Going Big in Psychotherapy:
Expanding and Enhancing Your Treatments with Conceptualization-driven Interpersonal Behavioral Therapy

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Welcome and a few notes…

- Thanks for coming!
- Some (massive) revisions to slides that were sent for translation (time dependent)
- The set up for today
  - The didactic part
    - Why interpersonal variables matter
    - Principles and mechanisms of change
    - Case conceptualization and functional assessment
    - Interpersonal behavioral therapy
  - Case consultation role plays

Our take-aways for today

- Interpersonal connections and relationships are fundamental in sustaining and alleviating suffering
- We can use psychological principles to help define mechanisms of clinical problems and mechanisms of client change
- We can conceptualize client interpersonal problems using behavioral principles and use these to bring about clinical change in-session

This idea of going big..

- Recent case consult – client with overwhelming anxiety
- Focus was on thoughts (ACT, mindfulness)
- Therapist asked about broadening context to somatic experience (cue exposure)
- Discussion revealed that client struggled with an intense need for approval
  - This is a big part of the client’s context of struggle
  - AND where the intervention became focused

This idea of going big..

- Going big here means
  - taking a larger view of the client’s context to include interpersonal variables
  - assessing these problems and defining them using psychological principles
  - moving towards interventions that include interpersonal variables
  - including responding to behaviors as they occur in-session

Backing up to some assumptions

- We are a very social species related to other very social species (a la common ancestors)
- 98.4% of our genetic structure shared with chimpanzees
  - Much of that 1.6% is considered filler

Human imperative?

- Need to connect may be part of our genetic make up
- Assumption lends to human connection as fundamental to survival
- From here, our focus on alleviating human suffering can shift to or include the interpersonal

Research on interpersonal as suffering

- Interpersonal Theory of Suicide
  - Belongingness, Perceived burdensomeness (Joiner, 2005)
- Suicide prevention efforts aimed at social connectedness (CDC, 2011)
- Data on increased likelihood of survival (50% mortality risk reduction) through social connectedness (Holt-Lunstad, Smith, Layton, 2010)

Going big with our assumptions about why we suffer

- Human suffering is caused by problems that are intra- AND interpersonal in nature
- Intrapersonal
  - Our (primate) mind may be built for fear and reactivity (pattern detection)
  - Trouble with strong feelings or responding effectively to (thoughts of) fear
  - Many psychotherapies emerged with goal to alleviate these troubles of “mind”

Going big with our assumptions about why we suffer

- Human suffering is also caused by problems that are interpersonal
  - May be built into evolution as necessary - have trouble connecting with, supporting, and being supported by others
  - Still – can be hard to do connect genuinely and with appropriate vulnerability
  - These are essential skills that are often hard to directly instruct
  - Far fewer therapies focus on these skills

Interacting constructs

- Always consider that intrapersonal distress and interpersonal distress are deeply intertwined
  - Argue that these should **not** be viewed as distinct or operating separately
    - If I'm disconnected from others, it may bring about sadness that is very hard to feel and seek to avoid it
    - My inability to feel hard feelings (e.g., fear) may make it difficult to engage others

Quick big (ACBS) assumptions!

- Behavior can only be understood as an act in context
- When behavior is considered without an analysis of context, it loses its meaning
- Our job is to try to see the larger context of human suffering
  - This can help us in many ways!

Consider this

- A client cries for most of the therapy session.
  - Is this a good thing for the client or a problematic thing?
- A client tells the therapist, "I need you to stop and just give me space."
  - Is this a good thing or problematic?

Quick therapeutic assumption

- We can shift our conceptualization of human suffering from intrapersonal content to interpersonal process (and back again)
- The focus can shift from
  - interventions on how to respond to/change/accept content (thoughts/feelings)
  - to developing skills/learning more effective process (focus on relating)

So…How do we do this?

- Intrapersonal content is addressed several ways
- Consider these as the mechanism of the problem and mechanism of change
  - **Dysfunctional thoughts/schema**
    - Identify, challenge, replace with accurate schema
  - **Experiential avoidance**
    - Identify, notice/diffuse, develop acceptance skills

Using principles to drive treatments

- Psychological principles are helpful!
  - Can help us understand complex problems
  - Can guide us and help us ask useful questions
  - Can allow us to test assumptions and strategies
  - Can allow us to teach complex behaviors
- Compare this with mid-level philosophical terms
  - e.g., Awareness, courage, love; defusion

Principle-based mechanisms

- From contemporary behavioral perspective (AKA third wave, AKA functional contextualism)
  - Mechanism of the intrapersonal problem:
    - **Negatively reinforced (complex) escape and avoidance behaviors** (repertoires of psychological experiences)
      - Learned behaviors under contingent control (stimuli, responses, reinforcement)
    - ACT: experiential avoidance of thoughts and feelings that function to decrease anxiety, etc.

Principle-based mechanisms

- Mechanism of the interpersonal problem:
- **Insufficiently developed (reinforced) AND/OR problematic repertoires (including escape, excesses, and deficits)** for complex social engagement
  - History of **punishment** for interpersonal behaviors
  - History of **negatively reinforced escape** or avoidance of feelings of vulnerability or other aversive affective experiences in the presence of other people
  - **Reinforced excess** responding and/or problematic **deficits**
  - These are both directly reinforced AND verbally derived responses that become verbal as well as nonverbal operants

Mechanism of change

- Mechanism of change for intrapersonal problems (third wave therapies)
  - Exposure to affective and cognitive experiences and development of a (verbal) repertoire that is differentially reinforced
    - and then derives relations from there (a la RFT)

Mechanism of change

- Mechanism of change for intrapersonal
  - Establishment of experiential (range from tolerance to acceptance) and verbal repertoire
    - Verbal repertoire identifies distal reinforces that are constructed
    - May serve as narrative in form of values statement that control more local behavior
- ACT, DBT, MBCT, MBSR, CBT all have mechanisms that accomplish parts of all this

Interpersonal mechanism of change

- Mechanism of change for interpersonal problems:
- Differential reinforcement of more effective social repertoire using salient social reinforcers
  - Reinforcement occurs in vivo more than instructed
  - Contact with social contingencies in the moment
  - Attempting alternative behavior that may serve goals of social connection, intimacy, etc.
- Functional Analytic Psychotherapy (1991)

Remember: Interacting constructs!

- Intrapersonal and interpersonal constructs are intertwined
  - Our focus on these constructs as separate creates a false distinction
  - Consider these as shifts in our therapeutic lens or unit of analysis
  - Want to determine when it is useful to target different repertoires at different times to best help the whole client
  - This is based on the needs of the client!

Remember: Interacting constructs!

- Being disconnected from others may bring about great sadness that is hard to feel and to be avoided
  - Learning to experience that sadness and move forward with connection appears paramount
- Learning to feel hard feelings does not exist by itself or as its own goal
  - We want a client to be able to move with those feelings toward connection with others

Remember: Interacting constructs!

- Connecting with others can be hard especially if we are vulnerable (but still safe!)
  - Feelings like being scared or sad or vulnerable can be hard
  - And connecting with others can be hard
    - We work towards both repertoires simultaneously
- For this reason, ACT, FAP, DBT, MBSR are simply focused strategies
  - These do not need to be our only therapeutic strategies

Conceptualizing client interpersonal problems using behavioral principles

Conceptualizing client interpersonal problems using behavioral principles

Take it away, Bill!

Case Conceptualization: What is it?

- Attempts to discover which factors in environment maintain difficult behaviors and interfere with establishing more effective behaviors
- Attempts to determine the function of the behaviors

How do we determine the mechanisms?

- Function = what the behavior does or accomplishes
  - Can appear many different ways (topography)
    Behaviors that function to produce the same effect make up a functional class
  - Try to assess what comes before and after the behavior of interest that affects the rate of behavior = functional assessment
- Maintaining/reinforcing functions
  - Escape/avoidance
  - Tangible
  - Attention
  - Sensory

Functional Assessment

- Identifies target behaviors and the conditions that maintain or reduce them
- Aids in the selection of treatment
- Provides a way to monitor client progress
- Helps evaluate effectiveness of the intervention

Consider this case…week 3

- T: You've talked about being emotionally overly self-protective and how that has hurt your relationships leading to you feeling sad and depressed.
- P: I don't want to talk about it.
- T: We can talk about it when you are ready.
- P: Thank you, doctor. Sometimes I think psychologists just want to make someone feel badly thinking it is good therapy. You're different. You care about my feelings.

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…week 4…

- T: I'd like to get back to the issue that seems so important to why you are feeling sad - difficulty talking about your feelings.
- P: I feel like I'm broken…(sobs uncontrollably for rest of session)
- [Therapist talks over sobbing]:You aren't broken. There are many examples of how well you function in lots of situations.

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…week 5…

- T: I can't help but comment on the fact that you were 20 minutes late for session today.
- P: My dog is very ill. Have you ever lost a dog that meant everything to you, doctor?
- T: Yes
- P: That must have been very difficult for you.
- T: (therapist sobs uncontrollably)

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…week 6…

- T: I know talking about withdrawing emotionally is difficult…
- P: If you were a decent therapist, I'd be better by now.
- T: So you don't think I'm being effective for you?
- P: Duh. It's been 6 damn weeks and I'm missing work and, if anything, I'm worse than ever.
- T: Can you tell me what would be helpful?
- Xanax

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…week 7…

- T: I'd like to get back to an important topic that we haven't been able to discuss, namely, how you don't seem to be able to talk about your feelings about others.
- P: I think that's important, too.
- T: Good. Let's talk about that.
- P: We should. Before we do, last night I got out a bottle of Xanax and a fifth of vodka. Luckily, my mother called. Do you think that's important to talk about first?
- T: Aaargh!!!

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…week 8…

- (Therapist sits in office waiting for a client who doesn't show for session…therapist begins cutting on himself.)

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One Supervision Scenario

- T: This client is wreck. Every week there is a different problem. The patient is emotionally labile, is attacking, and makes suicidal gestures.
- S: On top of everything else, this sounds like a personality disorder, most likely a borderline. If I were you, I'd stock up on your own supply of Xanax and vodka.

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A Second Supervision Scenario

- T: This client is wreck. Every week there is a different problem. The patient is emotionally labile, is attacking, and makes suicidal gestures.
- S: It looks to me like every time you want to talk about emotional expressiveness the patient emits some kind of avoidance behavior. So far, how do you think you participate in strengthening or replacing that functional class?
- *T: [Jeez - why can't I see the obvious*
- *…I suck…where's my Xanax and vodka]*

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Case Conceptualization: Why Does It Matter?

- Fundamental to doing CBA in general and IBT in particular
- Contains
  - Conceptualization of both strengths and weaknesses
  - Behavioral deficits and excesses
  - Examination of contingencies of client's behavior
- Functions
  - Helps guide therapy in the moment and over time
  - Allows measurement of targeted variables

Not Time to Discuss All the Relevant Principles

Lack of Discriminative Control
Momentum
Multiple-exemplars
Lack of Appropriate Consequences
Tacts/mands
Schedule effects
Chaining
Generalization
Inappropriate Discriminative Control
Equivalence
Consequential Control Inappropriate
Resurgence
Discounting
Matching
Competing Contingent Control
Schedule thinning
Extinction
CER
Shaping
Rule governance
Variability

Layers of Conceptualization

- Broad understanding of this client and his or her life
- Understanding his or her goals for treatment
- Understanding this session or series of sessions with focused goals
- Understanding this interaction now and its impact on therapist

Layers of Conceptualization (cont.)

- All of these tie to each other
  - How does this strategy I am attempting now tie into my goals for this session given my intervention in the context of this client's life?
- The conceptualization applied to these levels will tell the therapist what to do next

Layers of Conceptualization (cont.)

CONTEXT

Layers of Conceptualization (cont.)

Context of Client's Life

Goals of Therapy

Goals of Session

NOW

Our therapy objectives

- Global objectives for contemporary behavior therapies
  - **Broadening** client repertoire to create more opportunity for responding and reinforcement
  - Create response **flexibility** so that there are more opportunities in more contexts for reinforcement
  - Create more **autonomy** of client responding by developing ability to observe and analyze own behavior, and allow client to engage in more opportunities for reinforcement
- Specific objectives are defined by the focused intervention AND are defined idiographically
  - For IBT- situated interpersonal problems

IBT presumes

- Distress is consequence of not obtaining sufficient quality/density of valued social reinforcement

IBT presumes

- Client's strengths and liabilities will show up in the therapy room in the context of the therapist-client relationship

IBT requires a case conceptualization

Where do we begin….

As soon as client walks into the room!

- We look for controlling variables that are
  - Causal
  - Important
  - Changeable

Client says…

I am worthless, no one does what I want or cares about me.

Therapist starts generating (loosely held) hypotheses about how this sentence (behavior) suggests functional targets.

I am worthless, no one does what I want or cares about me.

- "I" requires a set of valued discriminations/Can pt say "I Like", "I don't like?"
- Does she behave consistently with her valued behaviors?

I am worthless, no one does what I want or cares about me.

- "I" requires a set of valued discriminations/Can pt say "I Like", "I don't like?"
- Does she behave consistently with her valued behaviors?

- Is tact accurate?
- Is original verbal community same/different as current?

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- Does she behave consistently with her valued behaviors?

- Is tact accurate?
- Is original verbal community same/different as current?

- Assess social community for responsiveness, diversity.
- Discrimination errors?
- Verbal behavior exaggerated? If so, why?

I am worthless, no one does what I want or cares about me.

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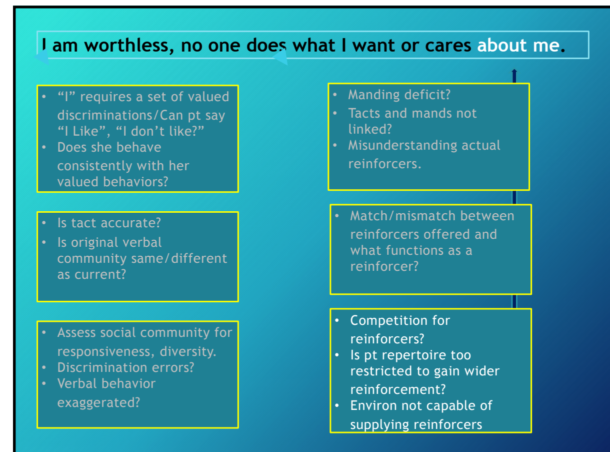
- Assess social community for responsiveness, diversity.
- Discrimination errors?
- Verbal behavior exaggerated?

- Manding deficit?
- Tacts and mands not linked?
- Misunderstanding actual reinforcers?



Sitting in the room and given the above, what would you say or do now?

… That must be a scary or lonely place to be. Perhaps it was a difficult decision to come to therapy. I so appreciate you coming to see me and letting me be a part of the change you seek. I hope I can make clear how much you matter and that you are successful.

Interpersonal Behavior Therapy

- IBT (older FAP)
  - Focuses on **in-session responding** by client to therapist
    - These responses can be inter- and intrapersonal
  - Utilizes the therapeutic relationship to help alter the problematic behaviors AND **increase the more effective behaviors**

Interpersonal Behavior Therapy

- IBT (and FAP)
  - A real focus is on empathic understanding
    - Empathy vs sympathy
    - This creates connection
    - This requires a particular level of vulnerability
  - What do we do when we don't know what to say?

IBT assumptions

- Many client problems are fundamentally interpersonal
  - These are about or inextricably tied to relationships
- Clients form relationships with therapists as a part of treatment
- Those client behaviors that occur in relationships with others will occur with the therapist as a relationship is developed

Assumptions

- These client relationship behaviors with the therapist are the same behaviors that the client does with other people
  - These include problem behaviors and improvements
  - These behaviors are not metaphors or re-enactments
  - These are the real deal, live, and in-person
    - AND…

Assumptions

- The therapist has direct access to the client behavior as it occurs in-session
  - Of course, outside of session behavior is important
  - But, therapist only has direct access to *verbal report* of that out of session behavior
  - SO…

Assumptions & mechanisms

- The therapist attempts to change client behavior by directly responding to that behavior in-session
  - The assumption here is that the behavior the client does inside of session is the same as what he or she does outside of session with others
    - How do we know?
    - We'll get to that…

Mechanisms of change

- Mechanism of clinical change: in vivo contingent responding responding to client behaviors
- In-session contingent responding to client problems and improvements
  - Use therapeutic relationship to provide consequences to improvements and ineffective strategies (**differential reinforcement**)
  - Respond to client behaviors as they impact the therapist

Mechanisms of change

- Therapist gives response as member of social community to how the client's behavior impacts the therapist
- Requires less "therapist style" and more genuineness, authenticity, or realness
  - (Thank you Dr. Rogers)
  - Looking for generalization here

IBT (FAP) is

- using compassion, understanding, honesty, openness, willingness, and caring
- to share with a client how he or she impacts us
- to better help them identify their values, needs, impact, and experiences
- in order to help become more effective in achieving those in relationships
- using principles of reinforcement to behaviors as they occur in-session

Mechanisms of change

- Need to provide feedback to client
  - about what works
  - when something is not working or causing interpersonal problems
- MUST prompt for an alternative and more effective behavior and reinforce those successive approximations toward the goal
  - Compassion is key here

Therapist Behavior

- Responding
  - According to a behavioral case conceptualization
  - Strategy based on behavioral principles
- Are there right and wrong responses
  - Yes
  - But…
    - This is determined by case conceptualization (and ultimately function)
    - There is room to be wrong and repair

Responding: Individual Strengths and Weaknesses

- Can you anticipate hard cases given your repertoire/history?
- Are there repertoires on which you might rely too strongly?
- What are your strengths?
- How can you make this an in-vivo learning opportunity?

Responses

- What is your response?
- What is the logic underlying your response (based on the case conceptualization)?
- What would make you change your response?
- Keep in mind your strengths and weaknesses

Checking in: What's new here? What are you hearing so far?

Case Application: Look for places to apply what we just discussed in a clinical case

Consider: What principles might we see here?

Clinical case example

- The client presents describing obsessive concerns that they have harmed or will accidentally harm someone. Their most debilitating symptoms occur in the context of driving. The client reports being troubled by obsessions and compulsions for approximately 4 hours each day.
- When the client drives over a pothole or speed bump, they experience overwhelming uncertainty about whether they may have accidentally run over a child. In an attempt to ease the anxiety, the person drives back and forth on their street in order to search for any indication that a child has been injured.

Clinical case example

- When the client completes these compulsions, they return to their home and engage in checking compulsions for any evidence of blood or clothing under their car or on their tires.
- Although the person is aware that their concerns are irrational, they find it very difficult to resist their impulses to engage in these rituals.
- The client then calls their partner repeatedly at work to ask for reassurance that they have not harmed anyone.

Clinical case example

- The client has begun to ask the therapist for reassurance and has brought up the desire to have more frequent sessions.
- The client stated that they find it difficult to form new relationships because they feel “damaged” and “broken,” stating, “If it weren’t for this OCD, I am sure I would be happy and have lots of friends, but I just can’t. I have too much OCD”

Case Application: Consultation Role Play

Discussion: What did you notice? What would look different here from our typical interventions?

Discussion:

How would you use this in the room?

How does this add to your conceptualization and interventions?

Going big in our therapies

- Notice that interpersonal connections and relationships are fundamental in human suffering
- We can use psychological principles to help define mechanisms of clinical problems and mechanisms of client change
- We can conceptualize client interpersonal problems using behavioral principles and use these to bring about clinical change in-session

Going big in our therapies

- This is challenging but very doable, AND…
- Remember that all behavior occurs in a context
- The broader the context the more likely it represents our actual client
- The more we apply principles, the more likely we will understand and help our client
- We have direct access to the client behavior we observe
- and can have some of our largest impact on the client in-session to help them better connect with others in the world

Thank you!

- We appreciate your time and attention!
- Answers to CE quiz:
  - 1 b
  - 2 a
  - 3 c
  - 4 d
  - 5 c
  - 6 d
  - 7 b
  - 8 d
  - 9 b
  - 10 a
  - 11 a
  - 12 d
  - 13 b
  - 14 d
  - 15 c