

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 benefits of group and family therapy.



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behavior therapy therapy that applies learning principles to the elimination of unwanted behaviors.

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.

Classical 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

AP® Exam Tip

Before you read the next several pages of this module, you may want to quickly review the material on classical and operant conditioning in Unit VI.



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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 is petrified of rabbits and other furry objects. Jones plans 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 midafternoon 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, hardly notices. On succeeding days, she gradually moves the rabbit closer and closer. Within two months, Peter is tolerating the rabbit in his lap, even stroking it while he eats. Moreover, his fear of other furry objects subsides as well, having been *countered*, 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 30 years later that psychiatrist Joseph Wolpe (1958; Wolpe & Plaud, 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 fear, and thus overcome their fear of the fear response itself. As people can 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 petrified them (Rosa-Alcázar et al., 2008; Wolitzky-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. Yours 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 raising 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 anxiety-filled ones. Conquering your anxiety in an actual situation, not just in your imagination, raises your self-confidence (Foa & Kozak, 1986; Williams, 1987). Eventually, you may even become a confident public speaker.

counterconditioning behavior therapy procedures that use classical conditioning to evoke new responses to stimuli that are triggering unwanted behaviors; include *exposure therapies* and *aversive conditioning*.

exposure therapies behavioral techniques, such as *systematic desensitization* and *virtual reality exposure therapy*, that treat anxieties by exposing people (in imagination or actual situations) to the things they fear and avoid.

systematic desensitization a type of exposure therapy that associates a pleasant, relaxed state with gradually increasing anxiety-triggering stimuli. Commonly used to treat phobias.



Virtual reality exposure therapy

Virtual reality technology exposes people to vivid simulations of feared stimuli, such as a plane's takeoff.



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 (Parsons & 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 (Gorjani, 2007). For example, someone with social anxiety disorder might visit virtual parties or group discussions, which others join over time.

virtual reality exposure therapy

an anxiety treatment that progressively exposes people to electronic simulations of their greatest fears, such as airplane flying, spiders, or public speaking.

aversive conditioning a type of counterconditioning that associates an unpleasant state (such as nausea) with an unwanted behavior (such as drinking alcohol).

AVERSIVE CONDITIONING

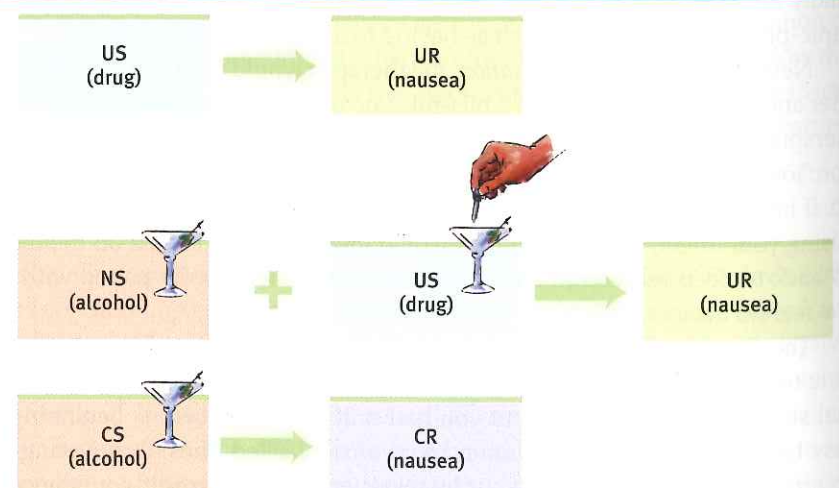
In systematic desensitization, the goal is substituting a positive (relaxed) response for a negative (fearful) response to a *harmless* stimulus. In **aversive conditioning**, the goal is substituting a negative (aversive) response for a positive response to a *harmful* stimulus (such as alcohol). Thus, 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 (Baskind, 1997). To treat alcohol use disorder, an aversion therapist offers the client appealing drinks 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 unconditioned stimulus, UR is unconditioned response, NS is neutral stimulus, CS is conditioned stimulus, and CR is conditioned response.)



Does aversive conditioning work? In the short run it may. Arthur Wiens 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 three 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 influenced 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, uncommunicative 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 40 comparable children not undergoing this effortful treatment, only one showed similar improvement. (Ensuing 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 have been successfully 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 wean patients from 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.

token economy an operant conditioning procedure in which people earn a token of some sort for exhibiting a desired behavior and can later exchange the tokens for various privileges or treats.

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 institutionalized 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.

AP® Exam Tip

Behavior therapies focus on what we do. Cognitive therapies focus on what we think. That's a very basic distinction, but it is critically important for your understanding.



Cognitive therapy for eating disorders aided by journaling

Cognitive therapists guide people toward new ways of explaining their good and bad experiences. By recording positive events and how she has enabled them, this woman may become more mindful of her self-control and more optimistic.

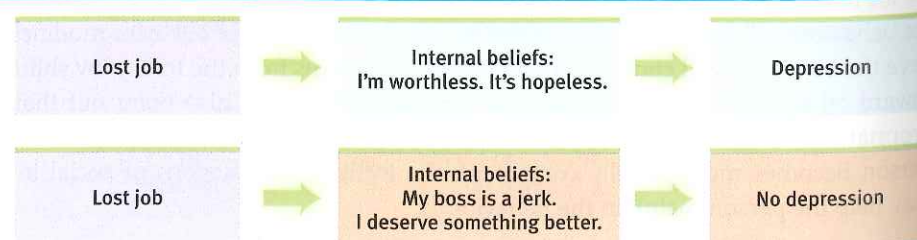
cognitive therapy therapy that teaches people new, more adaptive ways of thinking; based on the assumption that thoughts intervene between events and our emotional reactions.

"Life does not consist mainly, or even largely, of facts and happenings. It consists mainly of the storm of thoughts that are forever blowing through one's mind." -MARK TWAIN, 1835-1910

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.

Figure 71.2

A cognitive perspective on psychological disorders The person's emotional reactions are produced not directly by the event but by the person's thoughts in response to the event.



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):

[She] 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; and the rational-emotive therapist is exactly that: an exposing and nonsense-annihilating scientist.

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 Freudian 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?

rational-emotive behavior therapy (REBT) a confrontational cognitive therapy, developed by Albert Ellis, that vigorously challenges people's illogical, self-defeating attitudes and assumptions.

Client: (tearful) That I couldn't get into law school.

Beck: And what does that mean to you?

Client: That I'm just not smart enough.

Beck: Anything else?

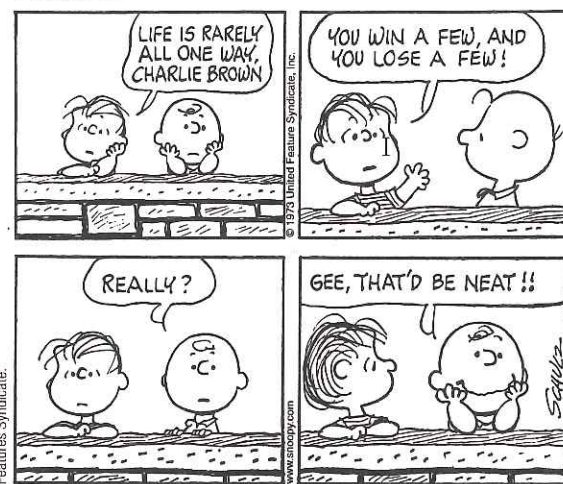
Client: That I can never be happy.

Beck: And how do these thoughts make you feel?

Client: Very unhappy.

Beck: So it is the meaning of failing a test that makes you very unhappy. In fact, believing that you can never be happy is a powerful factor in producing unhappiness. So, you get yourself into a trap—by definition, failure to get into law school equals "I can never be happy."

PEANUTS



Drawing by Charles Schulz, © 1995. Reprinted by permission of United Features Syndicate.

We often think in words. Therefore, getting people to change what they say to themselves is an effective way to change their thinking. Perhaps you can identify with the anxious students who, before a test, make matters worse with self-defeating thoughts: "This test's probably going to be impossible. All these other students seem so relaxed and confident. Wish I were better prepared. Anyhow, I'm so nervous I'll forget everything." To change such negative self-talk, Donald Meichenbaum (1977, 1985) offered *stress inoculation training*: teaching people to restructure their thinking in stressful situations. Sometimes it may be enough simply to say more positive things to oneself: "Relax. The test may be hard, but it will be hard for everyone else, too. I studied harder than most people. Besides, I don't need a perfect score to get a good grade in this class." After being trained to dispute their negative thoughts, depression-prone children, teens, and college students exhibit a greatly reduced rate of future depression (Seligman, 2002; Seligman et al., 2009). To a large extent, it is the thought that counts. **TABLE 71.1** provides a sampling of techniques commonly used in cognitive therapy.

Table 71.1 Selected Cognitive Therapy Techniques

Aim of Technique	Technique	Therapists' Directives
Reveal beliefs	Question your interpretations	Explore your beliefs, revealing faulty assumptions such as "I must be liked by everyone."
	Rank thoughts and emotions	Gain perspective by ranking your thoughts and emotions from mildly to extremely upsetting.
Test beliefs	Examine consequences	Explore difficult situations, assessing possible consequences and challenging faulty reasoning.
	Decatastrophize thinking	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.
Change beliefs	Take appropriate responsibility	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.
	Resist extremes	Develop new ways of thinking and feeling to replace maladaptive habits. For example, change from thinking "I am a total failure" to "I got a failing grade on that paper, and I can make these changes to succeed next time."

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 (Aldao & Nolen-Hoeksema, 2010). An effective CBT program for these emotional disorders trains 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., 2010a,b; 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 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 or three months, the weekly therapy sessions continued, with relabeling and refocusing practice at home. 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 (Covin 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 (Barak et al., 2008; Kessler et al., 2009; Marks & Cavanaugh, 2009; Stross, 2011).

"The trouble with most therapy is that it helps you to feel better. But you don't get better. You have to back it up with action, action, action." -THERAPIST ALBERT ELLIS (1913-2007)

cognitive-behavioral therapy (CBT) a popular integrative therapy that combines cognitive therapy (changing self-defeating thinking) with behavior therapy (changing behavior).

group therapy therapy conducted with groups rather than individuals, permitting therapeutic benefits from group interaction.

Group and Family Therapies

71-4 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 (Fuhriman & 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.

Group Therapy ABC Family's and *Seventeen Magazine's* 2011 film *Cyberbully* realistically portrayed main characters attending group therapy, where they found they were not alone in their troublesome feelings.



Photograph Courtesy of Muse Entertainment Enterprises Inc.

- *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 we also need to connect with them emotionally. Some of our problem behaviors arise 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 (Hazelrigg et al., 1987; Shadish et al., 1993).

Self-Help Groups

Many people also participate in self-help and support groups (Yalom, 1985). 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-discuss illnesses (Davison et al., 2000). AIDS patients, for example, are 250 times more likely than hypertension patients to be in support groups. Those struggling with anorexia and alcohol use disorder 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 twelfth 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 (Ferri et al., 2006; Moos & Moos, 2005). The more meetings members attend, the greater their alcohol abstinence (Moos & Moos, 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**.

FYI

With more than 2 million members worldwide, AA is said to be "the largest organization on Earth that nobody wanted to join" (Finlay, 2000).

family therapy therapy that treats the family as a system. Views an individual's unwanted behaviors as influenced by, or directed at, other family members.

Table 71.2 Comparing Modern Psychotherapies

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

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

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?

- *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.

71-2 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.

71-3 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.

71-4 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 FRQs

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 a similar problem working together to overcome that problem.

2. Explain what systematic desensitization is, then describe the two major components of the therapy.

(3 points)