Cognitive-Behavioral Family Therapy

Beyond Stimulus and Response

When they first began working with families, behavior therapists applied learning theory to train parents in behavior modification and teach communication skills to couples. Although these approaches were effective with simple problems and well-motivated individuals, behavior therapists had little appreciation of ways misbehavior and poor communication were embedded in family systems. Since then, however, behavioral family therapy has evolved with increasing use of cognitive principles and attention to family dynamics.

Sketches of Leading Figures

The early principles of behavior therapy were developed by two key figures: Joseph Wolpe and B.F. Skinner. In 1948 Wolpe introduced *systematic desensitization*, with which he achieved great success in the treatment of phobias. Systematic desensitization deconditions anxiety through *reciprocal inhibition* by pairing responses incompatible with anxiety to previously anxiety-arousing stimuli. Thus, for example, if a woman were afraid of spiders, Wolpe would teach her deep muscle relaxation and then have her imagine approaching a spider in gradual steps. Each time the woman became anxious, she would be told to relax. In this way her anxiety about spiders would be systematically extinguished because the state of relaxation served as a replacement for the state of anxiety.

An even greater influence on behavioral therapy was Skinner's **operant conditioning**. While most people look to the past for the cause of problems, Skinner taught us that all behavior is regulated by its consequences. Responses that are *positively reinforced* will be repeated more frequently; those that are *punished* or ignored will be *extinguished*.

The operant conditioner carefully observes target behavior and quantifies its frequency and rate. Then, to complete a **functional analysis of**

behavior, the consequences of the behavior are noted to determine the *contingencies of reinforcement*. For example, someone interested in a child's temper tantrums would begin by observing when they occurred and what the consequences were. A typical finding might be that the child throws a tantrum whenever his parents deny his requests and that the parents give in if the tantrums are prolonged. Thus the parents would be reinforcing the very behavior they didn't want.

Operant conditioning is particularly effective with children because parents have control over their rewards and punishment. Gerald Patterson, at the University of Oregon, pioneered behavioral parent training. Patterson's treatment was based on the premise that if parents change their contingencies of reinforcement, then their children's behavior will change. An excellent example of Patterson's approach is described in *Case Studies in Couple and Family Therapy* (Forgatch & Patterson, 1998). In this case, the therapist taught a single mother to develop a family management program to encourage her unruly child with prosocial behavior and discourage his misbehavior. The mother learned to do this gradually with skills taught in sequence (*shaping*). She was first helped to define her child's positive and problematic behaviors in terms of specific and readily observable actions. After a week of keeping track of her child's target behaviors, the mother was taught to reinforce prosocial behavior through contingent encouragement with incentive charts. This process also promotes positive relationships between parents and children. Children earn rewards while they learn prosocial skills and, in the process, their self-esteem grows with their success and their parents' positive attention.

Patterson also took the lead in introducing disciplinary techniques, such as time-out, because he discovered that ignoring problem behavior is not always sufficient, especially with aggressive children. In addition, his parent training included problem-solving techniques, communication training, negotiation, and contracting. He also taught parents to monitor their children's behavior outside the home by keeping in touch with other parents and teachers and activity leaders. Among others prominent in behavioral parent training are Anthony Graziano, Rex Forehand, Daniel and Susan O'Leary, and Roger McAuley.

A second leading figure in the development of behavioral family therapy was Robert Liberman. In his 1970 paper, "Behavioral Approaches to Family and Couple Therapy," Liberman outlined an operant conditioning approach to the family problems of four adult patients with depression, intractable headaches, social inadequacy, and marital discord. In addition to employing contingency management of mutual reinforcers, Liberman introduced the use of **role rehearsal** and **modeling** (Bandura & Walters, 1963).

Another major influence on behavioral family therapy was the **contingency contracting** of Richard Stuart (1969). Rather than focusing on how undesired behavior could be reduced, Dr. Stuart focused on how the exchange of positive behavior could be maximized using **reinforcement reciprocity**.

During the 1970s, behavioral family therapy evolved into three major packages: parent training, behavioral couples therapy, and sex therapy. At present, the leading figures in behavioral couples therapy include Robert Weiss, Richard Stuart, Michael Crowe, Mark Dadds, Ian Falloon, Gayola Margolin, and Matthew Sanders.

While the behavioral approach, with its emphasis on stimulus and response, was initially seen as linear and simplistic by family systems therapists, behaviorists have grown increasingly sophisticated in their understanding of family dynamics. The late Ian Falloon, for example, was a strong proponent of an open systems approach. He considered the physiological status of individuals as well as their cognitive-behavioral and emotional responses, along with the interpersonal transactions that occur within their family, social, vocational, political, and cultural networks (Falloon, 1985).

Cognitive-behavior therapy refers to those approaches inspired by the work of Albert Ellis (1962) and Aaron Beck (1976) that emphasize the need for attitude change to promote and maintain behavior modification. According to the *cognitive mediation model* (Beck, 1976), emotions and actions are mediated by specific cognitions. Understanding these cognitions (beliefs, attributions, and expectancies) makes it possible to identify factors that trigger and

maintain dysfunctional emotional and behavioral patterns. In practice, this boils down to uncovering hidden assumptions that keep people stuck.

Rational-emotive therapists help family members see how illogical beliefs serve as the foundation for their emotional distress. According to the *A-B-C theory*, family members blame their problems on certain events in the family (A) and are taught to look for irrational beliefs (B), which are then challenged (C). The therapist's role is to teach the family how emotional problems are caused by unrealistic beliefs and that, by revising these self-defeating ideas, they may improve the quality of family life (Ellis, 1978).

With rational-emotive therapy it was hard to separate the approach from its creator. Ellis didn't merely challenge people's assumptions; he punctured them with fierce and gleeful sarcasm. It isn't necessary to imitate Ellis's acerbic style to take advantage of his insights. It seems fair to say, however, that rational-emotive therapists generally contented themselves with lecturing people about generic assumptions rather than probing for more specific, personal beliefs.

The cognitive-behavior method, which balances an emphasis on cognition and behavior, takes a more expansive approach by focusing in greater depth on patterns of family interaction (Epstein, Schlesinger, & Dryden, 1988; Leslie, 1988). Cognitions, emotions, and behavior are seen as exerting mutual influence on one another, so that a cognitive inference can evoke emotion and behavior, and emotion and behavior can influence cognition.

The late 1980s and early 1990s saw the cognitive-behavior approach applied more widely in family therapy. Edited books by Epstein, Schlesinger, and Dryden (1988) and a short text by Huber and Baruth (1989) were among the first works to address the cognitive approach to family therapy. This was elaborated in subsequent articles by Schwebel and Fine (1992), Dattilio (1994, 1997), and Teichman (1992). Dattilio (1998) produced a major casebook that discusses the integration of cognitive-behavioral strategies with various modalities of couples and family therapy. Among the leaders in cognitive-behavioral family therapy are Donald Baucom at the University of North Carolina, Norman Epstein at the University of Maryland, and Frank Dattilio at Harvard Medical School and the University of Pennsylvania.

Theoretical Formulations

The basic premise of behaviorism is that behavior is maintained by its consequences. Consequences that accelerate behavior are *reinforcers*; those that decelerate behavior are *punishers*.

Some responses may not be recognized as operants—something done to get something—because people aren't aware of the reinforcing payoffs. For example, whining is often reinforced by attention, although the people doing the reinforcing may not realize it. In fact, a variety of unwelcome behaviors, including nagging and temper tantrums, are commonly reinforced by attention.

As behavior therapists shifted their attention from individuals to family relationships, they came to rely on Thibaut and Kelley's (1959) **theory of social exchange**, according to which people strive to maximize rewards and minimize costs in relationships. In a successful relationship partners work to maximize mutual rewards. In unsuccessful relationships the partners are too busy trying to protect themselves from getting hurt to consider ways to make each other happy.

Despite the mechanistic sound of "maximizing rewards and minimizing costs," behavior therapists have increasingly become aware that people not only act but also think and feel. This recognition has led to efforts to integrate stimulus-response behaviorism (Skinner, 1953) with cognitive theories (Mahoney, 1977). The central tenet of the cognitive approach is that our interpretation of other people's behavior affects the way we respond to them. Among the most troublesome of automatic thoughts are those based on *arbitrary inference*, distorted conclusions, shaped by a person's **schemas**, or core beliefs. What makes these underlying beliefs problematic is that although they are generally not conscious, they bias how we respond to everything and everyone.

Normal Family Development

According to **behavior exchange theory** (Thibaut & Kelley, 1959), a good relationship is one in which giving and getting are balanced—or, in the model's terms, there is a high ratio of benefits to costs. Examples of "costs" might be a spouse's outbursts of

temper or one sibling borrowing another's clothes without asking. In some relationships costs are outweighed by rewards, such as a spouse's affection or siblings' loyalty to each other. Thus it is the balance of costs and rewards that determines family satisfaction.

Weiss and Isaac (1978) found that affection, communication, and child care are the most important elements in marital satisfaction. Earlier, Wills, Weiss, and Patterson (1974) found that unpleasant behavior reduced marital satisfaction more than positive behavior increased it. A good relationship, then, is one in which there is an exchange of positive responses and, even more important, minimal unpleasantness. Another way of putting this is that good relationships are under *positive reinforcement control.*

Having good communication skills—the ability to converse, especially about problems—is considered by behaviorists the most important feature of good relationships (Gottman, Markman, & Notarius, 1977; Jacobson, Waldron, & Moore, 1980). (It's also the most easily observed feature of relationships.)

In time all couples run into conflict and, therefore, a critical skill in maintaining family harmony is conflict resolution (Gottman & Krokoff, 1989). Healthy families aren't problem free, but they have the ability to address conflicts when they arise. They focus on issues and keep them in perspective, and they discuss specific behaviors of concern to them. They describe their own feelings and request changes in the behavior of others, rather than just criticizing and complaining. "I've been feeling lonely and I wish you and I could go out more often" is more likely to get a positive response than "You never do anything I want!"

Some people assume that good relationships will evolve naturally if people love each other. Behaviorists emphasize the need to develop relationship skills. Good marriages, they believe, aren't made in heaven but are a product of learning effective coping behavior. The late Neil Jacobson (1981) described a good relationship as one in which the partners work to maintain a high rate of rewards:

> Successful couples . . . expand their reinforcement power by frequently acquiring new domains for positive exchange. Spouses who depend on a limited quantity and variety of reinforcers are bound to suffer the ill effects of satiation. As a result, over time their interaction becomes depleted of its prior reinforcement value. Successful couples cope with this inevitable reinforcement erosion by varying their shared activities, developing new common interests, expanding their sexual repertoires, and developing their communication to the point where they continue to interest one another. (p. 561)

Development of Behavior Disorders

Behaviorists view symptoms as learned responses. They don't look for hidden motives or blame marital conflict for children's problems. Instead they look for specific responses that reinforce problem behavior.

At first glance it might seem puzzling that family members would reinforce undesirable behavior. Why would parents reward temper tantrums? Why would a wife reinforce her husband's distance? The answer lies not in some convoluted motive for suffering but in the simple fact that people often aren't aware that they reinforce those responses that cause them the most distress.

Parents commonly respond to misbehavior by scolding and lecturing. These responses may seem like punishment, but they may in fact be reinforcing, because attention—even from a critical parent—is a powerful *social reinforcer* (Skinner, 1953). The truth of this is reflected in the axiom, "Ignore it, and it will go away."

The problem is most parents have trouble ignoring misbehavior. Notice, for example, how quickly children learn that certain words get a big reaction.[1] Moreover, even when parents do try to ignore misbehavior, they usually don't do so consistently. This can make things worse, because *intermittent reinforcement* is the most resistant to extinction (Ferster, 1963). That's why compulsive gambling is so difficult to extinguish.

In addition to behavior problems unwittingly maintained by parental attention, others persist because parents don't know how to make effective use of punishment. They make threats they don't follow through on; they punish too long after the fact; they use punishments so mild as to have no effect; or

[1] Some of these children grow up to become stand-up comedians.

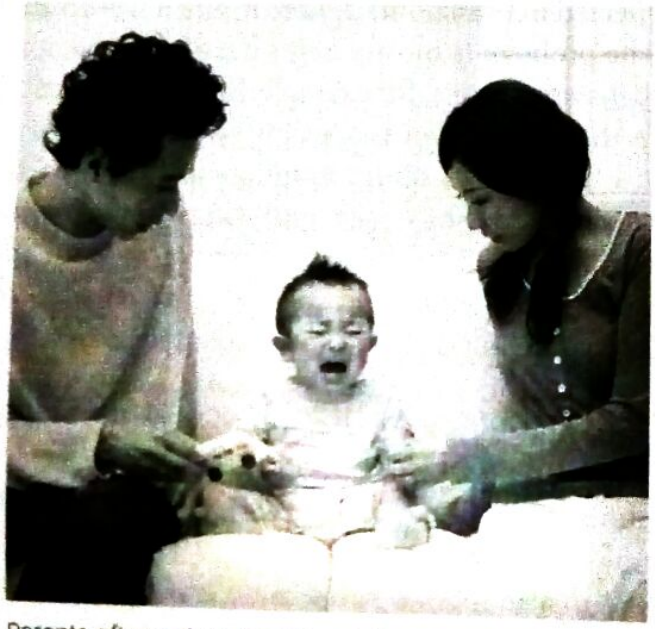
they use punishments so severe as to generate more anxiety than learning.

Learning, moreover, isn't just a one-way street. Consider the behavior of a mother and daughter in the supermarket:

> The little girl asks her mother for a candy bar. The mother says no. The child begins crying and complaining. The mother says, "If you think I'm going to buy you candy when you make such a fuss, you have another thing coming, young lady!" But the child escalates her tantrum, getting louder and louder. Finally, exasperated and embarrassed, the mother gives in: "All right, if you'll quiet down, I'll buy you some cookies."

Obviously, the child has been reinforced for having a tantrum. Not so obvious, but also true, the mother has been reinforced for giving in—by the child's calming down. Thus a spiral of undesirable behavior is maintained by *reciprocal reinforcement*.

The reinforcement of undesirable behavior can take even more complex forms in family dynamics. The following is a typical example: A mother, father, and small child are riding in the car. The father speeds up to make it through a yellow light. His wife insists that he slow down and drive more carefully. The father, who hates being told what to do, gets angry and starts driving faster. Now his wife yells at him to slow down. The argument escalates until the child, crying, says, "Don't fight, Mommy and Daddy!" Mother turns to the child and says, "It's okay, honey. Don't cry." Father feels guilty and begins to slow down. Consequently, the child learns at a young age the power and control she has in the family.



Parents often unintentionally reinforce temper tantrums by giving in or merely by giving the tantruming child extra attention.

The use of **aversive control**—crying, nagging, withdrawing—is often cited as a major determinant of marital unhappiness (Stuart, 1975). Spouses tend to reciprocate their partners' use of aversive behavior, and a vicious cycle develops (Patterson & Reid, 1970).

People in distressed relationships also show poor *problem-solving skills* (Vincent, Weiss, & Birchler, 1975; Weiss, Hops, & Patterson, 1973). When discussing a problem, they frequently change the subject; they phrase wishes and complaints in vague and critical ways; and they respond to complaints with counter-complaints. The following exchange demonstrates sidetracking, cross-complaining, and name-calling, all typical of distressed marriages:

> "I'd like to talk about all the sweets you've been giving the kids lately."
>
> "What sweets! Talk about *me*, you're always stuffing your face. And what do you ever do for the kids? You just come home and complain. Why don't you just stay at the office! The kids and I get along better without you."

Most behavioral analyses point to a lack of reinforcement for positive behavior in distressed families. The old adage "The squeaky wheel gets the grease" seems to apply. Depression, headaches, and temper tantrums tend to elicit concern and therefore get more attention than pleasant behavior. Because this process is unwitting, family members are often mystified about their role in reinforcing annoying behavior.

In the following case study, Dattilio (1983) describes how operant techniques were used to resolve psychosomatic headaches in a child.

CASE STUDY

Clay's mother reported that her 12-year-old son had been complaining of headaches for several weeks. A thorough neurological examination, including a sleep EEG and an MRI, yielded negative results. At this point, behavioral counseling was recommended.

Clay first complained of headaches shortly after his parents separated, at which time his mother started spending less time with him because of her work schedule. The headaches usually occurred in the morning before school and in the evening at bedtime. The headaches lasted anywhere from an hour to two hours during which Clay would cry and complain until his mother gave him some Tylenol and sat with him until the pain subsided. Occasionally Clay's morning headaches would result in his missing school and his mother's staying home with him. On the basis of these observations, the therapist concluded that Clay's headaches were being reinforced by his mother's attention.

The primary goal of therapy was to reduce the frequency of Clay's headaches and to increase his school attendance, but also to help him find more appropriate ways of getting attention from his mother.

It was decided to implement the use of positive reinforcement for days when headache pain was not reported and to ignore Clay's complaints of headache when his mother suspected that he was just looking for attention. To help her distinguish real from feigned headaches, Clay's mother was taught to take his temperature.[2] Headaches accompanied by an elevated temperature were to be considered "legitimate" and treated with Tylenol and confining Clay to bed with no additional attention.

The treatment protocol involved a simple reinforcement schedule, with positive rewards of praise and one-to-one interaction, like playing games and talking with his mother. Clay was instructed to report to his mother every day if his headaches recurred, while she kept a written record of episodes of headache. The mother was also reminded not to reinforce reports of headache with extra attention—rather, she was to treat Clay as sick and send him to bed. When a day passed with no headaches reported, Clay's mother was to reward him generously with praise and attention.

After twelve weeks, Clay's headaches were almost totally eliminated. In a follow-up session, the therapist talked to Clay about how he could get positive attention from his mother in a variety of constructive ways, and he and Clay's mother discussed ways that she could balance her schedule in order to spend more time with her son.

[2]Obviously, not all headaches are accompanied by an elevated temperature, but Clay's mother thought that taking Clay's temperature would be a way of discouraging him from feigning headaches when he wasn't sick.

According to cognitive-behaviorists, the schemas that plague relationships are learned in the process of growing up. Some of these dysfunctional beliefs are assumptions about specific family roles, while others are about family life in general. These schemas are the basis of biased assumptions that poison relationships by distorting family members' responses to each other. The following are typical cognitive distortions:

1. Arbitrary inference: Conclusions are drawn in the absence of supporting evidence; for example, a man whose wife arrives home late from work concludes, "She must be having an affair," or parents whose child comes home late assume, "He must be up to no good."
2. Selective abstraction: Certain details are highlighted while other important information is ignored; for example, a woman whose husband fails to answer her greeting first thing in the morning concludes, "He must be angry at me again," or a child who is in a bad mood may be perceived by his or her siblings as ignoring them.
3. Overgeneralization: Isolated incidents are taken as general patterns; for example, after being turned down for a date, a young man decides that "Women don't like me; I'll never get a date"; or a teenager whose parents deny him a night out generalizes to, "They never let me do anything."
4. Magnification and minimization: The significance of events is unrealistically magnified or diminished; for example, a husband considers the two times in one month he shops for groceries as fulfilling his share of the household duties, while his wife thinks, "He never does anything."
5. Personalization: Events are arbitrarily interpreted in reference to oneself; for example, a teenager wants to spend more time with his friends, so his father assumes that his son doesn't enjoy his company.
6. Dichotomous thinking: Experiences are interpreted as all good or all bad; for example, Jack and Diane have some good times and some bad times, but he remembers only the good times, while she remembers only the bad times.
7. Labeling and mislabeling: Behavior is attributed to undesirable personality traits; for example, a

woman who avoids talking with her mother about her career because her mother always criticizes is considered "withholding."

8. Mind reading: This is the magical gift of knowing what other people are thinking without the aid of verbal communication; for example, a husband doesn't ask his wife what she wants because he "knows what's going on in her mind"; and children often believe that their parents know what is bothering them without them having to express themselves.

Goals of Therapy

Cognitive-behavior therapists tailor treatment to fit the case, but the general intent is to extinguish undesired behavior and reinforce positive alternatives (Azrin, Naster, & Jones, 1973). Thus, for example, parents of a child with temper tantrums might be taught to ignore the tantrums and reward the child for putting his feelings into words.

Sometimes it may be necessary to redefine a family's goal of decreasing negative behavior in terms of increasing incompatible, positive responses (Umana, Gross, & McConville, 1980). Couples, for example, often state goals of reducing aversive behavior (Weiss, 1978), but a behavioral therapist will establish a goal of helping them increase satisfaction by accelerating positive behavior.

Married partners often state their goals negatively: "I wish he wouldn't always argue with me" or "She nags too much." Most people have difficulty describing behavior that they want their mates to accelerate. To help them do so, some therapists (Azrin, Naster, & Jones, 1973) ask couples to make a list of pleasing things their partners do during the week. Reviewing these lists in the following session provides an opportunity to emphasize the importance of positive feedback.

Cognitive-behavior therapy also has an educational agenda. In addition to applying learning theory to alleviate specific behavioral problems, cognitive-behaviorists also teach communication, problem-solving, and negotiation skills. Furthermore, these therapists not only help clients reexamine distorted beliefs to solve specific complaints, but also make an effort to teach families how to use cognitive strategies to resolve problems in the future.

Conditions for Behavior Change

The basic premise of behavior therapy is that behavior will change when the contingencies of reinforcement are altered. Behavioral family therapy aims to resolve targeted family problems through identifying behavioral goals, learning theory techniques for achieving these goals, and social reinforcers to facilitate this process.

The first task of the therapist is to observe the frequency of problem behavior, as well as the stimulus conditions that precede it and the reinforcement that follows it. In addition to the reinforcing responses that immediately follow a specific behavior, more remote reinforcers also play a part. These may include tacit approval of aggressive behavior, particularly by men in the family, often accompanied by modeling of this behavior. Spanking children for fighting demonstrates by example the violence a parent may wish to discourage. In addition, behavior that is reinforced by peers may be difficult to modify at home—especially if the therapist fails to take this wider context into account.

The primary approach in behavioral parent training is operant conditioning, where the reinforcers employed may be tangible or social. In fact, praise and attention have been found to be as effective as money or candy (Bandura, 1969). Operant techniques may be further divided into *shaping*, *token economies*, *contingency contracting*, *contingency management*, and *time-out*.

Shaping (Schwitzgebel & Kolb, 1964) consists of reinforcing change in small steps. **Token economies** (Baer & Sherman, 1969) use points to reward children for good behavior. **Contingency contracting** (Stuart, 1971) involves agreements by parents to make certain changes following changes made by their children. **Contingency management** (Schwitzgebel, 1967) consists of giving and taking away rewards based on children's behavior

& Masters, 1974) is a punishment made to sit in the corner or sent to

vior change remains the primary more behavior therapists are le of cognitive factors in resolving ems. The cognitive approach first s a supplement to behavioral cou- olin, Christensen, & Weiss, 1975), led to the recognition that cogni- cant role in all family interactions ons, 1982).

xander, who call their approach *herapy* (Barton & Alexander, 1981; & Waldron, 1988), point out that py families tend to attribute their ve traits (laziness, irresponsibility, rol) in others. Such negative attri- y members with a limited sense of ves. After all, what can one person er person's "laziness," "irresponsi- ulse control"?

e appraisal plays such a significant nembers respond, restructuring dis- ght to play a pivotal role in changing vior. Thus, uncovering and reevalu- core beliefs, of family members is thought to be essential in helping the and interactions that surround prob

THERAPY

■ Behavioral Parent Training

Assessment

In common with other forms of be ent training begins with a thorough the procedure varies from clinic to ments are based on Kanfer and Phil model of behavior: *S* for stimulus, organism, *R* for the target response, tingency of consequences. For exa parents who complain that their s cookies between meals and throws t give him any, the tantrums would b get behavior, *R*. *O*, the state of the o out to be hunger or, more likely, bor *S*, might be the sight of cookies in the contingency of consequences, *K* parents give in by feeding the boy especially if he makes enough of a fu

In simple cases such as this ap model is straightforward, but it qu

complex with families, in which there are long chains of interrelated behavior. Consider the following.

CASE STUDY

Mr. and Mrs. J. complained that their two small children whine and fuss at the dinner table. A home observation reveals that when Mr. J. yells at the children for misbehaving, they start to whine and stand by their mother's chair.

Given this sequence it's not difficult to apply the SORKC model. Imagine, however, that the above sequence is only part of a more complex picture.

In the morning, Mr. J. makes a sexual overture to his wife, but she, tired from taking care of the children, rolls over and goes back to sleep. Mr. J. is hurt and leaves for work after making some unkind remarks to his wife. She, feeling rejected by her husband, spends the entire day playing with the children for solace.

By the time she has to cook dinner, Mrs. J. is exasperated with the children. Mr. J. comes home after a hard day at the office and tries to make up with his wife by hugging her. She responds but only perfunctorily because she's busy trying to cook. While she's at the stove, the children and Mr. J. vie for her attention, each one wanting to tell her something. Finally, she blows up—at her husband—"Can't you see I'm busy!" He goes into the den and sulks until dinner is ready.

Just as his wife finds it difficult to express her anger at the children and takes it out on him, Mr. J. has trouble directing anger at his wife and so tends to divert it onto the children. At the dinner table he yells at them for the slightest infraction, at which point they whine and turn to their mother. She lets one sit on her lap while she strokes the other's hair.

In this longer but not atypical sequence, what is stimulus and what is response? Obviously these definitions become circular, and their application depends on the perspective of the observer.

Assessment in behavioral parent training entails observing and recording the frequency of the behavior to be changed, as well as the events that precede it and those that follow. Interviews, usually with the mother, are designed to provide a definition of the problem and a list of potential reinforcers. Observations may be conducted behind a one-way mirror or during home visits. Typically, parents are trained to pinpoint problem behavior, record its occurrence, and note various actions that might serve as stimuli and reinforcers. Checklists and questionnaires provide information that may have been overlooked in interviews.

Therapeutic Techniques

Once the assessment is complete, the therapist decides which behaviors should be increased and which decreased. To accelerate behavior, the **Premack principle** (Premack, 1965) is applied; that is, high-probability behavior (popular activities) is chosen to reinforce behavior with a low probability of occurrence. Where once it was thought that reinforcers must satisfy some basic drive, such as hunger or thirst, it's now known that any behavior chosen more frequently (given a variety of choices) can serve as a reinforcer for those chosen less frequently.

CASE STUDY

Mrs. G. complained that she couldn't get her five-year-old son Adam to clean his room in the morning. She went on to say that she tried rewarding him with candy, money, and toys, but "Nothing works!" A functional analysis of Adam's behavior revealed that, given his choice of things to do, the most probable behaviors were watching television, riding his bicycle, and playing in the mud behind his house. Once these activities were made contingent on tidying his room, he quickly learned to do so.

A variety of material and social reinforcers have been used to accelerate desired behaviors, but as the Premack principle demonstrates, to be effective, reinforcers must be popular with the child. Although money and candy seem like powerful rewards, they may not be as effective for some children as a chance to play in the mud.

Once effective rewards are chosen, parents are taught to *shape* desired behavior by reinforcing successive approximation to their goals. They are taught to raise the criteria for reinforcement gradually and to present reinforcement immediately after the desired behavior.[3] Once a child is regularly

[3]The importance of immediate proximity is what makes time-out such an effective punishment and grounding such an ineffective one.

Time-out is a highly effective form of punishment for young children.

performing the desired response, reinforcement becomes intermittent in order to increase the durability of the new behavior.

Disciplinary techniques are usually instituted after progress has been made in reinforcing positive behavior. For preadolescent children, the most widely used punishment is *time-out*. Time-out involves removal to a boring place for five minutes. (Older children are sent to graduate school and required to sit through lectures.) When a child refuses to go to time-out, parents are taught to add additional time, up to a ten-minute maximum. If the child continues to refuse, a privilege is removed. When parents are consistent, children soon learn to go to time-out rather than lose the opportunity to watch TV or use the computer.

Other techniques used to decelerate behavior include verbal reprimand and ignoring. Simply repeating commands to children is the most ineffective way to change their behavior (Forehand, Roberts, Doleys, Hobbs, & Resnick, 1976). Chores are broken down into steps, with points given for each step. Rewards include food treats, special time with a parent, household resources (e.g., computer or TV time), privileges, and toys. Rewards are changed regularly to keep things interesting.

Because of the inconvenience of reinforcing behavior immediately after it occurs, token systems have been popular with parent trainers. Points are earned for desirable behavior and lost for undesirable behavior (Christophersen, Arnold, Hill, & Quilitch, 1972).

CASE STUDY

Mrs. F. is a mother of two small children who came to the clinic complaining of headaches and crying spells. The intake interviewer found her to be mildly depressed and concluded that the depression was primarily a reaction to difficulty coping with her children. Suzie, age five, was a shy child who had frequent temper tantrums. Robert, who was eight, was more sociable but did poorly in school. The children were a handful, and Mrs. F. felt helpless in dealing with them.

A functional analysis of behavior revealed that Suzie's shyness resulted in extra attention from her anxious mother. Whenever Suzie declined an invitation to play with other children, her mother spent a great deal of time doing things to make her feel better. The therapist selected social behavior (not shyness) as the first target response and instructed Mrs. F. to reinforce all efforts at socializing and to ignore Suzie when she avoided social contact. Thereafter, whenever Suzie made any attempt to socialize with other children, Mrs. F. would immediately reinforce her with attention and praise. When Suzie chose to stay home rather than play with other children, her mother ignored her, instead busying herself with her own activities. In three weeks, Mrs. F. reported that Suzie "seemed to have gotten over her shyness."

Following this initial success the therapist felt it was time to help Mrs. F. tackle the more difficult problem of Suzie's tantrums. Since the tantrums were unlikely to occur while the family was at the clinic or during home visits, the therapist instructed Mrs. F. to make observational notes for a week. These notes revealed that Suzie generally had tantrums when her parents denied her requests for a treat or some special indulgence, such as staying up to watch television. Tantrums were especially likely to occur at the end of the day when Suzie (and her parents) was tired. As for how the parents responded to these maddening outbursts, Mrs. F. reported, "We've tried everything. Sometimes we try to ignore her, but that's impossible; she just screams and shrieks until we can't stand it anymore. Then sometimes we spank her—or give her what she wants, just to shut her up. Sometimes after we spank her she cries so much that we let her watch television until she calms down. That usually works."

After listening to this description, the therapist explained how Mr. and Mrs. F. had inadvertently been reinforcing the tantrums and told them what they would have to do to stop them. For the next week, the F.s were

instructed to ignore fits of temper whenever they occurred. If they occurred at bedtime, Suzie was to be put in bed; if she continued to cry and fuss, she was to be left alone until she stopped. Only when she stopped were her parents to talk with her about what was on her mind.

The following week Mrs. F. reported that the tantrums had indeed decreased, except for one night when they took on a new and more troubling form. When Suzie was told that she wouldn't be able to stay up late to watch television she began to yell and cry as usual. Instead of relenting, Mrs. F. put Suzie in her room and told her to get ready for bed. However, realizing that her parents were going to ignore her, as they had earlier in the week, Suzie began to scream and smash things in her room. "It was awful; she was completely out of control. She even smashed the little dog-shaped lamp I bought her. We didn't know what to do, so just that once we let her stay up." Again the therapist described the consequences of such behavior and explained to Mrs. F. how, should Suzie again become destructive, both parents should hold her until the tantrum subsided.

At the next session, Mrs. F. described how Suzie did "get out of control again." This time, however, instead of giving in, the parents held her as they had been told. Mrs. F. was amazed at the fury and duration of the resulting tantrum. "But we remembered what you said—there was no way we were going to give in!" It took twenty minutes, but Suzie finally calmed down. This, it turned out, was the last time Suzie ever became violent during a temper tantrum. Nevertheless she did continue to have occasional flare-ups during the next few weeks.

According to Mrs. F., the few tantrums that did occur seemed to take place in different settings or under different conditions than the usual episodes at home (which Suzie had now learned would not be reinforced). For example, one episode took place in the supermarket when Suzie was told she couldn't have a candy bar. By this time, however, Mrs. F. was thoroughly convinced of the necessity of not reinforcing the tantrums, and so she didn't. Because she was embarrassed at all the noise her daughter was making in public, she did find it necessary to take Suzie out of the store. But she made Suzie sit in the car and took pains not to let it be a pleasant experience. Very few tantrums followed this one.

Next the therapist turned her attention to Robert's school performance. A careful assessment revealed that Robert usually denied that he had any homework. After checking with Robert's teacher the therapist discovered that the children generally did have homework and that they were expected to work between thirty minutes and an hour a night. Mrs. F. selected a high-probability behavior watching television, and made it contingent on Robert's having completed his homework. For the first two weeks of this regimen, Mrs. F. found it necessary to call the teacher every night to verify the assignments. But soon this was no longer necessary. Doing homework fairly quickly became a habit for Robert, and his grades increased from Ds and Cs to Bs and As. At this point, everyone was happier, and Mrs. F. felt the family no longer needed help.

A follow-up session in the fall found things continuing to go well. Suzie was now much more sociable and hadn't had any temper tantrums in months. Robert was doing well in school, although he had begun to neglect some of his more difficult assignments. To address this, the therapist explained to Mrs. F. how to institute a token system, and she was able to use it with excellent results.

With teenagers, contingency contracting (Alexander & Parsons, 1973; Rinn, 1978) is more widely used. Contracting is introduced as a way for everybody in the family to get something by compromising. Parents and teenagers are asked to specify what behavior they'd like each other to change. These requests form the nucleus of an initial contract. In order to help family members arrive at contracts, the therapist encourages (1) clear communication of wishes and feelings, (2) clear presentation of requests, leading to (3) negotiation, with each person receiving something in exchange for some concession.

■ Behavioral Couples Therapy

Assessment

As with parent training, behavioral couples therapy (BCT) begins with a thorough assessment. This process usually includes clinical interviews, ratings of specific target behaviors, and marital satisfaction questionnaires. The most widely used is the Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959), a twenty-three-item questionnaire covering various aspects of marital satisfaction, including communication, sex, affection, social activities, and values.

Assessments are designed to reveal strengths and weaknesses of a couple's relationship and the manner in which rewards and punishments are exchanged. Interviews and questionnaires are used to specify and elaborate target behaviors. Jacobson (1981) offers an outline for pretreatment assessment (see Table 9.1).

Table 9.1 Jacobson's Pretreatment Assessment for Marital Therapy

A Strengths and skills of the relationship

What are the major strengths of this relationship?
What are the major strengths of each spouse are highly valued by the other?
What behaviors on the part of each spouse are highly valued by the other?
What behaviors on the part of the couple currently engage in?
What shared activities does the couple currently engage in?
What common interests does the couple share?

B Presenting problems

What are the major complaints, and how do these complaints translate into explicit behavioral terms?
What are the major complaints, and how do these complaints translate into explicit behavioral terms?
What are the reinforcers maintaining these behaviors?
What are the reinforcers maintaining these behaviors?
What behaviors occur at less than the desired frequency or fail to occur at appropriate times from the standpoint of each spouse?
What behaviors occur at less than the desired frequency or fail to occur at appropriate times from the standpoint of each spouse?
What are the consequences of these behaviors currently, when they occur?
What are the consequences of these behaviors currently, when they occur?
How did the current problems develop over time?
How did the current problems develop over time?
What kinds of decisions are made collectively as opposed to unilaterally?
What kinds of decisions are made collectively as opposed to unilaterally?

C Sex and affection

Is either spouse currently dissatisfied with rate, quality, or diversity of sex life together?
Is either spouse currently dissatisfied with rate, quality, or diversity of sex life together?
If sex is currently a problem, was there a time when it was mutually satisfying?
If sex is currently a problem, was there a time when it was mutually satisfying?
What are the sexual behaviors that seem to be associated with current dissatisfaction?
What are the sexual behaviors that seem to be associated with current dissatisfaction?
Are either or both partners dissatisfied with the amount or quality of nonsexual physical affection?
Are either or both partners dissatisfied with the amount or quality of nonsexual physical affection?
What is the couple's history regarding extramarital affairs?
What is the couple's history regarding extramarital affairs?

D Future prospects

Are the partners seeking therapy to improve their relationship, to separate, or to decide whether the relationship is worth working on?
Are the partners seeking therapy to improve their relationship, to separate, or to decide whether the relationship is worth working on?
What are each spouse's reasons for continuing the relationship despite current problems?
What are each spouse's reasons for continuing the relationship despite current problems?

E Assessment of social environment

What are each person's alternatives to the present relationship?
What are each person's alternatives to the present relationship?
How attractive are these alternatives to each person?
How attractive are these alternatives to each person?
Is the environment (parents, relatives, friends, work associates, children) supportive of either continuance or dissolution of present relationship?
Is the environment (parents, relatives, friends, work associates, children) supportive of either continuance or dissolution of present relationship?

F Individual functioning of each spouse

Does either spouse exhibit emotional or behavioral problems?
Does either spouse exhibit emotional or behavioral problems?
Have they been in therapy before, either alone or together? What kind of therapy? Outcome?
Have they been in therapy before, either alone or together? What kind of therapy? Outcome?
What is each spouse's past experience with intimate relationships?
What is each spouse's past experience with intimate relationships?
How is the present relationship different?
How is the present relationship different?

Source: Adapted from Jacobson, N. S. 1981. Behavioral marital therapy. In *Handbook of Family Therapy*, A. S. Gurman and D. P. Kniskern, eds. (pp. 395–444). New York: Brunner/Mazel.

Therapeutic Techniques

Stuart (1975) lists five strategies that summarize the behavioral approach to troubled marriages:

1. Couples are taught to express themselves in clear, behavioral descriptions, rather than in vague complaints.
2. Couples are taught new behavior exchange procedures, emphasizing positive control in place of aversive control.
3. Couples are helped to improve their communication.
4. Couples are encouraged to establish clear and effective means of sharing power and making decisions.
5. Couples are taught strategies for solving future problems as a means to maintain and extend gains initiated in therapy.

Behavior exchange procedures are taught to increase the frequency of desired behavior. A typical device is to ask each partner to list three things he or she would like the other to do more often. While explicitly exchanging "strokes" in this way, couples are implicitly learning ways of influencing each other through positive reinforcement. Stuart (1976) has couples alternate "caring days," where one partner demonstrates caring in as many ways as possible.

The following vignette, taken from a video workshop series, illustrates how Stuart concentrates on helping couples learn to make each other happy, rather than trying to solve the problems that bring them to therapy.

CASE STUDY

Wesley and Adele are a middle-aged, working-class couple. This is her third marriage and his fourth. Wesley feels rejected because Adele frequently works late; at the same time, she feels that he isn't affectionate with her and that he pulls away whenever she makes a sexual overture. Dr. Stuart begins with a brief family history of each spouse and then explores the history of their relationship. In the second half of the interview, Dr. Stuart offers suggestions for improving the couple's relationship by making an effort to act "as if" things were good and they cared for each other.

When Stuart tells the couple that they can choose to make their marriage work by acting in loving ways toward each other, they seem a little skeptical. When Adele reveals that she doesn't know if Wesley is committed to staying in the relationship, Dr. Stuart suggests that she needs to feel safe in his commitment and, using the example of his own marriage, tells them again that they can accentuate the positive by making a point of expressing their caring for each other.

Later Stuart suggests that Wesley start acting "as if" he felt close to Adele and reassures him that if he acts affectionately, she will respond in kind. Again, Stuart uses his own marriage as an example of how two people can make themselves happy by making a point of acting lovingly toward each other. In fact, he guarantees Wesley that if he acts affectionately Adele will respond, and Stuart asks Wesley to agree to try doing so as an experiment. Though they still seem a little skeptical, both Wesley and Adele agree to try the idea of acting positively toward each other.

In a carefully designed longitudinal study, Gottman and Krokoff (1989) found that arguments and angry exchanges, which have often been considered destructive to relationships, may not be harmful in the long run. These patterns were correlated with immediate dissatisfaction but were predictive of improved satisfaction after three years. Defensiveness, stubbornness, and withdrawal from conflict, on the other hand, *did* lead to long-term deterioration in marriages. Conflict makes most people uneasy, but it may be an essential prelude to facing and solving problems. The anger that accompanies direct expression of dissatisfaction may be painful, but it may also be healthy. Gottman and Krokoff (1989) conclude, "If the wife must introduce and elaborate disagreements in marriages, our data suggest that, for the sake of long-term improvement in marital satisfaction, she may need to do this by getting her husband to confront areas of disagreement and to openly vent disagreement and anger" (p. 51). In other words, confrontation is effective only if it doesn't make the partner defensive. It isn't just honesty that counts but honesty expressed in a way the partner can tolerate.

Training in communications skills may be done in a group format (Hickman & Baldwin, 1971;

Pierce, 1973) or with individual couples. Couples are taught to be specific, phrase requests in positive terms, respond directly to criticism instead of cross-complaining, talk about the present and future rather than the past, listen without interruption, minimize punitive statements, and eliminate questions that sound like declarations.

Once a couple has learned to communicate in ways that are conducive to problem solving, they are introduced to the principles of contingency contracting—agreeing to make changes contingent on the partner making changes. In **quid pro quo** contracts (Knox, 1971), one partner agrees to make a change after a prior change by the other. Each partner specifies desired behavior changes, and with the therapist's help they negotiate agreements. At the end of the session a written list is made and both partners sign it.

An alternative form of contracting is a *good faith contract*, in which both partners agree to make changes that aren't contingent on what the other does (Weiss, Hops, & Patterson, 1973). Each partner's independent changes are independently reinforced. For example, a husband who comes home each night by 6:00 p.m. and plays with the children after supper might reward himself by buying a new shirt at the end of the week or be rewarded by his wife with a back rub.

Problem-solving training is used in situations that are too complicated for simple exchange agreements. Negotiations are preceded by a careful definition of problems. Discussions are limited to one problem at a time. Each person begins by paraphrasing what the other has said, and they are taught to avoid inferences about motivation—especially inferences of malevolent intent. They're encouraged to avoid aversive responses. When defining a problem, it's more effective to begin with a positive statement; instead of saying, "You never . . . ," partners are taught to say, "I appreciate the way you . . . and in addition I wish. . . ."

The following guidelines for problem-solving communication are adapted from *The Lost Art of Listening* (Nichols, 2009).

1. Speak for yourself and express your perspective as your own thoughts and feelings, not as absolute truths.
2. Ask for what you want in the form of specific requests, not general complaints.
3. Speak calmly and don't go on and on. Give your partner a chance to respond.
4. Knock to enter: Don't try to talk when your partner is unprepared or is doing something else.
5. Invite your partner to express his or her thoughts and feelings.
6. Listen with the intent to understand, rather than just waiting to respond.
7. Try to understand what the other person is feeling, rather than just reacting to the words.
8. Let your partner know that you understand by acknowledging what he or she has said—and invite him or her to elaborate or correct your impression.
9. When there is major conflict or misunderstanding, devote one entire conversation to drawing out and acknowledging your partner's point of view. Wait until you've demonstrated that you understand him or her before trying to express your side, perhaps in a subsequent conversation.
10. When it comes to discussing solutions, invite your partner's ideas first. Listen to and acknowledge those ideas.
11. When suggesting your own solutions, make sure they address both of your needs.
12. Find a solution that's agreeable to both of you, but plan to implement it on a trial basis, and review the solution at the end of the trial period.

■ The Cognitive-Behavioral Approach to Family Therapy

Assessment

The goals of a cognitive-behavioral assessment are to (1) identify strengths and problems in individuals, the couple or family, and the environment; (2) place individual and family functioning in the context of developmental stages; and (3) identify cognitive, emotional, and behavioral aspects of family interaction that might be targeted for intervention.

Among the family patterns of interaction therapists look for are the style and degree to which family members express their thoughts and feelings to each other, who interrupts whom, and who speaks for

whom. These unstructured observations may be supplemented by structured communication tasks in the initial interview (Epstein & Baucom, 2002). Based on information provided by the clients, a therapist can select an unresolved issue in the family and ask them to spend ten minutes or so discussing it while the therapist observes or perhaps videotapes. Family members might be asked just to express their feelings about the topic at hand, or they might be asked to try to resolve the issue in the allotted time. Either way, the therapist has an opportunity to observe how family members think about their problems and how they interact with one another.

Some cognitive-behaviorists use coding systems, such as the Marital Interaction Coding System-IV (Heyman, Eddy, Weiss, & Vivian, 1995), as guidelines for identifying sequences of family members' interactions (e.g., positive physical contact, constructive and counterproductive behavior, and complaints). This data serves as an interactional sample, which might be typical of family processes, but which requires verification through repeated observations and reports from family members about their interactions at home. Therapists take an empirical approach to assessment, using initial observations to form hypotheses, but waiting for repetitive patterns to emerge before drawing conclusions about a family's patterns.

For example, when parents say that they have rules for their teenage son and that they work together to enforce them, a therapist might assume that there is a clear power hierarchy in the family. However, if in a subsequent interview the son says that he can easily bend the rules and usually talk his parents out of punishments, and later the parents fail to respond when their son repeatedly interrupts them, the therapist might revise the initial hypothesis and conclude that the parents have little authority and are disorganized in their parenting skills.

After collecting sufficient information from interviews, questionnaires, and behavioral observations, the therapist meets with the couple or family and offers a summary of the patterns that have emerged, including the family's strengths, major concerns, stressors, and patterns of interaction that seem to be influencing their present difficulties. At this juncture the therapist and family together set priorities for change, as well as discuss some of the interventions that might be used to alleviate problems.

Therapeutic Techniques

Cognitive-behavioral family therapy assumes that members of a family simultaneously influence and are influenced by each other. The behavior of one family member triggers behavior, cognitions, and emotions in other members, which in turn elicit reactive cognitions, behavior, and emotions in the original member. Epstein and Schlesinger (1996) cite four means by which family members' cognitions, behavior, and emotions may contribute to spirals of conflict:

1. The individual's own cognitions, behavior, and emotions regarding family interaction (e.g., the person who notices himself or herself withdrawing from the rest of the family)
2. The actions of individual family members toward him or her
3. The combined (and not always consistent) reactions several family members have toward him or her
4. The characteristics of the relationships among other family members (e.g., noticing that two other family members usually are supportive of each other's opinions)

Just as individuals maintain schemas, or core beliefs, about themselves, their world, and their future, they also maintain beliefs about their families. Dattilio (2005) suggests that individuals maintain two sets of schemas about family life: (1) schemas related to the parents' experiences growing up in their own families, and (2) schemas related to families in general, or personal theories of family life. Both types of schemas influence how individuals react in the family setting. For example, a woman raised with the belief that family members should do things together is likely to feel threatened if her husband wants to do certain things on his own.

Teaching families the principles of cognitive-behaviorism promotes a collaborative relationship and increases their cooperation with treatment.

Therapists typically give a brief overview of the model and periodically refer to specific concepts during therapy. In addition to presenting such information, readings are often assigned. Understanding the model keeps family members attuned to the process of treatment and reinforces the importance of taking responsibility for their own thoughts and actions.

Cognitive interventions are designed to increase family members' skills at monitoring the validity of their own cognitions. This is an important point: Cognitive therapy should not be reduced to generic interpretations ("It's a mistake to be dependent on others." "Who says it's disastrous when things go wrong?"), nor should the therapist do all the work. Rather, for cognitive intervention to be effective, specific cognitive distortions must be uncovered, and clients must learn to test their own assumptions. This exploration is carried out in a process of Socratic questioning, rather than offering explanations and making suggestions.

A major goal of the cognitive approach is to help family members learn to identify automatic thoughts that flash through their minds. The importance of identifying such thoughts ("She's crying—she must be mad at me.") is that they often reflect underlying schemas ("Women usually hold men responsible for their unhappiness.") which may be inaccurate.

To improve their skill in identifying automatic thoughts, clients are encouraged to keep a diary and jot down situations that provoke automatic thoughts and the resulting emotional responses. The therapist's role then is to ask a series of questions about these assumptions, rather than to challenge them directly. Here's an example.

CASE STUDY

When thirteen-year-old Kylie's parents caught her walking home from school with a boy she was forbidden to see, they responded by saying "We can't trust you!" and grounded her for a week. Kylie's automatic thought was "They'll never trust me again," which made her feel, in turn, worried and then angry. This conclusion was followed by the thought "Now I'll *never* have any freedom. To hell with it, I'm going to do what I want."

After helping Kylie identify these thoughts, the therapist asked her to test these assumptions and then to consider alternative explanations. "What evidence exists to substantiate this idea?" "Might there be alternative explanations?" "How would you test this assumption?"

Kylie decided that it was too soon to be sure how her parents would treat her in the future. She decided to test the proposition that if she stopped lying to them they would eventually start to trust her again, and that, in this way, she could slowly win back her freedom. Kylie was also asked to examine her defiance and think about the specific connotation it had (anger? emancipation? pride?).

Once clients have learned to identify the automatic thoughts behind their actions, the next step is to help them test, and possibly revise, their automatic thoughts through a process of restructuring, which involves having them consider alternative explanations. In order to accomplish this, family members must examine evidence for the validity of their thoughts and their appropriateness to the family situation. The following questions may be asked to help family members examine their thoughts:

"Based on your past experiences or events in your life, what evidence exists that supports the thoughts you just shared? How could you obtain additional information to better help you assess whether your thought is accurate?"

"Could you consider an alternative explanation that might explain your partner's (or child's or sibling's) behavior?"

"Referring to the list of cognitive distortions, which cognitive distortion, if any, do you view your automatic thoughts applying to?"

From this point, the therapist coaches family members to identify how they might have been engaging in one or more cognitive distortions, such as overgeneralization or dichotomous thinking. The therapist then encourages individuals to ask other family members to describe their thoughts and feelings in more detail. The following case (taken from Dattilio, 2005) is an example of how this process plays out in treatment.

CASE STUDY

The family entered treatment because of conflict over the mother's rigid attitudes. Based on her experience with her own fragile and demanding parents, she tended to overreact to any sign of problems in her husband or children. Her anxiety made her intolerant of the children's crying and complaining. The family felt they needed to "walk on eggshells" to avoid making her worry. Thus, the father and children became aligned against the mother, whom they came to regard as a "nut case."

The father's own mother was controlling and overbearing, which led to his developing a schema that women were bossy and unreasonable. His failure to challenge his wife about what he saw as her unreasonableness was thus partly a carryover from his experience with his mother. Instead of confronting his wife, he formed a coalition with his children against her, just as he and his father had joined forces to cope with his own domineering mother.

The therapist used the cognitive technique of the *downward arrow* to identify the mother's core beliefs (see Figure 9.1). This technique was implemented by asking a series of questions to uncover the basic schemas underlying each person's assumptions: "So if that were to occur, what would it mean?"

FIGURE 9.1 Downward Arrow Technique

The children were afraid to be themselves around their mother. They saw her as unreasonable and attributed her unyielding views to having grown up with a mother who had attempted suicide and blamed her daughter for not being attentive to her concerns. When the therapist attempted to uncover the children's core beliefs about the situation, one daughter said, "I think my mother is probably on the edge, with all of the stress she's been under her entire life. We have to go along with her, or something bad might happen to her, and we don't need that—although we resent having to live this way—all because of my stupid grandmother's problems." The schema adopted by this child was "Children must be cautious with parents who have problems."

In addressing the schemas in this family, the therapist followed a series of eight steps to uncover and reexamine them:

1. *Identify family schemas and highlight those areas of conflict that are fueled by them. (e.g., "We have to walk on eggshells with mom. If we show any signs of weakness, she flips out.").* Schemas are uncovered by probing automatic thoughts through techniques such as the downward arrow. Once schemas have been identified, verification should be made by obtaining agreement from other family members.
2. *Trace the origin of family schemas and how they evolved to become an ingrained mechanism in the family process.* This is done by exploring the parents'

4. *Elicit acknowledgment of the need to change or modify existing dysfunctional schemas.* This step paves the way for collaborative efforts to change. When family members have different goals, the therapist's job is to help them find common ground.
5. *Assess the family's ability to make changes, and plan strategies for facilitating them.* In this case, the mother was asked what evidence supported her idea that signs of weakness were always a problem. She was helped to consider that this idea might be a distortion based on her own childhood experience. As an experiment, she was asked to see if an occasional display of emotion really was dangerous by allowing herself to cry once in a while in front of her family. The fact that her husband and children seemed relieved to see her show her feelings helped her to think that maybe it's not so terrible to show unhappy emotions at times. "In fact, it felt kind of good," she noted. In a similar process, the husband discovered that if he avoided interfering to protect his wife when she seemed upset, the children were able to be supportive and "nothing terrible happened." The children found out that when they expressed the wish to avoid being put in the middle of their parents' conflicts, they were free to be themselves without worrying about negative consequences.
6. Implement change. The therapist encouraged family members to consider modifying some of their beliefs in a collaborative process of brainstorming ideas and weighing their implications. This family considered how they would act with each other if they decided to adopt the belief that "It is important to be tactful in expressing negative feelings to other family members, but family members should have the freedom to share such feelings with each other."
7. *Enact new behaviors.* This step involves trying out changes and seeing how they work. Family members were each asked to select an alternative behavior consistent with the modified schema and to see how acting on it affected the family. Once the children began to see their mother's behavior as her way of expressing love for them in order to protect them from what she went through as a child, they became less defensive and more supportive of her—which, in turn, softened her anxious vigilance.
8. *Solidify changes.* This step involves establishing the new schema and its associated behavior as a permanent pattern in the family. Family members were urged to remain flexible about the possible need for future reevaluations. Although the mother might be seen as the identified patient in this family, the therapist felt it was important for the father and children to recognize their own roles in perpetuating the status quo. They began this process by expressing how they felt, instead of just avoiding the mother. Then, in an effort to challenge their automatic thoughts about the family and see how their own beliefs might be part of the problem, all of the family members were asked to weigh alternative explanations and consider their implications. Dattilio notes that this process is similar to *reframing* but with an important difference: In cognitive-behavior therapy, family members are asked to gather data and weigh the evidence in favor of changing their thinking, rather than merely accept the therapist's alternative explanations.

Imagery and role-playing may be used to help family members remember past incidents that helped them form assumptions. On occasion, family members are coached to switch places in role plays to increase their empathy for each other's feelings (Epstein & Baucom, 2002). An example of this would be having siblings play each other's role in reenacting a recent argument. Focusing on the other person's frame of reference and feelings provides new perspective that may help family members soften their views of each other.

Even while cognitive interventions have become increasingly important, cognitive-behavior therapists still use many of the elements of traditional behavioral therapy, including communications training, problem-solving training, and homework assignments. In summarizing some of the problem-solving strategies taught in cognitive-behavioral therapy, Epstein and Baucom (2002) describe helping clients learn to set clear, behavioral goals without attacking other family members' ideas, evaluating the advantages and disadvantages of each proposed solution, and then selecting a solution that appears to be feasible and agreeable to all. A trial period is then proposed to test the implementation of the proposed solution and assessing its effectiveness.

Among the homework assignments commonly used in this approach are practicing communication skills—for example, deliberately engaging in an argument but without attacking or using condescending language; assigned readings, linked to particular issues that emerge in the course of treatment; self-monitoring exercises in which clients are asked to keep track of their thoughts and moods between sessions. In the "Daily Dysfunctional Thought Sheet" (Beck, Rush, Shaw, & Emery, 1979), clients are asked to record their thoughts during arguments and make connections about how their thoughts, moods, and behavior are interrelated.

Dattilio (1999) introduced the "pad-and-pencil" technique to help family members overcome the annoying habit of interrupting each other. Family members are given a pad and pencil and asked to record the automatic thoughts that go through their minds when someone else in the family is talking. Once the first person has finished speaking, the therapist asks the other person talk about the thoughts and feelings he or she were having while listening.

One of the early criticisms of cognitive-behavior therapy was that it neglected the role of emotions. If that was ever true, it isn't now. Contemporary cognitive-behaviorists see emotions and cognitions as interrelated in a circular process of mutual influence. Research has shown that dysphoric emotions cloud cognitive processing and lead to a depressing frame of mind that may be consuming, such as in someone who is always looking on the dark side of things (Gottman, 1994). Gottman found that pessimistic moods initiate pessimistic cognitive processing, which then leads to selective attention to negative events. From this selective attention, negative attributions develop and lead to negative expectations for the future. Beck described this as "negative frame" which renders individuals vulnerable to seeing the world in a pessimistic light.

Cognitive-behavior therapy offers a host of interventions to improve emotional regulation (Epstein & Baucom, 2002; Dattilio, 2010). Therapists provide guidelines and coaching to help clients learn to express themselves in ways that won't lead to recrimination. This may involve using *downward arrow* questioning to help family members learn to differentiate and articulate their feelings and the cognitions underlying them, coaching clients to notice internal cues to their emotional state, having them learn to express their emotions in understandable terms, refocusing attention on emotional topics when clients attempt to change the subject, and engaging family members in role plays about relationship conflicts in order to elicit emotional responses and learn to express them in productive ways.

When family members report emotionally upsetting interactions, a therapist may be able to help them work through these experiences by scheduling times to discuss distressing topics; coaching individuals in self-soothing activities, such as relaxation techniques, improving their ability to monitor and reassess upsetting automatic thoughts; and encouraging individuals to seek support from family and friends. Therapists may also help clients increase their ability to tolerate distressing feelings and enhance their skills for expressing emotions constructively so that they will pay greater attention to what is occurring.

Recently, mindfulness meditation has been employed as an adjunct to cognitive-behavior therapy. Mindfulness teaches open and receptive attention to the present moment, which in turn promotes a more accepting and less-avoidant response to challenging emotions. Recent studies have indicated that improving emotional skills and mindfulness were related to improved marital adjustment (Hayes, 2004). Mindfulness meditation has also proven helpful in teaching couples to improve their level of empathy for each other and greater closeness in their relationships.

■ Treatment of Sexual Dysfunction

The introduction of *systematic desensitization* (Wolpe, 1958) and *assertiveness training* (Lazarus, 1965) led to major advances in the treatment of sexual dysfunction. While these behavioral remedies were often helpful, the real breakthrough came with the publication of Masters and Johnson's (1970) approach. This was followed by others who applied and extended Masters and Johnson's basic procedure (Kaplan, 1974, 1979; Lobitz & LoPiccolo, 1972). More recently Weekes and Gambescia (2000, 2002) have offered a more comprehensive treatment model, integrating couples therapy, sex therapy, and medical

Although the details vary, there is a general approach followed by most sex therapists. As with other behavioral methods, the first step is a thorough assessment, including a complete medical examination and extensive interviews to determine the nature of the dysfunction and establish goals for treatment. In the absence of medical problems, cases involving lack of information, poor technique, and poor communication are most amenable to sex therapy.

Therapists following Masters and Johnson tended to lump sexual problems into one category—anxiety that interferes with couples' ability to relax into passion. Helen Singer Kaplan (1979) pointed out that there are three stages of the sexual response and hence three types of problems: disorders of desire, arousal disorders, and orgasm disorders. *Disorders of desire* range from low sex drive to sexual aversion. Treatment focuses on (1) deconditioning anxiety and (2) helping clients resist negative thoughts. *Arousal disorders* include decreased emotional arousal and difficulty achieving and maintaining an erection or dilating and lubricating. These problems are often helped with a combination of relaxation and teaching couples to focus on the physical sensations of touching and caressing, rather than worrying about what comes next. *Orgasm disorders* include the timing of orgasm (premature or delayed), the quality of the orgasm, or the requirements for orgasm (e.g., some people have orgasms only during masturbation).

Premature ejaculation usually responds well to sex therapy; lack of orgasm in women may respond to sex therapy, usually involving teaching the woman to practice on her own and learning to fantasize (Weekes & Gambescia, 2000, 2002).

Although sex therapy must be tailored to specific problems, most treatments are initiated with *sensate focus*, in which couples are taught how to relax and enjoy touching and being touched. They're told to find a time when they're both reasonably relaxed and free from distraction and get in bed together naked. Then they take turns gently caressing each other. The person being touched is told to relax and concentrate on the feeling of being touched. Later the one being touched will let the partner know which touch is most pleasing and which is less so. At first couples are told not to touch each other in the sensitive breast or genital areas in order to avoid possible anxiety.

After they learn to relax and exchange gentle caressing, couples are encouraged to gradually become more intimate—but to slow down if either should feel anxious. Thus sensate focus is a form of *in vivo desensitization*. Couples who are highly anxious and fearful of having sex (which some people reduce to a hectic few minutes of poking and panting) learn to overcome their fears through a gradual and progressively intimate experience of mutual caressing. As anxiety decreases and desire mounts, they're encouraged to engage in more intimate exchanges. In the process, couples are taught to communicate what they like and don't like. So, for example, instead of enduring something unpleasant until she finally gets so upset that she snaps at her partner or avoids sex altogether, a woman might be taught how to gently show him "Like this."

Once sensate focus exercises have gone smoothly, the therapist introduces techniques to deal with specific problems. Among women the most common sexual dysfunctions are difficulties with orgasm (Kaplan, 1979). Frequently these problems are rooted in lack of information. The woman and her partner may be expecting her to have orgasms reliably during intercourse without additional clitoral stimulation. In men, the most common problem is premature ejaculation, for which part of the treatment is the *squeeze technique* (Semans, 1956), in which the woman stimulates the man's penis until he feels the urge to ejaculate. At that point, she squeezes the frenulum (at the base of the head) firmly between her thumb and first two fingers until the urge to ejaculate subsides. Stimulation begins again until another squeeze is necessary.

Techniques to deal with erectile failure are designed to reduce performance anxiety and increase sexual arousal. These include desensitization of the man's anxiety; discussions in which the partners describe their expectations; increasing the variety and duration of foreplay; the *teasing technique* (Masters & Johnson, 1970), in which the woman alternately starts and stops stimulating the man; and beginning intercourse with the woman guiding the man's flaccid penis into her vagina.

Successful sex therapy usually ends with the couple's sex life much improved but not as fantastic as frustrated expectations had led them to imagine—expectations that were part of the problem in the first place. As in any form of directive therapy, it's important for sex therapists to gradually fade out their

involvement and control. Therapeutic gains are consolidated and extended by reviewing the changes that have occurred, by anticipating future trouble spots, and by planning in advance to deal with problems according to principles learned in treatment.

Evaluating Therapy Theory and Results

The principles of behavioral family therapy are derived from classical and operant conditioning and, increasingly, cognitive theory. Target behavior is carefully defined in operational terms; operant conditioning, classical conditioning, social learning theory, and cognitive strategies are then used to produce change. As behavior therapists have gained experience with family problems, they have begun to address such nonbehavioral concerns as the therapeutic alliance, the need for empathy, and the problem of resistance, as well as communication and problem-solving skills. However, even when dealing with such traditional issues, behaviorists are distinguished by their methodical approach. More than by any technique, behavior therapy is characterized by careful assessment and evaluation.

Behavior therapy was born and bred in a tradition of research, and so it's not surprising that it is the most carefully studied form of family treatment. Two trends emerge from this substantial body of evidence. The first is that both behavioral parent training and behavioral couples therapy have repeatedly been shown to be effective. Among the most well-supported versions of these approaches are Gerald Patterson's parent training therapy (Patterson, Dishion, & Chamberlain, 1993; Patterson & Forgatch, 1995), Neil Jacobson's behavioral couples therapy (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995), and Fals-Stewart and colleagues' behavioral couples therapy (Fals-Stewart et al., 2000).

The second trend in research on behavioral family therapy is that exponents of this model have begun to see the need to extend their approaches beyond the basic contingency contracting and operant learning procedures of traditional behavior therapy. One form this has taken has been the incorporation of cognitive techniques into traditional stimulus-response behaviorism (Epstein & Baucom, 2002; Dattilio & Padesky, 1990; Dattilio, 2010).

Cognitive-behavior therapy still emphasizes behavior change. There are two general categories of intervention: substituting positive for aversive control and skills training. An example of the former would be, to counteract the negativity that characterizes many distressed couples, a cognitive behavior therapist might ask each partner to write down one positive thing that the other person did each day, compliment or express appreciation to that individual for this action, and bring the list to therapy for further discussion (Baucom, Epstein, & LaTaillade, 2002).

The cognitive component of cognitive-behavioral therapy comes into play when clients' attitudes and assumptions get in the way of positive behavior changes—when, for example, family members notice only negative things about each other. The cognitive-behavior therapist helps clients explore their assumptions in a process of Socratic questioning. Thus, cognitive-behavior therapy still focuses on behavior; therapists are still active and directive, but there is more attention paid to unhappy emotions and the assumptions underlying them.

Patterson and colleagues parent management training (PMTO), based on social learning theory, emphasizes the role of the child's social environment in the maintenance of delinquent behavior. PMTO utilizes behavioral analysis and operant conditioning to help parents bring about positive changes in their children. Patterson and his colleagues have done extensive research to identify different parent practices (discipline, positive support, monitoring, problem solving, parent involvement) and how these practices are associated with aggressive behavior in children (Forgatch & DeGarmo, 2002). They have also conducted intervention studies showing that PMTO effectively reduces delinquent behavior in chronically offending adolescents (e.g., Bank, Marlowe, Reid, Patterson, & Weinrott, 1991). A version of PMTO has also been shown to effectively prevent the emergence of delinquent behavior in adolescents at risk for substance abuse (Dishion, Nelson, & Kavanagh, 2003), families in high crime areas (Reid, Eddy, Fetrow, & Stoolmiller, 1999), divorced mothers (Forgatch & DeGarmo, 1999), and stepparent families (Forgatch, DeGarmo, & Beldavs, 2005).

The late Neil Jacobson, in partnership with Andrew Christensen, went even further in modifying

traditional behavioral couples therapy by incorporating elements of experiential therapy. They retained the behavioral change techniques but added strategies to bring about increased emotional acceptance in clients (Jacobson & Christensen, 1996). In other words, before they start working with couples to produce changes in the partners' behavior, they endeavor to help them learn to be more accepting of each other. So different, in fact, is the resulting approach that we will consider it more extensively in our chapter on integrative approaches (Chapter 13).

Fals-Stewart, O'Farrell, and colleagues have amassed substantial support for the use of another variation of behavioral couples therapy in the treatment of substance abuse. This version of behavioral couples therapy emphasizes the therapeutic benefit of partners rewarding abstinence, suggesting that reduction in marital distress can decrease the likelihood of substance abuse and relapse. This model primarily targets substance-related couple interactions in hopes of modifying them to support positive changes in substance-abusing behavior (Ruff, McComb, Coker, & Sprenkle, 2010). In particular, research has shown that BCT can successfully reduce alcohol (Fals-Stewart, Birchler, & Kelley, 2006; Fals-Stewart, Klosterman, Yates, O'Farrell, & Birchler, 2005) and illicit drug abuse (Fals-Stewart et al., 2000, 2001; Kelley & Fals-Stewart, 2007). It has also been shown to improve relationship adjustment (Fals-Stewart, Birchler, & Kelley, 2006; Kelley & Fals-Stewart, 2008) as well as child psychosocial outcomes (Kelley & Fals-Stewart, 2007, 2008). A number of studies have also examined the effect of BCT in reducing intimate partner violence (which often occurs when one member of a couple is abusing substances) (Fals-Stewart, Kashdan, O'Farrell & Birchler, 2002; Fals-Stewart et al., 2006).[4]

As you are probably aware, cognitive-behavior therapy is one of the most widely taught approaches to psychological treatment. In a survey conducted by the American Association for Marriage and Family Therapy (Northey, 2002) that asked family therapists to describe their primary treatment approach, the most frequent response (named by 27.3 percent of two hundred ninety-two randomly selected therapists) was cognitive-behavior therapy.

One reason for this popularity is that cognitive-behavioral couples therapy has been subjected to more controlled outcome studies than any other therapeutic approach. Baucom and associates' (1998) review of outcome studies indicated that cognitive-behavioral couples therapy is effective in reducing relationship distress, especially as an addition to a program that includes communication training, problem-solving training, and behavioral contracts. While outcome studies have demonstrated the effectiveness of behaviorally oriented family interventions with child conduct disorders (Nichols & Schwartz, 2006), cognitive interventions per se have not been evaluated as frequently.

Despite increased public and professional interest in sex therapy, there are few well-controlled studies of its effectiveness. In a careful review, Hogan (1978) found that most of the literature consists of clinical case studies. These reports are little more than "box scores" of successes and failures. Absent are pre- and postmeasures, specification of techniques, points of reference other than the therapist, and follow-up data. Moreover, since most of these reports have come from the same handful of therapists, it's impossible to discern what's being evaluated—the techniques of sex therapy or the skills of these particular therapists. This state of the research hadn't changed much by 1990, according to later summary reports (Crowe, 1988; Falloon & Lillie, 1988).

Sex therapy appears to be an effective approach to some very vexing problems. Most observers (Gurman & Kniskern, 1981) agree that it should be considered the treatment of choice when there is an explicit complaint about a couple's sex life.

Three areas of research in family intervention that seem ready to move to a more advanced stage of development are: conduct disorders in children (Morris, Alexander, & Waldron, 1988; Patterson, 1986), marital conflict (Follette & Jacobson, 1988), and schizophrenia (Falloon, 1985).

Summary

Although behavior therapists have been applying their techniques to family problems for more than forty years, they have done so for the most part within

[4] It should be noted that questions have been raised about the legitimacy of Fals-Stewart's findings (*Business First*, February 16, 2010).

a linear frame of reference. Family symptoms are treated as learned responses, involuntarily acquired and reinforced. Treatment is generally time limited and symptom focused.

Initially, the behavioral approach to families was based on social learning theory, according to which behavior is learned and maintained by its consequences and can be modified by altering those consequences. This focus has been broadened considerably by the introduction of cognitive interventions to address unhelpful assumptions and distorted perceptions. An essential adjunct to social learning theory is Thibaut and Kelley's theory of social exchange, according to which people strive to maximize interpersonal rewards while minimizing costs. Hence, the general goals of behavioral family therapy are to increase the rate of rewarding exchanges, decrease aversive exchanges, and teach communication and problem-solving skills.

More contemporary approaches to cognitive-behavioral therapy have expanded this approach to include the examination and restructuring of thoughts and perceptions. So, while specific techniques are applied to target behaviors, families are also taught general principles of behavior management along with methods for reevaluating automatic thoughts with an attempt to identify distortions and address misconceptions.

Some of the more recent efforts of cognitive-behavior therapists (Baucom & Epstein, 2002; Dattilio, 2010) have incorporated emotional regulation and attachment work. Thus, contemporary cognitive-behavior therapy is a progressively more integrated and comprehensive model, which in turn has led to its increased acceptance among couple and family therapists.

The behaviorists' focus on modifying the consequences of problem behavior accounts for the strengths and weaknesses of this approach. By concentrating on concrete problems, behaviorists have been able to develop an impressive array of effective techniques. Even such relatively intractable problems as delinquent behavior in children and severe sexual dysfunctions have yielded to behavioral technology. Contemporary cognitive-behavior therapists take the posture, however, that behavior is only part of the human condition, and the problem person is only part of the family. You can't simply teach people to change if unresolved conflict is keeping them stuck.

Unhappiness may center around a behavioral complaint, but resolution of the behavior may not resolve the unhappiness. Treatment may succeed with the symptom but fail the family. Attitudes and feelings *may* change along with changes in behavior but not necessarily. And teaching communication skills may not be sufficient to resolve real conflict. Behavior change alone may not be enough for family members whose ultimate goal is to feel better. "Yes, he's doing his chores now," a parent may agree. "But I don't think he *feels* like helping out. He still isn't really part of our family." Behavior isn't all that family members in distress are concerned about, and to be responsive to their needs therapists need to deal with cognitive and affective issues as well.

Traditional behaviorists rarely treat whole families. Instead they see only those subsystems they consider central to the targeted behavior. Unfortunately, failure to include—or at least consider—the entire family in therapy may doom treatment to failure. A therapeutic program to reduce a son's aggressiveness toward his mother can hardly succeed if the father wants an aggressive son or if the father's anger toward his wife isn't addressed. Moreover, if the whole family isn't involved in change, new behavior may not be reinforced and maintained.

Despite the earlier shortcomings, cognitive-behavior therapy offers impressive techniques for treating problems with children and troubled marriages. Furthermore, its weaknesses can be corrected by broadening the focus of treatment to include families as systems. Perhaps the greatest strength of behavior therapy is its insistence on observing what happens and then measuring change. Cognitive-behaviorists have developed a wealth of reliable assessment methods and applied them to evaluation, treatment planning, and monitoring progress and outcome. A second important advance has been the gradual movement from eliminating or reinforcing discrete marker behaviors to the teaching of general problem-solving, cognitive, and communicational skills. A third major advance in current behavioral family therapy is modular treatment interventions organized to meet the specific and changing needs of the individual and the family.

CHAPTER 9 PRACTICE TEST

The following questions will test your application and analysis of the content found within this chapter. For additional assessment, applying, analyzing, synthesizing, and evaluating chapter content with practice, visit **MySearchLab**.

1. In early behavior therapy, who were the two leading figures, and what did they contribute to the field? How did their contributions differ in relation to each other?

2. In which situations is operant conditioning most effective? How did Patterson use operant conditioning and why was it effective?

3. According to Weiss and Isaac, what three factors are most important to marital happiness? How do they define a good relationship?

4. What is the basic premise of behavior therapy? What are the tasks involved in changing the problem behavior?

5. What is a major goal of the cognitive behavioral approach for family members? How are family members encouraged to achieve this goal?

6. Why is cognitive-behavior therapy so popular? Why is it so effective?

7. What is the traditional treatment for families experiencing behavioral problems? Is this approach effective? Why or why not?