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THE THERAPEUTIC ALLIANCE IN BEHAVIOR THERAPY

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It may be argued that behavior therapy has proceeded with minimal regard for the therapeutic alliance (TA) as a key mechanism of change. However, ignoring the role of TA in behavior therapy may not only be problematic on a practical level, but also may be inconsistent with basic principles that underlie behavior therapy. In beginning to address these issues, the authors consider the role of TA in behavior therapy with a focus on relevant basic principles. Keeping a focus on these basic principles, the authors then outline three contemporary behavior therapies that already incorporate a focus on the therapeutic relationship and conclude with a clinical case illustration.

Keywords: reinforcement and punishment, establishing operations, shaping, and fading

A positive therapeutic alliance (TA), or "working alliance," refers to the collaborative, mutually respectful, caring partnership that characterizes a productive patient–therapist relationship (Horvath, 2001). Although TA may be considered as one element of the overall therapeutic relationship along with transference-countertransference configuration and the "real" relationship, Gelso and Carter (1994) suggest it may be the most fundamental if therapy is to proceed effectively or at all. As defined by Bordin (1979), TA is a tripartite concept encompassing the bond between therapist and patient and the subsequent agreement on the goals of therapy and the tasks that will enable the achievement of those goals. TA has been shown to be a significant predictor of treatment success and may be a common mechanism of change underlying psychotherapy interventions (Horvath & Luborsky, 1993). Whereas TA is a defining feature of psychodynamic and humanistic/experiential approaches (see Horvath & Luborsky, 1993 for a detailed historical account), its role in behavior therapy has been less clearly explicated. With notable exceptions (Brown & O'Leary, 2000; Hyer, Kramer, & Sohnle, 2004; Klein et al., 2003), behavior therapists traditionally have assumed that specific therapy techniques largely account for treatment outcome variance and that the therapist-patient relationship generally is a "neutral stimulus" that has minimal relevance toward assessing treatment efficacy (cf. Kohlenberg, 2000). However, it could be argued that ignoring the role of TA in behavior therapy may not only be problematic on a practical level, but also may be inconsistent with basic principles that underlie behavior therapy (Kohlenberg, 1999; Raue, Goldfried, & Barkham, 1997). We begin to address these issues by considering the role of TA in behavior therapy with a focus on relevant basic principles. We then outline three contemporary behavior therapies that already incorporate a focus on TA, and we conclude with a clinical case illustration.

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Reinforcement, Punishment, and Establishing Operations

The principles of reinforcement and punishment are the core of behavior therapy. Defining a *reinforcer* as a stimulus that leads to an increase in a particular target behavior and a *punisher* as a stimulus that leads to a decrease in a particular target behavior, the concepts of reinforcement and punishment allow for the functional analysis of behavior, including a focus on what motivates a patient toward pursuing and continuing psychotherapy. One key feature of this framework is that a particular stimulus will not serve as a reinforcer or punisher across all individuals or even necessarily within individuals across situations. In this manner, focusing interventions to address idiographic and contextual variables is crucial. Indeed, making efforts toward understanding the patient's particular unique environmental experiences not only increases the likelihood of identifying functional reinforcers or punishers within particular contexts, but also demonstrates empathy and understanding that can enhance therapeutic alliance.

When considering reinforcement and punishment, it is important to determine exactly what causes a particular stimulus to serve as a reinforcer or punisher in a given situation, or stated differently, what motivates behavior. Although the term *motivation* may not be a well-referenced concept in the behaviorist's lexicon, the notion of establishing operations serves as the operationalization of motivation. In this way, establishing operations may be defined as environmental events, operations, or stimulus conditions that affect an organism's behavior by altering the reinforcing or punishing effectiveness of other environmental events and the frequency of occurrence of that part of the organism's repertoire relevant to those events as consequences (Laraway, Snycerski, Michael, & Poling, 2003). It is impossible to account for the multitude of factors that influence a patient's behavior, but efforts to consider a patient's current environment and past experiences may help the therapist more productively use the concepts of reinforcement and punishment in the development of TA and subsequent application of treatment interventions.

One final issue to consider regarding punishment is that it should not be used in isolation from more positive contingency management processes. For example, imagine a patient who often behaves unproductively in therapy, perhaps using tangential speech patterns that are irrelevant to primary treatment goals. The therapist may decide to punish such behavior through extinction or mild verbal reprimand. However, doing so without understanding the particular function of this behavior, and without providing the patient with alternative strategies to address the same function, may suppress the particular unwanted verbal behavior but likely will have little effect on the initial motivation to engage in the behavior and may simply result in the creation of other distracting behaviors (i.e., symptom substitution). Thus, providing the patient with an opportunity in therapy to address and replace problematic behavior patterns with more effective and adaptive behaviors will not only improve the relationship between the patient and therapist, but also provide useful practice for situations outside of therapy.

Shaping

The principle of shaping involves the generation of a desired target behavior through reinforcement of successive approximations of the target behavior. Shaping is perhaps most often considered with reference to basic animal research (Mills, 2003). Much as animals may be trained to develop particular behaviors via shaping processes, there are a multitude of studies demonstrating the impact of shaping on the development of abnormal behavior as well as studies supporting the effectiveness of shaping as an applied clinical procedure (Delprato, 2001; Hall, 2004; Marks, 2002; Ullrich, 1993). As a clinical example of shaping, consider a substance-dependent patient who has now become sober and must tackle the daunting task of getting finances in order. Above the refrigerator sits a box of bills dating back several months, some of which the patient does not currently have the money to pay. Of course, in the real world, the target response would be opening bills when they arrive and paying them prior to the due date. If this ultimate target response is not attainable for this individual at the current time, however, abbreviated responses are first necessary. In doing so, shaping would suggest the therapist assign each step for subsequent sessions, giving praise for each weekly success and providing problem solving when a step is not successfully completed. In this situation an initial behavioral ap-

proach might involve several clearly differentiable steps including (a) sorting the envelopes by company or creditor, (b) opening the envelopes and subsequently calculating debt, (c) mailing out payment for affordable bills, and finally (d) seeking information on debt consolidators to address currently unmanageable bills.

As an example of shaping specific to TA, one may imagine a patient that has difficulty disclosing information about past traumatic experiences. Instead of expecting the patient to immediately disclose the full details of an experience, the therapist may arrange an environment in which the patient begins with approximations of the full disclosure. These approximations may include a discussion of less traumatic events within the scope of the larger traumatic experience or of peripherally relevant information. In line with shaping principles, the therapist may provide ample support for such disclosure and may not require the patient to progress immediately so long as there is some general movement toward the issues of greatest concern. Such incrementally increasing responses provide the patient with attainable successes, which are verbally praised by the therapist. Thus these shaping processes may not only be essential toward treatment progression, but may also provide a framework in which TA can evolve and improve (through verbal interactions). Indeed, behavioral changes in the patient will presumably be affected by verbal reinforcement from the therapist for subthreshold responses that typically might be ignored or unrecognized in the natural environment.

Fading

The principle of fading requires a particular target behavior, in its final form, for the delivery of a reinforcer. Fading also requires the necessary assistance of the therapist to ensure the completion of the target behavior. At the outset, fading may include a considerable amount of prompting, which is gradually "faded" out as the individual learns to complete the target behavior without therapist assistance. In this way, there is an underlying assumption that both therapeutic assistance and the patient's completion of the target behavior (and corresponding reward) are essential toward developing a modified behavioral repertoire.

As was noted with shaping, in the natural environment, patients rarely obtain the level of support necessary to adequately reward and thereby facilitate continued completion of desired target responses, as evidenced by notoriously low levels of social support in the lives of individuals with psychopathology (Corrigan & Phelan, 2004). Again as with shaping, the application of fading procedures provides ample opportunity for therapists to develop a therapeutic relationship. For a patient with social anxiety, the therapist initially may role-play numerous social scenarios with the patient and provide behavioral scripts for initiating, maintaining, and terminating a conversation with a stranger. As the patient develops greater social prowess, the therapist will praise the patient's success and perhaps only offer suggestions on ways to deal with specific situations in which the patient reports continued difficulty. This display of respect and trust from the therapist will then theoretically serve to further enhance the patient's confidence and strengthen their therapeutic alliance.

A more general example that may be relevant across disorders is the patient who has difficulty completing homework assignments outside of therapy. The therapist may provide the patient with a considerable amount of in-session verbal praise to supply the patient with the support necessary to inspire completion of the assignment outside of therapy. Over the course of therapy, as homework completion becomes more routine, the in-session focus may be "faded out." Of course, before utilizing fading, it should first be determined if a better approach might be to simplify the assignment (more in line with shaping). However, if the patient has the ability to complete the assignment but simply is lacking the support necessary to do so, the therapist can utilize fading to provide that support.

Three Contemporary Behavior Therapies That Emphasize the Therapeutic Alliance

Functional Analytic Psychotherapy

Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1995) is meant to "supercharge" traditional behavior therapy by intensifying and personalizing the patient–therapist relationship and using it as the primary vehicle for therapeutic change (Kohlenberg & Tsai, 1995). FAP may be utilized as an independent therapeutic modality, but it also incorporates principles and applications that are easily integrated into

alternative behavioral and cognitive therapy applications (Hopko & Hopko, 1999; Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002). FAP also is particularly well-suited for patients with personality disorders or interpersonal problems that have proven resistant to other forms of therapy (Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004; Callaghan, Summers, & Weidman, 2003; Follette, Naugle, & Callaghan, 1996). These problem social behaviors are bound to manifest themselves in multiple relationships, including that with the therapist. Thus, the expression of problematic behaviors displayed during the session allows for ongoing assessment and opportunities to reinforce, shape, and even on some level punish inappropriate social behaviors (Follette, Naugle, & Callaghan, 1996). Even potentially mundane therapy experiences such as checking on homework assignments or rescheduling a session can provide an opportunity for the display of emotional or social clinically relevant behaviors (CRBs) such as rebelliousness, nonassertiveness, and anxiety. Once these CRBs manifest themselves during therapy, the therapist facilitates the patient's observation and interpretation of his or her own behaviors, and subsequently reinforces improvements made during the session while failing to reinforce (and occasionally punishing) more maladaptive behaviors. Along these lines, naturally occurring contingencies such as increased or decreased attention or spontaneous verbal exclamations of affection or hurt feelings might be used to reward, shape, or decrease undesirable behaviors, much like these principles would operate in the natural environment.

The guiding principle of FAP is that significant therapeutic change will result from immediate contingent therapist reinforcement of presently occurring behaviors. For example, if a patient avoids eye contact and the therapist responds by showing boredom and pointing out this connection to the patient, then the patient will understand a real-world association between one's own behaviors and others' responses to those behaviors. As FAP aims to approximate real-world interactions that might arise in close relationships, it promotes the use of reinforcement strategies that other therapeutic interventions explicitly avoid. For example, a reinforcer could be a sincerely spoken, "I feel very close to you right now," to a patient who has opened up to the therapist after previous trouble expressing emotions to loved ones. Indeed, very few topic areas are prohibited within the application of FAP, including topics that are rarely discussed in more traditional behavior therapy, such as hurt feelings on the part of the therapist, the patient's reaction to the physical and personality characteristics of the therapist, and naturally occurring therapist errors. The patient's reaction to any of these issues can and should be candidly discussed and used to further progress, as similar issues often manifest in some form outside of the therapeutic environment. This approach certainly is more engaging than more traditional behavioral approaches, insofar as these conventional methods emphasize addressing problems outside the therapy setting, with little attention to problems as they occur within the therapy session. Moreover, FAP reinforcement contingencies also might vary substantially from those associated with conventional behavior therapy and often include genuine feedback about how a patient's behavior may positively or negatively impact the therapist's reaction to the patient (Kohlenberg & Tsai, 1995).

In FAP, as in psychodynamic, humanistic, and experiential approaches, TA should approximate an intimate social relationship as closely as possible so that the patient can easily generalize treatment effects from the session to the natural environment. FAP would therefore be impossible without a therapeutic relationship that is caring, genuine, sensitive, involving, and emotional (Kohlenberg & Tsai, 1987). An FAP therapist must be equally invested in creating an authentic and close therapeutic alliance because both therapies rest on the supposition that a patient will interact with the therapist in much the same way as he or she behaves with peers and loved ones. FAP also requires that the therapist carefully observe instances of CRBs such as patient withdrawal from or resentment toward the therapist. Kohlenberg and Tsai (1987) note that this aptitude for observing minor changes in the patient's relationship with the therapist is characteristic of especially competent psychodynamic therapists who use transference as the primary medium of therapeutic change. In FAP, behavior therapists must be similarly aware of the patient's interpersonal actions during session, as the basis of FAP is the assumption that the patient–therapist relationship and the patient's real-world relationships are functionally similar (Kohlenberg & Tsai, 1995).

The necessity of a strong therapeutic alliance is evident in the techniques and overarching theory of FAP. For instance, the constant scrupulous observation, which is required in FAP, would be difficult if a therapist did not take an active and genuine interest in the patient. Also, a therapist must express natural emotional responses to the patient's CRBs, but these might seem forced and unnatural if the therapist did not have a true rapport with the patient. Thus, Kohlenberg and Tsai have highlighted the notion that an intense therapeutic alliance can be a necessary component of behavior therapy, particularly for certain patients who have found limited success with more technique-focused approaches. Further research will be helpful toward better establishing not only the efficacy and effectiveness of this intervention and its adjunctive use with other treatment approaches, but also the extent to which positive treatment outcome is associated with the proposed active mechanism of change, namely the patient-therapist relationship (Follette, Naugle, & Callaghan, 1996).

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is a behavioral treatment that focuses on decreasing experiential avoidance and facilitating/fostering willingness of private experiences in the context/service of valued action. ACT includes five main components, however, not all components are necessarily used with all patients, and the therapy does not necessarily progress through these components in a linear manner. Given the focus on experiential avoidance, ACT is particularly suitable for avoidance behaviors linked to substance abuse (Heffner, Eifert, Parker, Hernandez, & Sperry, 2003), anxiety (Zettle, 2003), eating disorders (Hayes & Pankey, 2002), and even psychotic disorders (Bach & Hayes, 2002).

Although the goals of ACT may be intrapersonal in nature, the means are decidedly interpersonal, that is, they hinge upon the trusting and collaborative nature of TA. This may be best described using the two-mountains metaphor from ACT: The therapist and patient are conceptualized as climbing their own separate mountains. While the therapist can help the patient, it is stressed that the therapist is an individual who also has problems climbing his or her own mountain. Thus, while the therapist may be vulnerable to traps and pitfalls on his or her own mountain, the therapist does have a unique view of the patient's mountain that may be useful for assisting the patient in their struggles. Thus, as with TA, ACT is not hierarchical but instead a collaborative process.

In the first two components of ACT, the patient must first accept the past and current difficulties associated with controlling aversive private experiences, an acknowledgment that may be deeply emotional and difficult for a patient who is experiencing significant distress. By accepting creative hopelessness, the patient learns that previous avoidance-based solutions have actually become the problem and that there may be great benefits in letting go of the struggle of trying to rid one's life of uncomfortable experiences (avoidance). The therapist uses an open dialogue with the patient, employing metaphor and questioning to help the patient realize that control has been the problem and that trying something new involves moving away from different presentations of the same basic avoidance strategy. In attempting to isolate the establishing operations in effect via a functional analysis, the patient can articulate information about internal and external setting events that precipitate the avoidance behavior and can begin to generate novel strategies. The collaborative nature of the therapeutic bond is critical to allowing and easing the admission of past failure and the critical examination of one's own behavior from a functional analytic perspective.

In a third component of ACT, the patient is taught to separate personal self from various psychological phenomena such as physiological reactions, cognitions, and emotions, with a focus on the establishing operations underlying one's actions. This technique involves a careful extrication of what one *is,* from what one experiences. The avoidant alcoholic may successfully separate the idea of self from the negative experiences of binge drinking or possessing poor social skills, and therefore would not be defined by their symptoms. A strong therapeutic relationship is of great consequence here because it creates a venue for highlighting the reality of the psychological problem. The supportive environment that is formed when the patient exposes his or her private thoughts and feelings to the therapist is vital to an honest analysis of the problem.

In the fourth component, the patient is asked to reexperience aversive events in order to over-

come avoidance and pursue previously identified valued directions. Using graduated exposure, the patient's behavior is gradually shaped to approach and accept valued situations. Similarly, the reinforcement of a series of interrelated behaviors via chaining may be utilized to develop a specific repertoire for pursuing valued directions, and subsequently, approaching stimuli that may be experienced as threatening. Under the principle of fading, the socially avoidant alcoholic may willingly be able to experience the anxiety of social interactions, given that there will be ample opportunity to process these experiences in session. Alternatively, this exposure could utilize shaping, which may begin with simple positive social skills such as making eye contact, and then gradually include other steps in subsequent social interactions, again with the patient obtaining comfort and praise from the therapist for completing these steps at subsequent sessions. These aspects of TA encourage and provide instances of success in the patient's pursuit of an otherwise intimidating target behavior, until the natural contingencies of such behavior take hold. Should the TA rupture due to mistrust, the patient may be less likely to place himself or herself in the psychological distress that is integral to this method.

The final component of ACT seeks a *commitment* between patient and therapist in pursuing behavioral change. Behavioral principles such as shaping are integral here because the patient likely does not possess the desired behavioral repertoire (i.e., acceptance). Therefore, it is necessary to "start somewhere." In reinforcing initial small yet valued actions that lead up to larger target goals, the therapist is able to provide the impetus for behavioral change. As commitment develops, fading of other therapist-delivered aids are necessary to make behavior modification more permanent and independent of the program. As with shaping, the ultimate generalization to in vivo situations requires confidence on the part of both therapist and patient that the new behavior will endure despite the change in environmental circumstance (i.e., rewards, therapist assistance), as well as honest collaboration when these behaviors do not occur to allow for further problem solving. Thus, proper use of shaping and fading techniques is possible only when the collaborative spirit within the therapeutic alliance is readily apparent and enables the patient and therapist to embark upon the journey of behavioral change *together*, with the latter taking backseat to the lead of the former. The tasks of therapy are inextricably linked with the goals of behavioral change, which is furthermore strengthened by the existing TA.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT; Linehan, 1993) is another example of a treatment approach that demonstrates the importance of the therapeutic alliance in behavior therapy. DBT is a form of psychotherapy that incorporates principles of behavior therapy, cognitive therapy, and Zen philosophy. DBT was originally developed to treat chronically suicidal, self-injurious women and is the only psychosocial treatment found to be effective for borderline personality disorder (BPD) using randomized controlled trials across multiple research sites (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Koons et al., 2001). Compared to treatment-as-usual in the community, DBT has been shown to reduce the frequency and medical risk of parasuicidal behavior (Linehan et al., 1991), suicidal ideation, hopelessness, depression, and expression of anger (Koons et al., 2001). In addition, reductions in psychiatric inpatient days and improved social adjustment have been observed over a 1-year period following DBT treatment (Linehan, Heard, & Armstrong, 1993).

DBT traditionally involves six months of weekly individual therapy sessions aimed at increasing motivation, weekly skills training groups, telephone consultation on an as-needed basis to facilitate skill generalization and maintain the therapeutic relationship, and consultation meetings among therapists. Patients are encouraged to repeat the process twice to maximize learning. The behavior therapy component of DBT is based on the assumption that many maladaptive behaviors are learned and therefore may be replaced by more adaptive behaviors through new learning in the form of modeling, operant conditioning, or respondent conditioning. The dialectics component of DBT is a process of synthesizing opposing elements, ideas, or events. DBT's overarching aim is to model and teach a more balanced, synthesized, and dialectical approach to thinking and behavior. Components of this process include improving emotion regulation and interpersonal relationship effectiveness in addition to promoting mindfulness (e.g., present moment focus, nonjudgmental aware-

ness, and attentional flexibility) and the ability to tolerate emotional distress.

More so than most other forms of psychopathology, the nature of borderline personality disorder demands that TA be a principal element of DBT. DBT utilizes a collaborative patient-therapist relationship involving commitment to treatment, mutual identification of target behaviors, comprehensive behavior analysis, and acceptance and agreement that targeted behaviors are problematic and in need of modification. Failure to collaborate with the therapist and/or continually overstepping the therapist's stated limits (e.g., frequency of telephone calls) are considered therapy-interfering behaviors and are second only to suicidal and self-harm behaviors in importance for targeting change. It is the therapist's responsibility to point out how noncollaborative behaviors interfere with the patient's goals and interfere with the therapist's ability to motivate the patient toward change.

Two strategies utilized in DBT that fit well within a focus on TA are contingency management and reciprocal communication. In contingency management, the therapist arranges for adaptive targeted behaviors to be reinforced while related maladaptive behaviors are extinguished through lack of reinforcement or, if necessary, the use of punishment. Although a primary goal is to help patients develop contact with reinforcers outside of the therapy context, therapist approval, interest, concern, warmth/affection, and reassurance directed in a contingent manner are crucial, especially at the onset of therapy (Robins & Koons, 2000). In some instances, it may be necessary for a break from therapy to be implemented as a punishment, so that access to the therapist is withheld contingent upon some behavior change or commitment. For the contingency management approach to be successful, the DBT therapist must work to establish a strong TA by developing a mutual and genuine attachment between the therapist and the patient. In addition, the therapist must carefully monitor his or her own behavior and empathic inclinations such that reinforcing behaviors are not expressed following maladaptive behavior by the patient.

Reciprocal communication requires that a therapist respond in a manner that is relevant to the content of the patient's statements and to their questions. Self-disclosure is a type of reciprocal communication. This may take the form of disclosing reactions to the patient's behavior (e.g., "I am very pleased to hear that you were able to use your wise mind while talking to your father"). Alternatively, self-disclosure may reflect the therapist's reaction to the patient's act of crossing stated limits (e.g., "I was upset when you phoned me repeatedly on Friday night when we had discussed that I would be at a family function"). Finally, personal self-disclosure may be used, according to the therapist's comfort level, as a form of modeling. However, self-disclosure should be closely monitored to ensure it is occurring for the benefit of the patient and/or the enhancement of the therapeutic relationship, and not to address any personal needs of the therapist. Another stylistic strategy is irreverent communication, which may involve reframing something the patient says in an unorthodox way or adopting the opposite level of intensity of the patient. For example, if the patient says, "I don't need to do any more of these role-plays," the therapist may respond, "Great, I assume that all of your interpersonal relationships have improved?" The therapist would then carefully provide a safety net for the patient by adding, "Let's talk about how you can feel more comfortable with role-playing." When used appropriately in the context of a strong therapeutic alliance and surrounded by validation, this strategy can result in moments of humor and guide the patient out of a rut.

One concern with using cognitive modification procedures is that they may be interpreted as blaming the patient (e.g., "It's all in your head"). Thus, DBT focuses on first validating the patient's cognitions, then targeting maladaptive beliefs and schemas, and lastly teaching self-observation through mindfulness exercises, the identification of maladaptive cognitions, the generation of alternative cognitive content, and the development of guidelines for when patients should question the validity of their initial interpretation of their cognitions (e.g., trust cognitions less when emotions are high). For example, when a patient expresses failure in all major aspects of life while highlighting success of others in those same domains, the therapist would first identify the truth in the patient's statement (e.g., "It does seem as though your roommate and classmates are productive and successful in many areas of their lives"), then identify the distortions in the patient's statements (e.g., "However, people often focus on only the positive aspects of others' lives, neglecting the fact that every person has

their own struggles to deal with," or "Doesn't your roommate frequently pay her portion of the rent late?").

Consistent with the FAP and ACT approaches, the same fundamental behavior principles are relevant toward understanding the development of a strong therapeutic alliance in DBT. In addition to the reinforcement and punishment strategies outlined above, fading and shaping procedures are highlighted as important features of DBT (Linehan, 1993). In forming the TA and progressively moving through the DBT protocol, for example, the therapist provides a significant degree of modeling, instruction, and coaching as it pertains to skill development. Once skills are developed however, the therapist fades skills-training procedures to an intermittent schedule, ". . .such that the therapist provides less frequent instructions and coaching than the patient can provide for herself, and less modeling, feedback, and reinforcement than the patient is obtaining from the natural environment" (Linehan, 1993, p.343). Shaping procedures also are heavily relied upon in relationship development and skill acquisition. For example, shaping is used in the initial stages of therapy to obtain verbal commitment to change, and throughout therapy to develop increased emotional awareness and interpersonal skills with both the therapist and in group sessions. Indeed, it is through such basic behavioral principles of reinforcement, punishment, fading, and shaping that the strength of TA evolves and the movement toward emotional acceptance and behavioral change is recognized.

Case Study Example of the TA in Behavior Therapy

Jennifer was a 28-year-old single Hispanic female whose case nicely illustrates the relevance of the therapeutic alliance in behavior therapy. A thorough discussion of assessment and case conceptualization for Jennifer, as well as the initial progress of her treatment is available in Hopko, Sanchez, Hopko, Dvir, and Lejuez (2003). Jennifer was assessed using two semistructured interviews (Structured Clinical Interview for *DSM–IV* Axis I Disorders [First, Spitzer, Gibbon, & Williams, 1996] and the Structured Clinical Interview for *DSM–IV* Axis II Personality Disorders [First, Spitzer, Gibbon, Williams, & Benjamin, 1997]) and her primary presenting problems were major depressive disorder and borderline personality disorder (BPD). Her most recent depressive episode was characterized by dysphoric mood, avolition, suicidal ideation, difficulty concentrating, fatigue, excessive sleep, and feelings of low self-worth and hopelessness. BPD symptoms included intense and unstable interpersonal relationships, affective instability, unstable self-image, a pattern of sabotaging personal goals and accomplishments at the moment they are about to be realized, suicidal ideation and behavior, and impulsivity with respect to eating. Jennifer reported "walking on eggshells" during her childhood because her father frequently was hostile, angry, and non-nurturing. She reported feeling as though she often had to "put on a happy face" in front of other people. Partially due to these circumstances, Jennifer developed perfectionistic standards and engaged in self-punishment, developing emotional dysregulation over time as a consequence of living in a nonvalidating environment. A functional analysis identified rigidity of thought (i.e., polarized thinking), avoidance behaviors, inadequate distress tolerance, periodic feelings of invalidation, and discomfort with change as maintenance factors associated with BPD and depressive symptoms. Her depressive symptoms and suicidal ideation reportedly began at a very young age, but Jennifer did not receive any mental health treatment until beginning college in 1994 at the age of 18. During this period, Jennifer was experiencing problems with interpersonal relationships, difficulties with time-management (she was also employed part-time), and high levels of academic stress.

Given a primary diagnosis of major depressive disorder, Jennifer initially was treated using the Behavioral Activation Treatment for Depression (BATD; Lejuez, Hopko, & Hopko, 2002). BATD is a behavioral treatment that may be an effective and parsimonious treatment for major depressive disorder in inpatient, outpatient, and primary care settings (Hopko, Bell, Armento, Hunt, & Lejuez, in press; Hopko, Lejuez, & Hopko, 2004; Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Lejuez, Hopko, LePage, Hopko, & McNeil, 2001). BATD seeks to assist patients in developing an environment in which the likelihood of obtaining reinforcement for healthy behavior increases. Systematically increased activity is considered a precursor to the reduction of depressed mood and parasuicidal, suicidal, and self-harm behavior (Hopko, Sanchez et al., 2003). BATD involves

efforts to reduce reinforcement for unhealthy behaviors (e.g., via behavioral contracting), self-monitoring through daily diaries (Hopko, Armento, Chambers, Cantu, & Lejuez, 2003), a life value assessment, generation of behavior and activity goals through utilization of an activity hierarchy, and the systematic monitoring of targeted goals with progressively heightened difficulty. Treatment progress was assessed by monitoring suicidal activity and scores on the Beck Depression Inventory, Version II (BDI-II; Beck, Steer, & Brown, 1996). When treatment began, Jennifer's BDI-II score was 43, indicating severe depressive symptoms.

Initial efforts to initiate BATD were undermined by considerable resistance by the patient due to the structured problem-focused nature of the treatment. Indeed, the patient had expected therapy to consist entirely of discussing her problems, and she had not anticipated the active role she would have to take both within and outside of the therapy context. Due to (rigid) patient expectations and initial treatment resistance, we determined that continuing to implement BATD at this point in therapy might seriously damage the therapeutic relationship. Accordingly, our treatment team evaluated alternative interventions that would better align with Jennifer's expectations and still effectively address her presenting problems. This process also was designed to preserve therapist-patient rapport and thereby increase the likelihood of positive treatment outcome.

At this juncture, it seemed clear that treatment would be most effective through the introduction of DBT treatment strategies such as emotional validation, mindfulness and distress tolerance training, and communication skill development. Although not completely distinct from BATD strategies, the packaging of these skills within DBT seemed more consistent with Jennifer's preconceptions of the therapeutic process. It should be noted that we did not intend to terminate BATD, but rather to develop an alternative, compatible, and effective mode of therapy that would simultaneously provide a supportive and comfortable environment from which the patient could work. Although DBT strategies clearly were important toward addressing BPD symptoms, their use along with venting time also served as a reinforcer for completing BATD assignments. In line with the principle of establishing operations, addressing Jennifer's particular longer-term goals and expectations, as well as shorter-term needs, could be used to motivate her to complete her BATD goals, with the intention that as she progressed and ultimately terminated therapy, she would continue to prioritize her increased activity level and exposure to positive experiences. In line with fading principles, therapy sessions initially were conducted in a highly structured manner, with decreased prompting and increased patient independence as therapy progressed. Shaping procedures also were utilized in that BATD strategies progressively were integrated with DBT components, together allowing for systematic development of the patient's behavioral repertoire.

Throughout the initial integrated DBT/BATD treatment approach (12 sessions), suicidal ideation decreased substantially, although there was minimal impact on other depressive symptoms (Hopko, Sanchez et al., 2003). After a break from therapy during the summer, the therapist's intention was to reinitiate BATD to address the intractable depressive symptoms, but in a way that would encourage greater patient commitment and simultaneously develop a stronger therapeutic relationship. Based on previous patient contact, it was clear that Jennifer greatly enjoyed her "venting time." Originally this time lasted for 10 minutes at the end of each session and was provided regardless of her treatment compliance. In an attempt to improve Jennifer's completion rate for BATD activities, a contingency system was implemented. Specifically, Jennifer was given 10 minutes of venting time if she completed 80% of her activities and only 5 minutes if less than 80% of the activities were completed. Thus, consistent with shaping applications, the final goal was 100% completion each week, but in the meantime, 80% compliance initially would be considered sufficient for reinforcement. This approach worked with moderate success, but it was determined that the opportunity to gain 5 minutes of venting time for less than 80% completion of homework interfered with her progress, and often resulted in her omitting activities that were essential to primary goals she had set (e.g., changing careers).

Although we were somewhat concerned about alienating the patient, we also were aware of the strong reinforcing value of venting time and decided to use this to increase treatment compliance. For the final 7 months of therapy (24 ses-

sions), a more stringent contingency system was established whereby if Jennifer did not complete all activities for the week, the session ended 30 minutes early and did not include any "venting time." This strategy utilized the DBT problem-solving principle of reducing the therapist's availability, creating a direct link between failure to complete homework and the contingency that access to the therapist was reduced. Compliance with BATD activities improved significantly and there were only a few sessions during the final 7 months of therapy in which Jennifer had not completed all of her activities.

The enforcement of a strict contingency management system was balanced by the need to continue to develop the TA. Prior to changing the contingency system, the rationale for the change was discussed and the patient agreed that the new system would help reduce her self-sabotaging behaviors. When Jennifer completed 100% of her activities, she received verbal praise. On the few occasions when she did not complete all activities and the session ended early, the contingency and the rationale behind it were reiterated and she was encouraged to complete all activities the following week. Again, for a patient who greatly valued "venting time," there was a risk in withholding it if assignments were not completed. However, the strong TA established prior to implementing the contingency system and the careful discussion surrounding application of the punisher resulted in successful outcome. Jennifer did not feel abandoned by the therapist, even on the weeks when she was not allowed to "vent," due to the strong therapeutic alliance which had previously been built. The trust and respect which had already been established with her therapist helped Jennifer accept this new punishment technique without feeling rejected or resentful, despite her tendency toward such feelings in her other interpersonal relationships.

Despite the incompatibility traditionally associated with the combined use of behavioral techniques and an emphasis on therapeutic alliance, strategies based upon basic principles actually enhanced the therapeutic relationship, which in turn led to further compliance with the utilized behavioral techniques on the part of the patient. For example, a major factor related to Jennifer's negative mood was dissatisfaction with her job, and switching jobs was identified as a primary treatment goal. However, this task was extremely anxiety-provoking for Jennifer because she reportedly felt like a failure for not having completed her combined baccalaureate/master's program and for being in her midtwenties without having established a career. For nearly a year, steps toward changing careers were actively pursued. However, associated activities were frequently omitted from her BATD activities. Under the revised contingency system, compliance improved but progress remained slow, with decisions (e.g., whether to pay the deposit at a school to which she had been admitted) belabored for weeks to months. This provided the therapist with a challenge in balancing orientation to change with validation of the patient's emotions. Through use of the strict contingency system, a validating environment, and a strong TA, toward the end of her two and a half years of treatment, Jennifer was able to overcome her fear of pursuing another educational program, chose a new profession, applied to a professional school, and began training for her new career. Ultimately, the primary mechanism of change could be conceptualized as a strong therapeutic alliance that initially evolved through therapist flexibility and validation experiences that previously had been quite foreign to Jennifer. Together with initial learning of distress tolerance strategies and communication skill development that provided for verbal reinforcement from the therapist as well as more natural social contingencies, these factors allowed Jennifer to develop a stronger relationship with the clinician. This alliance was reflected in Jennifer's increased acceptance of the fading and shaping processes as implemented in the context of BATD as well as periodic in-session punishment strategies, all of which were central to positive treatment outcome.

In the final two months of therapy, Jennifer began a part-time professional education program and was employed part-time. She had also commenced with bible studies and attending church on a regular basis, two goals that were identified at the beginning of treatment. Jennifer's BDI-II scores and self-reported mood improved during the final three months of therapy, with her BDI-II score decreasing from a high of 51 to a low of 10 at the final session. In addition, her score on the Borderline Symptom List (Bohus, Limberger, Ulrike, Ingrid, Tanja, & Stieglitz 2001) decreased from 126 when assessed in February 2004, to 43 in November 2004, indicating an improvement in

borderline personality characteristics into a nonclinical range. At discharge, Jennifer reported feeling significantly better and being comfortable with taking a break from therapy. She stated that she had never reached this point in therapy before and appeared hopeful about her future. In addition to the activities practiced using BATD and the skills learned using DBT, both the therapist and the patient felt as though a large part of Jennifer's significant progress throughout treatment was the result of the supportive environment created in therapy and the strong therapeutic alliance that was created.

Summary and Conclusions

Relative to other treatment modalities, it may be argued that behavior therapy has proceeded with minimal regard for the therapeutic alliance as a key mechanism of change. As illustrated in preceding sections, however, basic behavioral principles at the core of behavior therapy are fundamental both to the development of a strong therapeutic alliance and to the provision of more specific behavioral applications that are based on these principles. Indeed, the contextual philosophy of behaviorism and its reliance on functional analysis stress that all contingencies in a situation must be examined in accounting for certain behaviors, and it is evident that even the most subtle and unplanned therapist actions may serve to elicit or reinforce patient behaviors, and vice versa (Kohlenberg, 2000). Contemporary behavioral interventions such as FAP, ACT, and DBT have capitalized on these assertions. These interventions strongly emphasize the interrelationships among basic principles and their relevance to therapeutic alliance and interconnected intervention strategies, and available treatment outcome data are encouraging insofar as supporting the contention that therapeutic relationship variables may be integral to understanding the success of behavioral interventions (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004; Hayes, Masuda, & DeMey, 2003; Robins & Chapman, 2004). In moving forward, behavior therapists may be wise to continue in such explicit attempts to incorporate TA directly into interventions both on a clinical and research level, using assessment instruments developed to measure alliance such as the Working Alliance Inventory (Horvath, 1982), the California Psychotherapy Alliance Scales (Gaston, 1991), and the Combined Alliance Short Form (Hatcher & Barends, 1996) to provide the type of empirical data that epitomizes the behavior therapy tradition.

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