Clinical Behavior Therapy with Adults

ALAN S. BELLACK and MICHEL HERSEN

INTRODUCTION

The history of behavior therapy can be roughly divided into three partially overlapping phases or eras: development, scientific documentation, and dissemination. The development phase comprises the first 10 or so years, in which Wolpe, Skinner, Lazarus, Cautela, Ayllon, Azrin, and others invented an entirely new repertoire of clinical techniques: systematic desensitization, contingency management, the token economy, thought stopping, and so on (Kazdin, 1978). The second phase, which comprised 10–15 years, established the efficacy of behavioral techniques. Stimulated by a series of seminal group-comparison studies by Paul, Lang, Davison, and others and by single-case designs by Hersen, Barlow, Leitenberg, Agras, and others, a new generation of clinical scientists conducted dozens of controlled trials that documented the superiority of the behavioral approach to other psychosocial strategies and our ability to modify behavior that had previously been thought to be intractable (Bellack, Hersen, & Kazdin, 1990).

Scientific “evidence,” like beauty, is often only in the eye of the beholder. Although legions of behavior therapists were convinced of the value of the behavioral approach, the broader psychological/psychiatric community remained skeptical. Some of the reluctance to accept behavioral claims stemmed from the threat that such claims posed to traditional practices and theoretical beliefs. However, a good deal of the skepticism resulted from the well-founded contention that much of the research had questionable relevance to the clinical arena (Bellack & Hersen, 1985). As is by now well known, the creativity that led to the development of novel treatment strategies was matched by the development of innovative techniques for evaluating behavioral change and new designs for conducting outcome research. The modus operandi was the analogue study, as exemplified by the voluminous literature using college students with small-animal phobias as subjects and the Behavioral Approach Test as the primary criterion of outcome (Borkovec & Rachman, 1979; Matthews, 1978).
Curiously, in the developmental phase, early behavior therapists worked with the most severely impaired clients, such as autistic and profoundly retarded children, chronic schizophrenics, and obsessive-compulsives and phobics unresponsive to conventional treatment. But in an effort to ensure scientific rigor, behavioral scientists substantially abandoned these difficult-to-study populations for much of the subsequent documentation era. The original intent of analogue studies was to provide a parallel to the clinical arena which afforded greater ability to objectify and standardize procedures. The legacy of this approach, including manualization of treatment protocols and behavioral observation, has been a profound influence on clinical practice and treatment outcome research (Kazdin, 1991). However, for an extended period, the analogue approach became reified in the behavioral literature, and the links to clinical practice were lost. Rather than being viewed as imperfect representations of the actual clinical environment, analogue protocols were frequently perceived as being equivalent. The conclusions about psychopathology and clinical practice derived from this mistaken assumption ranged from overly optimistic to inaccurate and, occasionally, naive (e.g., diagnosis is simply an overgeneralization and is superfluous; behavioral treatment is always brief and effective; if treatment is not effective, the fault lies in a faulty functional analysis). Of course, exaggerated claims and overstatements were partially a reaction to the cynicism and criticism that emanated from the mental health establishment. For much of the first 20 years, behavior therapists were something of a voice in the wilderness, needing to shout in order to be heard.

Fortunately, the field has continued to evolve and has moved from documentation and rhetoric to the current dissemination phase. The behavioral perspective has become more clinically realistic, techniques are more sophisticated, and claims are more tempered. Behavior therapy is increasingly becoming part of the mainstream of clinical practice. It is used in more diverse settings, including the psychiatric hospital and clinic. In many leading departments of psychiatry, it is seen as a partner to pharmacotherapy—the treatment of choice for some conditions and a reasonable alternative for others. Training in behavior therapy has also become a standard component of residency training curricula. Yet, the transition from research protocol and university clinic to the psychiatric environment is not complete. There are cultural, conceptual, and procedural differences that have yet to be resolved. In addition, further education is necessary both for behavior therapists making the transition to the psychiatric setting and for their nonbehavioral colleagues. The purpose of this book is to help bridge the gap. This initial chapter is intended to highlight some of the differences and issues that must be considered in the application of behavioral techniques in the psychiatric setting. We will briefly consider the nature of the clinical environment in such settings and the implications for assessment, implementation of treatment strategies, and issues related to the use of psychoactive medication.

THE CLINICAL ENVIRONMENT

The public and private mental-health establishment in most Anglo-European countries is based on a medical tradition. Whether or not a physician is in charge, this tradition has a powerful influence on clinical and administrative practices. It is reflected in the professional language, as well as in ways of thinking about cases; for example, the use of terms such as patient (vs. client), diagnosis (vs. behavioral analysis), and medical record or chart (vs. behavioral observations). It also affects the types of information needed to communicate about cases; for example, mental status, review of coexisting physical disorders and concurrent treatment, personal and family medical history, and blood work and toxicology screen. In contrast to the case in most psychology-oriented settings, treatment cannot begin in many psychiatric settings unless the individual has recently had a complete physical examination. In many cases, records must be signed by physicians even if the information is gathered or service is provided by a non-