

Behaviour Therapy & Cognitive Behaviour Therapy

Forms of psychotherapy derived from learning theory. Maladaptive thoughts and behaviours are eliminated or modified using strategies drawn from:

1. The Conditioning Paradigm and its two subclasses:

i. **classical conditioning** (Type S, Pavlovian or associative conditioning.) A stimulus that elicits a natural, unlearned or reflexive response must occur first e.g. meat powder → salivation; hyperventilation → unpleasant, panic-like sensations; an mva → fear response.

However, previously neutral stimuli that are present can by association come to evoke the same response without the original powerful stimulus present. This is associative conditioning.

Etiological Examples: Returning to the supermarket where the hyperventilation episode occurred results in panic → agoraphobic avoidance or just the smell of fried chicken bought at the drive thru just before an accident provokes a fear-like sickening feeling → food aversion. Orgasm paired with fetish object → object arouses.

"Psychosomatic" variations of many disorders may represent unfortunate examples of classical conditioning e.g. bronchial asthma, essential hypertension, headaches, GI tract disturbances...

Treatment Examples: Extinction of conditioned response (e.g.fear) by repeated exposures to newly conditioned stimuli (supermarket or smell of chicken, driving a car, fetish object) without the original stimulus (hyperventilation, accident, orgasm) and often with the addition of an active counter-response or inhibition of usual response e.g.slow, steady breathing or a physical/mental relaxation technique, pairing orgasm only with appropriate stimulus.

ii. **operant conditioning** (Type R) the response not the stimulus must come first - no learning occurs until the response is made. The learner acts upon the external or internal environment, or operates on it, which in turn produces changes in it.

Behaviour is learned and maintained by these changes via: reward (smile returned by other -- if feels nice, more likely to repeat) = "positive reinforcement"; escape from punitive conditions (overeating distracts from upsetting events, self-injury blocks unbearable psychic pain) = "negative reinforcement"; or suppressed by punishment/loss of reinforcers (being yelled at, 'time-out', fines, jail term). All of these must follow responses.

Etiological Examples: Overly solicitous responses from spouse increases pain behaviour (e.g. limping, groaning) which reinforces invalidity. Child gains attention, even though punitive, for bad behaviour and little or none for good behaviour → behavioural disturbance. Destructive relationships reinforce self-image as bad or unlovable. Not pursuing challenges avoids pain of 'inevitable' failure for underachiever. Chronic pain litigant negatively reinforced for not

gradually responding to treatment because thinks would be branded a liar by courts, insurance companies, workmates. Pain un-consciously conditioned because escapes this aversive experience.

Treatment Examples: Assertiveness Training, with its emphasis on role play practice that generalises to the real world, leads to positive responses from others and increased pro-social behaviour and self-respect. Ignoring head-banging of autistic child -- cuddling child when stops and looks at carer/answers question. Training in marital communication rules = more harmonious relationships. In chronic pain, learn to relax or pace activity, reduces pain, more likely to repeat behaviour.

Strictly behavioural procedures i.e. those based on conditioning theory alone follow a systematic analysis of all possible *observable*, as opposed to *introspective*, antecedents and consequences. Cognitions (thoughts, imagery, fantasies etc) are too subjective for behaviourists -- too difficult to assess and modify. Environment /what person does easier, more efficient. Enter the cognitivists ...

2. Cognitive Behavioural Paradigm.

Cognitive-behaviour therapy (CBT) de-emphasises external contingencies and instead focuses on uncovering unique internal representations of experience. CBT aims to directly modify how person views event. Not trying to change events.

Etiological Examples: Student fails one exam and thinks "It's all my fault, I'll fail all future exams/ things will never get better and it just proves how totally useless I am as a person." → depression (The 3P's of one cognitive theory about depression - Personal vs externally caused, Permanent vs temporary effect, and Pervasive vs limited effect.)

Patient hears doctor say "spine is degenerating" and takes this to mean "it is turning to chalk and will do so more quickly if I engage in too much activity" which → anxiety about future, restricted lifestyle and depression as a result.

Treatment Examples: Cognitive therapy for depression may help patient challenge and change cognitive styles like overgeneralising, dichotomous thinking, catastrophising and pessimism. Strategies include externalising thoughts and writing out challenges that become ego-syntonic with repetition.

After interview assessing concomitants of pain, corrective info that activity is actually better may alter cognition.

In sum

A behaviourist would say that "if you wish to change feelings e.g. anxiety, anger, depression then change behaviour and/or the environment. Changes in thoughts and feelings will follow."

A cognitivist would say "if you wish to change feelings then change thoughts. Changes in behaviours and feelings will follow."

Behavioural Analysis (see next handout) precedes interventions. It is a sine qua non of all learning based therapy, irrespective of paradigm used. Behavioural and cognitive components may receive different emphases though depending on therapist orientation to problem.

Characteristics of behaviour therapy include:

1. PSYCHO-EDUCATIONAL FORMAT
2. SYSTEMATIC MEASUREMENT
3. INDIVIDUALLY-TAILORED TREATMENT
4. "HOMEWORK" ASSIGNMENTS
5. SELF-MANAGEMENT AND SELF-CONTROL = Ultimate Aim

Conditions suitable for behaviour therapy:

- ANXIETY DISORDERS e.g.
 1. PANIC DISORDER WITH OR WITHOUT AGORAPHOBIA
 2. OBSESSIVE-COMPULSIVE DISORDER
 3. SOCIAL PHOBIA
 4. POST-TRAUMATIC STRESS DISORDER
 5. SPECIFIC PHOBIAS
 6. GENERALISED ANXIETY DISORDER
- DEPRESSION
- CHRONIC PAIN
- SOCIAL SKILLS DEFICITS
- MARITAL PROBLEMS
- SEXUAL PROBLEMS
- CHILD BEHAVIOUR DISORDERS
- EATING DISORDERS
- HABIT DISORDERS e.g. Sleep disturbances
- PERSONALITY DISORDERS
- ABNORMAL GRIEF REACTIONS

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