A Radical Behavioral Understanding of the Therapeutic Relationship in Effecting Change

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This paper presents a behavior analytic understanding of the functional components of the therapeutic relationship. While other models of understanding therapy have offered interpretations of the importance of the client-therapist alliance, few have specified mechanisms responsible for mediating change that have a foundation in experimental psychology. Consistent with the radical behaviorally based Functional Analytic Psychotherapy (FAP), we describe, using a contemporary understanding of verbal behavior, how the therapist establishes him or herself as a provider of social reinforcement in order to shape change using contingent and noncontingent responding and propose a reason why a limited amount of client-therapist contact can produce large changes in behavior. The paper closes with a description of a research strategy for evaluating the proposed model of effecting client change as a function of the therapeutic relationship.

In the last decade there have been creative and thoughtful advances in a behavioral analytic understanding of psychotherapy. These advances have begun to acknowledge the complexity of the therapeutic relationship (e.g., Schaap, Bennun, Schindler, & Hoodguin, 1993). We hope by now that clinical psychologists realize that the S-R psychology that is usually presented as being synonymous with behaviorism (such as provided by Mahoney, 1974; 1989) is an inaccurate and anachronistic caricature of contemporary radical behaviorism. There are at least two contemporary radical behavioral approaches to adult, outpatient psychotherapy that are theoretically coherent and well-developed therapies, Acceptance and Commitment Therapy (Hayes, 1987; Hayes, 1995; Hayes, Strosahl, & Wilson, in press; Hayes & Wilson, 1994) and Functional Analytical Psychotherapy (Kohlenberg & Tsai, 1991, 1995). Although radical behaviorism is often misunderstood and is criticized as simplistic (Kohlenberg, Hayes, & Tsai, 1993), we believe that a contemporary behavioral analysis offers a great deal to understanding the process of psychotherapy.

In this article we focus on one aspect of therapy often overlooked, or at least under-appreciated, in the behavioral literature – the therapeutic relationship. Two factors have prompted us to offer this analysis. First, there is a growing literature on the nature of the interactions between the therapist and client from a variety of perspectives that is becoming methodologically and statistically more sophisticated (e.g., Hentschel & Bijleveld, 1995). What is interesting to us is an emerging appreciation that the relationship between the therapist and client is itself important in producing effective therapy outcomes and is not only to be understood in terms of transference and countertransference. However, theoretical explanations why the therapeutic relationship matters remain largely rooted in clinical theory rather having a basis in any kind of experimental tradition (for a summary see Horvath & Luborsky, 1993).

Second, a casebook of behavior therapy (primarily cognitive behavioral) was recently published (Last & Hersen, 1994) where several of the contributors described the importance of the therapeutic relationship, but none offered any kind of analysis of why and how the relationship is important. The preface of the book only mentioned that one important purpose of the therapeutic relationship is to get clients to carry out their homework. More recent work has expanded the view of the client-therapist relationship (Wright & Davis, 1994), but the extent to which this analysis is empirically testable remains questionable. Thus, two very distinct clinical traditions (psychodynamic and behavioral) recognize the importance of the therapeutic relationship, but neither has offered what, to us, is a very useful analysis.

Much of what we have to say derives directly from the work of Kohlenberg and Tsai (1991) who presented Functional Analytic Psychotherapy (FAP), a treatment based on a radical behavioral analysis of the therapy process. Functional Analytic Psychotherapy is distinct from other more traditional behavior therapies where the goal is typically to apply specific techniques in order to modify some target behavior or behaviors. In our experience, FAP is most appropriate for clients whose behaviors are not targeted by or have not improved with standard behavioral interventions. Specifically, FAP aims to treat individuals whose primary presenting problem includes long-standing interpersonal difficulties. We have found FAP to be an effective intervention for clients whose relationship difficulties are characterized in the diagnostic criteria of various personality disorders listed in DSM-IV (Diagnostic and Statistical Manual, fourth edition; American Psychiatric Association, 1994). In this paper, we discuss several of the many aspects important to the client-therapist relationship including the role of this relationship in effecting change, how the therapist becomes reinforcing in that process, the importance of the therapists' repertoire, and a method for empirically assessing whether treatment efficacy is a function of specifiable aspects of the client-therapist relationship (see also Callaghan, Naugle, & Follette, in press).

The Therapeutic Relationship in Behavior Therapy

Although the behavioral literature has traditionally underemphasized the relationship between the client and

the therapist in behavior therapy, the importance of the therapeutic relationship has not been ignored. Several writers have noted the utility of particular aspects of the therapeutic relationship associated with clinical change. For example, behavior therapists historically have labeled themselves as "behavioral engineers" or "social reinforcement machines" where the primary role of the behavior therapist was to modify client behavior using operant techniques (Wilson & Evans, 1977). Although Krasner (1962, 1963) recognized that elements such as social reinforcement and the interpersonal nature of therapy were important treatment factors, the success of behavioral interventions continued to be attributed to the technology of operant conditioning (Sweet, 1984; Wilson & Evans, 1977) as opposed to specific factors of the therapeutic relationship.

Although lacking empirical support, several discussions of behavioral assessment have emphasized the important role of relationship variables in conducting a comprehensive assessment (e.g., Morganstern, 1988; Rimm & Masters, 1974). These writers suggest that the therapist display the traditionally Rogerian or client-centered qualities of warmth and empathy in order to establish rapport with clients and maximize the likelihood of gathering accurate and comprehensive information. Similarly, many clinical handbooks describing specific behavioral or cognitive-behavioral interventions provide an overview of therapist characteristics believed to be important in delivering effective therapy (see for example Barlow, 1993; Beck, Rush, Shaw, & Emery, 1979; Last & Hersen, 1994; Lazarus, 1972).

The relationship factors and therapist variables that have been viewed as important in the behavioral assessment literature and in clinical handbooks have also been examined empirically. For example, Ford (1978) found that ratings of clients' perceptions of the therapeutic relationship early on in therapy predicted attrition rates in a study investigating different approaches to assertion training. In addition, client ratings of the therapeutic relationship obtained later in therapy were predictive of posttest outcome. The variance in these ratings was associated with differences in the behavioral styles of the therapists. There is additional empirical support to repudiate the view of behavior therapists as cold, aloof technologists: Behavior therapists have been rated more highly on measures of empathy, level of interpersonal contact, and genuineness compared to psychotherapists from other schools (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975).

A minority of behavior therapy researchers believe that relationship factors do not significantly impact the effectiveness of behavioral interventions (e.g., Glasgow & Rosen, 1978). A more commonly held position views a favorable therapeutic relationship as a necessary aspect of effective behavior therapy which is worthy of empirical examination. However, advocates of this position contend that the therapeutic relationship itself is not a sufficient condition for meaningful clinical change (Foa & Goldstein, 1980; Sweet, 1984; Wilson & Evans, 1977). While behavior therapists do not ignore or fail to utilize important interpersonal qualities in their interactions with clients,

they continue to underscore the implementation of specific behavioral techniques as the important and necessary mechanism of change.

Therapist qualities such as empathy, warmth, and unconditional positive regard have frequently been referred to as "nonspecific" variables. Wilson & Evans (1977) suggest that use of the term "nonspecific" is a misnomer and propose it is more accurate to describe these factors as "unspecified" variables rather than as "unspecifiable." The authors attempt to specify the relevancy of these factors by providing an overview of different theoretical models for understanding the role of relationship variables. From a social learning perspective, behavior therapists have noted the importance of social influence factors and acknowledge the therapist as a fundamental source of such factors in effecting client change (Wilson & Evans, 1977). The therapist has been described in general terms as a provider of social reinforcement. However, the value of reinforcement in strengthening client responses has been investigated primarily in cases concerning the client's verbal repertoire and the impact of the therapist's contingent responding in shaping other complex client behavior has not been demonstrated.

While the therapeutic relationship is sometimes characterized as unidirectional, psychotherapy is a process of mutual influence. Not only does the therapist impact the responses of clients, clients also affect therapist behavior. The effectiveness of behavior therapists has also been attributed to their ability to elicit client behavior (Wilson & Evans, 1977) in that the therapist may act as a discriminative stimulus for a variety of client responses. In this paper, we discuss why this is an incomplete analysis that does not account for how the therapist's eliciting function generalizes outside of therapy.

Although behavior therapists have attended to important relationship variables in effective behavior therapy, they have not adequately examined how the therapeutic relationship itself can bring about change in therapy (Rosenfarb, 1992). In this article, we extend the thoughtful analysis provided by Rosenfarb (1992) and attempt to specify what have remained "nonspecific" relationship factors in the therapeutic relationship. We offer an analysis of how the therapeutic relationship between the client and therapist is an important and useful mechanism of change. While we focus primarily on the integral role of the relationship in Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), the analysis provided has broader implications for behavior therapy in general as well as treatments not specifically behavioral in orientation.

The Therapeutic Relationship as the Mechanism of Change

Clinicians from many theoretical orientations acknowledge the importance of the relationship between the client and the therapist in effecting change (e.g., Bordin, 1979; Horvath & Luborsky, 1993; Rogers, 1957; Wright & Davis, 1994), and the term "therapeutic alliance" is commonly used to refer to the most significant aspects of the relationship which impact gains in therapy (e.g., Gelso

& Carter, 1994). Though a conceptual understanding of what is meant by therapeutic alliance exists, how the therapeutic relationship brings about change remains inadequately specified in most schools of therapy (e.g., Hougaard, 1994). One facet of a psychodynamic understanding of the therapeutic relationship emphasizes the client-therapist relationship as a metaphor for the types of interpersonal problems clients have experienced in the past. Clients respond to therapists as if they were someone else; though, there is an emerging recognition that the relationship between the therapist and client may have important meaning in itself (cf., Gelso & Carter, 1994; Greenberg, 1994).

Functional analytic psychotherapists (Kohlenberg & Tsai, 1991; Kohlenberg et al., 1993) do not view the therapeutic relationship as a metaphor for anything. Rather, the direct experience that occurs between the client and the therapist *is* the behavior of interest, and the additional learning history acquired by interacting with the therapist during treatment is the mechanism of change. Problem behaviors that clients emit in session (e.g., emotional avoidance, mistrust, assertion deficits) are of the same general class of behaviors they emit with others. Wachtel (1977) states that a clinician knows through his or her direct experience the relationship between the client and therapist better than he or she knows any other relationship the client describes. This is consistent with our assumption that those interpersonal behaviors that occur in session can be directly modified by the therapist (Kohlenberg et al., 1993)[1]. The therapeutic relationship is a place where clients engage in problem behaviors and learn new, more effective ways of responding.

The consequences of behavior emitted in the client-therapist relationship are, for the FAP therapist, what lead to client change. In order for therapy to be effective, the clinician needs to identify problem behaviors and shape more functional behaviors during session. Specifically, the FAP therapist shapes behavior by differentially reinforcing approximations to more useful interpersonal behaviors. The therapist reduces counterproductive client behaviors by either failing to reinforce them, establishing competing behaviors that are more useful, or occasionally punishing them when they are harmful to others. The therapist is a strong, active provider or deliverer of social reinforcement[2] with the ultimate goal of generalizing improvements that occur in-session to interactions the client has outside therapy. The process by which a therapist becomes such a salient deliverer of reinforcement is described below.

General and Specific Contingent Reinforcement of Client Behaviors

Traditional client-centered therapy presumes that a therapist's ability to express unconditional positive regard or respond noncontingently to a client's behavior is a necessary and sufficient condition to effect therapeutic change[3] (Rogers, 1957). More contemporary approaches, however, propose that an integration of contingent and noncontingent responding is necessary for therapeutic gain (Prochaska, 1979; Schmitt, 1985). In contrast to a client-centered perspective, we do not assume that "unconditional positive regard" or wholly noncontingent responding are sufficient conditions in therapy to bring about change. In addition, our analysis is distinct from a client-centered understanding in determining why contingent and apparently noncontingent reinforcement are important.

The role of seemingly noncontingent reinforcement: General contingent reinforcement. It is important for therapists to provide general expressions of support for clients simply being in treatment, given the problems the client may be experiencing and the fact that therapy can be difficult. The client behaviors that the therapist supports comprise such a broad class of behaviors that the therapists' positive responses appear "noncontingent." For example, the therapist might support the client's efforts for coming into therapy by saying, "It's really great you're willing to come back here to work on these issues," or, "I appreciate you working on what must be very difficult areas in your life." However, the therapist is not reinforcing behavior randomly and, hence, is not actually responding noncontingently. In a technical analysis, the therapist's general support and acceptance of a client's effort to change is better understood as *general contingent responding* by the therapist. The class of behaviors reinforced by the therapist are those necessary for therapy to occur. In essence, the therapist is differentially reinforcing approximations to client improvements by beginning with very generally behaviors and necessary responses (e.g., staying in therapy through the first session) before beginning to shape more specifically effective client responses (Rosenfarb, 1992). We propose the distinction between types of contingent responding not to create a dichotomy in the responses a therapist provides, but to suggest some terminology we find useful to describe the process by which this differential reinforcement process occurs.

Client-therapist relationships are not merely *quid pro quo* relationships where social reinforcement occurs only in the presence of the desired target behavior. The therapist provides general contingent reinforcement to the client for being willing to struggle with being in therapy, disclosing their shortcomings, trying and sometimes failing, and still being willing to continue with the effort. Again, the therapist is not providing noncontingent reinforcement (i.e., consequences that are independent of any response). Rather, the therapist is reinforcing a larger set of behaviors necessary for therapy to occur that include coming into treatment, being involved in the interaction, and trying to change. We distinguish this general form of contingent feedback from *specific contingent reinforcement* in the section that follows. At the more general level of

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[1]This statement is true when one conducts exclusively office-based therapy. We recognize that doing therapy outside in the world may provide larger effects.
[2]By social reinforcement we mean generalized conditioned reinforcement with a specific emphasis on verbal reinforcers as described by Skinner (1957).

[3]Most readers will recognize that providing completely noncontingent reinforcement has been shown to be difficult, if not impossible, to attain as even Rogers responded contingently to clients (Truax, 1966).

contingent responding, the therapist is reinforcing the client's behaviors related to attending sessions and attempting to change. Reinforcing this general set of behaviors makes a distinction between acceptance of the client as a worthwhile person attempting to change and acceptance of the client's problem behaviors. General contingent reinforcement prevents clients from feeling as if the therapist only cares about them when they behave in ways consistent with how the therapist thinks they should.

Our analysis of general contingent responding differs from a client-centered therapy notion of unconditional positive regard as necessary and *sufficient* for treatment success (Rogers, 1957). While a therapist's general contingent responding is a necessary condition that allows the therapist to deliver the sufficient mechanism for therapeutic change (described below), it is not a sufficient condition. That is, to begin shaping more specifically effective client responses, broadening his or her interpersonal repertoire, the therapist must first shape responses that allow this process to occur. While these early, more general orienting and attending responses are indeed necessary, they are not, in our model, the causal agent responsible for change. Further, basing a therapy entirely on general reinforcement of a client's willingness to change in our analysis would simply maintain an established repertoire and would not introduce new, more effective client behaviors. An additional risk of noncontingently or randomly reinforcing client behaviors is that it may also inadvertently produce an ineffective client response repertoire, increasing the future probability of less effective behaviors.

This does not diminish the importance of general contingent reinforcement. Conveying general contingent support and caring, especially initially, allows the therapist to become a salient provider of social reinforcement and sets the stage for subsequent, specific contingent feedback. In our experience conducting FAP, the use of general contingent reinforcement helps clients stay in therapy when specific contingent responding and the differential reinforcement of much more specific and complex behaviors may otherwise be aversive to the them. In our opinion the therapist should provide this more general level of reinforcement to the client's participating in therapy independent of initial progress toward specifically targeted treatment goals.

Moving from general to specific contingent responding: The increase in successive approximations to targeted behaviors. It is important to delineate the process by which the therapist begins to respond more specifically to useful and more effective client behavior. The class of behaviors to which therapists respond with general contingent reinforcement is broad and includes behaviors from simply coming into treatment to actually working on more goal-related issues. A type of funneling or narrowing of this general type of reinforcement occurs over the initial sessions with each client. In the earliest sessions, therapists reinforce any approximations at efforts to change. Therapists include in that broad class of events such instances as the client coming to session and talking with the therapist about a variety of topics.

It would be difficult for a client to describe the specific topic or content that the therapist was most pleased with in early sessions, as any general effort to engage in an interpersonal interaction has been reinforced. Similarly, if the client merely sits in silence in early in therapy, the therapist may acknowledge how difficult the change process is for the client. Gradually, the focus of this general contingent reinforcement is funneled to include behaviors that are more relevant to the goals of treatment previously identified by the client and therapist. Behaviors that are progressively reinforced begin to include focusing on difficult topics, disclosing to the therapist, and other similar responses. Again, the therapist is reinforcing successive approximations to the targeted behaviors the client will acquire. This process is fluid in that more and more specific instances of improvement will be required and reinforced by the therapist. Occasionally, the therapist, for example, will return to an earlier, more broad set of reinforced client behaviors and will remind a client that they appreciate the client's willingness to come back to treatment when it is clearly difficult to do so. By reinforcing these client responses acquired earlier in treatment, the therapist is attempting to intermittently reinforce the necessary but not sufficient client behaviors required for treatment to effect change.

The role of specific contingent reinforcement. Although important, general contingent reinforcement is not the mechanism by which change occurs. Most of the change in client behavior occurs by the therapist responding contingently and differentially reinforcing specifically targeted client behaviors. Contingent responding means that the therapist responds to client behavior as he or she is naturally impacted by this behavior. If the client emits a behavior the therapist finds particularly effective during the session, the therapist responds accordingly. If the client is ineffective, the therapist experiences whatever aversive properties occur and responds in a way that indicates the real effect the client behavior had on him or her and then works with the client to figure out how to produce the effects the client actually desired. The client is able to learn the consequences of his or her behavior on the therapist without having to risk failing outside of sessions with less accepting people as he or she learns new, adaptive ways of interacting. When a client presents for therapy with a history of poor interpersonal relationships, the therapeutic relationship is a setting where clients are presumed to show similar problems, can experiment with trying alternative responses, fail, and still have the therapist reinforce the (general) attempts to change; that is, the therapist still cares about the client even when the client emits problematic behavior. In our experience the therapist cannot expect to effect change without first differentially reinforcing these more general client responses.

At a more technical level, the therapist is trying to establish useful operants. The therapist is required to respond contingently when the client exhibits problem behaviors that occur in-session as well as when the client responds in interpersonally effective ways. This contingent responding is the mechanism by which more useful responses may be differentially reinforced and shaped. For

example, consider a client who is mistrusting and his or her attempts to disclose feelings have historically been ignored or punished. During sessions some clinically relevant disclosure will occur, and the therapist needs to notice and respond contingently to this new behavior (no matter how slightly it is exhibited) by expressing a preference for how this new response engenders some increased trust in the therapist. The therapist supports the willingness and efforts of the client to change, but differentially or selectively reinforces specific responses or attempts to change.

As an example, consider a client who has not been able to initiate or maintain a relationship with another person due to a tendency to sexualize the relationship between the two of them, limiting his or her availability of social reinforcers. While a case such as this would likely present for treatment of other issues as well, we will simplify the example to include this broadly specified problem. The therapist's task in this example is to first outline to the client the role of the therapeutic relationship and the specific limitations placed on the client and therapist both ethically and legally (see Callaghan et al., in press for a description of how to define this relationship for both therapists and clients). The therapist would then begin, while gathering specific information to functionally analyze the case (e.g., Kanfer & Saslow, 1969), to reinforce the general client behaviors that will allow the therapist to reinforce more specific approximations to having the client relate to the therapist openly and honestly without sexualizing the relationship. A more general approximation might include returning to therapy after the relationship has been explicitly defined as the opposite of the relationships the client has had, or discussing difficult feelings about past relationships. The therapist would provide general reinforcement for effective interpersonal relating that did not involve elements of interpersonal closeness that might historically lead to sexualization of the relationship. In this case the therapist is attempting to build on the client's pre-existing behavioral strengths (Hawkins, 1986).

Gradually the client and therapist will begin discussing how the client feels about his or her interactions with the therapist and whether the client is able to respond to the therapist as a person who cares about him or her while not engaging in a sexual relationship. As therapy progresses and the therapist begins responding contingently to the client's specific behavior, he or she will reinforce all approximations and attempts to relate to the therapist openly without a hidden agenda (i.e., where the client's behavior is under the contingent control of the interaction not of an obvious, but unstated goal of flirting with or seducing the therapist). When the client behaves more flirtatiously, the therapist will respond to the client with how this impacts him or her, perhaps informing the client that when he or she does that it feels as if the client discounts the relationship and is less interested in having an open and honest interaction.

It likely strikes the reader that to engage in this type of specific contingent responding to a client could risk having the client prematurely terminate treatment. This is sometimes the case; however, in our experience the two things a therapist does to prevent a client from leaving

therapy are first, to discuss with the client the importance of why he or she responds contingently if it is not clear to the client, and second to point to, and in some sense rely on, the longer history of general contingent reinforcement of client behaviors that has occurred prior to this moment in therapy.

Establishing the Therapist as a Deliverer of Social Reinforcement

We have described a therapy process where the therapist successively shapes more useful behavior by the client by reinforcing approximations of client improvement. This analysis implies that the therapist's behavior functions to increase effective responding by the client, and that the client finds this behavior reinforcing to the extent that he or she feels the therapist cares and the client continues to return to treatment. The therapist must take into consideration what verbal reinforcers he or she can deliver to increase the probability of future client responding so that he or she does not inadvertently punish an emerging repertoire that is effective (Callaghan et al., in press).

How is it that the therapist comes to operate as a strong and effective deliverer of social reinforcement? Applying a basic operant analysis, the therapist becomes a discriminative stimulus for a client's disclosure, trial and error learning, and puts the client into contact with the consequences of these behaviors. The professional status of the clinician itself may serve as an establishing stimulus (Michael, 1982) for clients to begin engaging in this process. The status of the therapist as a helping professional establishes unique stimulus properties of a particular therapist as an occasion for client behavior to be reinforced for participating in the interaction. In our model, it is necessary to reinforce client disclosures early on in therapy so that the therapist becomes a discriminative stimulus for this behavior to continue.

A contemporary analysis of verbal behavior, through arbitrarily applicable relational responding (also known as relational frame theory, e.g., Hayes, 1994; Hayes, Gifford, & Wilson, in press), allows us to understand how a therapist's verbal behavior changes the way events function as reinforcers or punishers for the client (i.e., augmenting functions; Zettle & Hayes, 1982). In nonverbal organisms stimulus functions of events must be either directly trained or acquired through the process of stimulus generalization. Because the stimuli to which the clients respond in therapy are verbal events, traditional stimulus generalization cannot account for how the client comes to disclose to the therapist.

Stimulus generalization could account for the continuation of responding to others outside treatment in the same manner as the client learned in therapy. However, this generalization would be to physical properties shared by the therapist and other people in the natural environment. While this account most likely applies to some of the learning that occurs with clients, the stimulus control of relating only to a person, because the therapist is also a person, is too general. Similarly, if the client learned to respond only to particular stimulus

features of the therapist that others shared (e.g., style of dress, facial characteristics, etc.), the client would be under too strict of stimulus control. Neither of these types of stimulus control adequately explain the generalization necessary for lasting change as a result of therapy.

This behavior requires a verbal analysis distinct from responses to discriminative stimuli traditionally described as stimulus generalization. In verbal organisms, stimulus events come to have functions as the result of indirect training histories. For example, if a child learns that object A goes with object B, he or she learns that B goes with A without direct training (Lipkens, Hayes, & Hayes, 1993). If we extend this analysis to therapy, the therapist may begin to take on stimulus properties that participate in verbally derived equivalence classes (Hayes & Hayes, 1992) as well as arbitrarily applicable relational response classes beyond simple equivalence formations (e.g., combinatorial entailment, see Hayes et al., in press). For example, the client may describe the therapist as warm and caring and then behave in ways similar to how he or she behaved when feeling cared about in the past. That is, when the client has felt cared about in other relationships, he or she discloses more, trusts the therapist to continue to support him or her, etc. Conversely, the client may respond to other relationships that occur outside session as they have learned to do with the therapist. In other words, clients may identify those qualities of the relationship with the therapist they value and come to respond to those qualities in other relationships with their spouse, partner, friend, or family member, behaving more effectively as he or she has learned to do with the therapist. The client learns new responses in a caring, therapeutic relationship that are very useful and generalizes these responses to other people who share those qualities.

These verbal relations do not need to be indirectly derived as the sole mechanism of achieving the goal of generalization of response classes. It is often, in our experience, more efficient to also supplement therapy by helping the client explicitly identify how he or she can form these verbal relations. The therapist assists the client in identifying what the client likes (i.e., finds reinforcing) about the therapist that he or she could find in others in the natural environment. The therapist's task is to then have the client emit behaviors in his or her emerging repertoire with those people with similar verbally defined characteristics (e.g., "a good listener," "a patient person," "thoughtful," etc.) and notice the consequences of engaging in that behavior with them to ultimately come under stimulus control of the verbally defined relation.

An example of verbal relating that helps bring the client's behavior under control of the therapist, establishing him or her as a salient deliverer of social reinforcement, can be found in a client presenting for on-going relationship difficulties following the termination of a long-term relationship. While this person may present with classic "symptoms" of depression, the behavior therapist could conceptualize the case as a decrease in the availability of social reinforcers. By forming a relationship with the client, the therapist responds to him or her uniquely (assuming for this case that the client has a recent history of little support) by listening, reflecting, suggesting, and responding contingently to the client's behavior. The client then summarizes with the therapist how he or she feels about the therapist and describes qualities the client likes, as well as those the client finds less enjoyable. The client will then either directly or indirectly derive the arbitrary verbal relations between the description of the therapist and his or her feelings. The therapist can also assist this process by having the client notice, for example, that he or she "trusts" the therapist, the therapist listens and responds back to the client, and that this is associated with the client "feeling better." This verbal relating is an important factor in having the therapist become a provider of the social reinforcement necessary to shape specific client behaviors.

The client may also begin to behave in response to the therapist's social reinforcers because the client has a history where "trusting" and "responding back" to him or her was reinforced in the past. These behaviors may be discriminative stimuli for larger classes of reinforcing behaviors engaged in by others such as caring and showing affection and may have resulted in more interpersonally close behaviors by the client. According to this model and consistent with relational frame theory, if the client notices the therapist has these qualities (though not necessarily noticing this overtly or vocally), the client will engage in more interpersonally close behaviors with the therapist. To generalize these effective behaviors the therapist would encourage, and even require, the client to attempt to establish a relationship with someone else with characteristics the client likes about the therapist in order to contact the consequences of trying this newer or re-emerging repertoire with other people. The client's new repertoire could then be reinforced by others so that the therapist is not the only person delivering reinforcement for the client's behavior (see Ferster, 1972).

How Can Such a Small Amount of Contact Bring About Change?

In order for a therapist to be effective, he or she must learn to deliver reinforcement similar to that likely to be provided by others outside therapy. Ferster (1967, 1972, 1979) refers to this type of reinforcement as natural reinforcement as contrasted with arbitrary reinforcement (see also Kohlenberg & Tsai, 1991; Rosenfarb, 1992). Natural reinforcers occur more readily in the environment and under a broader set of circumstances, whereas arbitrary reinforcers are contrived and not generally evident in situations outside therapy. A therapist interested in what a client is saying may smile, lean forward, raise his or her eyebrows, or do a number of things that reinforce that client behavior. All of these behaviors are similar to what occur outside therapy and are considered natural reinforcers if they strengthen preceding client behavior. Arbitrary reinforcers are often of a specific rather than general type and frequently are delivered under a limited set of circumstances Arbitrary reinforcers are frequently delivered based on the need of the therapist for the client to behave in a particular way rather than behavior that would be more effective for the client in his or her natural environment (Ferster, 1972, 1979). While arbitrary

reinforcers function to increase behavior in session, they are not as likely to be the kind of reinforcers others use to reinforce a response. Therapists saying, "That's good" or "Thanks for sharing" following a client's expression of anger are examples of arbitrary reinforcers. A more useful, natural response would be to take the client's anger seriously, provide feedback to the client about how his or her response affects the therapist in that moment, and to focus on more useful expressions of anger. While verbal feedback occurs outside therapy, it is not the only thing people do to provide contingent feedback. When therapists limit their responses to convenient but arbitrary methods to increase behaviors in session, without considering what types of reinforcers are applied out of session, they severely limit the potential for those new behaviors to be generalized beyond therapy. The use of arbitrary reinforcers can ease the transition from client behavior under control of the therapist and the therapy setting to those providing reinforcement outside therapy, increasing the likelihood that these behaviors will continue in the future as the client interacts in the natural environment (Ferster, 1972).

In our understanding of FAP, delivering natural reinforcement is essential to generalize client improvements beyond therapy, even though the effective behavior is not necessarily reinforced with the same frequency outside session. We believe that the density of accurate contingent feedback and consistent delivery of natural reinforcement in-session are what allow a relatively small amount of contact with clients to be effective in promoting and maintaining change. This is one reason why the limited amount of contact is so salient for clients. When therapists respond contingently to client behavior at a very high frequency, there is a much greater chance of clients learning more effective responses than when this feedback comes at random intervals. We are not suggesting that contingent, natural reinforcers occur in-session on a fixed interval or fixed ratio basis. Therapists reinforce behaviors in-session on a variable ratio schedule. The ability of this schedule to sustain responding may explain why client responses continue during periods of lean reinforcement. This is the same schedule with which behaviors are reinforced outside of therapy. In-session natural reinforcers, however, probably occur on a richer variable ratio schedule than occur outside of therapy. In our model of FAP, the therapist provides reinforcers on a fixed interval or fixed ratio schedule early in therapy to establish new responses at a more rapid rate. As therapy progresses these reinforcers are delivered on a more variable schedule, maintaining client responding out of session when others might fail to reinforce new client behavior.

One could effect change more rapidly by increasing the amount of contact with clients and providing consistent differential reinforcement more frequently. However, for practical reasons, it is necessary during each hour to maximize the opportunities to respond naturally to clients in order to shape more useful behavior and to enhance their effective repertoires and relationships outside of therapy.

The therapeutic relationship may be potent because of the higher density of reinforcement provided by the therapist. Clients often come into therapy with a number of complaints about not getting as much out of life as they would like. They often indicate that there is little in their life currently that is reinforcing. More technically, clients are in a state of deprivation for conditioned secondary reinforcement (i.e., social reinforcement, Skinner, 1957). Therapy becomes an establishing stimulus for disclosing, displaying affect, etc. to be reinforced. Because these behaviors are not frequently reinforced outside of session, clients will attempt to maximize the opportunities for reinforcement in-session. Therapy becomes an environment where clients will experiment with new behaviors more frequently than they do elsewhere because reinforcement occurs more frequently and aversive consequences less often than elsewhere.

A third reason that such a small amount of contact can bring about change involves the way the client feels and talks about therapy. Clients, like most people, attend more closely to events which are different from those that occur with great regularity. Essentially, we notice that which stands out. Because therapists provide contingent feedback to clients with such frequency (while also reinforcing their behavior of coming to and staying in treatment), therapy is likely to be viewed as one of those unique events. The way they describe the experience is likely part of a verbally derived relation, as discussed in the previous section. When clients describe the therapeutic relationship as important, caring, and supportive and respond to these aspects of therapy, it is not necessarily through direct training. Rather, feelings about and descriptions of the therapy process participate in functional and relational classes with events that occurred in past relationships and were reinforced. When clients understand the therapeutic relationship as caring and supportive, and they begin to disclose, feel cared about, trust their therapist, (assuming these are lower frequency behaviors outside therapy) they will identify this as a unique, special relationship given their current lack of these with other people. Events that are unique in their past have engendered special attention and often require special effort to sustain. Because the relationship has qualities that are unique, the client will emit a set of behaviors that will increase the chances of this continuing. Simply put, because the therapist has acted in a way that is unique to the client or is experienced much less outside treatment, the client will behave in ways that are unique to him or her.[4] The goal, ultimately, is to help the client identify and engage in situations where the same discriminative stimuli give rise to effective client behaviors in the natural environment. If therapy is the only place where effective client behaviors are maintained, treatment is largely unsuccessful. Often in FAP, much effort is spent

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[4] There are, of course, other aspects of the therapy setting that are unique to the client, such as a professional environment and privacy, that may control equally unique client behavior. For example, clients who have been in treatment at least several sessions may sit down and begin disclosing a very personal event to the therapist within the first one or two minutes of session. The therapy environment may control this behavior to the extent that the disclosing behavior occurs so rapidly because the client has an established history of not being interrupted once the office door is closed.

reinforcing client attempts to engage in these new behaviors outside session and functionally analyze the similarity of behaviors that occur both inside and outside of therapy.

Relational responding as an analysis of verbal behavior allow us to more accurately identify the mechanisms by which clients feel so strongly about therapy. In the event clients do not have a history of feeling cared for and supported, this analysis may not appear as immediately beneficial. However, as the therapist begins shaping the client to emit more and more personal statements and teaches the client to identify and label emotions as they occur, it is likely that relational classes will emerge. Helping clients decide what is important to them in relationships and making the features verbally explicit, helps establish these classes. In the same manner as described earlier, clients will learn to seek out relationships that have similar qualities as the therapeutic relationship and will behave with others as they have learned to with the therapist.

For some clients, verbal stimuli such as "I care about you" may participate in a functional class where withdrawing from others has been reinforced. Withdrawal is adaptive given a history where punishment by a primary caregiver frequently followed an expression of caring. When verbal stimuli participate in functional classes that result in undesirable behaviors, it is necessary to directly address this difficulty and explicitly provide a new reinforcement history that allows caring to bring about behaviors that are more useful to the client (see also Callaghan & Follette, 1996). Much of what occurs in therapy can be understood as creating a new learning history for the client. Because much of therapy is verbal, a new history for the client includes establishing a new, more useful verbal repertoire. Eventually, when the client has experienced a positive history following the therapist saying "I care about you," the client responds quite differently to others saying those same words. If the therapist has established an effective, healthy social repertoire for the client using natural reinforcers, the outside environment is more likely to sustain better relationships for the client.

Empirically Assessing Treatment Effectiveness as a Function of the Client-Therapist Relationship

The assumption that the client-therapist relationship is responsible for client improvement that occurs in and out of session can be tested provided that the mechanisms by which that change occurs are specified. In the description of therapy we have offered, the process responsible for mediating change is the differential reinforcement of client improvements in session. Follette and Callaghan (1995) describe a methodology to assess the effectiveness of FAP through the use of conditional probabilities and multiple baseline designs. Coding client behavior and therapist's contingent responding would allow a researcher to assess whether clients' in-session problem behaviors are decreasing and more effective behaviors are increasing. A simple type of cumulative record could be used to demonstrate that clients' effective behaviors are increasing

over time while less effective responding decreases (see for example, Callaghan & Follette, 1996). These improvements can be tied to both standardized measures appropriate to the client's presenting problems and to observations made outside therapy to determine whether effective behavior has generalized to other situations.

In order to test whether these changes are a result of a therapist's contingent reinforcement, researchers could code client and therapist behaviors, and using a lag sequential approach (e.g., Bakeman & Gottman, 1986; Rosenfarb, 1992), test whether the probability of a client response changed given a therapist's contingent reinforcement. Lag sequential analyses indicate the conditional probability of an event occurring following a specified target event and can be used to investigate the statistical relationship between sequences of variables that are thought to be related. Lag sequential analyses are especially well suited to discover moment by moment relationships between variables. If therapy worked as expected, it could be shown that clients emit more effective responses as a function of the type of feedback they are given by the therapist. The strength of the therapeutic relationship can be indexed by the rate of client change given therapist contingent responding.

As an additional method, a multiple baseline approach could be used to demonstrate that as one class of problem behaviors is targeted, client improvements increase while other problem behaviors left unaddressed remain at baseline level. Demonstrating that improvements occur as a function of what behaviors are targeted offers further support for the relationship between the client and the therapist as the mechanism responsible for change[5]. Either of these approaches could be used to empirically demonstrate that the client–therapist relationship is responsible for changing client behavior via in-session differential reinforcement. This type of empirical demonstration of how the process of therapy impacts outcome and how the specified mediating mechanisms are responsible for change is one that is missing for most psychological therapies (Follette, 1995).

Conclusion

This paper has addressed an important aspect of psychotherapy, the therapeutic relationship, from a radical behavioral framework. We have tried to briefly demonstrate that one can understand and study the functional importance of the client-therapist relationship using a well-researched and consistent set of psychological learning principles. Such principles can be the basis of specifying aspects of the therapeutic relationship that have been previously aggregated into "non-specific treatment

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[5] The use of multiple baseline measurements in interventions that are verbally based may pose some challenges to determine the change in a targeted behavior. Because verbal relations are arbitrarily derived and applicable, it is possible that an intervention aimed at one class of verbal behaviors will effect other verbally based behaviors not apparently related to it. While this poses no problems in terms of unplanned benefits for clients, it does create difficulties in interpreting the success of an intervention using a multiple baseline approach.

effects." The ability to specify these active components is a necessary step before empirical research can proceed. We hope that this type of article demonstrates the capability of understanding complex behaviors and situations using a contemporary behavioral analysis. In addition to beginning a discussion of a behavioral view of the therapeutic relationship, we hope the reader realizes that a radical behavioral perspective of therapy is capable of addressing complex clinical issues from a scientifically productive perspective.

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