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DOES PROBLEM BEHAVIOR JUST HAPPEN? DOES IT MATTER?

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ABSTRACT: This article questions whether it is useful to think of problem behavior as caused, and whether causal information about problem behavior is a necessary prerequisite to changing it. Psychoanalytic, behavioral, systemic, and solution-focused approaches to the issue are discussed briefly. Taking the perspective that the cause or causes of a particular client's problem behavior cannot be known, it is argued that attempts to discover them may be unnecessary, misguided, or even counterproductive. It may not even be necessary to know what the problem behavior is in order to change it.

Does Problem Behavior Just Happen? Does it Matter?

The question of how people acquire the kinds of problem behavior that bring them to therapists has always seemed important, if only because of its apparent relevance to arranging for change.

Many psychologists believe that the labeling of troubling or troublesome behavior as abnormal serves the useful purpose of singling it out from other, presumably normal, behavior. Once brought from ground into figure, called attention to, identified, categorized, and otherwise intellectually separated from the behavior stream, it can be addressed. There has been an ongoing debate (e. g., Szasz, 1961; Ullmann & Krasner, 1975) as to whether or not there are actual scientific dividends to be gained from classifying behavior based on the DSM taxonomy-by-ballot. The economic dividends are clearer: the more conditions, syndromes, and disorders that can be identified, the wider the range of behavior that may be labeled abnormal, and the greater the range of change-inducing services to be reimbursed.

Even therapists who are concerned with problem behavior, rather than the categories it is purported to represent, frequently view such behavior as abnormal and create questions for themselves such as, "How did this come about?" For example, if a young man can't stop thinking of the face of his beloved, his behavior requires no explanation; but if he can't stop thinking of her feet then a cause is sought for his "obsession" or "fetish" (Krasner & Ullmann, 1973; Ullmann & Krasner, 1975).

Over the years, a number of different answers have been proposed to the question of how problem behavior comes about. These answers have had strikingly different effects on the behavior of therapists, and, thus, on their clients, who, in

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turn, influence them through their changed behavior. Therapists who seek particular kinds of information and make related interventions implicitly communicate what they are looking for; and, as a result, they often wind up observing it. Through this circular process, therapists' beliefs about the origin of problem behavior may become self-fulfilling prophesies.

This article will briefly review, in historical sequence, some of the more important answers to the question of how people acquire problem behavior. It will then examine relevant assumptions underlying those answers and discuss implications for therapy. The current trend, away from concern with the past and toward the present and future, has been associated with briefer therapy and greater optimism about the possibilities for change. Questions about the origin of problem behavior have begun to seem beside the point, and discussion of such issues with clients often appears to be counterproductive (de Shazer, 1991, 1994).

Overdetermination, Current Maintenance, or Natural Occurrence?

Psychoanalysis

Psychoanalysis, an approach of historical significance which is still widely represented in current practice, views problem behavior as overdetermined (Cameron, 1963; Fenichel, 1945). "Symptoms" are seen as compromise formations between unconscious impulses and defense mechanisms. These, in turn, are the outcome of a process of personality development extending back to and largely completed in early childhood. Problem behavior is seen as an inextricable aspect of personality. The principle of overdetermination implies that a particular problem behavior is the only and inevitable output (or "symptom") of a given defensive structure, which perfectly balances the psychological forces giving rise to it. For this reason, the only way to bring about meaningful and enduring change in problem behavior is to change the personality of which it is a part. Since personality is complex and enduring, therapy is a long and possibly even interminable process (Freud, 1937/1963). Changing the personality of which the problem behavior is a part involves tracing the causal chain back to childhood origins.

Behavior Therapy

The behavior therapy movement offered a radical simplification and reconceptualization of problem behavior and its origins. Problem behavior, viewed as no different from other behavior, was also seen as acquired, maintained, and changed throughout life according to the same psychological principles that govern other behavior (viz., Ullmann & Krasner, 1965). Independent of how the behavior might have come about, all that was necessary to change it was to modify those elements currently maintaining it. This shift in emphasis effectively made the past irrelevant in changing problem behavior (except insofar as a discussion of matters such as its onset might give clues to current maintenance). The controlling variables for the behavior were not only the immediate discriminative and reinforcing stimuli, but also included a range of factors that were functionally related to it. The term

"behavior influence" was offered as a more useful alternative to "personality" (Krasner & Ullmann, 1973). In particular, expectancy/placebo effects were seen as especially important in the acquisition, maintenance, and change of problem behavior (Fish, 1973; Frank, 1961; Kirsch, 1990). All that was necessary to change the behavior was a knowledge of the influences currently affecting it; and, once identified, they could be modified and the behavior would change.

Systems Movement

The systems movement, with its contextual and interactional emphases, broadened the focus beyond the problem behavior of a single person to patterns of mutually reinforcing behavior among multiple individuals. Viewed from the perspective of the larger social fabric, the problem behavior could be seen as but a single element which could be changed by reorganizing the larger interactional pattern within which it was embedded.

A system consists of patterned interaction among multiple elements, so its definition is largely in the eye of the beholder. Several different and overlapping systems have been defined by systemic therapists, from varying theoretical perspectives, as useful for understanding and changing problem behavior. Some of the most prominent include the system of interactions around the problem behavior, especially involving problem-maintaining solutions (Watzlawick, Weakland, & Fisch, 1974), the system as a hierarchical organization (Haley, 1976; Minuchin, 1974), and the system as a complex, multi-generational pattern of familial interactions (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). From all of these perspectives, however, problem behavior was regarded as adventitiously acquired—selected by chance from the stream of events, magnified, and perpetuated by feedback processes within the system. While its origin may have been an historical accident, the inappropriate behavior persisted because of interactional sequences maintaining it. Rapid, discontinuous change—extending beyond the problem behavior to that of others in the interactional field—became possible by disrupting and/or reorganizing these interactional patterns (Fish, 1992). This reorganization could be accomplished by interventions aimed at the context of the problem behavior. Examples of such interventions include (a) introducing positive (deviation enhancing) feedback into the system, as by paradoxical directives to increase unwanted behavior, (b) making changes in event sequences, as by reordering who does what to whom, and (c) restructuring hierarchical relationships, as by getting parents to agree between themselves on disciplinary rules for the children. While systemic approaches addressed the organizational rather than individual level of behavior, they were similar to behavioral approaches in their focus on maintenance, rather than cause, of problem behavior. The Mental Research Institute of Palo Alto (MRI), for example, has emphasized interfering with problem-maintaining solutions (Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974). The conceptual similarity of this to changing the contingencies affecting the problem behavior has not escaped notice (e. g., Coyne & Biglan, 1984).

Solution-Focused Therapy

More recently, solution-focused therapy (de Shazer, 1988, 1991, 1994; de Shazer et al., 1986; Walter, & Peller, 1992) has grown out of the systems movement. While its advocates locate its roots in constructivism and the philosophy of language, solution-focused therapy's emphasis on clear behavioral description makes it seem as if it could equally well have sprung from the behavior therapy movement. The approach begins by denying that therapists can discover the causes of their clients' problem behavior by talking with them, since the relationship between specific reported behavior and specific events outside the consultation room is unknowable. Solution-focused therapists, in their zealous application of Occam's Razor, continue by denying the relevance of the causes of problem behavior, and even beyond eschewing interest in what is maintaining it. They argue that *knowledge of the problem behavior itself is unnecessary to change*. Clearly specifying goals (including those unrelated to the problem) and appropriate interventions are sufficient to change behavior. From this viewpoint, doing something unrelated but positive, and allowing behavior previously singled out as a problem to recede into the background, may be all that is needed. As the title of Watzlawick's book (1983) suggests, sometimes "the situation is hopeless but not serious." Solution-focused therapy argues that, rather than encouraging clients to try to resolve insoluble problems, therapists would do well to get them interested in more productive activities, the implication being that *a solution may be unrelated to the problem behavior* (de Shazer, 1991, chap. 10).

While "problem talk" leads the client to think negative thoughts and expect negative outcomes, "solution talk" encourages positive thoughts and expectancies. Solution-focused therapists propose that being "problematic" is not a quality of behavior, but rather a result of the behavior being singled out of the event stream, thought of, talked about, and otherwise addressed. Since there are exceptions to all problems (i. e., occasions when the problem doesn't occur), a focus on the exceptions instead of the problem points the way to reaching the goal. Because solution-focused therapy may be unfamiliar to behaviorists, I am including the following illustrative example:

> A couple came for therapy with the problem of the wife's nymphomania. She demanded sex nightly before going to sleep, and viewed her behavior as a problem rooted in her infancy that would require deep therapy. Her husband felt he was being robbed of the opportunity to be romantic toward her; rather than her lover, he had become just a stud. The therapist (Insoo Kim Berg) eventually suggested that, since the wife couldn't get to sleep without having sex, perhaps the problem was insomnia rather than nymphomania. The couple accepted this reordering of what was primary and secondary about the problem, and the focus of the session shifted to devising a behavioral homework assignment for overcoming the wife's insomnia. Two weeks after the session, the woman sent a note thanking the therapist and the team for seeing that her "insatiable need for sex" was but "a symptom of her insomnia."(de Shazer, 1991, pp. 63-70)

In cases such as this, where the definition of reality is ambiguous, issues of causality seem beside the point. In order for something to be caused, it must first

exist. Efforts to determine the origins of the woman's nymphomania, or to find out what was maintaining it, could have reified the problem. Similarly, the main function of the behavioral assignment was to validate a new definition of the problem behavior as insomnia.

How Useful Is the Search For Causes?

Analytically oriented therapists might look for causes as part of their effort to trace current behavior back to its childhood origins. Unfortunately, a question such as, "How did I come to act or feel this way?" and an answer, "This is how your personality was formed so as to make you act or feel this way," tend, pessimistically, to perpetuate the misplaced focus. Acceptable explanations of the inevitability of behavior, while reducing perplexity about its source, simultaneously encourage the assumption that it will continue. (This is also why unacceptable "paradoxical" explanations have been effective in leading to change [Haley, 1984].) The questions—"What do you want?" and "What can you do differently to get it?"—emphasizing the need to change behavior, point the client in a different direction. While psychoanalysts believe that insight is necessary for behavior change, one might argue that attempts to achieve insight make change more difficult—and confirm both the analyst's and the client's belief that therapy must be a long and arduous process.

When examined closely, the view that personality—or aspects of behavior that are invariant across situations—must change in order for problem behavior to change, seems to imply that change can not take place. Its usefulness as a therapeutic stance is akin to the argument that the height of a person who has stopped growing would have to change in order to affect his or her behavior. (Fortunately, the view that "personality" is invariant is open to question. At the very least, therapy—or other life experiences—can lead clients to seek out different kinds of situations in which they act in new ways. They may even happen upon transformative experiences by chance. Whether this means that they are expressing previously dormant aspects of their personality or that they have changed in a manner presumed to be impossible is open to discussion. Similarly, just how enduring "personality" would be under greatly altered environmental circumstances—such as moving to another culture for an extended period of time, or suffering through a war or other behavioral calamity—is also open to question.)

Behavior therapists have made an important contribution by emphasizing the clear description of behavior. However, their clear descriptions have tended to be more of problem behavior and the circumstances surrounding it than of the desired alternative behavior. The notion that a description of problem behavior in its situational context can suggest ways of changing it is certainly an advance over tracing the roots of the behavior back to childhood. Unfortunately, the close investigation of problem behavior can generate negative feelings and the anticipation of negative outcomes (e. g., "Tell me in detail about situations where you feel depressed."). This difficulty can be avoided by focusing on exceptions to the problem behavior. A clear description of what is going on when the client is not depressed in otherwise problem-evoking situations can prove more useful than a catalog of the

client's miseries. Similarly, a clear description of the way the client wants to act or think can be more useful than a clear description of current unwanted acts and thoughts.

The process of describing problem behavior and the circumstances surrounding it helps therapists to form an hypothesis and intervene, following which effects on the client's behavior can lead to revised hypotheses and revised interventions. In this way, behavior therapists may get the impression that it was their focusing on the problem behavior which enabled them to effect change. An alternative explanation is that it was the hypothesis testing process itself, with its self-corrective feedback mechanism, which led to change. If this is the case, then initial hypotheses might at least as fruitfully come from describing exceptions to problem behavior as from describing the behavior itself. In this way, therapy could be enhanced by the intertwined effects of both hypothesis testing and of the positive feelings and anticipation of positive outcomes associated with "solution talk."

Overdetermination in psychoanalysis is a "strong causality," which completely determines what will happen in a given instance. Overdetermination both makes it possible in principle to know how problem behavior comes about (since only one thing can happen), and makes change very difficult (because problem behavior uniquely satisfies multiple determinants). In contrast, behavioral probabilistic determination is a "weak causality," which asserts only that certain events are more likely or less likely under given circumstances. Change becomes much easier, since altered circumstances can lead to different probabilities, but the theory surrenders the possibility of asserting what leads to what in a given situation—instead of certainty, it settles for probabilities. Since behavioral theory accepts the lack of certainty about causes, one might hazard a guess that behavior therapists would be more willing than psychoanalysts to direct their professional energies away from seeking them.

In a manner similar to behavior therapists describing problem behavior and the circumstances surrounding it, systemic therapists have developed circular descriptions of problem behavior and the interactional patterns of which it is a part. (Behavioral descriptions tend to be "up close," and provide fine-grained detail of brief events involving few participants. Systemic descriptions, though varying from one approach to another, frequently are made from a greater distance and deal with general interactional patterns among multiple individuals over days, weeks, months, or even years.) These descriptions then serve as the basis for interventions aimed at disrupting and/or reorganizing the pattern. Based on the results obtained, a new hypothesis and intervention may be developed (viz., Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980); and this process is similar to the hypothesis testing and revision that behavior therapists go through. Once again, in a manner similar to that of behavior therapists, the focus remains on problem behavior rather than exceptions or solutions; and this emphasis does not encourage positive feelings and the anticipation of positive outcomes. In yet another parallel, systemic therapists might unjustifiably gain the impression that it was their focus on problem behavior which contributed to positive outcomes, when their self-correcting hypothesis testing might have been the responsible factor.

Since many systemic interventions are aimed at changing interactional sequences which appear to function homeostatically, an oppositional relationship is set up

between the therapist's pressure toward change and systemic moves toward continuity. Studies of the comparative effectiveness of different interactional strategies have shown a decided advantage for those based on cooperation (Axelrod, 1984). Hence, "paradoxical" and related strategies aimed at taking advantage of—and even encouraging—resistance pay a high price for their effectiveness, and may complicate the therapeutic relationship. Studies of paradoxical interventions suggest that the strategy of pushing problem behavior and the interactional sequences maintaining it to the point where they self-destruct and give rise to a positive alternative is an effective one (Ascher, 1989). Still, the paradoxical provocation of resistance involves more effort on the part of the therapist, and is less interpersonally comfortable, than is "cooperating" with what is already working—that is, encouraging exceptions to problem behavior and supporting the sequences maintaining them. These alternative strategies have led solution-focused therapists to write optimistically about "the death of resistance" (de Shazer, 1984). Meanwhile, the shift in focus from the context of problem behavior to the context of exceptions (or "solutions"), has made the question of the origin of problem behavior almost irrelevant.

Contrary to the language in which their ideas have been presented here, solution-focused therapists often describe their approach in ways that appear orthogonal to a scientifically based therapy. They view therapy as a conversation, and describe their interventions in terms of the thought of linguistic philosophers like Wittgenstein and Derrida (viz., de Shazer, 1991, 1994). They view themselves as unable to know whether or not clients' descriptions of their problems correspond to any objective reality outside the therapy session, and thus these therapists view change as consisting of differences in what clients say. They understand "exceptions" as differences in meaning (rather than behavior) which can be used to "deconstruct" what clients think of as problems. Nevertheless, their evolving work is clearly operationalized and lends itself to alternative descriptions such as those provided in this article. For example, exceptions to problem behavior can be viewed as low probability alternative responses, and encouraging exceptions can be seen as analogous to differential reinforcement of other (DRO) behavior. Solution-focused therapy emphasizes encouraging hope and defining explicit achievable goals, both of which are known to have positive effects on behavior. These kinds of "translations" can be seen as analogous to Dollard and Miller's translation of psychoanalytic concepts into Hullian ones (1950). Such translations allow empirically oriented therapists to make use of solution-focused contributions, both in interacting with clients and in considering theoretical questions like the origin of problem behavior, while retaining a commitment to verifiability. They also provide an invitation to researchers to investigate the substantive content of solution focused therapy, without having to adopt its philosophical stance.

Along these lines, a comparison of Steve Hayes's acceptance and commitment therapy (Hayes & Wilson, 1994; Hayes, Kohlenberg, & Melancon, 1989; Kohlenberg, Hayes, & Tsai, 1993) with solution-focused therapy suggests interesting similarities and differences in their views of what goes on in therapy. Acceptance and commitment therapy takes the stance that there is an objective, observable reality, and that client reports of events reflect it, however inadequately. Solution-focused

therapy takes the stance that the therapist cannot know whether client statements bear any relationship to events outside the session. Both Hayes and de Shazer see the relationship between words and actions as a central focus of therapeutic attention, but deal with it in quite different ways. Acceptance and commitment therapy attempts, through the encouragement of creative hopelessness, to break down the rule-governed linkage between words and actions, and views change as consisting of differences in behavior in everyday life. Solution-focused therapy views change as consisting of differences in language during the session. Thus, defining concrete goals, discussing exceptions to problems, and encouraging clients to do more of what they say already works for them are seen as "language games." These result in clients changing their way of talking from complaining about problems to expressing satisfaction with their lives. When clients say that they (a) have changed their behavior in acceptable ways, or (b) are acting the same but have changed the way they think about their problem so that it no longer bothers them, or (c) are involved in satisfactory new activities, and cease referring to their problems, these are all seen as changes in their way of talking. Meanwhile, acceptance and commitment therapists' encouragement of clients to "choose and value a direction" bears some similarity to the process in solution-focused therapy of constructing solutions. This is so especially with regard to the notion of a solution as a process rather than an end point, and to working with clients to be "on track" in a desired though perhaps open-ended direction.

It is easy to see that—even though solution-focused therapists adopt a bland, almost solipsistic stance toward events in the world outside the therapy room—empirically oriented researchers could easily satisfy themselves as to whether or not clients' reported changes reflect what the researchers consider to be real changes.

As one might imagine, there have been calls for controlled outcome studies of solution-focused therapy (e. g., Shoham, Rohrbaugh, & Patterson, in press). To date, only an uncontrolled, unpublished follow-up study exists (Kiser, 1988)—with all attendant limitations. In referring to that study, de Shazer (1989) wrote that "...our average number of sessions per case has declined from seven in 1979 to 4.5 in 1988" for the 1000 cases most recently completed at the time, and that, for 163 randomly selected cases, "Our success rate has increased from 72.1% in 1979 (clients met their goal or made significant progress) to 80.37% in 1988." (p. 232). In a subsequent reference to that study, de Shazer (1991) indicated that "When recontacted at 18 months, the success rate had increased to 86%." (p. 161).

As might be expected, such high success rates in an uncontrolled study have provoked skeptical reactions on a number of grounds (Shoham, Rohrbaugh, & Patterson, in press). At the same time, the study also suggests that further experimental investigation of solution-focused therapy is warranted.

In a sense, behavioral, systemic, and solution-focused therapists are all contextualists (Pepper, 1942; Hayes, 1988; Hayes, Hayes, & Reese, 1988) and would tend to view the question of the origin of problem behavior in a pragmatic light. Since it appears to offer little of value in changing behavior, it might be more reasonable to set it aside and pursue other more productive questions.

Is Causation A Cultural Construction?

If the question of how problem behavior comes about isn't particularly useful, then why have therapists been so concerned with it? Since therapists have begun to recognize the relevance of cross-cultural perspectives on their work (viz., Hayes & Toarmino, 1995), it is interesting to speculate about possible cultural origins of their views of causality.

Cross-cultural psychologists have observed that Western thought—especially that of the United States—implicitly understands events as being caused (Stewart & Bennett, 1991, pp. 38-39). It has even been argued that the English language, with its subject-verb-object structure, encourages a view of the world in which a single cause produces a single effect (Stewart & Bennett, 1991, pp. 51-52). This cultural predisposition may be useful for some purposes—e. g., training scientists—but may be a liability in other areas where it doesn't fit as well. "The idea of a 'natural happening' or 'occurrence' is not familiar or acceptable for Americans as it is for the Chinese and many other non-Westerners. Events do not just happen naturally; they require a cause or an agent that can be held responsible." (Stewart & Bennett, 1991, pp. 38-39). One might note in passing that, with respect to acausality, the concept of a natural happening resembles that of a free operant.

So there may be a cultural predisposition which makes it difficult for therapists to look for what is going well in the client's life and ask how they can make it increase, rather than look for what is wrong and try to find its causes.

How Might Therapists Change?

Perhaps therapists occasionally notice that they aren't searching for the cause of events.

They might ask themselves what they are doing instead.

Perhaps, even rarely or fleetingly, they occasionally think of problem behavior without wondering how it came about. Perhaps they sometimes accept their clients' problem behavior as a natural happening or occurrence, and see where they can go from there.

They might ask themselves how they do that.

And they might do it more often.

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