

RADICAL BEHAVIORAL PSYCHOTHERAPY: TWO CONTEMPORARY EXAMPLES

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ABSTRACT. *Two new systems of adult outpatient psychotherapy based on Skinner's radical behaviorism are described. They do not resemble traditional behavior therapy. Functional analytic psychotherapy (FAP) relies on an involved, emotional, nonmanipulative client-therapist relationship as the vehicle of change. Acceptance and commitment therapy (ACT) gives the client a counterintuitive method of accepting, rather than changing or eliminating, troublesome thoughts and feelings. The descriptions of these therapies are offered (a) to illustrate how intensive, in-depth psychotherapies can be derived from radical behaviorism, and (b) to circumvent the frequent misunderstandings that characterize the discussions between behavior analysts and their critics. The nature of ACT and FAP methods appears to dispel many common myths about contemporary behavior analysis.*

When we asked several of our colleagues what came to mind in response to the terms *Skinnerian psychotherapy* and *radical behaviorism*, their responses included "simplistic," "rigid," "mechanistic," "controlling," "manipulative," "chauvinistic," "devoid of emotion and sensitivity," "ignores the unconscious," "doesn't foster creativity," "assigns no role to self or sense of self," "confined to behavior common to people and animals," "ignores the importance of the client-therapist relationship," "ignores feelings and thoughts," "deals only with what can be seen publicly." All of these conceptions are false.

Radical behaviorists have often complained claimed that behavior analysis is easily misunderstood (e.g., Catania, 1991; Morris, 1990). Unfortunately, when debates and

discussions about radical behaviorism are conducted, understanding rarely results. In part this is because radical behaviorism is based upon unusual philosophical assumptions that modify the meaning of many key terms (Hayes & Hayes, 1992). For instance, the radical behaviorist believes that reality is unknowable independent of perceiving. Perceiving, in turn, is a behavior which is shaped by the individual's experiences from birth to the present. Thus, when a behavior analyst uses the term *stimulus*, it is by assumption holistic, idiosyncratic in nature, and dependent on the individual's history. Meanwhile, a critic may accept the notion of a fixed, knowable reality and use the term *stimulus* to speak of a real object in the environment. From this viewpoint, there is a serious problem with the term *stimulus*. The problem is that different organisms perceive the "same" stimulus in different ways. The resolution to the problem requires that the organism actively construe the stimulus. Thus, the critic may accuse the behavior analyst of failing to deal with the active role of the individual perceiver in establishing the meaning of stimuli. On the other hand, the behavior analyst may accuse the critic of needlessly adding mediational terms, since meaning and the individual have already been taken into account. Both may go away missing the point that entirely different "stimuli" were being discussed.

The present article approaches these topics differently. We will work backwards, so to speak, by presenting two comprehensive systems of psychotherapy that are based on radical behavioral thinking: functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1987, 1991) and acceptance and commitment therapy (ACT) (Hayes, 1987; Hayes & Melancon, 1989). As detailed by Kohlenberg, Hayes, and Hayes (1991) and Hayes and colleagues (Hayes, Brownstein, Devany, Kohlenberg, & Shelby, 1987; Hayes, Kohlenberg, & Melancon, 1989), ACT and FAP are designed on the basis of laboratory findings and conceptual approach of radical behaviorism. In this article, however, ACT and FAP interventions are described in some detail, with only a minimal discussion of the theoretical analyses on which they are based. This approach may be less likely to lead to detailed knowledge of radical behaviorism, but seems more likely to facilitate communication between behavior analysts and other clinicians.

Behavior analytic authors have described psychotherapy as a complex process involving verbal behavior and the client-therapist interaction (Ferster, 1979; Glenn, 1983; Hamilton, 1988; Skinner, 1953). Unlike most forms of behavior therapy, both FAP and ACT are concordant with the expectations of clients who seek an intensive, emotional, in-depth therapy experience. While FAP and ACT are quite different, they also cohere with each other theoretically and technically (Hayes et al., 1989). Neither look very much like what persons outside of behavior analysis might expect of radical behavioral forms of psychotherapy.

FUNCTIONAL ANALYTIC PSYCHOTHERAPY (FAP)

Two practicing clinicians, Kohlenberg and Tsai, used behavioral concepts (a) to account theoretically for the dramatic and pervasive improvements shown by some clients when involved in intense client-therapist relationships, and (b) to delineate the steps therapists can take to facilitate intense and curative relationships. The result is a treatment in which, in contrast to popular misconceptions about radical behaviorism, the client-therapist relationship is at the core of the change process. FAP theory indicates that, in general, the therapeutic process is facilitated by a caring, genuine, sensitive, and emotional client-therapist relationship.

Rationale

Although behaviorism is well known for its emphasis on reinforcement, it is less well known that Skinnerians have differentiated between two types of reinforcement that are

termed *contrived* and *natural* (Ferster, 1967, 1972; 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 for not making eye contact is contrived, while the spontaneous wandering of the therapist's attention 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 us 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 because it was followed by a smile would not be prepared to express anger during daily life. Contrived reinforcers are often inappropriate for adult outpatient psychotherapy for this reason. 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, even the deliberate use of natural reinforcers can become contrived and 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 would call "countercontrol."

Use of reinforcement in psychotherapy thus presents a major dilemma to a radical behaviorist. 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, chauvinistic treatment.

The dilemma is obviated, however, when the therapy is structured so that genuine reactions of the therapist to client behavior naturally reinforce improvements as they happen. Such a process is likely to occur only when the therapeutic situation evokes the client's presenting problem. 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 problem. 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.

Synopsis of FAP

The clinical application of FAP will be discussed in terms of (a) types of client behavior that are clinically relevant, and (b) rules or guidelines for therapeutic technique. Client behaviors include daily life problems that occur during the session, improvements that occur during the session, and interpretations of their own behavior. Therapist guidelines are rules or methods that are aimed at evoking, noticing, reinforcing, and interpreting the client's behavior.

Clinically Relevant Behaviors (CRBs). As stated previously, types of client problems that are suitable for FAP occur during the therapy session. Three client behaviors of particular relevance are referred to as clinically relevant behaviors (CRBs).

CRB1: Client problems that occur in session. CRB1s are related to the client's presenting problems, and should decrease in frequency during therapy. For example, a client who has no friends may exhibit these CRB1s: 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.

Client problems can also involve thinking, perceiving, feeling, seeing, and remembering that occur during the session. For example, problems known as "disturbances of the self" (see Kohlenberg & Tsai [1991] for an extensive discussion on how such disturbances are acquired and treated), such as "not knowing who the real me is" and multiple personality disorder, are translated into behavioral terms (e.g., problems with stimulus control of the response "I") and conceptualized as CRB1. The "self" referred to above is the same self discussed below in the section on ACT. In general, FAP is well suited for clients who have difficulties in intimate relationships and/or have diffuse, pervasive interpersonal problems typified by Axis II diagnoses in the DSM-III-R.

CRB2: Client improvements that occur in session. In the early stages of treatment, these behaviors typically are not observed or are of low strength. 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.

CRB3: Client interpretations of behavior. CRB3 refers to clients' talking about their own behavior and what seems to cause it. It includes "reason giving" (Hayes, 1987; Zettle & Hayes, 1986) and "interpretations." The best CRB3s involve the observation and description of one's own behavior and its associated reinforcing, discriminative, and eliciting stimuli. Learning to describe functional connections can help in obtaining reinforcement in daily life. CRB3 includes descriptions of functional equivalence that indicate similarities between what happens in session and what happens in daily life. For example, Esther, age 41, had not been sexually intimate with anyone for over 15 years. After a course of FAP with Dr. Tsai, Esther became the lover of a man she met through church. Her CRB3 was,

The reason I'm in that intimate relationship is because you had been there for me. It's such a phenomenal change. If not for you, I wouldn't be there. With you it was the first safe place I had to talk about what I feel, to find reasons why it's desirable to be sexual. There was a period of time that I was more overtly attracted to you, and you were accepting of my feelings. I learned that it was better to be whole and feel my sexuality than to be armored and empty, and I practiced learning how to be direct with you.

Rules of Therapy. The FAP therapist is urged to follow five strategic rules of therapeutic technique: (a) watch for CRBs, (b) evoke CRBs, (c) reinforce CRB2s, (d) observe the potentially reinforcing effects of therapist behavior in relation to client CRBs, and (e) give interpretations of variables that affect client CRB. Each rule is described in turn below.

Rule 1: Watch for CRBs. This rule forms the core of FAP. Kohlenberg and Tsai's (1987)

major hypothesis is that following this rule improves therapeutic outcome—that is, the more proficient a therapist is at observing CRBs, the better will be the outcome. It is also hypothesized that following Rule 1 will lead to increased intensity—stronger emotional reactions—between therapist and client.

From a theoretical viewpoint, the importance of Rule 1 can not be overemphasized. If this is the only rule that a therapist follows, 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 react naturally to these instances. Thus, a therapist following Rule 1 is more likely to naturally reinforce, punish, and extinguish client behaviors in ways that foster the development of behavior useful in daily life. Any technique that helps the therapist in the detection of CRB1 has a place in FAP. For example, 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.

Rule 2: Evoke CRBs. The ideal client-therapist relationship evokes CRB1 and provides for the development of CRB2. The degree to which this ideal is met depends, of course, on the nature of the client's daily life problems. In many cases, however, 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 limits on boundaries. Such a structure often evokes the clients' conflicts and difficulties in forming and sustaining intimate relationships.

Clients' descriptions of what they want from therapy point to the importance of an evocative relationship. As one client stated, "Therapy is about building a loving relationship. If you can overcome your blocks with one person, you can go on to do it with others." Another client echoed similar sentiments, "If bad relationships messed me up, then it follows that I need good relationships to help me heal. And this is a good relationship."

Rule 3: Reinforce CRB2. 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 seems to 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. 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: (a) dispositions to act in intimate and caring ways and (b) 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. If therapists have been emitting behaviors that they think are 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. Feedback of this type is needed to increase therapist effectiveness.

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. For example, a client Angela, in treatment with Dr. Kohlenberg, stated that she did not have initiative or take risks because whenever she even thought about it, she felt like she did not "have a right to exist," and that she was "just so much trouble." Her therapist offered interpretations which stressed that her feeling of not having the right to exist and her inability to take initiative were the result of her history of being punished by her mother for being assertive, confident, or for doing almost anything that called her mother's attention to her existence.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

Imagine a client who is willing to experience a full range of emotions, thoughts, memories, bodily states, and behavioral predispositions, including those that are "negatively" evaluated, without necessarily having to change them, escape from them, do what they say, or avoid them. When private behaviors need not be changed or believed, their controlling effects over overt behavior might be reduced considerably, and concern could shift from emotional or cognitive manipulation to the more direct consequences of overt action. In short, the issue would be doing what works, particularly in the long term, rather than feeling "good" (or not feeling "bad") in the short run. This is the essential goal of ACT.¹ It is designed to treat emotional avoidance, excessive literal response to cognitive content, and the inability to make and keep commitments to behavior change (Hayes, 1987; Hayes et al., 1989; Hayes & Melancon, 1989; Zettle & Hayes, 1986). As such, it is a treatment that is especially oriented toward the chronic, severe, treatment-resistant, multiply disordered client.

Rationale

Most adult psychotherapies deal, implicitly or explicitly, with the effect of client thoughts and feelings on overt behavior. In the usual view, certain undesirable emotions or thoughts are believed to produce undesirable patterns of living. On that basis these thoughts or emotions are targeted for change, control, or elimination. Such a normative focus in psychology is readily revealed both in the way behavioral disorders are named (e.g., "anxiety disorders" or "affective disorders") and treated ("anxiety management" or "cognitive restructuring"). In a behavior analytic view, behavior includes everything that organisms do in interaction with the world, including subtle or private events such as thinking or feeling (Skinner, 1945, 1953), but the relation between one behavior and another always occurs in a historical and situational context (Hayes & Brownstein, 1986). The question "What role do thoughts or emotions play in controlling human behavior?" would be changed to "What types of contexts produce an emotion-overt behavior relation?"

Rather than trying to change private events, ACT attempts to recontextualize them. At least three aspects of the normal social-verbal context for human action are thought to

¹Acceptance and commitment therapy was previously termed "comprehensive distancing," but the therapy has recently been renamed to avoid the undesirable and inaccurate dissociative connotation of the term. Also, ACT is pronounced "act," not A-C-T.

contribute to the establishment of undesirable control by private behaviors: (a) the impact of literal meaning and evaluation, (b) the acceptance of verbal reason-giving as a valid explanation for individual behavior, and (c) social training that cognitive and emotional control can, and should, be achieved as a means to successful living.

Literality. Words are used as if they mean or are the things to which they refer. Thus, a word and the situation that it refers to can easily be confused, and many functions that would adhere to the situation become present with regard to the words.

We conceptualize these relations behaviorally by an appeal to "stimulus equivalence" and other such relational classes (Hayes & Hayes, 1989; Sidman & Tailby, 1982). At around 16 months a child taught to name an object will also orient toward the object given the name (Devany, Hayes, & Nelson, 1986; Lipkens, Hayes, & Hayes, in press). These kinds of derived relations are based not upon the form of the events related, but rather on the arbitrary application of a conventionally trained relation (Hayes, 1991). These conventions are what we mean by "the context of literality."

Importantly, functions given to one member of an equivalence class will transfer to others. If our same child loves to play with dogs, and hears someone say "oh, a dog," the child may approach without ever having responded to such a statement in the past and secure reinforcement. Such effects have already been documented in the equivalence literature (Hayes, Brownstein, Devany, Kohlenberg, & Shelby, 1987; Hayes, Kohlenberg, & Hayes, 1991; Kohlenberg, Hayes, & Hayes, 1991; Wulfert & Hayes, 1988).

The verbal community is constantly tightening the equivalence between our talk and the world. Verbal stimuli are purely arbitrary stimuli, and there are few impediments to fairly tight equivalence classes emerging. Consequently, when we think something, it is not always obvious that it is even a thought. One member of the class is treated as if it is the same as another member of the same class. For example, a person may think "this is awful." The person may then act as if he or she is in an awful situation, not in a situation in which they have the thought "this is awful." Such context of literality establishes functions for thought that would be appropriate to the situations constructed, but may not be for the thought itself.

Reason-Giving. A second source of an emotion-overt behavior relation is reason-giving. People are required to give verbal explanations for their behavior, even if its sources are unknown or obscure (Semin & Manstead, 1985). Thoughts and feelings are commonly pointed to in these reasons (an action that is supported by the culture). A person saying "I felt so anxious I couldn't go" will certainly be thought to have said something reasonable and understandable. He or she may even garner sympathy or reassurance. "I have no idea why I didn't go" will probably receive a much less positive response.

Unfortunately, these rules come to control behavior (cf. Skinner, 1966). We come to believe our own reasons and explanations. Thus, emotions or thoughts may indeed lead to maladaptive avoidance, in part because it is "reasonable" to respond to one's thoughts and emotions in this fashion, and thus the avoidance is supported by the social community. The true reasons for action may often be remote and unaccessible, but following these verbal rules competes with the direct contingencies (Hayes, 1989).

In place of these contexts ACT establishes a verbal community of two in which literal meaning and reason-giving is deemphasized, emotional and cognitive acceptance is encouraged (the competing context of control is described below), the necessary link be-

tween private and other behaviors is undermined, and goal-setting and achievement are approached directly.

Synopsis of ACT

Most clients come into therapy with the general outlines of a “solution” to their problems. Usually it consists of the elimination of disturbing emotions, thoughts, memories, impulses, and so on. In our view, this eminently logical, sensible, and commonsense view of the “solution” is instead one aspect of the problem.

The identified set of problems and solutions arises from a set of practices established and maintained by the community of verbal organisms of which we all are a part. Because they are so ubiquitous, these social/verbal contexts for action are difficult to challenge and to change. Five stages can be delineated as part of that process.

Creative Hopelessness. In the first stage of ACT, an attempt is made to establish a state of “creative hopelessness” in which former “solutions” begin to be seen as impossible to implement. When all “solutions” are no longer solutions, the client feels hopeless, but it is a creative hopelessness because now fundamentally new approaches are possible. Because the client’s solution is both logical and reasonable, the therapist must behave in ways that are neither.

All of the client’s efforts at emotional control are explored in detail, and in each case the client is asked if in his or her experience this approach solved the problem. Of course the answer must be no, or the client would not be in therapy. When the list is exhausted, the therapist denies any ability to eliminate, control, or reduce distressing emotions or reactions the client is experiencing. Instead, great exertion and minimal benefit of previous efforts to solve the problem are emphasized. Since the things clients have already attempted are typically logical, commonsense solutions, it becomes clear that some change beyond ordinary verbal logic is needed. The underlying fear that clients have that the situation is hopeless is brought out and affirmed. Within the context in which the client has been working, the therapist agrees that it is hopeless. The sense that the client has of being stuck is also brought out and affirmed.

ACT relies a great deal on uses of language that are not linear, such as paradox and metaphor. Use of metaphor fits fairly well with other, more humanistic uses of metaphor in the clinical setting (see McCurry & Hayes, in press, for a review), but it differs in that specific ACT-relevant themes are always at the focus of such metaphorical talk. An example of a metaphor used in this phase of ACT is as follows:

Therapist: Let me give you a metaphor that might help you see what I’m saying. The situation you are in is something like this. Imagine that you are blindfolded, given a tool bag, and told to run through a large field. So there you are, living your life, running through the field. Unknown to you, though, there are deep holes in this field. They are fairly widely spaced but sooner or later you accidentally fall into one. Now when you fall into the hole, you do the logical thing. You open the tool bag, take the tool you find there, and you try to get out. Unfortunately, the tool inside is a shovel. So you dig. And you dig. But digging is a thing that makes holes, not a way to get out of them. So the hole gets bigger and more elaborate. So you dig differently. You dig fast. You dig slow. You take big scoops. You take little scoops. But still you are stuck. So maybe you try other things. You might try to figure out exactly how you fell in the hole. “If I just hadn’t turned left at the rise, I wouldn’t be in here,” you might think. And of course that might be literally true, but it doesn’t make any difference. Even if you knew every step you took, it wouldn’t get you out of the hole. So you

think “Maybe I need a really great shovel.” That’s what you are asking from me. Maybe I have a gold-plated steam shovel. But I don’t and even if I did I wouldn’t use it. Shovels don’t get people out of holes — they make them.

Client: So what is the solution? Why should I even come here?

Therapist: I don’t know, but it’s not to help you dig your way out. Let’s start with what your experience actually tells you. You know what you’ve been doing hasn’t been working. But what I am asking you to consider is that it can’t work. Until you open up to that you will never let go of that shovel because as far as you know it’s the only thing you’ve got. But until you let go of it you have no room for anything else.

Confusion is used deliberately to prevent clients from intellectualizing and compartmentalizing their dilemma into the same solutions that have already failed. For example, the therapist might say “Whatever you hear me saying right now, I want to assure you with 100% confidence that is not what I’m saying.” In addition to being strategically useful, such a statement is almost certainly true, since the client behaviors at strength when considering solutions to problems are reason and logic, yet within this approach reason and logic themselves are being attacked.

Trying to Control Private Events Is the Problem. The second goal of ACT is to define emotional and cognitive control as the core problem. By the time the client comes to therapy, he or she has been well trained to view control of private events as important. There are at least four components of such training that seem apparent:

1. Direct efforts at control work well in many areas of living; thus, control of private events is likely due to generalization. We are taught to control our environments by deliberate and persistent action (“If at first you don’t succeed, try, try again”). This general strategy is beneficial in the world of objects. If one wants to get rid of weeds in the garden, digging them up will work. There seems to be no obvious reason not to apply the same strategy to private events.
2. Children are told to control emotions (“If you don’t stop crying, I’ll give you something to cry about”) or thoughts (“Just forget it”) with the implication that this is readily done.
3. By hiding their own emotions and thoughts, adults give every indication to children that they can control private events at will. Thus, most people seem to grow up thinking that emotional and cognitive control is workable and even necessary.
4. Attempts to alter private events often seem to work, at least over the short run, and when the emotions are relatively moderate. Distraction may remove a negative thought, for example, or relaxation may remove some of the bodily concomitants of anxiety. But if the effort is vitally important (e.g., because the thought is too terrible ever to think again) these strategies may not work as well. For example, even if distraction removes a thought, the person will have to think the thought to make sure it has stayed away.

These are four sources over the “context of emotional control.” In this part of ACT, clients are encouraged to examine their own experiences to see if the rule that works in the world of objects (“If you don’t like something, figure out how to get rid of it and then get rid of it”) has worked in the world inside the skin. We suggest that a more accurate rule for that arena is “If you aren’t willing to have it, then you’ve got it.” Metaphors are used to make the point:

Therapist: Suppose I had you wired up to a very fine polygraph. It is such a fine machine that there is simply no way you could possibly be anxious without my knowing it. Now imagine that I have given you a very simple task: don't get anxious. However, to help motivate you I pull out a gun. I tell you that to help you work on this task I will hold the gun to your head. As long as you don't get anxious, I won't shoot you, but if you get anxious you will be shot. What would happen?

Client: I'm a dead man.

Therapist: Right. But this is the situation you are in right now. Instead of a polygraph you have something even better—your own nervous system. Instead of a gun, you have your self-esteem or your success in life apparently on the line. So guess what you get?

“I” Versus What “I Do.” The third goal of ACT is to help the client distinguish between the person he or she calls “I” and the problem behaviors that the client wants eliminated. This is a difficult topic, and space limitations preclude a detailed discussion (see Hayes, 1984, 1987). The essential idea is that verbal training leads to a form of self-awareness that consists not of the context of action, but of its locus or organismic context. That is, humans learn not only to observe their own actions (one form of self-awareness), but to do so from a consistent locus or point of view—what is usually called “I.”

ACT uses various experiential exercises and metaphors to help this sense of “I” come into focus. Most people can experientially recognize the essential continuity between the “I”s referred to in the statements “I went to first grade” and “I am in therapy now” even if many decades have passed from one to the other and virtually everything in the realm of content has changed.

This sense of “I” is important because it does not change once verbal behavior is sufficiently established. It seems timeless or even spiritual (see Hayes, 1984). Such a sense of self provides a basis for acceptance of undesirable emotions without feeling threatened.

Other techniques are used at this point in ACT to begin to separate thoughts, emotions, and so on from the person having them. For example, we ask clients at least temporarily to adopt a particular verbal style in therapy, saying “I’m having the thought that I can’t go to the mall” (as opposed to simply stating, “I can’t go to the mall”) or “I’m having the evaluation that I’m a bad person” (as opposed to “I’m a bad person”).

Letting Go of the Struggle. In this phase of ACT we encourage clients to begin deliberately experiencing thoughts and feelings that, if taken literally, must be avoided. There are many times when self-rules point to ineffective actions. When we encourage clients to give up the struggle with control, we are not asking them to “grin and bear it,” or “tough out” their symptoms until they are able to be endured. Rather, we are asking the client to lean forward into the symptoms; we encourage them not only to stop struggling, but seemingly to embrace the very things that they most dread.

Many techniques are used in this process, especially “willingness exercises.” Private events avoided are brought into the therapy room (via imagery or exercises) and dissembled into component pieces: bodily sensations, thoughts, behavioral predispositions, memories, and so on. In all cases the goal is not to gain control over them but to experience them without any attempt to modify or escape them.

Commitment and Behavior Change. The fifth goal of ACT is making a commitment to action. In the ACT session, a client who makes a commitment has no acceptable excuses for a failure to follow through. Nor will any attempt be made to punish recalcitrant clients or to trick them into keeping their commitments. Rather, a verbal environment

has been created in therapy that allows no logical escape, and the issue is what works. Promises usually work best when they are kept. This is a direct and natural contingency, not one imposed by the therapist. Thus, ACT tries to establish a discrimination between self-rules that cannot be followed effectively (i.e., rules of emotional avoidance) and self-rules that can be followed effectively and if followed will lead to positive consequences (e.g., commitments to behavior change).

Outcome and Process Data on ACT

The impact of ACT has been studied with several populations. When presented in an individual format it was shown to be more effective than Beck's cognitive therapy in the treatment of depression (Zettle, 1984). When conducted in a group format, ACT was still superior, but only marginally so (Zettle & Raines, 1989). ACT has been used to treat the emotional distress of families with severely physically handicapped children—a situation in which removal of the stressor is not possible (Biglan, 1989). ACT has also been found to be effective with several different anxiety disorders (Hayes, 1987; Hayes, Afari, McCurry, & Wilson, 1990).

In line with theoretical expectations, process research tells us that ACT clients show a slower drop in the frequency of depressive beliefs than do cognitive therapy clients, but show a much more rapid drop in the believability of those thoughts (Zettle & Hayes, 1986). Similar differences have been seen in other studies (Zettle, 1984; Zettle & Raines, 1989). Also in line with ACT theory, beneficial outcomes have been shown to be related to reductions in emotional avoidance (Khorakiwala, 1991; McCurry, 1991).

FAP, ACT, AND CONTEMPORARY BEHAVIORISM

The differences between FAP and ACT are based on the behavioral systems they attempt to modify and the means relied on to do that. FAP focuses mainly on contingency-shaped behavior and thus is concerned with the role of reinforcement contingencies in psychotherapy. ACT focuses primarily on rule-governed behavior and is concerned with the role of faulty rule control.

Differences notwithstanding, the behavior analytic foundations of these two therapies result in some major similarities which reflect contemporary behavioral thinking. For instance, both FAP and ACT take the view that only behavior that emerges in therapy can be treated directly. In FAP this consists of the social behavior of the client in relationship with the therapist. In ACT this consists of human language, not in terms of its referential content, but of verbal processes themselves.

In addition, both FAP and ACT avoid use of mental entities and instead focus on learning principles and environmental events in explaining how behavior is acquired. In mentalism, processes and structures such as “ego functions” and “projective identification” (if defined as something other than behavior) are given homuncular power to cause behavior. If the goal of behavioral explanation is to make a therapeutic difference, any explanation that does not trace behavior back to an environmental context is necessarily incomplete because the therapist is always in the client's environment. Interventions can only start from there. For this reason mentalistic analysis can focus the clinician unproductively. For example, if self-observing and describing are viewed as “ego functions” rather than as learned behaviors, the therapist's attention might be shifted to the psychic drives involved in strengthening ego functions. But psychic drives cannot be altered directly, so it is unclear what the clinician should do. If viewed as learned behavior, the clinical implications are more direct: Prompt and reinforce the relevant behaviors.

A similar analysis applies to projective identification, a psychoanalytic (more specifi-

cally, object relations) concept involving a psychological mechanism in which the individual "unconsciously projects a part of the self into another human being as a means of converting an inner struggle over badness and unacceptability into an external one" (Cashdan, 1988). According to Cashdan, a major projective identification is that of dependency, which induces caretaking in others. A FAP therapist would view the projective identification of dependency in these ways:

1. Nothing is projected into someone else; the client is acting dependently because he or she was reinforced for it in the past, and was probably punished as a child for exhibiting more independent behaviors.
2. No conversion of an inner struggle into an outer one takes place; the inner struggle is a side effect of both dependent behaviors and independent behaviors having been punished at different times.
3. Being this dependent has lost much of its past adaptive value; dependence now constitutes an avoidance behavior which prevents the client from contacting more positive contingencies associated with building in new behaviors (e.g., being assertive, being able to give and take).

Implications of the FAP analysis for the therapist are direct. Conversely, in Cashdan's analysis all of the action is "inside," and thus only indirectly accessible to the therapeutic interaction.

CONCLUSION

A reexamination of the list of characteristics ascribed to Skinner and radical behaviorism in the opening paragraph by our nonbehavioral colleagues shows an obvious lack of correspondence with FAP and ACT. For instance, "assigns no role to self or sense of self" does not cohere with the centrality of "I" in ACT. "Ignores the importance of the client-therapist relationship" is inconsistent with the centrality of the client-therapist relationship in FAP. "Ignores feelings and thoughts" does not correspond with the centrality of emotions and cognitions in both FAP and ACT.

Of course, it could be argued that FAP and ACT are somehow not really based on radical behaviorism. Several responses are possible: (a) The developers of these techniques were behaviorally trained and self-consciously relied on behavioral principles in developing these procedures; (b) every component of both therapies has been behaviorally rationalized (due to space limitations, naturally only examples of this have been presented here, but the interested reader can assess this further in the various referenced sources); and (c) both of these procedures have been presented in symposia and workshops at behavior analytic conventions, where this argument has never been made to us by behavior analysts themselves.

Neither FAP nor ACT were generated to answer criticisms directed toward Skinnerians. They were generated by behavior analytic clinicians trying to get a particular job done. The fact that they conflict with common conceptions of behaviorism, we believe, is due to a simple reason. These common conceptions are incorrect.

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