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What Can Functional Analytic Psychotherapy Contribute to Empirically-Validated Treatments?

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Although empirically-validated treatments are useful in treating a variety of psychological dysfunctions, there continues to be a number of problems and criticisms regarding strict adherence to these treatment protocols. One such criticism concerns the fact that many individuals are unresponsive to manualized treatment approaches and require more individualized assessment and treatment. Using cognitive therapy for depression, behavioural marital therapy, and dialectical behaviour therapy as exemplar therapeutic interventions, we present functional analytic psychotherapy (FAP) as a promising mechanism by which to address this issue and thereby enhance the efficacy of empirically-validated treatments. Copyright © 1999 John Wiley & Sons, Ltd.

INTRODUCTION

Managed care companies have placed a premium on time-limited empirically-validated treatments (Masia *et al.*, 1997; Bernstein, 1998). These treatments are often insufficient and inappropriate, however, to completely resolve psychological problems (Eifert, 1996). Consequently, the need arises to identify supplemental strategies that may augment existing treatments and facilitate behavioural change in those individuals not responding to traditional therapeutic techniques (Kohlenberg and Tsai, 1995). We argue that functional analytic psychotherapy (FAP; Kohlenberg and Tsai, 1991) may represent such a mechanism. In this paper, we explore the utility of incorporating FAP principles into existing empirically-validated treatments (see Chambless *et al.*, 1996) and suggest that FAP may represent a theoretical framework to enhance the efficacy of these treatments.

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EMPIRICALLY-VALIDATED TREATMENTS

Treatment approaches that meet criteria established by the American Psychological Association (APA; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) are designated as either *well-established* or *probably efficacious* empirically-validated treatments. Well-established treatments are those treatments that: (a) have been subjected to a minimum of two group designs or a large series of single-case design outcome studies conducted by different investigators, (b) are demonstrably superior to placebo or more efficacious or equivalent to an already established treatment, (c) follow treatment manuals, and (d) clearly specify characteristics of patient samples. Probably efficacious treatments are those interventions for which there is limited empirical support with the assumption that future research will remedy this deficiency. Although there are presently a number of empirically-validated psychological interventions (Chambless *et al.*, 1996; Woody and Sanderson, 1998), it is probable that more concentrated efforts

to scientifically demonstrate the efficacy of psychological treatments will occur as managed care organizations continue to reform health care policies.

There has been considerable debate regarding the utility of manualized protocols as opposed to more idiographic treatment approaches (e.g. Eifert, 1996; Fensterheim and Raw, 1996; Shaham and Rohrbaugh, 1996; Eifert *et al.*, 1997; Zvolensky and Eifert, 1998). The advantages associated with treatment protocols typically include spending less time on functional problem analysis, selection of target behaviours, and treatment planning; the use of behavioural measures to facilitate pre–post treatment change; and the promotion of internal validity of outcome studies through systematic replication across settings (Eifert *et al.*, 1997). Moreover, treatment outcome researchers have suggested that manualized treatments may in some cases be as effective, or perhaps superior to individualized approaches. For example, Emmelkamp *et al.* (1994) demonstrated that a standardized behavioural intervention and a more individualized approach based on functional analyses were equally effective in treating individuals with obsessive–compulsive disorder. Additionally, standardized protocols have been remarkably effective in the treatment of panic disorder (Barlow and Craske, 1994; Brown and Barlow, 1995) and superior to individualized treatment with patients presenting with phobic anxieties (Schulte *et al.*, 1992).

Among the criticisms directed at manualized treatment protocols are an over-reliance on manuals, potential for insurance misuse, and the neglect of alternate, potentially more beneficial treatments. Strict adherence to manualized treatments has been questioned on the basis that manuals discourage idiographic interventions and promote fixed, inflexible strategies inconsistent with behavioural practice (Eifert *et al.*, 1997; Iwamasa and Orsillo, 1997; Zvolensky and Eifert, 1998). Traditionally, an individualized functionally-based analysis of problematic behaviour has been the hallmark of behaviour therapy (Skinner, 1953; Schulte, 1973). The functional analysis of behaviour directly examines the explicit environmental and historical variables that control behaviour, thus specifying the cause(s) of problematic behaviour and identifying potential environmental manipulations to target within therapy. Given the documented successes of this approach (Masters *et al.*, 1987; Giles, 1993; Plaud and Eifert, 1998), many behaviourists are opposed to manuals, arguing that manualization may transform therapists into technicians, resulting in an incomplete functional analysis and subsequent treatment failure (Scotti *et al.*, 1991).

Second, there is the risk of managed care and insurance companies disregarding clinician judgment and providing reimbursement solely for empirically-validated treatments (Masia *et al.*, 1997). This could result in treatment being limited to those patients presenting with a particular disorder or therapists billing insurance companies under a pseudodiagnosis (Zvolensky and Eifert, 1998). The third limitation of empirically-validated treatments is the primary issue raised by this paper: although empirically supported, the need to supplement and improve these treatments is evident in that manualized treatments are not appropriate for all psychological problems (Linehan and Kehrer, 1993; Davison, 1995; Hollon and Devine, 1995). Moreover, because a therapy is 'validated', we should not be misled into believing that we know all we need to know about treating a particular disorder (Shoham and Rohrbaugh, 1996). Within the context of empirically-validated treatments, we present functional analytic psychotherapy as a viable means to improve the quality of psychological assessment and treatment approaches. Further, in addition to the augmentation of already established treatments, functional analytic psychotherapy may serve as a catalyst for other less substantiated treatments.

FUNCTIONAL ANALYTIC PSYCHOTHERAPY (FAP)

Functional Analytic Psychotherapy (FAP; Kohlenberg and Tsai, 1991) has been described as 'a Skinnerian functional analysis of the typical psychotherapy environment' (p. 1). Therapists utilizing the functional analytic approach conceptualize in-session behaviours emitted by the patient as samples of behaviours exhibited in more naturalistic settings. Within this framework, the therapist's tasks are to (a) identify problematic behaviours displayed during the session (clinically relevant behaviours; CRBs), (b) evoke CRBs for the purpose of developing more appropriate behaviours (CRB2), (c) facilitate patient observations and interpretations of their behaviours (CRB3), and (d) reinforce improvements made during the session while failing to reinforce and occasionally punishing maladaptive behaviours. Consequently, the mechanism of change is the therapeutic relationship, a context in which the FAP therapist shapes behaviour by differentially reinforcing approximations to more effective interpersonal behaviours (Follette *et al.*, 1996). As an

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example, a patient's lack of assertiveness during therapy may reflect an unassertive interaction style precipitating dissatisfaction with her spouse. Having identified this CRB, the therapist's responsibilities would involve the evocation of unassertive behaviour toward the therapist and the reinforcement of assertive behaviours displayed during the session. Ultimately, the objective is that these assertive behaviours will generalize to the natural environment (i.e. to interactions with her spouse).

FAP can be characterized as bridging the gap between psychodynamically-oriented treatments and radical behaviourism. From a radical behaviourist perspective, FAP has embraced fundamental behavioural concepts such as *contextualism* (i.e. problems do not exist in isolation but are shaped by language and learning) and *generalization* (i.e. natural and therapy environments are functionally similar if they evoke the same behaviour). Moreover, FAP has adopted the Skinnerian position that *verbal behaviour* is directly controlled by observable events (Skinner, 1957). Mentalism is rejected, and environmental variables rather than internal entities are posited as controlling behaviour. Finally, *reinforcement* is highly regarded, particularly within the context of therapy (i.e. to promote behaviour-reinforcer contiguity). Because of the limitations associated with contrived reinforcement (e.g. behaviour may not generalize to natural settings) reinforcers should be natural (e.g. the therapist's genuine emotional reaction to the patient's behaviour) as opposed to contrived (e.g. forced praise). FAP's similarity to psychodynamic treatments is evident in its emphasis on the therapeutic relationship. Although both paradigms conceptualize the therapeutic relationship as the mechanism of change, FAP posits that behaviour exhibited by the patient must be viewed contextually and not solely as transference. FAP theorists contend that an over-reliance on transference may result in improved behaviours not being reinforced (Kohlenberg and Tsai, 1991). For example, if a patient who normally dominates conversations and has difficulty listening in relationships says little during a session, rather than being interpreted as resistance, this is an improvement that the therapist should reinforce.

The Clinical Application of FAP

The therapist's responsibility is to identify clinically relevant behaviours (CRBs) that may be evoked in a variety of situations (cf. Kohlenberg and Tsai, 1991), such as time structure, therapist vacations, termination of therapy, fee issues, 'mistakes' or unintentional therapist behaviours, silence or lapses in conversation, expression of affect, reactions to positive feedback, reactions regarding development of therapeutic relationship, and assignment of homework. These situations could potentially give the therapist insight into issues such as how the patient manages money and time, or how the patient normally reacts to intimacy or abandonment within other relationships. Therapists must not only watch for CRBs, but evoke them if they are not occurring. For example, if a patient has difficulty being assertive (e.g. cannot refuse unreasonable requests), the therapist could begin to assign demanding homework assignments. If the patient assertively expressed discomfort with the homework, the natural reinforcer may be the therapist's modification of the assignment. The therapist should subsequently assess the effects of his or her behaviour to ensure the desired reinforcing outcome has been achieved.

Finally, the therapist should encourage patients to interpret their behaviours. Patients must engage in a learning process whereby they become skilled at providing 'reasons' (i.e. causes) for their behaviours (Hayes, 1987). This notion is based on the idea that as reinforcing, discriminative, and eliciting stimuli are identified, the knowledge of these functional relations will enable patients to obtain reinforcement in the natural environment (Kohlenberg *et al.*, 1993).

ENHANCING EMPIRICALLY-VALIDATED TREATMENTS USING FUNCTIONAL ANALYTIC PSYCHOTHERAPY

Cognitive Therapy for Depression

The cognitive theory of depression is based on the premise that individuals with depression experience negative 'automatic' thoughts, irrational beliefs, and problematic behaviours that result from maladaptive unconscious cognitive schemata (e.g. Ellis, 1962; Beck, 1967). Within this formulation, thoughts and beliefs are conceptualized as *cognitive products* while the underlying schemata are considered *cognitive structures* (Hollon and Kriss, 1984). Due in large part to the non-behavioural (i.e. unobservable) quality of cognitive structures, cognitive therapy for depression consists of teaching patients to monitor and evaluate underlying assumptions, beliefs, and errors in thinking, and modifying these cognitions to promote behavioural change (Beck *et al.*, 1979; Dobson, 1989; Sacco and

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Beck, 1995). Ellis' ABC paradigm is often employed, with A being the antecedent event, B the belief or cognition, and C the consequent behaviour or emotion. The therapist's task is to dispute B in order to affect C.

It is at this juncture that the distinction between the functional analytic and cognitive approaches becomes intelligible. First, FAP theorists posit that the role of cognitive behaviour as it relates to overt behaviour exists on a continuum, from having no effect to a very major impact. Kohlenberg and Tsai (1991) contend that the ABC paradigm excludes alternate ways that cognition and behaviour could be related. For example, A could lead directly to C in the case of contingency-shaped behaviour; A could lead to C then to B in the case of rule formulation; or A could lead to B then to C in the case of rule following (i.e. cognitive model). Thus, FAP offers more flexibility in case conceptualization and treatment than cognitive strategies that are strictly based on modifying rule governed behaviour. FAP-enhanced cognitive therapy is guided by the degree to which rules or contingencies contribute in the development and maintenance of problematic behaviour (Kohlenberg and Tsai, 1994). If the problem is primarily rule-governed, the FAP therapist would focus on evoking rules ('thoughts') in the session and take a more traditional cognitive approach to treatment. Conversely, if the problem is assessed as contingency shaped, the FAP therapist would concentrate more on in-session contingencies.

A second contribution of FAP-enhanced cognitive therapy is the increased focus on in-session behaviours that should be reinforced rather than punished (Kohlenberg and Tsai, 1994). As an example, consider an alcoholic patient who rejects the traditional ABC formulation in favour of an alternate paradigm. In a particular environmental context (e.g. bar), this patient finds himself drinking large quantities of alcohol and insists that he cannot identify specific thought patterns occurring prior to alcohol consumption. Although cognitive therapists may challenge the patient's interpretation by questioning the patient's logic or by suggesting that mediational variables (i.e. cognitions) exist but have not yet been identified, the FAP therapist would examine this behaviour as clinically relevant. For example, following a functional analysis of drinking behaviour, the determination may be made that drinking is a part of a more enduring pattern of impulsive behaviour that occurs when emotion is elicited. The behavioural response of drinking serves the function of emotional avoidance. To intervene, the FAP therapist might present this hypothesis to the patient, accept his A–C formulation of drinking behaviour, and teach the patient strategies to cope with emotional experiences. The therapist may then evoke CRBs within therapy (e.g. elicit strong emotion) and subsequently reinforce the patient for utilizing appropriate coping responses such as diaphragmatic breathing or verbal expression of feelings (CRB2s).

Finally, in contrast to traditional cognitive therapy that relies on between-session self-monitoring and disputation of dysfunctional thoughts, FAP-enhanced cognitive therapy: (a) is more concerned with thoughts and beliefs occurring within-session and in relation to the therapist and (b) the utilization of these within-session cognitions to facilitate behavioural change (Kohlenberg and Tsai, 1994). Therefore, CRBs are the patient's cognitions that are elicited through interactions with the therapist. The therapist's responsibility is to encourage and evoke the overt expression of these subvocations or self-statements (e.g. using a within-session thought log) and to reinforce behavioural change directly. Furthermore, the 'testing' of the patient's maladaptive thoughts is conducted in session, rather than the traditional behavioural homework assigned by cognitive therapists.

Based on a well-presented case study, Kohlenberg and Tsai (1994) maintain that FAP-enhanced cognitive therapy may be a promising strategy to facilitate positive behavioural change in patients that are resistant to traditional cognitive therapy. Compared to cognitive therapy only, FAP-enhanced cognitive therapy resulted in lower scores on the Beck Depression Inventory and an improvement in interpersonal skills.

Behavioural Couples Therapy

Behavioural marital therapy (BMT; Jacobson and Follette, 1985) originally consisted of two components, *Behaviour Exchange* and *Communication Problem-Solving Training*. The behaviour exchange component was designed to facilitate immediate change; couples are instructed on how to increase reinforcing and decrease punishing behaviours within the context of their home environment. Communication problem-solving training is perceived as the preventative component in which communication skills are taught during therapy. Despite early indications that BMT was a promising treatment for discordant couples (Jacobson and Follette, 1985; Baucom and Hoffman, 1986), a 2-year outcome study indicated that one-third of

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couples did not benefit from BMT, while one-third of couples that did respond to BMT relapsed (Jacobson *et al.*, 1987). Jacobson (1992) identified three primary limitations that may have accounted for the failure of traditional BMT to yield long-term behavioural change: (a) the intervention strategies and targets of treatment were not derived from idiographic functional analyses, (b) the use of arbitrary rather than natural reinforcers, and (c) an emphasis on conformity to rules which impeded contact with natural contingencies.

As a result of the shortcomings of traditional behavioural couple therapy, Jacobson (1992) developed Integrative Behaviour Couple Therapy (IBCT) utilizing acceptance and change strategies. In other words, couples are educated regarding the importance of compromising and being accommodating to the needs and desires of their partner (i.e. change) and giving up the struggle to change those behaviours of the partner perceived as undesirable (i.e. acceptance). IBCT incorporates three strategies to promote acceptance of one's partner and their negative behaviours: First, IBCT teaches couples a new communication strategy, namely to approach problems as a common enemy (e.g. as an 'it', rather than one individual's problem). Second, IBCT focuses on increasing tolerance to a partner's imperfections or negative behaviours. Third, independence is created to the extent that dependency issues are precipitating conflict (see Jacobson (1992) for a comprehensive description of these strategies).

The successful implementation of these acceptance strategies and subsequent enhancement of traditional BMT is heavily dependent on the application of FAP principles. Using this more idiographic approach, the therapist focuses on within-session couple interactions, identifying clinically relevant behaviours as samples of problematic behaviour exhibited in the natural environment. Kohlenberg and Tsai (1995) have identified common situations in couples therapy that evoke clinically-relevant behaviours: (a) making financial arrangements with the therapist and paying fees evoking issues of financial control, (b) setting up appointments, keeping track of homework assignments, and arranging for a babysitter indicating division of domestic duties and parenting demands, and (c) patterns of communication during therapy indicating typical patterns exhibited during conversations at home. A second application of FAP concepts involves the use of natural rather than arbitrary reinforcers. For example, if one partner frequently allows the other to interrupt during therapy, the therapist would not design a contract limiting conversational interruptions by the domineering spouse (i.e. contrived), but instead might selectively attend to comments and discuss unhappy feelings with the passive spouse (i.e. natural) while simultaneously ignoring the domineering partner. Thirdly, FAP is used in IBCT to reinforce in-session behaviours that are in the same 'response class' (i.e. share similar functions) as behaviours occurring in the natural environment with the objective of promoting generalization. As an example, a husband may have difficulties expressing intimacy issues with his wife because of her recent infidelity. This behaviour may be a function of fears of being betrayed and of a general distrust for his wife. In this instance, the therapist's task would be to decrease emotional avoidance (i.e. encourage expression of fear) by evoking issues of intimacy and trust. Subsequently, the therapist could reinforce the husband for expressing mistrust, fear, and other emotions toward his wife, the objective being that this behaviour will generalize to the home environment.

Considering the feelings of resentment, hopelessness, depression, and anxiety that may typify distressed couples (Jacobson *et al.*, 1982; Birchler *et al.*, 1984) along with the uniqueness and complexity of couple conflict (Birchler and Schwartz, 1994), efficacious treatments must acknowledge the idiosyncratic nature of couple distress and individualize treatment accordingly. With FAP as a solid foundation, the integration of acceptance and change strategies with traditional BMT shows excellent promise as a means to accomplish this goal (Cordova and Jacobson, 1993).

Dialectical Behaviour Therapy for Borderline Personality Disorder

Designated as a 'probably efficacious treatment' dialectical behaviour therapy for borderline personality disorder (DBT; Linehan *et al.*, 1991; Linehan, 1993; Kern *et al.*, 1997) is described as a blend of psychodynamic, interpersonal systems, and cognitive-behavioural approaches combined with elements borrowed from eastern philosophies and religions. Linehan and Kehrer (1993) define *dialectics* as the conflict or tension between forces (e.g. positive and negative, patient and therapist, etc.) that is critical to producing behavioural change. Dialectical behavioural therapy focuses on treating the emotional (e.g. episodic depression, anxiety, and anger), behavioural (e.g. impulsivity), cognitive (e.g. depersonalization, delusions), and interpersonal (e.g. chaotic, intense relationships)

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dysregulation typically experienced by individuals with borderline personality disorder (Linehan and Kehrer, 1993).

Linehan (1993) provides a comprehensive description of each stage of treatment. The focus of the first stage is to stabilize the patient's level of functioning. Behaviours that are targeted include suicidal ideation, self-injury, and quality of life issues (e.g. substance abuse, eating disorders, high-risk sexual acts, financial concerns, criminal activities, and health). Therapy is based on diary cards that are used to monitor these behaviours, and therapist–patient interaction is focused on structured and unstructured problem solving. Because psychopathology (e.g. behavioural impulsivity) is viewed as a function of an invalidating environment (i.e. the punishment of emotional expression), emotional, behavioural, and cognitive validation are core features of this treatment. Change procedures consist of managing contingencies, limit setting, skills training, and cognitive modification. When target behaviours are well controlled, exposure is conducted to reduce stress related to past traumatic events and emotions such as fear, anxiety, and anger. In addition to anxiety and anger reduction, the therapist's responsibility is to gradually fade assistance and reinforce the patient's independent attempts at problem solving and self-validation.

Linehan incorporates many aspects of FAP in her treatment. Specifically, in addition to change strategies outlined above, DBT focuses on the therapeutic relationship and is designed to validate (i.e. foster acceptance) within-session cognitive, behavioural, and emotional reactions. The rationale behind this technique is to reduce the fear, anger, and shame that an invalidating environment can elicit. To accomplish this goal, the therapist (a) reflects patient's thoughts, feelings and assumptions regarding their pattern of behaviour, (b) identifies aspects of the patient behaviours that are wise and/or valid, and (c) communicates to the patient that both distal and proximal behaviours and thoughts are understandable within the context that they occur (Linehan and Kehrer, 1993).

According to FAP theorists, personality disorders develop when one's behaviour is under the external stimulus control of others rather than under the private control of the verbal response 'I' (Koerner *et al.*, 1996). People with borderline personality disorder often feel empty and/or abandoned, which may indicate the absence of private stimuli controlling 'I' and the reliance on others for feedback regarding who they are and how they should feel (Kohlenberg and Tsai, 1991). One method of incorporating more aspects of FAP into DBT might be placing greater emphasis on within-session behaviour than on the discussion and analysis of behaviour that occurred during the week. For example, patients with problems of the self will exhibit lack of confidence in describing feelings, wants, etc. and will be overly concerned with the therapist's opinions during sessions. Therefore, the patient's 'I X (I am, I feel, I want, I see, I believe, etc.)' statements should be strongly reinforced in the session. One technique to evoke 'I X' statements in the absence of external cues would be for the therapist to play a more passive and less controlling role.

CONCLUSIONS AND RECOMMENDATIONS

Although empirically-validated treatments have been criticized on a number of grounds, as scientist-practitioners we are obligated to demonstrate that the treatments we use are beneficial to our patients. Nevertheless, the mere validation of a particular treatment does not preclude discontinuation of clinical research in that area. On the contrary, the continued evolution and enhancement of psychological interventions is dependent upon the incorporation of new theories and techniques that may better serve individuals with a wide array of psychological problems.

As demonstrated here, functional analytic psychotherapy is already being incorporated into several treatments with some evidence of success. This list is not intended to be exhaustive, because the potential benefits of FAP-enhanced treatment may extend to other psychological disorders and interventions. Within the context of psychotherapy, the balance between acceptance and change appears to be gaining momentum as a viable theoretical paradigm. In fact, the recently validated acceptance and commitment therapy (ACT; Strosahl *et al.*, 1998) displays many similarities to FAP, including the perspective that only behaviour that emerges in therapy can be treated directly (Kohlenberg *et al.*, 1993).

At this juncture, more controlled outcome studies investigating the integration of FAP and empirically-validated treatments are recommended. Kohlenberg and Tsai (1995) have initiated this endeavour, and are beginning to conduct studies of the effectiveness of FAP combined with other techniques compared to control groups using only cognitive-behavioural techniques. Moreover, Follette *et al.* (1996) make several useful suggestions for methods of assessing

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FAP treatment effectiveness, such as coding patient behaviour and therapist contingent responding, and testing whether the probability that a patient's response changes as a result of the therapist's contingent reinforcement. As an additional outcome measure, changes in the frequency of problem behaviours occurring in and out of sessions could be monitored. Further research is likely to establish FAP as an invaluable therapeutic strategy. When the reward is the more competent provision of service to our patients, it seems like a worthwhile endeavour.

REFERENCES

Barlow, D. H. and Craske, M. G. (1994). *Mastery of Your Anxiety and Panic—II.* Albany, NY: Graywind Publications.

Baucom, D. H. and Hoffman, J. A. (1986). The effectiveness of marital therapy: Current status and applications to the clinical setting. In: N. S. Jacobson and A. S. Gurman (Eds), *Clinical Handbook of Marital Therapy.* New York: Guilford Press, pp. 597–620.

Beck, A. T. (1967). *Depression: Causes and Treatment.* Philadelphia: University of Pennsylvania Press.

Beck, A. T., Rush, A. J., Shaw, F. B. and Emory, G. (1979). *The Cognitive Therapy of Depression.* New York: Guilford Press.

Bernstein, G. S. (1998). Present imperfect, future uncertain: Musings on the state of the profession and the future of AABT. *Behavior Therapist*, **21**, 89–92.

Birchler, G. R., Clopton, P. L. and Adams, N. L. (1984). Marital conflict resolution: Factors influencing concordance between partners and trained coders. *American Journal of Family Therapy*, **12**, 15–28.

Birchler, G. R. and Schwartz, L. (1994). Marital dyads. In: M. Hersen and S. M. Turner (Eds), *Diagnostic Interviewing*, 2nd edn. New York: Plenum Press, pp. 277–303.

Brown, T. A. and Barlow, D. H. (1995). Long-term outcome in cognitive-behavioral treatment of panic disorder: Clinical predictors and alternative strategies for assessment. *Journal of Consulting and Clinical Psychology*, **63**, 754–765.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A. and McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, **49**, 5–18.

Cordova, J. V. and Jacobson, N. S. (1993). Couple distress. In: D. H. Barlow (Ed), *Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, 2nd edn. New York: Guilford Press, pp. 481–512.

Dobson, K. S. (1989). A meta-analysis on the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, **57**, 414–419.

Davison, G. C. (1995). A failure of behavior therapy (circa 1966), or, why I learned to stop worrying and embrace psychotherapy integration. *Journal of Psychotherapy Integration*, **5**, 107–111.

Ellis, A. (1962). *Reason and Emotion in Psychotherapy.* New York: Stuart.

Eifert, G. H. (1996). More theory-driven and less diagnosis-based behavior therapy. *Journal of Behaviour Therapy and Experimental Psychiatry*, **27**, 75–86.

Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C. W. and Lau, A. W. (1997). Manualized behavior therapy: Merits and challenges. *Behavior Therapy*, **28**, 499–509.

Emmelkamp, P. M. G., Bouman, T. K. and Blaauw, E. (1994). Individualized versus standardized therapy: A comparative evaluation with obsessive-compulsive patients. *Clinical Psychology and Psychotherapy*, **1**, 95–100.

Fensterheim, H. and Raw, S. D. (1996). Empirically validated treatments, psychotherapy integration, and the politics of psychotherapy. *Journal of Psychotherapy Integration*, **6**, 207–215.

Follette, W. C., Naugle, A. E. and Callaghan, G. M. (1996). A radical behavioral understanding of the therapeutic relationship in effecting change. *Behavior Therapy*, **27**, 623–641.

Giles, T. R. (1993). *Handbook of Effective Psychotherapy.* New York: Plenum Press.

Hayes, S. C. (1987). A contextual approach to therapeutic change. In: N. Jacobson (Ed), *Psychotherapists in Clinical Practice: Cognitive and Behavioral Perspectives* New York: Guilford Press, pp. 327–387.

Hollon, S. D. and Devine, V. (1995). Treatment failure with conventional cognitive therapy: A case study. *Journal of Psychotherapy Integration*, **5**, 121–132.

Hollon, S. D. and Kriss, M. R. (1984). Cognitive factors in clinical research and practice. *Clinical Psychology Review*, **4**, 35–76.

Iwamasa, G. Y. and Orsillo, S. M. (1997). Individualizing treatment manuals as a challenge for the next generation: Commentary on 'Manualized behavior therapy: Merits and challenges'. *Behavior Therapy*, **28**, 511–515.

Jacobson, N. S. (1992). Behavioral couple therapy: A new beginning. *Behavior Therapy*, **23**, 493–506.

Jacobson, N. S. and Follette, W. C. (1985). Clinical significance of improvement resulting from two behavioral marital therapy components. *Behavior Therapy*, **16**, 249–262.

Jacobson, N. S., Follette, W. C. and McDonald, D. W. (1982). Reactivity of positive and negative behavior in distressed and nondistressed married couples. *Journal of Consulting and Clinical Psychology*, **50**, 706–714.

Jacobson, N. S., Schmaling, K. B. and Holtzworth-Munroe, A. (1987). Component analysis of behavioral marital therapy: Two-year follow-up and prediction of relapse. *Journal of Marital and Family Therapy*, **13**, 187–195.

Koerner, K., Kohlenberg, R. J. and Parker, C. R. (1996). Diagnosis of personality disorder: A radical behavioral alternative. *Journal of Consulting and Clinical Psychology*, **64**, 1169–1176.

Kern, R. S., Kuehnel, T. G., Jeffrey, T. and Hayden, J. L. (1997). Multimodal cognitive-behavior therapy for borderline personality disorder with self-injurious behavior. *Psychiatric Services*, **48**, 1131–1133.

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Kohlenberg, R. J. and Tsai, M. (1991). *Functional Analytic Psychotherapy: Creating Intense and Creative Therapeutic Relationships*. New York: Plenum Press.

Kohlenberg, R. J. and Tsai, M. (1994). Improving cognitive therapy for depression with functional analytic psychotherapy: Theory and case study. *The Behavior Analyst*, **17**, 305–319.

Kohlenberg, R. J. and Tsai, M. (1995). Functional analytic psychotherapy: A behavioral approach to intensive treatment. In: W. O'Donohue and L. Krasner (Eds), *Theories of Behavior Therapy*. Washington, DC: American Psychological Association, pp. 659–692.

Kohlenberg, R. J., Hayes, S. C. and Tsai, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. *Clinical Psychology Review*, **13**, 579–593.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D. and Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060–1064.

Linehan, M. M. and Kehrer, C. A. (1993). Borderline personality disorder. In: D. H. Barlow (Ed), *Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, 2nd edn. New York: Guilford Press, pp. 396–441.

Masia, C. L., Anderson, C. M., McNeil, D. W. and Hawkins, R. P. (1997). Managed care and graduate training: A call for action. *Behavior Therapist*, **20**, 145–148.

Masters, J. C., Burish, T. G., Hollon, S. D. and Rimm, D. C. (1987). *Behavior Therapy: Techniques and Empirical Findings*, 3rd edn. San Diego: Harcourt Brace Jovanovich.

Plaud, J. J. and Eifert, G. H. (1998). *From Behavior Research to Behavior Therapy*. Boston: Allyn & Bacon.

Sacco, W. P. and Beck, A. T. (1995). Cognitive theory and therapy. In: E. E. Beckham and W. R. Leber (Eds), *Handbook of Depression*, 2nd edn. New York: Guilford Press, pp. 329–351.

Sanderson, W. C. and Woody, S. (1995). Manuals for empirically validated treatments. *The Clinical Psychologist*, **48**, 7–11.

Schulte, D. (1973). Der diagnostisch-therapeutische ProzeB in der Verhaltenstherapie (The diagnostic therapeutic process in behavior therapy). In: J. C. Brengelmann and W. Turner (Eds), *Behavior Therapy—Verhhaltenstherapie*. Munchen: Urban und Schwarzenberg, pp. 28–39.

Schulte, D., Kunzel, R., Pepping, G. and Schulte-Bahrenberg, T. (1992). Tailor-made versus standardized therapy of phobic patients. *Advances in Behaviour Research and Therapy*, **14**, 67–92.

Scotti, J. R., Evans, I. M., Meyer, L. H. and Walker, P. (1991). A meta-analysis of intervention research with problem behavior: Treatment validity and standards of practice. *American Journal of Mental Retardation*, **96**, 233–256.

Shoham, V. and Rohrbaugh, M. (1996). Promises and perils of empirically supported psychotherapy integration. *Journal of Psychotherapy Integration*, **6**, 191–206.

Skinner, B. F. (1953). *Science and Human Behavior*. New York: Free Press.

Skinner, B. F. (1957). *Verbal Behavior*. New York: Appleton-Century-Crofts.

Strosahl, K. D., Hayes, S. C., Bergan, J. and Romano, P. (1998). Assessing the field effectiveness of acceptance and commitment therapy: An example of the manipulated training research method. *Behavior Therapy*, **29**, 35–64.

Task Force on Promotion and Dissemination of Psychological Procedures (1995). Training in and dissemination of empirically-validated psychological treatments. *The Clinical Psychologist*, **48**, 3–23.

Woody, S. R. and Sanderson, W. C. (1998). *Manuals for Empirically Supported Treatments: 1998 Update*.

Zvolensky, M. J. and Eifert, G. (1998). Standardized treatments: Potential ethical issues for behavior therapists? *Behavior Therapist*, **21**, 1–3.

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