behavioral</td>
<td>Self-harmful thoughts and behaviors</td>
<td>Promote healthier thinking and adaptive behaviors.</td>
<td>Train people to counter self-harmful thoughts and to act out their new ways of thinking</td>
</tr>
<tr>
<td>Group and family</td>
<td>Stressful relationships</td>
<td>Head relationships.</td>
<td>Develop an understanding of family and other social systems, explore roles, and improve communication</td>
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**Before You Move On**

- **ASK YOURSELF**
  Critics say that behavior modification techniques, such as those used in token economies, are inhumane. Do you agree or disagree? Why?

- **TEST YOURSELF**
  What is the major distinction between the underlying assumptions in insight therapies and in behavior therapies?

Answers to the Test Yourself questions can be found in Appendix E at the end of the book.
Module 71 Review

How does the basic assumption of behavior therapy differ from those of psychodynamic and humanistic therapies? What techniques are used in exposure therapies and aversive conditioning?

- Behavior therapies are not insight therapies. Their goal is to apply learning principles to modify problem behaviors.
- Classical conditioning techniques, including exposure therapies (such as systematic desensitization or virtual reality exposure therapy) and aversive conditioning, attempt to change behaviors through counterconditioning—evoking new responses to old stimuli that trigger unwanted behaviors.

What is the main premise of therapy based on operant conditioning principles, and what are the views of its proponents and critics?

- Therapy based on operant conditioning principles uses behavior modification techniques to change unwanted behaviors through positively reinforcing desired behaviors and ignoring or punishing undesirable behaviors.
- Critics maintain that (1) techniques such as those used in token economies may produce behavior changes that disappear when rewards end, and (2) deciding which behaviors should change is authoritarian and unethical.
- Proponents argue that treatment with positive rewards is more humane than punishing people or institutionalizing them for undesired behaviors.

What are the goals and techniques of cognitive therapy and of cognitive-behavioral therapy?

- The cognitive therapies, such as Aaron Beck’s cognitive therapy for depression, assume that our thinking influences our feelings, and that the therapist’s role is to change clients’ self-defeating thinking by training them to view themselves in more positive ways.
- Rational-emotive behavior therapy (REBT) is a confrontational cognitive therapy that actively challenges irrational beliefs.
- The widely researched and practiced cognitive-behavioral therapy (CBT) combines cognitive therapy and behavior therapy by helping clients regularly act out their new ways of thinking and talking in their everyday life.

What are the aims and benefits of group and family therapy?

- Group therapy sessions can help more people and costs less per person than individual therapy would. Clients may benefit from exploring feelings and developing social skills in a group situation, from learning that others have similar problems, and from getting feedback on new ways of behaving.
- Family therapy views a family as an interactive system and attempts to help members discover the roles they play and to learn to communicate more openly and directly.

Multiple-Choice Questions

1. Dr. Welle tries to help her clients by teaching them to modify the things they do when under stress or experiencing symptoms. This means that Dr. Welle engages in ________ therapy.
   a. behavior
   b. cognitive
   c. group
   d. rational-emotive behavior
   e. client-centered

2. Mary Cover Jones helped a little boy named Peter overcome his fear of rabbits by gradually moving a rabbit closer to him each day while he was eating his snack. This was one of the first applications of
   a. group therapy.
   b. virtual reality exposure therapy.
   c. aversive therapy.
   d. exposure therapy.
   e. cognitive therapy.

3. On which of the following are token economies based?
   a. Classical conditioning
   b. Operant conditioning
   c. Group therapy
   d. Cognitive therapy
   e. Cognitive-behavioral therapy

4. Which of the following is considered a benefit of group therapy?
   a. It is the most effective therapy for children.
   b. It is particularly effective in the treatment of antisocial personality disorder.
   c. It is particularly effective in the treatment of schizophrenia.
   d. It is the only setting proven effective for virtual reality exposure therapy.
   e. It saves time and money when compared with other forms of therapy.

Practice FROs

1. Name and describe two specific types of group therapy.

   Answer
   1 point: Family therapy is a means of treating an entire family as an interdependent system.
   1 point: Self-help groups, such as Alcoholics Anonymous (AA), are groups of individuals who share similar problems working together to overcome that problem.