Psychotherapy Guidebook

Learning Theory Therapy

Irving Berman

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e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

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DEFINITION

Learning Theory Therapy encompasses a wide variety of therapeutic procedures or techniques used to provide the client with learning experiences that promote desirable or adaptive ideational, behavioral, and affective (emotional) responses. The use of such procedures is based upon the assumption that a client's psychological problems are a function of maladaptive learning and are therefore modifiable by new adaptive learning experiences. Thus, psychological problems are not viewed as symptoms of some underlying intrapsychic, genetic, or biochemical disorder. Rather they are viewed as functionally related to current, antecedent, and consequent events, as well as developmentally related to prior maladaptive learning experiences.

TECHNIQUE

In the initial assessment, the therapist usually interviews the client to determine the problem(s) he wishes to change. After a problem has been identified, sufficient information is usually gathered to determine: 1) the

problem's situational context; 2) the frequency, intensity, and severity of the problem; 3) the events that precede and follow the problem's occurrence; and 4) the client's thoughts and feelings before, during, and after the problem's occurrence. The therapist will often gather additional information to determine whether the client's physiological arousal is a relevant factor, as well as whether the client has the necessary skills to perform appropriately in a problematic situation. This information is always gathered at least partially via the clinical interview, but additional methods may also be used, including various questionnaires and rating forms (Ciminero, et al., 1977). Clients are often assigned homework tasks requiring them to record one or more aspects of the above information in a diary or on self-monitoring forms that are then returned to the therapist.

The therapist then uses this information to conceptualize the problem by specifying client-specific functional relationships between the problem and current internal/ external events. A summary of the therapist's conceptualization of each problem is presented to the client, although it is always subject to modification based on additional information. When, for example, enough information is available to formulate hypotheses about etiological factors in the client's learning history that could account for the problem, this information is included in the conceptualization. During this presentation the therapist and client establish mutual agreement regarding: 1) the problem(s) to be addressed and ensuing therapeutic goals, 2) factors

currently contributing to or maintaining each problem, 3) the interaction of a client's maladaptive learning history and the development of each problem, and 4) the probable treatment procedures to be used and therapeutic rationale for their effectiveness. Mutual agreement on the goals and procedures of therapy is called a therapeutic contract and may be made in writing.

The principal techniques included in Learning Theory Therapy are classified here according to the type of clinical problems for which they are considered most appropriate: 1) skill deficits, 2) maladaptive approach responses, 3) maladaptive anxiety, stress, and avoidance responses, and 4) maladaptive self-statements, attitudes, and covert responses. See Rimm and Masters (1974) for a comprehensive discussion of the evaluative research and clinical application of these and other techniques.

1. **Skill deficits.** Clients frequently do not possess the behavioral capabilities (skills) to perform adequately in certain situations. A skill deficit, therefore, may be one factor contributing to the problem when the client frequently avoids certain situations and/or performs poorly in them. Common examples of such problems include: deficient interpersonal, heterosexual, assertive, or parenting skills. The principles applied to these problems are derived from operant conditioning (Williams, 1973).

   After a treatment contract has been established, the

therapist performs a task analysis of the target skill in which the desired target responses are conceptually broken down into their prerequisite subskills. The most basic subskills are taught first because this type of therapy approaches deficits by teaching (shaping) the desired complex set of responses in gradual steps (successive approximations) toward the eventual goal (target).

The specific therapeutic procedures used to teach a given skill include: 1) bibliotherapy — the client reading about how to perform a certain skill, 2) verbal instruction by the therapist, 3) modeling — demonstrations of the skill by the therapist, assistants, or via film, 4) prompting/fading — therapist cueing the desired response and gradually decreasing the cues, 5) role playing, role reversal, and behavioral rehearsal with feedback — acting out of relevant interpersonal interactions by client and therapist, with verbal praise and corrective suggestions by the therapist, and 6) homework — assigning the client increasingly complex homework tasks to perform in the natural environment. Therapist praise, encouragement, and corrective suggestions follow the client's performance report in each session. Homework of this nature is almost always used by Learning-Theory therapists in the treatment of all four major types of clinical problems.

2. **Maladaptive approach responses.** Approach responses may be maladaptive because: 1) they are inappropriate in their frequency, duration, or intensity or 2) they are directed toward inappropriate target objects, usually sexual in

nature. Examples of 1) include excessive food, alcohol, drug, and cigarette consumption. An example of 2) is sexual responses directed toward target objects that the client and/or "significant others" (people close to the client) consider to be inappropriate or undesirable, as in cross-dressing (transvestism). The principles used to assist the client in this type of problem are derived from operant self-control (Mahoney and Thoreson, 1974) and aversive conditioning (Sandler, 1975). The problem is approached therapeutically by decreasing the likelihood of the undesirable response and increasing the likelihood of responses that are incompatible with, or antagonistic to, the undesirable response.

The principal techniques used for 1) include: self-monitoring, self-reinforcement, contingency management, covert sensitization, and aversive conditioning. These techniques should be utilized hierarchically, moving toward more aversive procedures one step at a time, if necessary. Self-monitoring requires the client to record the frequency, intensity, or duration of the problem after it has occurred. Self-reinforcement dictates that the client reward himself when he has abstained from engaging in the undesirable behavior or has engaged in behavior incompatible with the undesirable response. Contingency management calls for rewards/punishments to be administered by the therapist or a significant other, dependent upon the nonoccurrence/occurrence of the undesirable response. Covert sensitization requires the client's imaginal pairing of unpleasant or noxious scenes with the imaginal undesirable

response. Aversive conditioning calls for the application of unpleasant or noxious stimuli soon after the occurrence of the undesirable response.

The procedures used for 2) include all of those for 1) with the addition of masturbatory conditioning. This technique requires that clients pair the pleasurable sensations leading to, and resulting from, orgasm with images of appropriate sexual partners. All of these procedures, with the exception of covert sensitization/aversive conditioning, are typically administered by the client in appropriate settings in the natural environment (home, work, etc.). The therapist instructs the client in the basic technique, monitors progress, and provides individual guidance to maximize therapeutic effect.

3. Anxiety, stress, and avoidance responses. An anxiety response may be defined as subjective tension or discomfort accompanied by physiological arousal. Subjective/physiological anxiety responses are often paralleled with the client's verbal/motoric responses to avoid or escape anxiety-provoking stimuli. Maladaptive anxiety can be reactive when it is secondary to some other psychological problem; e.g., an interpersonal skills deficit. When this is the case, treatment is directed toward the more primary problem; e.g., interpersonal skills training. Anxiety can also be self-produced, when it is primarily a mediated cognitive response resulting from specific maladaptive self-statements or more general cross-situational attitude

responses. When this is the case, treatment often deals more directly with the problematic cognitions through some form of cognitive restructuring (briefly described below). Finally, anxiety can be a conditioned response to specific external antecedent stimuli. In this case, some form of desensitization therapy is indicated (Paul and Bernstein, 1973). Implosion has also been recommended, but densensitization seems to be the preferred treatment. Desensitization is historically based upon the combined principles of reciprocal inhibition and counter-conditioning (Wolpe, 1958). According to these principles, conditioned anxiety responses will be permanently weakened (counter-conditioned) if a response incompatible with anxiety, i.e., relaxation, can be made to occur while the client is in the presence of the anxiety-provoking stimuli. The temporary weakening (reciprocal inhibition) of the anxiety response by relaxation occurs during the client's graduated exposure to the negative stimuli.

4. Maladaptive self-statements, attitudes, and covert responses. Learning Theory therapists have historically focused almost exclusively on clients' overt maladaptive behavior, but increasing attention has recently been devoted to clients' maladaptive cognitions. The client's perception of events and self-statements about those events seem to be gaining increasing acceptance as potentially important targets for therapy. Because the basic assumption in this approach is that maladaptive cognitions are a function of maladaptive learning, the problem responses are subject to improved learning experiences through cognitive restructuring.

Cognitive restructuring includes techniques described by Ellis (1962), among others. Whether the problem is a specific maladaptive self-statement in a particular situation or a more general maladaptive attitude that seems to occur in a variety of situations, the initial step is to define the problem and specify the cognitive targets for change. A therapeutic rationale is often presented that explains how the client's maladaptive cognitions developed and how therapy should facilitate their change. In-session treatment often involves the therapist's challenge of the maladaptive cognition in various ways, including consideration of the negative consequences of failing to change, as well as the positive consequences of altering the maladaptive self-statement or attitude. A more adaptive cognitive alternative is then proposed and practiced in the session. Homework assignments usually require the client to record relevant cognitive activity, and require the client to engage in behavior consistent with the adaptive cognitions that are being developed.

In summary, Learning Theory Therapy requires the therapist's application of one or more treatment procedures to ameliorate the client's problems. In- and extra-session learning experiences designed by the therapist lead the client to change ideationally, behaviorally, and affectively in the direction of mutually agreed upon goals. Therapy is terminated when these goals are reached.