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Behavior Modification

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Behavior Disorders. *See* DISRUPTIVE BEHAVIOR DISORDERS.

Behavior Modification. Behavior modification is "learning with a particular intent, namely clinical treatment and change" (Ullmann & Krasner, 1965, p. 1). Initially behavior modification referred largely to operant techniques and behavior therapy to respondent techniques. As early as 1965 the terms *behavior modification* and *behavior therapy* were used interchangeably (O'Donohue & Krasner, 1995). With publication of the journal *Behavior Research and Therapy* in 1963 and the founding of the Association for the Advancement of Behavior Therapy, behavior therapy became a general term for all of these techniques. Thus *behavior therapy* will be used in this discussion.

Behavior therapy is "the most influential therapy of the second half of the twentieth century" (O'Donohue & Krasner, 1995, p. xii). According to Krasner, 15 streams of research and theory contributed to its development. Among them were Wolpe's theory of reciprocal inhibition and B. F. Skinner's theory of positive reinforcement. Behavior therapy is often considered a simple-minded approach; behavior therapists are chided for thinking they can change the world with a supply of M&Ms. However, behavior theory is complex. It draws on many streams of theory and research and is applied to widely varied human problems.

Based on classical or respondent conditioning, behavior therapy emphasizes changing troublesome behavior directly rather than altering hypothesized internal processes (*see* Conditioning, Classical). Three basic principles are that learning theory provides the foundation; environmental events or stimuli control the problem behavior; changing events in the environment will change the problem behavior.

Behavior therapy uses a variety of techniques to weaken or extinguish undesired responses, develop or strengthen desired responses, bring responses under stimulus control so that they occur only as desired, and weaken or extinguish conditioned eliciting stimuli that produce troublesome emotional responses. Interventions include shaping and strengthening assertive responses; extinction and use of aversive techniques or punishment to weaken troublesome behaviors such as tantrums, aggression, and substance abuse; shaping desired responses such as attending school, performing assignments, giving correct responses, and the like; self-management (by rewarding desired responses; for example, taking a break after a difficult task or keeping a record of exercise and reporting it to a friend); and desensitization, implosion, and flooding to eliminate learned fear responses.

Recent Trends. Recent developments in behavioral approaches include the emergence in the 1970s of the social learning principles of imitation, modeling, and vicarious processes. Cognitive-behavioral models became common in the 1980s. O'Donohue and Krasner (1995), however, consider the term *cognitive-behavioral* an oxymoron because it seeks to bring together emphases on internal processes (cognitions) and external behavior, approaches they view as antithetic. Further, they note that "behavior therapy in its original paradigm included variables that are now labeled as 'cognitive' such as feelings, thoughts, and so on; hence to add this new adjective is redundant, misleading, and unnecessary" (p. 20).

Perhaps the most significant development, however, has been the gradual emergence of integrative models combining elements of psychodynamic, behavioral, cognitive, and experiential approaches. Controversy will continue, although the integrative trend likely foreshadows emergence of a new paradigm.

Outcome Research. Outcome research provides support for the effectiveness of exposure desensitization for phobias and obsessive-compulsive disorders; behavioral and cognitive-behavioral interventions have been effective for depression, panic attacks and agoraphobia, social phobia, tension headaches, chronic pain, and bulimia. Behavioral approaches to marital therapy have been effective but seem to work best when combined with elements from other approaches. Finally, behavioral family interventions, along with maintenance on neuroleptics, have been shown to reduce relapse rates in schizophrenics (Emmelkamp, 1994). Outcome research on behavior therapy has generally been supportive but has strengthened the move toward integrative models.

Christian Perspectives. Behavior modification has had mixed reception in the Christian community. The chief concerns arise from behaviorism, the philosophical position of Skinner and many of his colleagues. Behaviorism is a philosophy or worldview that assumes materialism, reductionism, determinism, scientism, naturalism, evolution, and uniformity (see Collins, 1977). It often accompanies behavioral theory. Determinism is of particular concern to Christians. Christian theology holds that humans have some degree of personal choice along with accountability. Bufford (1981) argues that causality and choice form a paradox: both causality and choice are affirmed by Christian theology. Thus neither complete freedom nor determinism fits with most Christian perspectives (*see* Determinism and Free Will).

Another concern is that some behaviorists, notably Skinner, adamantly oppose punishment. Skinner holds that punishment is temporary and produces harmful emotional side effects. Bufford (1981) affirms this but points out that Skinner's view is inconsistent with the behavioral data. The data suggest punishment is effective and has both beneficial and undesirable side effects. Further, punishment parallels reinforcement, which also has temporary effects and emotional consequences. A Christian worldview is compatible in most respects with behavior therapy; many parallels exist with biblical teachings. For example, God uses reward (Heb.

11:6) and punishment (Heb. 12:6) and encourages us to be careful about social influence processes (Prov. 22:24).

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See Applied Behavioral Analysis; Learning; Behavioral Psychology.