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Functional analytic psychotherapy: A radical behavioral approach to treatment and integration

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Abstract

Although initially many readers may react negatively to the radical behaviorism on which this paper is based, we believe that the widespread view of radical behaviorism as miscreant is a vestige of its theoretical, philosophical, and methodological positions that used to be at odds with the zeitgeist. A re-examination of these positions reveals a well-developed theory with explicitly defined concepts that are uncannily relevant in terms of current interests in contextualism, the therapeutic relationship, and integration. In this paper we will demonstrate that a radical behaviorally based approach to psychotherapy, functional analytic psychotherapy (FAP), is a comprehensive theory that helps clinicians to be open to the potential usefulness of any therapeutic viewpoint and technique. The major question we address is, "What is the rational basis for selecting the technique which is appropriate for a particular client at a particular time?" In exploring the answers to this question, we examine the theoretical foundations of FAP, describe the five major guidelines for doing FAP, and illustrate how the principles of FAP embrace and enhance concepts and techniques from therapies as diverse as psychoanalysis and cognitive therapy. FAP offers not only translation across theoretical boundaries, an essential requirement for integrative theory, but also preserves deeper meaning and clinical implications. Most importantly, FAP calls for varied therapeutic stances and techniques that no single therapeutic orientation would predict, depending on 1) what will evoke client issues, 2) whether client problems are rule-governed or contingency-shaped, and 3) what will be naturally reinforcing of client target behaviors.

Functional Analytic Psychotherapy (FAP) (Kohlenberg and Tsai, 1991), a recently developed treatment whose theoretical foundations stem from radical behaviorism (Skinner 1953, 1974), offers a timely and unique integrative approach. Undoubtedly, many readers will react negatively to the prospect of a new radical behavioral psychotherapy. The proliferation of therapeutic approaches is a recognized problem, and a therapy based on behaviorism may seem anti-integrationist and anachronistic. We believe that the widespread view of behaviorism as miscreant is a vestige of its theoretical, philosophical, and methodological positions (discussed below) that used to be at odds with the zeitgeist. Times have changed, however, and a re-examination of these positions reveals a well developed theory with explicitly defined concepts that are uncannily relevant in terms of current interests in contextualism and the therapeutic relationship. FAP is a logical extension of one of modern psychology's earliest theories, and exemplifies a recent trend of behavior therapists returning to their roots (Jacobson, 1991) and developing radically behaviorally informed treatments (Jacobson, 1992; Kohlenberg, Hayes, & Tsai, 1993; Hayes, 1987).

Psychotherapy integrationists generally emphasize openness to other schools and techniques (Norcross & Newman, 1992; Goldfried & Newman, 1992), and integrationism is differentiated from eclecticism in that the former provides "some coherent framework for predicting and understanding change and for determining choices of therapy procedures" (Arkowitz, 1992, p. 263). In this paper we will demonstrate that FAP is a comprehensive, well-established, laboratory data-informed theory that helps clinicians to be open to the potential usefulness of any therapeutic viewpoint and technique. The major underlying theme for this paper is the question, "What is the rational basis for selecting the technique which is appropriate for a particular client at a particular time?"

In exploring the answers to that question, we will first lay the groundwork by examining the theoretical foundations of FAP, then we will describe the five major guidelines for conducting FAP, and finally we will illustrate how the principles of FAP embrace and enhance concepts and techniques from therapies as diverse as psychoanalysis and cognitive therapy.

The Theoretical Foundations of FAP

The theory upon which FAP is built is deceptively simple--you and I and our clients act the way we do because of the contingencies of reinforcement we have experienced in past relationships[1]. Based on this theory, it follows that clinical improvements, healing, or psychotherapeutic change, all of which are certain acts of the client, also involve contingencies of reinforcement that occur in the relationship between the client and therapist. Important therapeutic implications, to be discussed below, follow from the combination of this theory of change and behavioral definitions of "act" and "contingency." We complete this section on theory with discussions of context, rule governance, and functional similarity, all of which provide guidance for FAP as an integrative approach.

Acts

Most people see radical behaviorism as a narrow theory, one that deals only with overt behavior, not thoughts or feelings. With an understanding of what an act or behavior is, it's possible to see how radical behaviorism deals with the same phenomena of interest that are considered to be non-behavior by others. Specifically, acts, also known as behavior, are anything a person does. This includes private, beneath the skin acts as well as public acts. Examples include talking, thinking, feeling, seeing, hearing, experiencing and knowing. Every aspect of being human is included is this definition, as long as it is expressed as a verb. Thus, instead of "memory", people "remember." Instead of having values, people value. Since behaviorism is a theory of behavior change, if mental entities of interest can be specified as a verb, an action, or a process, it is much clearer what needs to be focused on in therapy. For example, instead of having low self-esteem, people think, believe, attribute, feel, and act in other ways that are labeled low self-esteem by themselves and others. Instead of having problems of the self, people have difficulty with the experiencing or sensing of an abiding awareness. Schafer (1976) has called for and demonstrated the feasibility a similar translation of psychoanalytic structures into processes. Translating nouns into verbs also facilitates the possibility of a common language across different therapeutic systems, as discussed later.

Consider, for example, cognition, which is defined as the activity of thinking, planning, believing and/or categorizing. Cognitions, although covert, are nevertheless nothing more or less than acts, and are cut from the same cloth as any other behavior. This casts the often made distinction between thoughts, feelings and behavior and the primacy of the "cognition--behavior" relationship in a new light--the relationship between these two becomes a behavior 1 (cognition)--behavior 2 (external or emotional) relationship, e.g., a sequence of two behaviors. This in turn raises two questions. First, where do these behaviors come from (e.g., how can we account for the differing beliefs, attitudes, and cognitions of individuals)? Second, and perhaps more importantly, how, why and when does cognition (behavior 1) affect subsequent behavior (behavior 2)? Given this formulation, the degree of control exerted by thinking over behavior is on a continuum. Some clients' subsequent actions (behavior 2) are greatly influenced by the prior cognition (behavior 1). Other clients may have the same cognition but are not appreciably influenced by it, e.g., they might say "I truly believe that I do not have to be perfect but I still feel like I have to be." In the former case, cognitive therapy would be maximally effective and, in the latter case it would be less so. In order to account for individual differences in cognition and provide a framework for deciding when to use cognitive therapy, the radical behaviorist ultimately turns to the deeper, more fundamental, and yes, unconscious motivations that are best viewed as the result of past contingencies. This behavioral approach to enhancing cognitive therapy is discussed in more detail later.

Contingencies of reinforcement

Unfortunately, saying "good" or offering a reward to a client for doing what you want are the typical images that come to mind when the term "reinforcement" is mentioned. We say "unfortunately" because

these images are not only technically erroneous but inappropriately focus on superficial aspects of reinforcement. We use the term "reinforcement" in its technical, generic sense, referring to all consequences or contingencies that affect (increase or decrease) the strength of behavior. Even though the conscious experience of pleasure often accompanies contingencies involving positive reinforcement, it is not a necessary part of the shaping and strengthening process and should not be confused with it.

Reinforcement is ubiquitous in our daily lives and in psychotherapy--it almost always occurs naturally and is rarely the result of someone "trying" to reinforce another. The strengthening occurs at an unconscious level--that is, awareness or feelings are not required. In radical behavioral theory, reinforcement is the ultimate cause of our actions. However, it may be sufficient or useful at times to view our client's problems as resulting from more proximal influences (causes) such as the current environment, thoughts, and emotions.

There is an important implication of the radical behavioral distinction between higher level influences (the client's present environment, feeling, and or thinking) and the ultimate fundamental cause--reinforcement. Complete radical behavioral explanations require one to go back into the past and necessarily involve reinforcement history. For example, a client may say he yelled at his spouse because he was angry. As a behavioral explanation however, it is incomplete, requiring information about the past contingencies[3] which account for 1) the getting angry, and 2) the yelling. That is, not every spouse gets angry under those circumstances, nor even if angry, do all spouses yell. A complete explanation addresses these issues in addition to the internal states and current situation.

The implications of contingencies for the practice of psychotherapy are based on the interrelated concepts of within-session contingencies, contingency-shaped behavior, natural reinforcement and shaping. Each will be discussed along with its integrationist implications.

Within-Session Contingencies. A well known aspect of reinforcement is that the closer in time and place the behavior is to its consequences, the greater will be the effect of those consequences. It follows, then, that treatment effects will be stronger if clients' problem behaviors and improvements occur during the session, where they are closest in time and place to the available reinforcement. For example, if a female client states that she has difficulty trusting others, the therapy will be much more powerful if her distrust actually manifests itself in the therapeutic relationship where it is reacted to immediately by the therapist as opposed to talking about such incidents that occurred in between sessions. Thus, from this viewpoint, significant therapeutic change results from the contingencies that occur during the therapy session within the client-therapist relationship.

Natural Reinforcement. We have emphasized the importance of contingencies of reinforcement in the change process. Many misconceptions exist, however, about the nature of the contingencies of reinforcement and how they enter into in the change process in adult outpatient treatment. The distinction between natural and contrived reinforcement is especially important (Ferster, 1967a; Skinner, 1982). Natural reinforcers are typical and reliable in the natural environment, whereas contrived ones generally are not. For example, giving a child candy for putting on his coat is contrived, whereas being chilled for being coatless is natural. Similarly, fining a client a nickel for not making eye contact is contrived, while the spontaneous wandering of the therapist's attention when the client is looking away is natural.

Contrived reinforcers can be highly effective in treating clients who are restricted in movement and/or who live in controllable environments such as schools, hospitals, or prisons. In these settings, contrived reinforcers can be used consistently and not just in a brief therapeutic interaction. Contrived reinforcement can fall short, however, when the changed behavior is expected to generalize into daily life. Consider, for example, a client for whom expressing anger is a problem. Let's say the client actually expresses anger during the therapy session about the therapist's inflexibility regarding payment terms. A therapist who then smiles and says "I'm glad you expressed your anger toward me" is probably delivering contrived reinforcement. Such a consequence is unlikely to occur in the natural environment, and clients who learn to express anger be-

cause it was followed by a smile would not be prepared to appropriately express anger during daily life. A natural reinforcer probably would have consisted of the therapist taking the client seriously, discussing and perhaps altering the payment policy. Any changes produced by these consequences would be more likely to carry over into daily life.

Unfortunately, the deliberate use of natural reinforcers can become contrived or "phony" and lose its effectiveness (Ferster, 1972). This problem was alluded to by Wachtel (1977) who observed that behavior therapists were often overly exuberant in their use of praise, thereby diminishing its effectiveness. Furthermore, deliberate use of consequences can be viewed as manipulative or aversive by clients, and induce efforts to reduce or alter therapeutic change efforts--what Skinner (1953) would call "countercontrol."

The use of reinforcement in psychotherapy thus presents a major dilemma. On the one hand, natural reinforcement that is contingent on the goal behavior is a primary change agent available in the therapeutic situation. On the other hand, if the therapist attempts to purposely "use" the extant natural reinforcers, they may lose their effectiveness, induce countercontrol, and in the process, produce a manipulative treatment.

The dilemma is obviated, however, when the therapy is structured so that the genuine reactions of the therapist to client behavior naturally reinforce improvements as they happen. More specifically, because the dominant aspect of psychotherapy is interactional, the immediate natural reinforcement of client improvements is most likely when the client-therapist relationship naturally evokes the client's presenting problems. For example, an intense and emotional therapist-client relationship may evoke withdrawal in a client seeking help for intimacy problems. If so, the necessary precondition has been met, and a sensitive and genuine therapist may naturally reinforce improvements as they occur.

Shaping. The concept of shaping implies that there is a large response class of client behaviors for the therapist to reinforce. Shaping is contextual in that it takes into account a client's learning history and the behaviors present and absent from the client's repertoire. The same behavior may be considered to be a problem for one client but an improvement for another one. For instance, let's take a male client who pounds on his armrest and yells at the therapist, "You just don't understand me!" If this behavior came from a client who came into therapy unable to express his feelings, it would constitute an improvement and the therapist's openness to this outburst would be important. If however, outbursts like this were typical, the therapist may want to suggest an alternative way to express feelings of displeasure that did not involve aggressive physical demonstrations.

Context

Perceiving, like all other behavior, is shaped by contingencies--the individual's experiences from birth to the present. Thus, reality, and even the notion of reality, reflects experiential histories. Therefore, radical behaviorism is at its core a contextual theory that questions the existence of a fixed, knowable reality and instead adopts pragmatism (Hayes, S. C., Hayes, L. J., & Reese, 1988). In this contextualistic approach to understanding people, a client's reinforcement history, surrounding environment and circumstances help to give a total picture of the meaning of a particular behavior. If you take something out of this context, it becomes meaningless.

The conception of psychopathology is non-contextual; thus, any therapy that specifies what is pathological behavior in advance probably can be enhanced by taking context into account. The same behavior exhibited by two people, as discussed in the above section on shaping, could be considered a problem or an improvement depending on knowledge of the context in which the behavior occurred. For example, arriving late to a session would be considered maladaptive for an avoidant person, but for an obsessive compulsive person, such tardiness would constitute an improvement.

The radical behavioral view of language (Skinner, 1957) and hence, the verbal interchange during psychotherapy is also contextual. Thus, the psychoanalyst's attribution of symbolic, metaphorical, and latent meaning to client statements are embraced by radical behaviorists. For example, Kohlenberg and Tsai (1993) discussed the functional analysis of a client who began a session by complaining about a speeding ticket she received during the week. This

analysis resulted in an exploration of the client's issues about owing the therapist money, an important client-therapist interaction.

Contextualism yields the notion that any intervention from any therapy could be effective under the right context. In this integrative stance of FAP, no technique can be rejected off-hand as an intervention with value. On the other hand, the same notion suggests an intervention valuable under one set of circumstances will be inappropriate under others.

The contextual nature of radical behaviorism also has led to alternative methodologies for the establishment of facts and the definition of data. It is of interest to note that Skinner (1953) viewed experimentation as only one source of material relevant to a functional analysis. He also mentioned casual observations, controlled field observations, clinical observations. Examples of alternative approaches to data collection are Ferster's functional analysis of depression (1973) and most of Skinner's publications, including his functional analysis of language--Verbal Behavior (1957). In this tradition, Willard Day (1969) has elaborated on the compatibility of phenomenology and radical behaviorism (also see Leigland, 1992). Dougher (1989) applied Day's approach and concluded that it offered promise as an empirical epistemology for the analysis of verbal behavior in therapeutic contexts. Cordova and Koerner (1993) show how a radical behavioral approach to psychotherapy data leads to consideration of the contextual nature of truth.

Rule-Governed and Contingency-Shaped Behavior

Thus far we have emphasized the central role of contingencies of reinforcement. Acts that have been directly strengthened by reinforcement are called contingency-shaped. Much of what we do, however, is rule-governed rather than contingency-shaped. Rules are verbal statements that describe contingencies (Skinner, 1966; Zettle & Hayes, 1982). The classroom instructions given in driver's education are rules that describe what happens when you press down on the brake pedal. When driver's ed students first drive, they are mainly doing rule-governed behavior and may even be repeating the rules to themselves (self talk is a frequently occurring although not a necessary feature of rule-governed behavior) as they drive. In time of course, the natural contingencies take over and the driving of an experienced driver becomes contingency-shaped and is no longer rule-governed.

In the same way that a parent's statement, "You have to do your homework or you can't go out to play" is a rule for the child, a theory of psychotherapy offers similar "if you do this then that will happen" promises to the psychotherapist. That is, the theory says, "if you classify clinical problems according to the theory and then act according to its prescriptions, then the client will get better." Thus, laws, logical principles, instruction and treatment manuals, injunctions, maxims, and threats are rules. The behavior that occurs as a result of the rule being issued is referred to as rule-governed behavior. Therapeutic interventions are rule-governed to the extent that a therapist's acts are guided by the theory. There is no guarantee, of course, that a rule of therapy will be followed. Therapists may act on intuition or on the unconscious effects of past experience rather than doing what the theory or supervisors say they should. As elaborated later, the distinction between consciously following a treatment and being intuitive is the same as the distinction between contingency-shaped and rule-governed behavior. "Rule following" is an act and will vary in strength from person to person and from situation to situation depending on history. Self rules are similarly more or less effective depending on the individual's experiences with "doing what you think you should" or "doing what you tell yourself to do." Rules have much in common with cognition and add to cognitive theory by suggesting that some clinical problems are "rule-governed" and may be particularly well suited for cognitive treatment, whereas other problems are not well suited because they are contingency-shaped.

Rule-governed behavior is important. Rules are extracted from one's own or others' direct experience of the contingencies of reinforcement or from the study of systems that arrange them. The development of the acts of "rule-extracting" and rule-governed behavior becomes a large part of what we do because it helps to shorten the tedious process of shaping.

From a therapeutic standpoint, it is important to note that appearance alone does not reveal whether a client's problem is rule-governed or contingency-shaped. For example, a poker player who figures out the odds to himself before making a play might make the same decisions as another player who has been shaped by contingencies, but their controlling variables are fundamentally different. One player is thinking about what to do before doing it and is highly influenced by this thinking; the other is probably relying on feeling or intuition, which is the experiential aspect of previous reinforcement history.

The Evocative Environment--Functional Similarity

Although it may appear that therapy sessions do not resemble the natural milieu, the occurrence of daily life problems in the session is evidence for its functional similarity to daily life. That is, rather than looking at physical characteristics in order to determine if therapy and daily life environments are similar, the environments are compared on the basis of the behavior they evoke. If they evoke the same behavior, then they are functionally similar. From a behavioral viewpoint, all similarities are functional in nature and reflect the history of the individual who experiences the similarity. Thus, the client who acts toward the therapist in the same problematic way as with others is experiencing the therapy in the same way that daily life is experienced. For example, a man whose presenting problem is hostility in close relationships would show that the therapy context is functionally similar to his daily environment if he becomes hostile toward the therapist as their relationship develops. Further, if the client experiences within-session contingencies that strengthens non-hostile ways to relate to his therapist, the same functional similarity would mediate generalization of improvements to daily life. Generalization would be impeded, however, if the therapy environment were functionally different from real life and gains made in treatment were confined to the therapist-client relationship. FAP attempts to deal with this problem in at least two ways. First, the emphasis on natural reinforcement requires, by definition, that the therapist represent the daily life community as measured by generalization outside of the client-therapist relationship. Second, it is recommended that interpretations (see Rule 5 below) involve comparisons between behavior in the session and in daily life.

The notion of functional similarity points to the possibility that a client's daily life dysfunctional cognitions and maladaptive patterns of behavior that are the focus of traditional cognitive/behavioral treatment could be changed in the context of the client-therapist relationship and generalize to daily life. With certain notable exceptions (Goldfried, 1982; Linehan, 1993: Safran, 1990a, 1990b), however, cognitive/behavior therapists traditionally have not attended to the therapeutic relationship. FAP provides a theoretical rational for enhancing and integrating traditional cognitive/behavioral with interpersonal treatment. Functional similarity is also central to the FAP focus on emotional expression. Since many client problems are closely associated with emotional expression (or its suppression), the therapeutic environment must evoke these emotions if it is functionally similar. The integration into FAP of systems focusing on affect is based on this concept.

The Clinical Application of FAP

Derived from the above radical behavioral constructs, the five strategic rules or guidelines of therapeutic technique for conducting FAP are: 1) Watch for clinically relevant behaviors (CRBs); 2) Evoke CRBs; 3) Reinforce improvements; 4) Observe the potentially reinforcing effects of therapist behavior in relation to client CRBs; and 5) Give interpretations of variables that affect client CRB. Each rule is described in turn below.

Rule 1: Watch for Clinically Relevant Behavior (CRB)

The core guideline for doing FAP is that a therapist should watch for clinically relevant behavior (CRB): In-session instances of the client's daily life problematic behavior (CRB1) and improvements (CRB2). FAP CRBs are similar to Linehan's (1993) target relevant behavior.

Much of what clients complain about in outside relationships have in-session representations with their therapists. Examples of CRB1s include: (1) A woman whose problem is that she has no friends exhibits these behaviors in session: Avoids eye contact, answers questions by talking at length in an unfocused and tangential manner, has one "crisis" after another and demands to be taken care of, gets angry at the therapist for

not having all the answers, and frequently complains that the world "shits" on her and that she gets an unfair deal, (2) A man whose main problem is that he avoids getting into love relationships always decides ahead of time what he is going to talk about during the therapy hour, watches the clock during the session so he can end precisely on time, states that he can only come to therapy every other week because of tight finances (he makes a relatively large income), and cancels the next session after making an important self-disclosure. CRB1's can also involve thinking[2], perceiving, feeling, seeing, and remembering that occur during the session. For example, problems known as "disturbances of the self," such as "not knowing who the real me is" and multiple personality disorder, can be translated into behavioral terms (e.g., problems with stimulus control of the response "I") and conceptualized as CRB1 (see Kohlenberg & Tsai, 1991, chap. 6, for a detailed discussion on how such disturbances are acquired and treated).

CRB2s, or client improvements that occur in session, typically are not observed or are of low strength in the early stages of treatment. For example, consider a male client who withdraws and feels worthless when "people don't pay attention" to him during conversations. This client may show similar withdrawal when interrupted by his therapist. Possible CRB2s for this situation include: a) being assertive and directing the therapist back to what the client was saying, or b) discerning the therapist's waning interest in what was being said before the therapist actually interrupted.

Given that contingencies are the primary means of change in FAP, it might appear inconsistent that there is no mention of contingencies or reinforcement in Rule 1. Instead, this guideline merely calls for "watching," on the part of the behavior therapist, a private behavior. The suggestion to watch for CRB has far reaching implications and is much more difficult to implement than it might appear. We contend that "watching for CRB" will raise the therapist's awareness level of CRB and automatically lead him/her to naturally reinforce improvements as they occur. Further, we argue that therapists who are unaware of CRB, that is do not follow Rule 1, might inadvertently block therapeutic gains and punish client improvements. For example, consider Betty, who was in treatment with the first author for speech anxiety, panic, and lack of assertiveness with male authorities at her work place. Her assertiveness problems were even greater if she had an ongoing relationship with the male authority. During the session, she asked Dr. Kohlenberg to call her physician and ask for a refill of her tranquilizer prescription because her doctor was resistant and she didn't want to confront him. Dr. Kohlenberg had several strong covert negative reactions: he was inclined to discourage medication use in favor of behavioral methods; getting a prescription refilled was Betty's responsibility, not his, and it was a chance for Betty to practice being assertive with her doctor; calling her physician was an intrusion on his time. On the other hand, because of Rule 1, he was aware that this request itself was a CRB2, a clear-cut within-session assertive response with a male authority that previously was absent from Betty's repertoire. Given his awareness, he consented to call her doctor and complimented Betty on her forthrightness in making this request. In a subsequent session, Betty described the considerable fear she had to overcome before making the request. She felt that interaction was a turning point in her willingness to assert herself with Dr. Kohlenberg, and most importantly, with other authority figures in her daily life. In contrast to this good outcome, a lack of awareness on the part of Dr. Kohlenberg that a CRB2 was occurring at the time she made the request could have led to an inadvertent punishment of her assertive behavior by his refusal to call her physician.

From a theoretical viewpoint, the importance of Rule 1 cannot be overemphasized since it alone should promote a positive outcome. In other words, a therapist who is skilled at observing instances of clinically relevant behavior as they occur is also more likely to naturally reinforce, punish, and extinguish client behaviors in ways that foster the development of behavior useful in daily life. Any technique which helps the therapist in the detection of CRB1 has a place in FAP. For example, as pointed out in our earlier discussion of context, FAP therapists interpret latent content of what the client says as a means to detect CRB although these interpretations are based on

the principles of verbal behavior and not on unconscious drives (Kohlenberg & Tsai, 1993).

Rule 2: Evoke CRBs

Ideally, therapy should evoke CRB1s and provide for the development of CRB2s. The degree to which this ideal is met depends, of course, on the nature of the client's daily life problems. Couples therapy easily provides such an ideal environment because the interactions between the spouses occur right in the session (as opposed to a partner working on marital issues in individual therapy who is able only to talk about the problems rather than to demonstrate them). Even for clients working on relationship issues in individual therapy, CRBs occur without the therapist having to take special measures. This happens because the typical structure of the therapy relationship involves contradictory elements such as the encouragement of trust, closeness and open expression of feelings versus a time limit of 50 minutes, a fee for service and clear boundaries. Such a structure often evokes clients' conflicts and difficulties in forming and sustaining intimate relationships.

Of course, a therapist can aid in evoking CRBs by focusing on the client's present moment feelings and relationship issues between the client and the therapist (see Kohlenberg and Tsai, 1991, chap. 3, for a more complete discussion of the behavioral principles underlying the relevance of "here and now" stimulus control to the evocation of CRB). The beginning, middle and termination phases of therapy each provide stimuli which often evoke different types of CRBs.

Rule 3: Reinforce CRB2s

Given the contrived versus natural reinforcement issues, it is generally advisable to avoid procedures that attempt to specify the form of therapist reaction in advance. Such specification can happen whenever one attempts to conjure up a reinforcing reaction (e.g., phrases such as "that's terrific" or "great") without relating it to the specific client-therapist history. These specific forms of response can be contrived because they were thought of outside the context of the client-therapist environment at the moment of reinforcer delivery.

The ways that therapists can be more naturally reinforcing are examined in detail by Kohlenberg and Tsai (1991). One such way is for therapists to observe their spontaneous private reactions to client behavior and to describe these private reactions. Such private reactions are accompanied by dispositions to act in ways that are naturally reinforcing.

To illustrate, consider a client who has intimacy concerns and lacks friends. Suppose that at some point in therapy this client behaves in a way that evokes the following private, spontaneous reactions in the therapist: 1) dispositions to act in intimate and caring ways, and 2) private reactions that correspond to "feeling close." Because these responses probably are not apparent to the client, the therapist could describe the private reactions by saying, "I feel especially close to you right now." Without such amplification, these important basic reactions would have little or no reinforcing effects on the client's behavior that evoked them (CRB2).

Rule 4: Observe the potentially reinforcing effects of therapist behavior in relation to client CRBs.

Rule 4 is directly derived from behavior analytic principles that stress the importance of the effects of the consequences of behavior on the future probabilities of that behavior. If therapists have been emitting behavior that they think is reinforcing, it would be important for them to actually observe whether they are in fact increasing, decreasing, or having no effect on a particular client behavior. Therapists' behavior and the focus of therapy can vary along many dimensions: a) structured versus unstructured, b) emotion-eliciting or cathartic vs. emotion containing or cognitive restructuring, c) changing behavior vs. attaining insight, d) warm and self-disclosing vs. distant and relatively silent, e) active and directive vs. passive, f) past vs. present, g) presenting problems vs. latent factors, h) conscious vs. unconscious. Ideally, by understanding a particular client's CRB1s and 2s, a therapist should be able to shift his/her behavior and focus to match the needs of the client. For example, a passive and distant stance may work well at the beginning of therapy with a client who is afraid of intimacy, because such a stance would not overwhelm the client by eliciting too much avoidance. If the therapist is not able to shift into a warmer way of interacting, however, then

the client's CRB1s won't be evoked, and no opportunities for learning intimacy behaviors (CRB2s) will be provided. Conversely, in a "co-dependent" client with little sense of self, starting out warmly and actively will allay the client's anxieties, but a shift needs to be made to a more passive stance so that the client can develop private control over thoughts and feelings. In all cases, observing the impact of one's behavior on a client increases the likelihood that we will act in ways that are naturally reinforcing to the client.

The therapist's observation of the reinforcing effects of his or her reactions on the client's behavior can help in giving interpretations (Rule 5) and in developing similar behaviors in the client. The most obvious way this occurs is when the therapist tells the client about the self-observation. For example, Dr. Kohlenberg noticed that he inadvertently had been punishing his client's talking about her spiritual beliefs. Once noticed, he offered the following interpretation: "I've noticed that each time you started talking about your spiritual beliefs I've changed the topic and you no longer bring it up." Thus, the therapist models making a statement of a functional relationship for the client.

Rule 4 can also lead the therapist to search for ways of enhancing the effects of reactions that could be reinforcing of CRB but that are not noticed by the client. For example, consider a male client who has had trouble expressing feelings because of a history of being ridiculed or criticized when he did so. He did not increase these behaviors even though his therapist listened intently with empathic facial reactions and softly spoken comments each time the client expressed a feeling. Inquiries led to the discovery that the therapist's reactions were not discerned by the client because the act of expressing feelings evoked such intense emotions (collateral private respondents) that outside stimulation was not noticed. After the therapist amplified the empathic reaction by speaking loudly and clearly, the client's rate of feeling expression appeared to increase.

Rule 5: Give interpretations of variables that affect client behavior

As a general strategy, the therapist can interpret client behavior in terms of learning histories and functional relationships. Giving interpretations or reasons for behavior can affect the client in two ways.

First, the reason can lead to a prescription, instruction, or rule. The interpretation, "You are acting towards your wife like you did toward your mother" can easily be taken as a prescription or rule that the client hears as, "Don't be so unfair to your wife; treat her differently since she obviously is not your mother. And if you treat her fairly, your marital relationship will improve." Second, a reason can enhance the salience of (increase contact with) controlling variables and increase positive and negative reinforcement density (Ferster, 1979). For example, a female client learns during FAP that the reason she feels rejected at times during the session is a function of the therapist's lack of attentiveness and, further, this lack of attentiveness is related to how harried or rushed the therapist appears at the beginning of the session. This interpretation could increase the client's noticing the therapist's mood at the beginning of the session and significantly affect the client's experience of a lapse in the therapist's attention. As a result, the client is in better contact (she notices how harried the therapist is), and then experiences less aversiveness when he is inattentive.

It should be pointed out that Rule 5 is based on the general idea that an interpretation is simply a verbal behavior and does not carry any special truthfulness. The reasons or explanations for problems that we teach our client to give are good only to the extent that they are useful. The rationale that we presented for teaching clients to give accounts of themselves in terms of history and functional relationships is that it is useful. This FAP approach to interpretation is integrative in that it has much in common with hermeneutics (Messer, Sass, & Woolfolk, 1988).

Embracing and Enhancing Other Systems of Psychotherapy

We will now explore how important concepts and therapeutic methods from other theories can be integrated into FAP in a theoretically coherent manner. As contextualists, we agree with Messer (1992) that when you change the context, you change the meaning, thus it is impossible to retain all of the original meaning when a concept is transported into another system. Our behavioral orientation requires that we change

the ontological status of many imported notions. That is, the action requirement will result in changing "things" to "processes." Even with these changes, however, we believe that we can capture the intent, essence and clinical implications of the original concept because the behavioral common language is based on preserving context. In other words, in embracing a concept, we translate it into behavioral language while at the same time trying to preserve its deeper meaning and clinical implications. In enhancing a concept or method, we place it into a larger context by viewing it with a wide angle lens, and we discuss refinements and differences added by a behavioral analysis. Most importantly, we provide a theoretical coherence for understanding why a particular technique is helpful, and when it should be used with a client. Due to space limitations, we chose to examine central concepts only from two of the most dominant modes of therapy today--transference from psychoanalytically-oriented therapy and cognition from cognitive therapy.

The Psychoanalytic Concept of Transference

The centrality of transference within psychoanalytic treatment parallels the significance given to rule 1 in FAP; in fact, Rule 1--"watch for CRBs" might be loosely translated as "watch for transference." FAP's contribution to this topic is derived from its view that transference phenomena are one part of the larger set consisting of all behavior that occurs within-session. From this perspective, not all within-session behaviors are CRBs, and of those that are, context must be taken into account to decide whether they are CRB1's (problems) or CRB2s (improvements). This larger picture of within-session behavior incorporates the essence of what is clinically useful about transference and yet adds to its utility by pointing out some theoretical and clinical limitations of this psychodynamic concept. Since psychoanalysis is a complex, diverse, and changing system, the meaning of transference is quite variable depending on which definition is used. Thus, our analysis applies only to the meanings specified below.

The concept of transference is imbued with a variety of characteristics in addition to the generalization of responses to important persons. Alexander and French (1946) defined transference as "any neurotic repetition of...stereotyped, unsuitable, behavior based on the patient's past" which is differentiated from "normal reactions to the therapist and therapeutic situation as reality" (pp. 72-73). Our previously stated view is that interpreting the abnormality of behavior independent of its context is almost impossible. Correspondingly, the terms neurotic, stereotyped, and unsuitable all require arbitrary judgments--whether acknowledged by the therapist or not. For example, it is obvious that not all "stereotyped" behavior is transference (abnormal). The client might "stereotypically" say hello at the beginning of each session and a therapist is unlikely to judge this as transference. Similarly, the therapist must provide a context from which to judge the unsuitability of a behavior. It is possible, for instance, that a therapist could have unconscious sexist values that lead to regarding a female client's desire to pursue a career as neurotic or unsuitable.

From a FAP viewpoint, including abnormality criteria in the definition of transference creates mixed clinical effects. Such a definition could serve as a rule that leads the therapist to notice those problematic, within-session behaviors specified in the definition, and this could have positive effects if a client's daily life problems happen to be included. On the negative side, relevant behavior not included in the definition might be missed.

Even if a CRB is noticed, a more serious problem concerns such a rule's impact on the reinforcing and punishing effects of the therapist's response to the CRB. Recall the assumption that a therapist who is vigilant for and aware of the client's CRB1s will naturally encourage and reinforce improved behavior. At times, viewing a client's response as transference would interfere with the reinforcement of improved behavior. For example, if a client historically has been compulsive in his daily life, then his repeatedly verifying appointment times could be appropriately classified as neurotic according to the definition of transference. If, however, the client historically has been remiss about keeping appointments, making schedules, and keeping track of time, then concern about appointment times would be an improvement. In this latter case, the therapist, who is guided by a fixed, noncontextual view of what is unhealthy, might offer an interpretation that inadvertently punishes

the improved behavior. Because formal definitions of abnormality ignore context, the therapist views the behavior as neurotic, unsuitable, or stereotyped, and his or her natural reactions are more likely to have unintended punishing effects.

The second part of Alexander and French's definition involves transference as distortion of reality. In behavioral terms, this meaning of transference could serve as a rule that directs analysts to examine their own "real" behavior and the "real" sequence of events in order to determine if the client's response is "normal" or not. In effect, this situation leads the therapist to attend to variables present in the session which affect the client's behavior. If the therapist would then share his or her observations with the client, even though this type of sharing is not usually part of psychoanalytic process, such an interaction could be beneficial because it is a description of functional relationships called for in Rule 5.

Although the real versus the transference distinction can lead therapists to examine their own contribution to the client's response, this view also could have negative clinical implications because it presumes a static, single perspective (the therapist's) of reality. The "I'm right and you're wrong" outlook of reality perhaps is not problematic when a client expresses extreme accusations, such as the therapist is secretly meeting with his boss and is plotting to kill him. The "true" reality, however, is not as clear in more typical client comments such as "I don't think you care enough about me," "You are bored with me," or "You're in this just for the money." Philosophically, there is reason to question the notion of a single, fixed truth. Even if there were just one "true" reality, however, it is unreasonable to presume that the therapist will always be correct.

Clinically, we are concerned that a therapist who accepts the distorted reality aspect of transference will be less inclined to genuinely consider the possibility that a client's perception is valid when it differs from the therapist's. This, in turn, could deprive the client of an opportunity to learn how to process and resolve an interpersonal situation in which each member of the dyad has a justifiable but different view of the world. Similarly, a submissive client with an inadequate sense of self could be punished for being assertive when his or her view of reality is different from the therapist's. We have similar concerns when validation (reinforcement) of a client's perceptions may be essential to their improvement. Such needed validation may be limited or hampered by the distorted reality notion.

We are also apprehensive that the distorted reality notion will inadvertently reinforce an authoritarian or rigid stance for therapists who are already inclined in those directions. Along these lines, psychoanalysts themselves have expressed concern that therapists might use the transference concept of "not real" to avoid real involvement with the client (Greenson, 1972). A lack of genuine involvement with the client deters the evocation of CRB and the occurrence of natural reinforcement, which is essential for therapeutic benefit in FAP.

Psychoanalysts also recognize the problems inherent in the assumption that the client's view of reality is an illusion. For example, Gill and Hoffman (1982) recently have proposed a different view of transference that is more consistent with the FAP position: "We believe that the therapist's actual behavior strongly affects the patient's actual experience, including what are usually designated as the transferential aspects of that experience....We differ, therefore, from those who emphasize distortion of reality as the hallmark of the transference" (p. 139). The rule-governing effects of Gill and Hoffman's view would be more likely to produce analyst behavior that resembles FAP's Rule 1.

It appears that Gill and Hoffman would like to show how a naive interpretation of transference is not appropriate, but they don't have a theoretical mechanism for doing so. Our FAP analysis provides such a mechanism by using the concepts of context, and CRB1s and CRB2s.

Products and Structures in Cognitive Therapy

A fundamental formulation in cognitive therapy is that a person's cognitions affect subsequent feelings and actions. The basic ABC paradigm, proposed by Albert Ellis (1962,1970) and depicted in figure 1a, shows that A represents external environmental events, B represents cognition, and C is the resulting emotion or action. In this paradigm, it is suggested that a person's

irrational beliefs about external events leads to problematic feelings.

As a step toward improving the ABC model, Hollon and Kriss (1984) used cognitive theory to revise what is meant by B (cognition). They identified two types of cognition, cognitive products and cognitive structures. Cognitive products are directly accessible, conscious, private behaviors, such as thoughts, self-statements, and automatic thoughts. This meaning of cognition corresponds with Ellis's formulation and seems to be used in day-to-day cognitive treatment in which the therapist tries to change the client's dysfunctional automatic thoughts, irrational beliefs, or maladaptive self talk. Cognitive structures, such as schemas, are defined as the underlying organizational entities that play an active role in processing information. Structures operate at an unconscious level since their content cannot be known directly and must be inferred from the products.

From the Hollon and Kriss perspective, the causal factor in the ABC formulation is the cognitive structure, whereas the cognitive products (irrational thoughts, self-statements, automatic thoughts) constitute "signs or hints of the nature of one's knowledge structures." Hollon et al. and others (Safran, Vallis, Segal, and Shaw, 1986; Beck, 1984) suggest that any clinical interventions that change cognitive products are merely symptomatic treatments.

Although necessitated by deficiencies in the original ABC hypothesis (e.g., the fact that C's sometimes occur in the absence of a B and that cognition was inconsistently defined, see review by Beidel & Turner, 1986), the shift in focus from products to structures has produced a theory-practice schism. The same cognitive therapists who reject the causative role of cognitive products are the ones who provide treatment manuals and clinical examples that focus on changing cognitive products. For example, Beck, Emery, and Greenberg (1986) stated that the therapist "must be able to communicate clearly that anxiety is maintained by mistaken or dysfunctional appraisal of a situation" and "gives this explanation...in the first session and reiterates it throughout therapy" (p. 168). In addition, Guidano and Liotti (1983) stated that first important step in therapy occurs "when patients understand that their suffering is mediated by their own opinions" (pp. 138-142).

From a FAP view, the theory-practice schism in cognitive therapy makes sense. Since clinical interventions are always limited to the behavioral realm, such as the client's thinking, feeling and talking (i.e., products), it is impossible to devise treatments that focus on nonbehavioral entities (i.e., structures) that cannot be directly contacted or observed by the therapist. As one cognitive researcher described it, a schema is like "the holy grail" (Zuroff, 1992, p. 274) of cognitive psychology. Thus, it has been difficult for cognitive therapists to create interventions aimed at structures that are substantially different from those aimed at products. For example, Beck et al. (1979) stated that "the cognitive and behavioral interventions (used) to modify thoughts...are the same as those...used to change hidden assumptions" (p. 252). It appears that the only procedures that differentiate the clinical treatment of products from structures is that the latter must first be inferred (e.g., the client must abstract or deduce the existence of the structure). Once identified, however, the same therapeutic methods used to change products are applied. Directed by theory to change a nonbehavioral entity (the underlying structure) while restricted to working with the behavior (products) of the client, the cognitive therapist is in an untenable position. These theoretically posited difficulties in changing schemas and the tenuous link between theory and how change occurs have been termed a dilemma by Hollon et al. (1984, pp. 46-48). Thus, it is not surprising that the actual nuts-and-bolts practice of cognitive therapy mainly operates according to an ABC model involving products.

The wholesale application, however, of an ABC formulation involving products to the exclusion of other possibilities leads to questionable clinical procedures. For example, clients may reject the ABC model by claiming they experience no conscious B that precedes the C, or they may report a B that is inconsistent with a C (e.g., "I intellectually accept I don't need to be loved by everyone, but I am still devastated when I'm rejected"). In such cases a cognitive therapist usually will continue to carry out an ABC treatment plan by questioning the client's logic or sincerity, or by proposing that there are additional, unconscious cognitions to be

discovered. Challenges can also be indirect, such as giving additional homework or assumption-testing assignments. Such nonacceptance of alternative paradigms is found in the cognitive therapy of Beck (1976), even though he rejects the theory implied by the ABC model. For example, Beck suggested that clients who say that they intellectually "know" they are not worthless, but who do not accept this on an emotional level (the Figure 1c paradigm) need more cognitive therapy because the dysfunctional feelings can occur only when they do not "truly believe" the rational thought (Beck et al., 1979, p. 302). Furthermore, a client's objecting to cognitive interventions could be desirable, that is, a CRB2. If such a client were seeking help with becoming more assertive or more confident with opinions, then objecting to the therapist's ABC theory would be an improvement that should be reinforced by the therapist's acceptance and not punished by the challenges.

The need for more flexible models is demonstrated by the tendency for cognitive therapists (as well as other types) to persist in their approach even though the client is not progressing (Kendall, Kipnis, & Otto-Salaj, 1992). Given the complexity of human behavior, the exclusion of coexistent, noncognitive mediated explanations as demanded by the ABC model seems unreasonable.

The FAP model, in contrast, does allow for a client's experience that matches the Figure 1c paradigm and also attends to the limitations of this model. On a descriptive level, Skinner's (1974) distinction between rule-governed behavior and contingency-shaped behavior seems to capture much of what is meant by the product-structure distinction. This view retains the clinical usefulness of that distinction, but avoids the problems of the original ABC cognitive hypothesis. In our revision of the ABC paradigm, B is conscious verbal behavior such as thinking, believing, choosing, reasoning, categorizing, labeling, self-talking of which the client is aware. In behavioral terms, B is a private verbal behavior that can serve as a rule. Depending on whether or not an individual has been reinforced for following rules, the B may or may not affect subsequent acting and feeling. The ABC formulation shown in Figure 1a represents the case in which B does have rule-governing properties and does influence C. Contingency-shaped behavior is represented by AC (Figure 1b). In this instance, the client has problems but doesn't consciously think, plan or attribute beforehand. Finally, Figure 1c shows the case in which both B and C are evoked by the same condition, are correlated, and have no influence on each other. In this later case, C is contingency-shaped and is directly evoked by A.

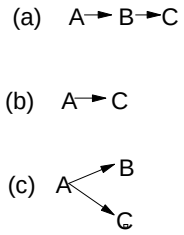

Figure 1. Paradigms showing relationships between A (antecedent event), B (belief or thinking), and C (consequent behavior or feeling): (a) thinking influences subsequent feelings and/or behavior; (b) feelings and/or behavior occur in the absence of prior thinking, (c) thinking does occur but does not influence subsequent feelings and/or behavior.

In other words, within the FAP framework, the degree of control exerted by thinking over clinical symptoms is on a continuum. Cognition (as products) can play either a major, minor, or no role in the client's problems. Correspondingly, cognitive therapy methods will be of varying effectiveness with different clients depending on the role that cognitive products has in the clinical problem. At one end of the continuum, the client's problem is primarily rule-governed, and treatment would be aimed at changing self statements, beliefs and attitudes using cognitive therapy techniques.

At the other end of the continuum the symptom has been shaped purely by contingencies. Although it is possible for a client with a deeper, unconscious contingency-shaped problem to improve when given a cognitive interpretation, less favorable outcomes are more likely. This is especially true for clients who grew up in dysfunctional families where they were abused, neglected, negated, or otherwise punished for expressing their feelings. Children who are repeat-

edly told, either directly or indirectly, that "there's no reason for you to feel or think that way" mistrust their feelings and are unsure of who they are. Suggesting to such clients that their beliefs are dysfunctional or irrational can replay the contingencies associated with the invalidation and alienation they experienced while growing up.

In clients whose symptoms are shaped by contingencies, treatment involves the "corrective emotional experience"--building caring relationships by exposing the client to positive reinforcement in therapy that would shape and sustain new behavior. Paying attention to contingencies is exactly what Jacobson (1989) did when he described how he used the therapist-client relationship to change a client's core belief about her "badness." According to Jacobson, the core structure was changed by the client's taking "the risk of being known intimately" by him, and the client's risk "paid off" in his continued acceptance and positive regard. Along these lines, Safran and colleagues (Safran, 1990a, 1990b; Safran, McMain, Crocker, & Murray, 1990; Safran & Segal, 1990) offer a significant modification of cognitive therapy that gives a central role to the therapist-client interaction in the change process. However, Safran and colleagues view the therapeutic interaction primarily as providing an opportunity to modify interpersonal schemas and not behavior. This leads to the same problems discussed above regarding changing schemas and not products. Further, Safran drew upon a nonbehavioral perspective, interpersonal theory, which has psychodynamic roots (Sullivan, 1953) as the source for the focus on the therapeutic interaction. The net result is an approach without a cognitive or behavioral rationale for the interpersonal focus.

In sum, our FAP analysis of cognitive therapy: 1) translates cognitive products and structures into rule-governed and contingency-shaped behavior, 2) accounts for instances where client problems are not influenced by prior conscious experiences, 3) provides suggestions for schema-based treatment, and 4) provides a theoretical basis for determining when cognitive therapy is appropriate and when it may be deleterious to clinical outcome.

Summary and Conclusions

We have discussed how FAP and radical behaviorism can provide a theory and perhaps a common language that could serve the process of integration. Although many other attempts at this type of integration have been made (for review, see Arkowitz & Messer, 1984), we believe FAP differs from these previous attempts by providing an integrative framework for all systems and not just a particular aspect of one theory or another. In this respect, FAP can be viewed from the perspective of Pepper's (1942) World Hypotheses. According to Pepper, a world hypothesis is a sufficient and adequate explanation of the phenomena of interest. All views exist independently and it is impossible to present data that would invalidate one in favor of another. He argues there are just four relatively adequate views that he refers to as formism, mechanism, organicism, and contextualism. According to this view, all psychotherapy theories could be characterized by one of the four. For the purposes of this paper, it is not important to detail each of these views except to note that contextualism differs from the others in that it uses a pragmatic truth criterion. This, in turn, makes it possible for contextualists to strategically use one of the other world views as advocated by psychotherapy integrationists. Since radical behaviorism has a contextualistic core (Hayes et al., 1988), FAP seems well-poised as an integrative theory from the world hypothesis perspective.

Arkowitz (1992) pointed out that integrative theory needs to be formal, as opposed to having a general perspective, and that the integration should lead to new predictions. Although FAP does have some abstract concepts, its radical behavioral underpinnings are formal and coherent. And although data are needed, our analyses of psychoanalysis and cognitive therapy do indicate differential predictions that neither theory would have made on its own. Specifically, we identify the circumstances when each of the two theories are most likely to produce therapeutic benefit. Our analysis suggests that very different therapeutic stances and techniques are called for depending on : 1) what will evoke the client's problems and issues in the session, 2) whether the client's problems are primarily rule-governed or contingency-shaped, and 3) what will be naturally reinforcing of the client's target behaviors. All three of these

form the basis of matching problem to therapeutic approach.

The question is often raised as to whether or not FAP is a mere translation of other theories into operant terms. It is our position that translation across theoretical boundaries is an essential requirement and a necessary first step for an integrative theory. FAP not only translates across theories, but attempts to preserve the important deeper meaning and clinical implications in the original theory by identifying the context for the original theoretician's techniques and conceptualization. Most importantly, FAP adds something new by going beyond the original context to provide a theoretically cohesive basis for predicting when procedures from a particular theory should or should not be used. Our discussion of transference and cognition illustrated how FAP both preserved deeper meaning and formulated new predictions for when psychoanalytic or cognitive techniques would be helpful versus not helpful for particular clients.

Just as Ferster (1967b) acknowledged the value of non-behavioral approaches in discovering what works, we also favor a multilingual approach (Messer, 1992). FAP was enriched by not only psychoanalysis and cognitive therapy, but by many other approaches we could not discuss due to space limitations: Gestalt therapy, spiritualism, grief therapy, client-centered therapy, conventional behavior therapy, self psychological, and objects relations. In turn, our hope is that behaviorism's qualities of comprehensiveness, objectivity, and precision will offer a basis for openness and communication among psychotherapists.

Footnotes

1. To be more technically correct, we do what we do because of genetic endowment and our history of interactions with the both the social and inanimate environment.

2. Another common misconception is that radical behaviorists do not deal with private behavior. Skinner has consistently tried to set the record straight on this matter since 1945 when he said, "My toothache is as real my typewriter."

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