

## BEHAVIOURAL ANALYSIS

### Behaviour Analysis Matrix (ABC x CAME)

	<u>A</u> ntecedent	<u>B</u> ehaviour	<u>C</u> onsequence
<u>C</u> ognitive	X	X	X
<u>A</u> utonomic	X	X	X
<u>M</u> otoric	X	X	X
<u>E</u> nvironmental	X		X

Table Source: V.Meyer and I.Turkat.(1979) "Behavioral Analysis of Clinical Cases" J.Behav'l Analysis Vol. 1 No.4 pp. 259-270

Good behaviour therapy based on good behavioural analysis. Basic assumption of behavioural analysis is that therapy should be an experiment or hypothesis testing of **antecedents and consequences** relevant to problem. Not interested in traditional assessment of global, stable traits or behaviours. Focus is on assessing construct (e.g. anxiety) - its molar units like "cannot leave house" with regard to specific stimuli and responses e.g. particular situations when it does and does not occur rather than reference to personal attributes. So, not enough to say person "has high state-anxiety". Change based on specificity is central. So e.g. "anxiety maximises as radius from home approaches and exceeds 4km - reduced to nil while in the home, hospital or other perceived 'safe-place'."

Behaviour therapy not just a bunch of routinely-applied technical procedures like exposure therapy, response prevention etc.. Instead interest is in assessing salient personal & environmental contingencies the "who, what, where, when, how often, how long, how many" - the ameliorators, exacerbators - both recent & remote. E.g. current environmental concomitants of difficulty, early relationships, expectations of marriage, presence or absence of specific communication skills, responses from all staff to patient aggression, number of daily pleasurable events, physical accompaniments, particular things person is afraid of (not just general level of fear.) Procedures grow out of assessment.

Basically **search & specification of the precise controlling variables** that are then manipulated and monitored in therapy - forming and reforming hypotheses if properly done treatments do not work. How certain variables control behaviour become hypotheses that are formulated so as to suggest treatment. Keep going through loop until treatment is successful. As in traditional experiments, hypo-thesis's utility is determined by outcome. An improvement on the old role of psychological diagnosis that just categorises/classifies people - tells us what to try to do with them. (Vague problems lead to vague solutions.)

## HOW TO SEARCH & SPECIFY

- \* external stimuli that precede or follow behaviour e.g. attention to pain behaviours, panic only when others 'in control', sight of blood / needles ...
- \* internal stimuli (i.e. produced in the individual) that have an impact on overt behaviour e.g. the influence of attitudes on behaviour, interoceptive cues ...
- \* search for precise variables - why person began to respond and why continues to behave in this way. Whenever possible look for common themes across particular situations. (As in most counselling & therapy trying to change patterns of responding, not isolated behaviours.) These become independent variables within experimental framework. Operationalisable measures are good dependent variables - often the initial assessment devices e.g. self-report questionnaires, logs, behavioural interview data, observations, thought listing, hourly ratings, frequency counts etc.

## TREATMENT

Tailored to a particular response - its producing stimuli or antecedents, its concomitant or component behaviour & consequences (**ABC**) at levels of (**CAME**)- the cognitive (e.g. thoughts & imagery,) autonomic (e.g. heart rate, blood pressure, galvanic skin response,) motoric (e.g. erratic upper-chest vs. steady diaphragmatic breathing,) & environmental (e.g. people, places & objects.)

**Operationalising of target behaviours like this is perhaps the hallmark of behaviour therapy.** Once cause & effect hypotheses formulated & modification program developed, monitor effect of *manipulating individual's CAME variables against CAM responses* using psychophysiological, behavioural (observable) & self-report measures.

**Options:** change causes, change responses, change both, change environment (often latter is most efficient method of change.)

**Implications:** Rejects homogenous disorder notion. Tailoring of treatment to unique individual's responses. Not a simple matching of techniques to vaguely formulated complaints. Strict attention to specifying parameters i.e. measurable features of each problem. Hypothesis testing is the basic strategy -- hypotheses continually reformulated & intervention based on testable constructs.