The behavioural approach assumes that all behaviour is learnt through conditioning (experience), it also assumes that all behaviour is learned and can therefore be unlearned and that abnormal behaviours are learned in the same way as normal behaviours.

Behaviour is learnt in three ways, association, reinforcement and learning socially. In the same way, abnormal behaviour can be learnt and the approach also assumes that it can be unlearnt in the same way it was learnt.

There are three types of conditioning:

- **Classical Conditioning** (Learning by association) – If we come across things that occur together, we can associate them to learn a new response. This conditioning can be used to understand phobias specifically.
  - Case study of Little Albert
  - Pavlov, Watson and Rayner
- **Operant Conditioning** (Learning by reinforcement) – Abnormal behaviour may be learnt if the behaviour is reinforced or rewarded in a number of ways.
  - Skinner: Rats and pigeons
- **Social learning** (learning through others) – This is where people learn by imitating and observing role-models. We are more likely to imitate behaviour if we see them get positive reinforcement – whether this is normal or abnormal behaviour. E.g. for anorexics, their role models may be beautiful celebrities who are very thin.
  - Bandura and the Bobo doll

The Behavioural approach assumes that the same laws apply to human and non-human animals. Many of the ideas surrounding the behavioural approach are tested using animals.

Behaviourists believe that we are a blank slate (tabula rasa) and we are shaped by our environment and nurture alone.

Mowrer (1960) proposed the two process model (2pm) this is where a phobia is acquired through CC and/or SL and maintained through OC (i.e. avoiding the object of the phobia acts as negative reinforcement).

Phobias are therefore very resistant to extinction (dying out) because the sufferer is constantly making reinforcing avoidant responses.

Evaluation...

-Rachman (1984) proposed the safety signal hypothesis to explain avoidant behaviours as not being motivated by a reduction in anxiety but instead related to the positive feelings associated with safe people and places - for example the agoraphobic who will leave the house with a specific person. This raises problems for the 2pm and is a plausible explanation for avoidant behaviour.

-Bounton (2007) 2pm neglects the influence of evolutionary history where avoidant responses are learned very quickly as natural defensive behaviour +the effectiveness of systematic desensitisation as a treatment for phobias lends support to the behavioural explanation of phobias.

-Not everyone in a car accident goes on to experience a phobia of cars and not everyone who has a phobia of cars was in an accident to there are clearly individual differences and this could be related to the DSM (diathesis stress model) whereby an individual has a genetic predisposition towards phobias and then an environmental experience acts as the trigger.
Developed by Wolpe (1958), this therapy works specifically on phobias and anxieties. The aim of Systematic Desensitisation (SD) is to put out the fear response and replace it with relaxation by systematically making a person more immune to their fear gradually – this is counter-conditioning (unlearning where you are taught a new association that runs counter to the original association).

The therapy is based on **reciprocal inhibition** = it is impossible to make people feel two opposite responses at once so one must disappear – fear and relaxation cannot be felt at the same time, so fear must be eliminated.

There are three steps:

1. **Relaxation Techniques** – The therapist teaches the client techniques such as controlled breathing and progressive muscle relaxation slowly so that it calms the client.
2. **Constructing a Desensitisation or Fear Hierarchy** – patient and the therapist will write up a list of scenarios involving the thing they fear most and put them in order of the amount of fear they would cause (from lowest to highest). E.g. fear of dogs: the least feared scenario would be seeing a picture of a dog, the next would be having a dog in the same room, and the most fearful would be stroking the dog.
3. **Working through the hierarchy** – Through the aid of the therapist, the client works through the scenarios whilst learning to be completely relaxed using the techniques they learnt. Once they have mastered one stage, they move on to the next.

Eventually, the client replaces the fear with the relaxation, gaining control over their phobia. Patients can use either the

- **In Vivo** (actually doing the scenarios) method or the
- **In vitro** (imagining the scenarios) method – especially for extreme phobics.

**Evaluation**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>Effective: It is extremely successful in treating simple and specific phobias. Jones (1924) used SD to effectively cure Little Peter of his phobia of white fluffy things (she didn’t call it SD as the term wasn’t created then!) McGrath estimated that it had a success rate of 75.</td>
<td>SD is ineffective in treating other abnormal behaviours apart from phobias – this means that it is not as flexible as other therapies such as CBT and Psychoanalysis which can be adapted.</td>
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<td>Time consuming - in contrast you could try flooding therapy</td>
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<td>May be blocking the outlet for underlying anxiety and so can result in symptom substitution.</td>
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<td>Appropriate: SD is quick and requires little effort on the patient’s part (as opposed to CBT and Psychoanalysis).</td>
<td>SD gives rise to some ethical issues – mainly, the patient is put under great harm and distress as their anxiety can reach extreme levels, and therefore the client needs to be monitored carefully and needs</td>
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