Principles of Behavior Therapy and Behavior Modification (Chapter 5 from The Human Reflex)

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PART III

Changing Human Behavior
5. Principles of Behavior Therapy and Behavior Modification

The emergence of behavior theory represents a striking shift from the previous history of ideas in the western world. Since the zenith of Greek civilization, it has been customary to explain behavior in terms of such internal factors as will, desire, purpose, intention, belief, expectation, memory, and character. The experimental analysis of behavior, however, shifts the locus of causal explanations for behavior from internal processes and events to external causes. In Skinner's words, "[This shift] quite naturally led to a flood of practical applications. An early stimulus-response formula was too simple and seriously misleading, but once the role of the causal environment was properly understood, a flourishing technology was inevitable." 1

This chapter examines the theoretical aspects of the application of behavioral psychology (technically, the experimental analysis of behavior) to the process of behavior therapy. Beginning with a brief history, we will then discuss the definition of behavior therapy and behavior modification, survey a conception of problem behavior that grows out of the behavioral approach, examine basic approaches to behavior therapy, look at specific behavior change techniques, discuss biblical parallels, and consider several areas of controversy.

Historical Introduction to Behavior Therapy

The early work in experimental psychology that laid the foundation for the technology of behavior therapy extends back to the turn of the century. Until the mid-50s, however, development was slow.
The first journal devoted to publication of research on "operant conditioning" was begun in 1958; the first journal to focus explicitly on the application of behavioral theory was the *Journal of Applied Behavior Analysis*, founded in 1968, ten years later. Since then, at least a dozen other journals have arisen to deal with aspects of behavior therapy ranging from *Behavioral Medicine* to *Law and Behavior*.

Because of the rapid growth and development of behavior therapy during the past two decades, it has undergone many changes. A few years ago, behavior therapy was the specialization of a close-knit handful of individual professionals; now there are enough practitioners to support three major professional societies in the United States alone, along with untold numbers of paraprofessionals and laypersons who practice some form of behavior modification.

Another result of this proliferation of behavioral approaches is that developments in behavioral technology have occurred much more rapidly than most people recognize. Even professionals in the forefront of the developing behavioral technology find it difficult to keep abreast of new developments. People on the fringes, and non-professional observers, tend to have a view of behavior modification which reflects a state of development several years out of date. Consequently, critics tend to focus on features of behavior modification that do not reflect current thinking in the field. Political scientist Bruce McKeown, for example, accuses Skinner (and, by implication, behaviorists in general) of holding the view that all behavior is the product of reinforcement. While such a view was once held by some behaviorists (e.g., Watson), most behaviorists now attribute important controlling roles not only to reinforcement, but to such variables as genetics, biological factors (e.g., physical health, disease, and trauma), punishment, and other setting events.

The behavioral movement is now characterized by great diversity. A behavioral psychologist may choose from among respondent conditioning models, operant conditioning models, multimodal approaches, cognitive behavioral approaches, and social learning approaches. In the context of such diversity, disagreement among practitioners is natural, and it is difficult to identify the boundaries within which behavior therapy is delimited.
DEFINITION OF BEHAVIOR MODIFICATION AND BEHAVIOR THERAPY

One of the problems in attempting to define behavior modification and behavior therapy is that the terms are used in different ways by different authors. Lazarus suggests that behavior therapy is generally used to refer to the treatment of anxiety by counterconditioning (respondent) procedures, while behavior modification refers more to operant procedures. Ullmann and Krasner, by contrast, use behavior modification to refer to virtually any approach to changing behaviors that have been labeled socially deviant. Because of these complexities, and for the sake of simplicity, the term behavior therapy will be used here to refer in general to all approaches to behavior change that derive from a behavioral perspective.

Social influence may be defined as any condition in which one is effective in programming the environment, including one's own behavior, in such a way as to alter the behavior of another individual. Because other people are a major source of reinforcement, seeking to influence the behavior of others is probably one of the most common activities in which humans engage. Social influence would include diverse approaches such as education, persuasion, coercion, use of propaganda, brainwashing, and a host of other techniques. All of these activities are maintained by the fact that they alter the behavior of others in ways that reinforce the influencing person, whether or not the resulting responses are socially desirable.

Behavior therapy implicitly involves two issues: a standard for deviancy, and social sanctioning of the process of behavior change. Ethical controversy is rare in a setting in which there is general agreement on a particular value system. In our pluralistic society, however, there is a diversity of opinion as to what constitutes moral behavior; hence there is broad disagreement on what behaviors should be considered socially deviant, and the types of remedies that should be embraced. This problem is illustrated by the practice of medicine in the United States, which—until recently—was guided by generally agreed upon principles. In the past few years, however, such questions as abortion, heart transplant surgery, and the use or disconnection of life support systems for the terminally ill have raised highly controversial moral/ethical questions.

This problem is even more prevalent in the area of behavior
therapy. For example, when a young man seeks therapy for a problem with homosexuality, the possible treatment approaches and goals are widely varied. A few years ago, the accepted practice was to seek to convert such a person to practicing heterosexuality. More recently, the prevailing opinion among psychologists and psychiatrists has shifted toward assisting the individual to become a comfortable homosexual practitioner. A biblical worldview suggests that sexual practice outside of marriage, whether with members of the same or the opposite sex, is equally undesirable. Thus the goal of therapy might be either one of chastity outside of marriage, or fidelity within a marriage relationship.

TRADITIONAL, BEHAVIORAL, AND BIBLICAL VIEWS OF MENTAL DISORDERS

The use of behavioral methods to correct deviant behavior implies a concept of the nature of deviant behavior that is radically different from the traditional model. Some of these conceptual differences must be addressed before we can begin to discuss behavioral approaches to treatment.*

TRADITIONAL VIEWS

Although there is considerable diversity among the various “traditional” approaches to behavior modification—enough diversity that entire books have been written to describe them—they all have central features that clearly distinguish them from behavioral approaches.

Broadly speaking, traditional approaches have emphasized medical or psychoanalytic conceptualizations of mental disorders. Disordered behavior is viewed as the result of disturbances in internal psychic functioning. Unresolved conflicts, blockages of impulses through the development of maladaptive defensive systems, and the resulting buildup of energy and tension result in overt behavioral

* While our discussion here must necessarily oversimplify and generalize, some of the central themes and focal perspectives of traditional approaches will be summarized so that we can compare traditional with behavioral approaches. One other note of caution is required. Over the past twenty years, there has been a considerable degree of mutual influence. Thus the distinction between behavioral and traditional approaches have become somewhat blurred.
manifestations that are called "symptoms." In the words of one traditional psychoanalyst, "Thus we have in psychoneuroses, first a defense of the ego against an instinct, then a state of damming up, and finally the neurotic symptoms which are distorted discharge as a consequence of the state of damming up—a compromise between the opposing forces. The symptom is the only step in this development which becomes manifest; the conflict, its history, and the significance of the symptom are unconscious." Although a neurotic conflict underlies the overt manifestations, only the symptom itself is available to immediate observation.

Consistent with an approach in which the overt manifestation is viewed as merely symptomatic of some underlying problem, diagnosis and classification become a central aspect of the treatment process in traditional approaches. Classification is based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Implicit in this diagnostic system is the notion of underlying cause. According to psychiatrist Morton Levine, "One precept has stood the test above all others. It can be phrased in this way: treatment which is based on adequate diagnosis is superior to treatment which is focused simply on the relief of symptoms."

Because intrapsychic conflict is central to disturbed functioning, symptom removal without dealing with the underlying conflict is presumed to be dangerous; while removal of the symptoms may be accomplished, it is anticipated that sooner or later new symptoms will appear. Treatment thus focuses on helping the individual to resolve the conflicting drives and to achieve a more adequate personality adjustment. The process includes (1) establishing a therapeutic relationship; (2) encouraging the person to express his or her feelings; (3) pointing out the feelings by means of suitably timed recognition and interpretations; (4) transference of inappropriate childhood attitudes to the therapist; and (5) development of new behavior.

This sort of therapy tends to be both open-ended and lengthy. Although the symptoms may eventually be removed, the individual is not cured until the underlying cause has been eliminated. Conversely, in some cases the patient may be "cured" although the symptoms remain. Insight is viewed as a crucial outcome of the treatment process. Many theorists suggest that insight into the
sources of one's behavior is a necessary prerequisite to behavior change.

Significantly, there seems to be a strong presumption that the underlying problem in mental disorders is neither cured nor curable within the traditional approach. In any event, since the underlying problem is not apparent to the individual, the therapist must judge when treatment is completed.

The traditional model has a number of implications. First, the whole field of treatment is viewed as a medical specialty. A concept of "mental health" is required as a standard for evaluation in diagnosis and as a goal for treatment. The criteria for cure and health become professional questions. Symptoms, as a manifestation of an underlying problem, are not the focus of treatment. Rather, treatment is focused on the underlying conflicts in an effort to eliminate the maladaptive psychic structures. Symptom substitution is presumed likely if this principle is not followed. Of course, diagnosis is required to identify the underlying psychic conflict from the manifest symptoms. Traditional treatment approaches are required, since they are directed at reconciling the underlying conflicts.

There are a number of implications for individuals who are considered thus psychologically disturbed. They are not responsible for their present conditions; as sick people they become passive recipients of treatment. They may be eligible for special treatment, such as freedom from legal responsibility for their behavior; but they may also lose their human rights, since they are held to be unable to control their behavior. Finally, the problem as experienced by such individuals is minimized; in fact, if they fail to see that they have any problems, this may be judged as evidence that the problem is even worse.¹³

**BEHAVIORAL VIEW**

From a behavioral perspective, terms such as "malapropriate behavior" or "socially maladaptive behavior" are used in preference to "mental disorders" or "abnormal behavior." Instead of labeling the overt manifestations as symptoms, in the behavioral approach they are considered to be the problem. Malapropriate behavior may include a wide variety of classes of overt behavior, such as
behavioral excesses (e.g., tantrums), behavioral deficits (e.g., failure to go to work), and inappropriate stimulus control over behavior (e.g., defecating in public). Naturally, there are medical illnesses associated with various kinds of maladaptive behaviors, and the illnesses themselves are a medical problem; within the behavioral model, maladaptive behavior per se is simply behavior that bothers someone else. The behavior may be considered maladaptive for a variety of reasons, including its particular topography, latency, intensity, frequency (unusually high or low), setting events, consequences, or eliciting stimuli. A particularly important factor in determining whether certain classes of operant behavior will be judged maladaptive are the settings in which the behavior occurs and the discriminative stimuli controlling the behavior; similarly important are salient social characteristics of the individual, such as age, sex, race, and social status.

In general terms, maladaptive behavior reduces the frequency, range, or value of reinforcement to the individual, increases the frequency, range or value of punishment which he or she receives, or has similar effects on the reinforcement and punishment delivered to key individuals around the person. Implicit in the concept of maladaptive behavior is the notion of a value system that specifies some behaviors as desirable and others as undesirable. Ullmann and Krasner suggest that the prevailing sociocultural practices are the standard by which various behaviors may be evaluated. Behavioral theorists view all behavior as normal in the sense that it is lawfully related to the individual's biological and learning history and to the present controlling conditions. The goal of behavioral intervention, then, is to bring the person's behavior into closer approximation to the prevailing sociocultural standards rather than to promote health, as in the traditional model.

This does not mean, however, that genetic predispositions and medical or other biological factors are ruled out. Such factors may play an important role in several ways. First, the individual's stimulus properties for others may be altered (e.g., a person with dark skin may be treated differently by people with light skin). Second, biological factors may limit response capabilities and access to stimuli (e.g., a man who is born blind is unable to respond to visual stimuli in the normal fashion, and may find it more diffi-
cult to obtain an education, learn about his environment and so on). Third, biological factors may function as setting events that affect a host of behavioral interactions (e.g., a child who is chronically ill with respiratory infections may be more irritable and disposed to throwing tantrums, and less disposed to engage in normal play behaviors as a result).

Assessment plays an important role in behavioral approaches, but it is not directed at diagnosing the underlying psychic conflicts. Rather, its aim is to precisely identify the problem behavior in terms of its frequency, intensity, topography, and controlling stimuli, and to evaluate response to treatment and maintenance of new behaviors.

While some have conceptualized treatment within the behavioral model as learning, it is more accurate to view the treatment process as involving all of the processes related to the alteration of the person's responses to stimuli, including the shaping, development, and strengthening of responses, the weakening and elimination of responses, and the establishment of stimulus control over responses. Thus behavioral approaches to treatment are more complex and diverse than is generally recognized.

The implications of the behavioral model are quite different from those of the traditional model. The behavioral model assumes that there is no radical discontinuity between socially appropriate and inappropriate or maladaptive behavior. The same principles account for the occurrence of both classes of behavior. Since there is presumed to be no underlying psychic conflict, the goal is to treat the overt behavioral manifestation. The methods used include all of the techniques that have been shown to be effective in developing and maintaining behavior, establishing stimulus control, and weakening and eliminating behavior. Broadly speaking, changes in behavior are accomplished by changes in the interactions between the behavior and the environment. In place of a concept of health, ethical and value considerations about what behaviors are acceptable and desirable determine the goals of treatment.

In the behavioral model, the individual's conceptualization of the problem is accepted at face value. Rather than becoming a passive recipient of treatment, the individual, or others around the individual, may play an active role. Neither special considerations nor loss
of legal rights is considered appropriate, and the individual is expected to face any legal consequences of his or her actions.

**BIBLICAL VIEW**

Attempts to relate biblical teachings to the current concepts of mental illness must overcome substantial difficulties. In a discussion of the biblical view of mental illness, philosopher William Hasker suggested that the Bible refers to moral transgression (i.e., sin), physical illness, and demonic influence; but there is no distinct biblical concept that corresponds to our current notion of mental illness. Minister Jay E. Adams essentially agrees with Hasker, and advocates that we divide mental disorders into two categories. Those with clear medical etiologies he proposes to call illness, and to treat along the lines of other physical illnesses. The remaining categories he lumps together and calls sin. Thus Adams implies that the biblical categories of sin, physical illness, and demonic influence are exhaustive.

Dissatisfaction with Adams's view seems to be widespread, but no carefully articulated alternative that deals with the complexity of the issues involved has yet been offered. Several thoughts help to focus some of the issues. First, at some level, mental illness is clearly a result of sin in our world; the Genesis accounts of the Garden of Eden and the Fall clearly suggest that before the entry of sin into the world, it was a paradisiacal place in which suffering and distress were not present. Thus, at some level, mental illness must necessarily be a result of sin's presence in the world. Second, while mental disorders may sometimes be the result of personal sin, there are instances in which personal sin is clearly not involved (e.g., in mental retardation and many organic brain syndromes). Third, the sinfulness of others may be a major factor in some mental disorders (e.g., a young woman who was sexually abused by her alcoholic father may experience difficulties in trust and interpersonal closeness, at least in part as a result of being the victim of her father's sinfulness).

We see, then, that Adams's conclusion that mental illness is just a euphemism for sin is too simplistic. But at the same time, sin is in some way involved. Perhaps one way to approach some of the issues raised here is to draw a distinction between sin and the ef-
fects of sin. The Bible has much to say about committing sin, but is not completely silent on its effects. Sin may have effects not only on the individual committing it, but also on others, especially those who are the victims of the sinful action.

The story of David and Bathsheba clearly indicates that unconfessed sin had adverse personal effects, including guilt, anxiety, physical ailments, and reduced ability to resist further sin on subsequent occasions. Social isolation, estrangement, and further transgression may follow in a continuing downward spiral. In addition to the effects of sin on the perpetrator, it also affects others adversely. Fears, anxieties, hurt, anger, distrust, feelings of personal inadequacy, and low self-esteem are often among the effects found in those who have been victimized by the sinfulness of others. Taken together, these effects of sin in the agent and the victim include many of the diverse elements included within mental disorders. Thus much of mental illness may prove to be a secondary effect of sin.

Further thought needs to be given to the question of how the concept of mental illness relates to biblical teachings. Reducing mental illness to sin, or concluding that the Bible has nothing relevant to say, are both untenable views. More effort needs to be given to serious exploration of the middle ground between these extremes. Perhaps the suggestion that mental illness is an effect of sin is a step in this direction.

Basic Approaches to Behavior Change

A central thesis of the behavioral approach is that simple removal of a response is not adequate. Rather, it must be replaced with a new and more adaptive response. According to Ullmann and Krasner, "... Behavior therapy can be summarized as involving systematic environmental contingencies to alter directly the subject's reactions to situations." The two crucial elements in this definition are: (1) the systematic arrangement of the stimulus environment; and (2) concentration on the response-stimulus relationship as opposed to just the response.

This section will briefly examine respondent and operant behavioral approaches.
RESPONDENT BEHAVIORAL APPROACHES

Respondent behaviors are controlled by stimuli that precede them. Respondent approaches are essentially limited to the establishment of new stimuli that are able to elicit a given respondent, and to the weakening or elimination of stimuli that elicit a given respondent. Modification of respondent behavior is thus limited to development or elimination of eliciting stimuli for a given respondent.

For example, salivation is a respondent behavior. Through a process of respondent conditioning, certain sounds, smells, and visual stimuli will come to elicit salivation. Since the sight or smell of food elicits the salivation response and suggests eating, weakening the eliciting power of food stimuli for an obese person, (e.g., by repeated presentation without eating) could help the person abstain from overeating and thus facilitate weight loss.

Fears and anxieties, insofar as they are emotional responses, are respondent in character. According to psychologists Hans J. Eysenck and Stanley Rachman, phobias are learned responses to specific stimuli that have acquired the capability of eliciting the phobic response by means of pairing previously neutral stimuli with an anxiety-inducing situation. Once previously neutral stimuli have acquired fear-producing properties, any response that avoids or terminates contact with those stimuli will be negatively reinforced.

Phobic responses include a variety of disabling fears that range from fears of dogs, cats, rodents, and snakes to fears of crowds, bridges, high places, small spaces, driving, injections, dentists, and so on. While many people share these fearful responses to some extent, such responses become phobic when they interfere significantly with the person's normal daily functioning. In Ullmann and Krasner's terms, "To be considered phobic the fear must be evaluated as disproportionate to the situation and socially disturbing by some observer, including the person himself. That is, the response deviates from what is expected in the culture and is disruptive."

Systematic Desensitization

Phobias can be treated by systematic desensitization, one of the most thoroughly investigated behavior therapy techniques, and the
first therapeutic technique for which clear-cut evidence of treatment effectiveness was established.

Systematic desensitization involves a procedure in which individuals are taught to relax their muscles, then to imagine or visualize situations that gradually increase in the degree of discomfort that they originally produced. If the individuals become anxious or tense while visualizing a particular situation, they are instructed to stop the image and resume relaxing. The idea is that if the individuals are able to relax while visualizing themselves in the situation, their anxiety in the actual situation will gradually abate. As anxiety abates, they will in turn become able to visualize more and more difficult situations without becoming anxious, and should also become more able to actually enter such situations.

For example, a woman who experienced a balcony collapsing under her and sustained a serious fall with bodily injury might subsequently develop a generalized fear of high places. In a process of systematic desensitization, this woman might first be trained to relax, then asked to visualize herself standing on the ground and looking up at a raised balcony from a safe distance. If fear to this stimulus is eliminated, she might then be asked to visualize herself looking at the balcony from closer ranges. She might next visualize herself looking out at the balcony from across the adjoining room. Next, she might visualize herself moving gradually closer to the window overlooking the balcony, then looking out the door at the balcony, and so on. Eventually, the woman would visualize herself stepping out onto the balcony, looking over the rail, relaxing, and allowing the balcony to support her.

While systematic desensitization clearly focuses on respondent behavior, operant behavior also plays a part. Once the emotional fear response to the stimulus is established, operant avoidance performances develop quickly, since escaping or avoiding the fear-producing stimuli is negatively reinforced. This complicates our picture of phobic responses, and suggests that both respondent and operant components are involved. It also illustrates the thesis that there is a constant and complex interaction between operant and respondent behaviors.

Because of the complex interaction of respondent and operant behaviors in phobias, it is common for treatment to involve a variety of additional elements beyond systematic desensitization, in-
including providing explicit social reinforcement for nonfearful behaviors, and modeling of such performances.

OPERANT APPROACHES

Because of the greater complexity of operant behavior, and because most important human social behavior is operant in character, operant behavior is a much more common concern for modification. The principles used in modifying operant behavior include all the principles of shaping, developing, strengthening, establishing stimulus control and discrimination, and weakening and eliminating operant behavior. While the basic principles are relatively few and simple, their application involves a range of complexity that is often not recognized even by individuals who are somewhat acquainted with the behavioral literature. Because of these complexities, the number of techniques that have been developed by behavioral psychologists for modifying operant behavior is enormous.

In addition to individual application of a wide range of specific operant procedures, several specialized "packages" of techniques have been developed, involving fairly standardized procedures for the application of a number of behavioral techniques in a coordinated treatment approach. While it remains a matter of controversy in some cases, these approaches may be considered specialized applications of operant principles. Examples of such package approaches include (1) token systems; (2) cognitive behavior modification; and (3) social learning.

Token Systems

The techniques of the token system or token economy were developed especially for application to large-scale, long-term institutional settings, but have also been applied in more limited settings such as the public school classroom. The token economy approach involves the application of reinforcement procedures at the level of the social system.

There are three basic elements to any token system. First, there is the identification of certain behaviors as desirable, and the decision to reinforce those behaviors with the awarding of tokens. Second, there is a medium of exchange; initially, plastic chips like poker chips were used, but many systems have adopted use of a
“paper money” or credit card system, which minimizes stealing. Third, there is a way of using the tokens to “buy” a variety of reinforcers such as food, a private room, cigarettes, TV time, recreational activities, and so on. In practice, the token system works much like a money system, with all its advantages and problems.

Basically, tokens function as generalized conditioned reinforcers. A conditioned reinforcer is any reinforcing stimulus that has acquired its ability to function as a reinforcing stimulus by means of specific learning experiences. A generalized conditioned reinforcer is one that has been associated with a variety of other reinforcing stimuli so that its reinforcing function is not limited to any specific reinforcing stimulus and the deprivation, satiation, or other operations that might temporarily weaken its reinforcing function. For example, a token good only for a roast beef sandwich may not be very effective after one has just consumed three sandwiches. However, a token that can be exchanged for a sandwich or for a variety of other reinforcing events and objects may continue to be effective even after having eaten several sandwiches.

A number of studies have been conducted using token systems in institutional settings. Results have consistently indicated that performances that are reinforced by tokens increase in strength, that stopping token reinforcement weakens the responses, and that reinstating tokens results in resumption of the desired performances. An additional benefit is the improvement in staff morale that occurs, when the staff finds that it is able to have an impact on the residents. Studies have shown both decreases in staff absenteeism and efforts by staffs in other units to adopt similar procedures.

Cognitive Behavior Modification

In the past few years (predominantly through the work of a handful of psychologists including Donald Meichenbaum, Michael J. Mahoney, and Aaron Beck) cognitive behavior modification has gained widespread recognition. The basic thesis of this approach is that people have extensive ranges of cognitive (that is, thinking) behavior, and that their cognitive performances are a major factor that influences other human performances. For many, cognitive behavior modification is viewed as a potential successor to radical behavioral or Skinnerian methods, which do not concern themselves with events not accessible to observation. The distinction,
however, may be more conceptual than real. Skinner wrote an entire book on what he called "verbal behavior" over twenty years ago, in which he acknowledges that people are characterized by extensive speaking repertoires, and that speech is a significant social behavior. Skinner even spends a good deal of space discussing ways in which speech and nonlanguage behaviors interact within the same person. The majority of phenomena that are of current interest to those involved in cognitive behavior modification can be adequately conceptualized from a radical behavioral perspective as well. Thus it will not be discussed further here, although it is of substantial theoretical interest.

There is considerable diversity among individuals within the cognitive behavior modification movement. As Meichenbaum notes: "Stated simply, there is no clearly agreed upon or commonly accepted definition of [cognitive behavior modification]." However, certain common elements may be detected within the diversity of approaches: (1) emphasis on such cognitive processes as beliefs, attitudes, expectations, and problem-solving strategies; (2) emphasis on thought processes exclusively, at least in some approaches to changing problem behavior; (3) the tendency to attribute controlling significance to the cognitive factors mentioned above rather than to external events; (4) postulation of internal events that can only be discovered by inference (noncognitivist or radical behaviorists prefer to avoid making such inferences); (5) use of mediational theories, which argue that various events, often conceptualized as stimulus–response events, occur internally and mediate between stimulus and response rather than the external stimulus directly producing a response; (6) postulation of other models of learning in addition to the basic behavioral processes of reinforcement and punishment (we noted earlier, for example, that Bandura tends to view imitation and modeling or social learning as a special form of learning that is superior to shaping and reinforcement).

A number of treatment techniques may be thought of as falling within the scope of cognitive behavior modification. Among these are Ellis' rational-emotive therapy, thought stopping, covert assertion, and attributional approaches. Bandura's approach of modeling, imitation, and vicarious reinforcement is significant enough that we have discussed it separately, although it is included within the cognitive approaches by many theorists.
We suggested earlier that much of what the cognitivists actually do in practice may be conceptualized readily within a noncognitive or radical behavioral framework. It must be recognized that when a therapist does outpatient treatment with an intelligent adult, a major focus of the treatment process will be on talking, especially within therapy sessions. Even Skinner acknowledges verbal behavior and shows that it plays an important role in human social behavior. With these factors in mind, it seems reasonable to approach therapy with adults in a verbal manner, whether or not one accepts a cognitive behavioral position.

SOCIAL LEARNING

Albert Bandura and his colleagues have popularized an approach that is variously referred to as social learning, modeling, imitation and vicarious processes, and so on. Bandura explicitly suggests that the social learning approach is an alternative to operant approaches, and is more effective in generating and altering performances. 34 Bandura tends to neglect the issue of how the process of imitation is initiated in children. A good case can be made that imitation or social learning is a class of operant performances that is unique only insofar as the response topographically resembles the controlling discriminative stimulus. Imitation seems to be learned much like other operant performances, then maintained by means of the reinforcing consequences that follow the performance. For our purposes, therefore, imitation and the related processes will be conceptualized as a complex operant performance rather than as a unique or distinctive type of behavior.

BIBLICAL PARALLELS

There are a number of parallels between biblical teachings and behavior therapy approaches. First is the emphasis on positive reinforcement and punishment as consequences that will influence behavior. We are told that “[God] rewards those who earnestly seek Him,” 35 and that he will surely punish the wicked. 36 A review of biblical teachings, especially the Old Testament history of the nation of Israel, shows a repeated pattern of obedience to God followed by His blessings, and of disobedience to God followed by his
punishment. There is thus some basis for the claim that “God was the first behaviorist with his ‘thou shalt’s and ‘thou shalt nots.’”

A second area of parallel between biblical teachings and behavior therapy is in the emphasis given to the important role of various social influence processes, such as modeling and imitation. The Bible suggests that children learn to act and think like their parents, and that association with evil persons will result in learning their ways. We are even told to imitate Paul as he imitates Christ.

Third, a clear biblical emphasis is that it is not enough to try to eliminate a problem behavior. Problem behaviors (sins) must be replaced with constructive alternatives.

Fourth, although there is considerable theoretical controversy over whether control actually lies within the person or in the environment, self-control procedures are widely used by behavior therapists. Biblically, self-control is presented as a desirable goal. As a manifestation of the Holy Spirit, self-control is an important goal, but appears to be unattainable on strictly human abilities, according to Scripture.

Finally, although this is an area of great controversy among behavioral psychologists, many nonetheless emphasize the use of punishment as a behavior therapy technique. As established in Chapter 4, the Bible clearly emphasizes the need for punishment under certain circumstances.

Areas of Controversy

While there are a number of parallels between behavioral approaches and biblical teachings, this in no way means that there are not a number of areas of potential or actual controversy. Controversy arises both from biblical and other perspectives. Ultimately, most of the controversial areas involve ethical and moral issues.

One area of practical difficulty is that of motivation. In the context of outpatient behavior therapy, it is usually plausible to assume that the client is genuinely motivated to make changes in behavior and circumstances because they are currently unsatisfactory in some way. But what can be done when motivation is lacking? Is it ethical to make food, clothing, shelter, or other reinforcers available only contingent upon some specific behavior (e.g.,
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completing a specific job)? As suggested earlier, the biblical teachings in this area provide guidelines concerning the ethical and moral obligations in dealing with a person who does not wish to work. At a second level, the Bible teaches that God influences our motivations. Perhaps one of the ways in which a relationship with God affects a person is in changing the person’s motivations. Conceptually, we might think of this as a setting event.

Other ethical issues involve the questions of manipulation, control, and behavioral goals and strategies. First, manipulation implies using or controlling another person to one’s own advantage. Clearly, the biblical teaching to love others as one loves oneself speaks against manipulation. To love others is to seek their advantage rather than to seek to take advantage of them. Thus manipulation is contrary to biblical teachings. Control, however, is another matter. The responsibility to exercise directing or restraining influence is clearly established by God and delegated to such persons as civil authorities, husbands, and parents. Further, mutual influence of a reciprocal sort is also clearly taught in Scripture; we are to “be subject to one another in the fear of Christ.” Thus accepting a biblical morality implies that control is legitimate, when exercised within the limits taught by Scripture.

Closely related to the issue of control are concerns about the specific methods of control and the goals toward which control is directed. From a biblical perspective, both the methods and the goals of control, of behavior therapy, or any other approach for that matter, must be examined in light of biblical teachings regarding which means and goals are acceptable.

Another area of some concern and controversy is that of generalization. Producing changes in a response in one environmental context is often not enough; if we can ensure that those changes generalize to other settings, significantly more has been accomplished. For example, eliminating tantrums at home is progress, but eliminating tantrums at school, church, and the supermarket as well is far superior. We cannot presume that generalization will occur; steps must be taken to foster it. Chapter 6 will consider some specific examples of procedures designed to foster generalization.

A final concern is the recurrence of problem behavior. From a traditional approach, this concern focused especially around the issue of symptom substitution. We have shown that the concept of
symptom substitution does not make sense from a behavioral perspective. However, it remains possible that old problem behaviors may recur, or that new problems may develop. Some approaches to these problems will be examined in the following chapter; here it will suffice to note that the environment that produced and supported the problem behavior in the first place may provide the conditions that reinstate it after change has occurred. For example, if Mary has learned to ask for what she wants and has stopped throwing tantrums, putting her in an environment that does not reinforce requests but does reinforce tantrums may result in recurrence of tantrums.

NOTES
3. Ibid
9. Ibid., p. 20.


20. This is explicitly stated for physical illnesses in John 9:1-5.

21. See 2 Sam., chapters 11–12:25; Ps. 32, 51.


23. Additional discussion of behavioral techniques may be found in Ullmann and Krasner, A Psychological Approach, and in Rimm and Masters, Behavior Therapy.


27. For a more extensive discussion of systematic desensitization, see Gordon L. Paul, Insight versus Desensitization in Psychotherapy (Stanford, Cal.: Stanford University Press, 1966).


35. Heb. 11:6, NIV.
36. Rom. 2:1–11; see especially 2:5.
40. 1 Cor. 11:1; see also 2 Thess. 3:7–10; Phil. 3:17; 1 Cor. 4:14–17; Heb. 13:7.
41. For example, see Eph. 4:20–24 ff.; Adams, The Christian Counselor’s Manual, discusses this issue extensively.
44. Eph. 5:21.