



The evolution of behaviour therapy and cognitive behaviour therapy



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ABSTRACT

The historical background of the development of behaviour therapy is described. It was based on the prevailing behaviourist psychology and constituted a fundamentally different approach to the causes and treatment of psychological disorders. It had a cold reception and the idea of treating the *behaviour* of neurotic and other patients was regarded as absurd. The opposition of the medical profession and psychoanalysts is explained. Parallel but different forms of behaviour therapy developed in the US and UK. The infusion of cognitive concepts and procedures generated a merger of behaviour therapy and cognitive therapy, cognitive behaviour therapy (CBT). The strengths and limitations of the early and current approaches are evaluated.

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The decision to start a journal devoted to publishing articles on the radical new developments in psychological therapy was taken after dinner on a rainy night in Professor Eysenck's house in south London in November 1962.

The new approach, behaviour therapy (BT), was a major shift away from the prevailing psychiatric treatment for psychological disorders (mainly medications and physical treatments), and fundamentally different from the psychoanalytic method.

In these circumstances it was difficult to publish clinical accounts of the new methods and associated research. The editors of medical journals were opposed to non-medical psychologists carrying out treatment and the analytic journals were closed because behaviour therapy was regarded as completely wrong and potentially harmful. The rejection letters from various journals were brief, occasionally rude and sometimes fruity.

Eysenck (1952, 1959, 1960), Eysenck and Rachman (1965) were a vigorous advocate of the new approach to therapy. In association with Dr. Joseph Wolpe, a brilliant, diffident, quietly cheerful clinical scientist, Eysenck sent proposals for a new journal to several publishers of scientific/academic journals but they were slow to respond and not interested. However, Pergamon Press had published Eysenck's important edited book on the new approach (*Behaviour Therapy and the Neuroses*, 1960), and it was felt that the owner of this rapidly expanding scientific publishing firm, Mr R. Maxwell, might be interested.

Accordingly, the full proposal was sent to Maxwell and a meeting was arranged. During a pleasant and lively dinner at Eysenck's house, politics, literature, and London were discussed. At the end of the evening as Mr. Maxwell prepared to leave, he casually said that the proposal was acceptable and he would publish the journal. "Call my assistant director Mr. Richards and he will supply you with whatever you need to start the journal."

The first issue of Behaviour Research and Therapy, with its chic acronym – BRAT – appeared in April 1963. Fifty years and 51 volumes later, the journal is widely read and has a consistently high citation index. Mr Maxwell's judgement has been vindicated.

What were these radical new developments, and what were the ideas driving them? The basic idea was that psychologists should apply the methods of behaviourism to clinical problems. Introspectionist psychology which focused on minute analyses of a person's reactions to physical stimuli, mainly auditory and visual, had nothing to offer, and the enterprise was embarrassed by failures of replication. Behaviourists rejected the discredited introspection and insisted on the need to study observable behaviour (Skinner, 1953, 1959; Watson, 1926). It was a move away from the stagnation of introspectionist psychology towards the optimism of behaviourism. As the distinguished historian E.G. Boring put it, "For a while in the 1920's it seemed as if all America had gone behaviourist" (Boring, 1950, p. 645).

Clinically-minded psychologists began to apply the behavioural ideas and techniques to abnormal behaviour. The founding Editor of Behaviour Research and Therapy, Hans-Jurgen Eysenck, stated the rationale succinctly: "Neurotic symptoms are *learned patterns of*

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behaviour which for some reason or another are unadaptive," (Eysenck, 1959, p. 62, original emphasis). Treatment should promote the extinction of the unadaptive behaviour and enhance adaptive behaviour. Eysenck's articulate advocacy of BT was a crucial element in the dissemination of the new ideas and methods (1960, 1990). He was a formidable critic and his 1952 article disputing the evidence that had been advanced in support of the claim that psychotherapy is effective, set off a storm. He asserted the need to introduce rigorous standards of evaluation, including controlled treatment trials (Eysenck, 1952). The article profoundly influenced the adoption of contemporary standards for evidence-based treatments.

Certain types of abnormal behaviour were suitable targets for the behavioural clinicians to take on. In the fifties and sixties there were many patients who suffered from agoraphobia (Mathews, Gelder and Johnston, 1981). Their unadaptive behaviour was restricted mobility which prevented them from leaving their homes, and intense fear when they attempted to do so. The clinical problem was construed as a problem of *observable behaviour*, and therefore respectable behaviourists felt free to proceed.

A behavioural treatment was developed. Patients were encouraged and assisted to engage in increasingly lengthy and prolonged therapeutic walks, and the method was reasonably effective. (The term 'agoraphobia' was not entirely appropriate because many of the affected people also experienced intense fear at home. Years later the emphasis shifted from restricted mobility to the occurrence of episodes or panic—see below).

The introduction of behavioural treatment sounds simple and it was, but at the time there was strong medical opposition to psychologists carrying out treatment. Moreover, a treatment for psychiatric patients *behaviour* seemed completely misguided and absurd. No medications, no physical treatments, no discussion of deep lying unconscious psychosexual complexes—simply modify the person's behaviour. Prominent psychoanalysts were convinced that the removal of a neurotic symptom by behaviour therapy would be followed by symptom substitution (it was not) and they were seriously worried that behaviour therapy would be harmful. However absurd the new ideas seemed to be, it became more and more difficult to ignore the accumulation of successfully treated cases; however, numerous editors and professors did manage to overcome the difficulty.

The medical opposition to psychologists was understandable. Prior to the introduction of behaviour therapy psychologists working in clinics/hospitals carried out tests of intelligence and aptitude. Diagnosis and treatment were not part of the curriculum and their clinical experience was narrow and minimal. Hence their attempts to provide therapy were opposed. They were obliged to teach themselves and they did. The gradual, discreet and sneaky expansion of clinical psychology from testing to treatment took place when the medical profession was hierarchical and dominating. Psychologists were limited to treating only those to patients referred by a physician. When case-reports of patients treated by psychologists were published they included an acknowledgement thanking the responsible psychiatrist for permission to see their patient.

Nevertheless, steady progress was made and fresh methods were developed for treating a variety of psychological disorders, particularly 'neuroses', roughly equivalent to 'anxiety disorders'. Large numbers of patients were helped and in the process a deeper understanding of fear and anxiety was achieved. Behaviour Research and Therapy played a major part in disseminating and promoting these developments.

The early attempts at behaviour therapy were followed by the development of cognitive therapy, and latterly by cognitive behaviour therapy (CBT). Behaviour therapy emerged in

independent but parallel paths in the United States and the United Kingdom during the period from 1950 to 1970. The second stage, the development of cognitive therapy, took place in the U.S. from the mid-1960s onwards. The third stage, the merging of behaviour therapy and cognitive therapy into CBT gathered momentum in the late 1980s and is now well established in Britain, North America, Australia and parts of Europe. It is the most broadly and confidently endorsed form of psychological therapy and is the mainstay of the momentous expansion of psychotherapy services in the U.K. (Rachman & Wilson, 2008). For a detailed description of the historical development from behaviour therapy to cognitive behaviour therapy see Rachman (2009).

The evolution of behaviour therapy

The origin of BT can be traced to Pavlov's fundamental work on the process of conditioning (Asratyan, 1953; Pavlov, 1955 Edition). His discovery of conditioned salivary reflexes led to many new findings and in time he established an experimental paradigm for investigating abnormal behaviour.

Pavlov proved that abnormal and lasting disruptions of behaviour can be produced by exposing animals to insoluble perceptual discriminations or to intense stress, and he mapped out the effects of these induced disturbances (Pavlov, 1955 ed., pp. 234–244). It is a curiosity that Pavlov never took the logical next step, from causation to cure. His recommendations for treating the induced neuroses and clinical conditions were conventional, not de-conditioning but drugs (especially bromides), sleep, rest, and removal to protected shelter (Asratyan, 1953; pp. 128–130).

Later researchers reasoned that if neuroses in animals can be developed through conditioning, it should be possible to de-condition them. Prominent among the pioneers of this exciting possibility were Gantt (1944), Liddell (1944), Masserman (1943), and Wolpe (1952). Pavlov's experimental model laid the basis for the scientific study of how abnormal behaviour, and fear in particular, is acquired (Mineka, 1985, 1987) and his work was used as the basis for a conditioning theory of fear acquisition (Wolpe, 1958; Wolpe & Rachman, 1960).

In 1920, Watson & Rayner published their famous case of little Albert to demonstrate how emotional responses can become conditioned in humans. A distinct fear was established in a stable 11-month-old boy by presenting him with a rat and then making a sudden loud noise behind him. After repeating this sequence a number of times the child began to display signs of fear when the rat was introduced. This reactivity persisted and then generalized to other stimuli. The significance of this demonstration of inducing a fear was over-interpreted, but the idea that human fears can be conditioned inspired the valuable research of Jones (1924) on the unlearning of children's fears. Her enterprise made therapeutic fear-reduction seem viable and directly influenced the forms of BT that were developed for children and adults some 30 years later. After testing a number of possible methods, Jones concluded that two were reliably effective in reducing the fears: direct conditioning, in which the feared object is repeatedly shown to the child at gradually increasing proximity and the child's negative reactions are dampened by associating them with pleasurable eating, and by the imitation of 'fearless' children. Remarkably, these two tactics still have merit and are used in many circumstances. The graded and gradual exposures to fear stimuli were an implicit element of her conditioning method and are a central feature of the contemporary method of exposure and response prevention (ERP). The full value of her work emerged after a dormancy of three decades and is an historical example that provides a spark of hope for clinical researchers who yearn for the recognition of our unjustly neglected flashes of insight.

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