Psychotherapy Guidebook

Broad Spectrum Behavior Therapy

James P. McGee, II

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DEFINITION

Behavior therapy is defined by Ullmann and Krasner as “treatment ... that aims to alter a person’s behavior directly through the application of general psychological principles.” More specifically, Wolpe relates behavior therapy to psychological learning theory by describing it as ... the use of experimentally established principles of learning for the purpose of changing unadaptive habits.”

Until recently the rather narrow definitions of behavior therapy provided by Krasner and Wolpe, which stressed the alleged sociopsychological and learning theory foundations of behavioral approaches, dominated the field. Broad Spectrum Behavior Therapy, a concept invented by Arnold Lazarus, was developed to extend the scope of behavioral intervention to include not only external, observable, and measurable behavioral deficits and excesses but also to alter internal private events such as maladaptive thoughts and feelings, attitudes and beliefs (Lazarus, 1971). “Narrow band” behavior therapy stresses the notion that behavior is acquired and maintained and thus also changed through processes of “conditioning” or learning. In contrast, the Broad Spectrum approach is essentially atheoretical in that it proposes the use of techniques that derive from various, and at

times competing, theoretical frameworks. Broad Spectrum Behavior Therapy is a form of "technical eclecticism" wherein the practitioner relies on not only strictly behavioral techniques, such as desensitization or assertive training, but also on more traditional strategies, such as interpretation, reflection, cognitive restructuring, as well as the relationship aspects of therapy. The selection of treatment approaches by the Broad Spectrum Behavior therapist is more determined by his perception of the needs of the patient and the patient's individual responses than to any specific set of theoretical assumptions.

HISTORY

The origins of behavior therapy, or the more generic term Behavior Modification, can be traced back to the philosophical tradition of empiricism as characterized by the British philosophers Locke, Hume and Hartley. Here emphasis was placed on the mind as a tabula rasa, or blank slate, upon which knowledge and behavioral tendencies were impressed by experience.

In the United States, the Behavioral School of Psychology was founded by John B. Watson, regarded by many as the "father of modern behaviorism." Some of Watson's early work in the 1920s, in which he applied learning principles to alter behavior patterns in children, can be seen retrospectively as behavior therapy. Watson's work was influenced by the research of Ivan

Pavlov on the conditioned reflex and the pioneer learning theorist E. L. Thorndike. Thorndike's "law of effect," which articulated the influence of reinforcing consequences on behavior, provided the foundation for B. F. Skinner's Behavioral Psychology of Operant Conditioning. Krasner (1971) regards the work of Skinner as the most important of fifteen various "streams of influence" that converged in the early 1960s to give birth to the field of behavior therapy. Perhaps the two other most important trends affecting the evolution of Behavior Therapy were the development of a social learning theory of psychopathology as a viable alternative to the disease or medical model, and a growing dissatisfaction with psychoanalysis and psychodynamic therapies because of their alleged inefficiency.

Current developments on the level of broad conceptualizations, as opposed to specific techniques, are directly linked to the work of Arnold Lazarus and his Broad Spectrum Behavior Therapy. This approach goes well beyond the strict Skinnerian and Pavlovian conditioning formulations that characterized the early history of behavior therapy. Even more recently, Lazarus has proposed a scheme he calls Multimodal Behavior Therapy (Lazarus, 1976) as the legitimate successor of Broad Spectrum Behavior Therapy. The mulitmodal approach to assessment and treatment stresses that the clinician attends to what Lazarus regards as the seven successful domains or "modes" of human functioning: behavior, affect (moods, emotions), sensation, imagery, cognition, interpersonal, and drugs (neurological,

biochemical functioning). The first letters of these seven modes spell out the acronym “basic id.” According to Lazarus, failure to adequately deal with a patient’s functioning in the areas of the basic id accounts for a large portion of relapse in patients treated by other therapies — including other behavior therapies.

TECHNIQUE

Subsumed under the heading of Broad Spectrum Behavior Therapy are all the standard behavioral strategies that are based largely on principles of Skinnerian and Pavlovian conditioning and imitation learning, plus the techniques of cognitive therapy, such as those developed by Albert Ellis and Aaron Beck. The more purely behavioral techniques include the following: systematic desensitization, implosion, flooding or response prevention, emotive imagery, assertive training, massed practice, modeling based procedures, operant conditioning based procedures, techniques of aversive control, behavioral methods of self-control, covert conditioning and covert reinforcement, and biofeedback.

(For a definition and description of these various techniques, consult either of the texts by O’Leary and Wilson or Rimm and Masters cited in the Bibliography.)

APPLICATIONS

Broad Spectrum Behavior therapists utilize any of the behavioral and cognitive techniques listed above either alone or, more frequently, in combination to treat all varieties of human deviance and psychopathology. For example, with the patient who shows neurotic anxiety and depression, assessment might reveal that this includes both "free-floating" and situation-specific anxiety. This patient may also suffer significant social-interpersonal anxiety that results in his acting withdrawn, passive, and submissive in social situations. Such a patient frequently experiences sexual difficulties, such as periodic impotence. The patient may also experience episodic depressive states characterized by feelings of low self-esteem, which are the result of the person's having very critical thoughts about himself. For this type of patient a combination of relaxation training and systematic desensitization for his free-floating anxiety and specific phobias is indicated. Secondary to that, the patient could receive a program of assertive training designed to reduce social anxiety while simultaneously increasing his repertoire of appropriate assertive responses. For the sexual difficulties some variation of the Masters and Johnson treatment for impotence might be utilized. For the patient's depression, a cognitive therapy strategy might be taken where the patient is encouraged to examine his irrational thoughts and self-condemnation, and to replace these with rational beliefs that include notions of self-acceptance.