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Acceptance and Commitment Therapy and the Therapeutic Relationship Stance

Abstract

This paper characterizes the ACT therapeutic relationship stance in the context of the findings of the common factors literature and the relationship between therapeutic alliance and outcomes. We describe some foundational aspects of the ACT model (its philosophical set of assumptions, its scientific theory of language and cognition, and its operating system of clinical intervention) and how they form the ACT therapeutic relationship stance. We also provide a possible theoretical model of the therapeutic relationship and a specific exercise to foster it that can be used by clinicians. Overall, we hold the therapeutic relationship as an important component of the therapeutic process and we argue that the ACT model, as a contextual behavioral science strategic approach (Vilardaga, Hayes, Levin, & Muto, 2009) provides a clearer understanding of the impact of the therapeutic relationship on outcomes, together with a clearer rationale to both improve the therapeutic relationship and research it.

Keywords: therapeutic relationship, ACT, Contextual Behavioral Science, common factors, deictic framing.

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Relating to another human being is hard. It takes effort, care, and skills to understand what it is like to be another, and even when we do so, we may avoid the discomfort that it might entail by pushing aside evident but unwanted thoughts, feelings and emotions or by not letting them have full-fledged status in our experience. But relating to other human beings can also be a source of joy, satisfaction and healing. It seems that the most intense experiences – positive and negative – in a human life generally have to do with relating to others individually and in groups.

Psychotherapy work occurs within the context of relating to others and thus, the pains and joys described above also apply to the relationship between therapist and client. The therapeutic relationship is also a process that can be difficult, on both sides, because it too evokes avoidant responses of all kind of forms and sizes. When they are overcome, however, it is a relationship that can lead to meaningful and transformative experiences.

In this paper, we will address this topic by examining the existing literature on the therapeutic relationship and then presenting the therapeutic relationship stance of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). In the past, some authors have written to the importance of the therapeutic relationship from a behavioral perspective (see Sweet, 1984, for a review), but truly behavioral accounts of this relationship did not emerge until the advent of a new generation of behavioral therapies (e.g., Follette, Naugle, & Callaghan, 1996; Hayes, Kohlenberg, & Melancon, 1989; Hayes & Wilson, 1993; Hayes & Wilson, 1994; Kohlenberg & Tsai, 1991) that took seriously the task of unpacking the behavioral processes (both verbally and non-verbally) that take place between two individuals in a therapeutic setting. The approach presented in this paper is part of this emerging tradition.

This paper is structured in the following way. First of all we will briefly review the literature on the therapeutic relationship. Following that we will proceed to lay out the foundations of the ACT model of intervention and how they have shaped the ACT therapeutic relationship stance. Finally, we will summarize both literatures and will draw some conclusions.

Researchers have used different terms to refer to the therapeutic relationship: Therapeutic alliance, therapeutic bond, working alliance, and so on. In view of some, the "therapeutic alliance" and the "therapeutic relationship" are two different constructs (e.g., Baldwin, Wampold, & Imel, 2007); others instead have interchangeably referred to both (e.g., Lambert & Barley, 2001). In this paper we will follow this second approach.

The Therapeutic Relationship in the Clinical Psychology Literature

Interest in the therapeutic relationship or alliance has its origins in psychoanalytic theory, in particular in some brief references made by Freud (see Horvath, 2001, for a more complete description of the origins of this concept) to the importance of a cooperative relationship between therapist and client and to the nature of that process. Freud argued that the bond between therapist and client could be the result of the client's identification of the therapist with benevolent individuals in his/her past. It was not until the late 1970s and early 1980s that the term alliance started to be adopted by therapists and researchers from multiple orientations (e.g., Ford, 1978; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976; Sweet, 1984).

This new construct was generally taken as "pantheoretical" and was viewed as an opportunity for scientists from different theoretical models or schools to find common grounds and conform to an objective and scientific understanding of psychotherapeutic processes without getting entangled in endless discussions of what therapy model was best.

One of the most influential conceptualizations of the therapeutic relationship was that of Bordin (1979), who published a seminal paper in which he described the therapeutic alliance as a composite of three different aspects: a) the relational bond between therapist and client, b) the tasks of psychotherapy, and c) the goals of psychotherapy (or the outcomes that are sought). Bordin's paper was very influential; in particular because he emphasized that there can be many kinds of therapeutic alliances as long as their essential feature, the presence of a shared purpose between therapist and client, was present. He also expressed concern over the proliferation of psychotherapies and he stressed the potential role of the therapeutic alliance research in order to advance the scientific understanding of the therapeutic process. Bordin's definition of the therapeutic alliance set the stage for the development of alliance measures and a series of investigations about the relationship between alliance and outcomes.

In the last decades studies on the therapeutic alliance have abounded (e.g., Allen et al., 1986; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Frank & Gunderson, 1990; Gallop, Kennedy, & Stern, 1994; Krupnick et al., 1996). The extent of the literature allowed that two impactful meta-analysis on the effect of therapeutic alliance on outcomes led to the conclusion that there was a robust association between therapeutic alliance and therapy outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In Horvath et al.'s (1991) meta-analysis the combined overall weighted effect size of the working alliance on outcome after reviewing 24 studies was .26 (as expressed with a Pearson correlation coefficient). Martin et al. (2000) performed a more systematic and inclusive review of 79 outcome studies, found that the averaged effect size of alliance on outcome was .22. Alliance was moderately related to therapeutic outcomes and was a consistent predictor. Such results were consistent across kinds of therapeutic alliance scales, sources of alliance reports, therapeutic approaches, and types of disorders treated. Year of publication or methodological soundness of the studies had no confounding effect on that relationship. The authors suggested that the therapeutic alliance might be therapeutic in and of itself, although they clarified that there might be underlying mechanisms that explain that relationship or interactions between alliance and some interventions which given the characteristics of their analyses could not be ruled out (Martin et al., 2000, p. 446). Horvath reported another meta-analysis with the inclusion of 90 clinical trials and computed an averaged effect size of .21, which would correspond to a Cohen's d of .45, a medium-sized effect that would account for 5% of the variance on outcome (Horvath and Beni, 2002).

Baldwin and Wampold (2007) in a more fine grain analysis of the alliance-outcome relationship found that therapists who formed stronger alliances with their clients tended to have better outcomes that those who did not while client's levels of alliance with their therapists were not predictive of therapy outcome. They also found that early outcomes change was unrelated to therapist alliance, suggesting that the alliance was not a byproduct of treatment success. The current state of the literature taken as a whole is that the relationship between working alliance and outcome is consistent and within the range of the effect sizes of standard treatments.

As we noted, from the beginning (Bordin, 1979), therapeutic alliance research has been linked to the search for common factors in psychotherapy. Wampold et al. (1997), based on a meta-analysis of psychotherapy outcomes, restated the *Dodo Bird Effect*, claiming that when treatments designed to be effective are compared, their effect sizes approach zero. Wampold argued that the emphasis of researchers on the specific components of psychotherapy models is due to the fact that psychotherapy has followed the medical model (a model for which specificity is key), and in his opinion this model is slowing down the scientific progress of psychotherapy (Wampold, 2005; Wampold, 2007). For Wampold most of the variance responsible for the effects of psychotherapy are aspects such as therapeutic alliance, alliance of the clinician with the model that he proposes, therapist competence and placebo effects, and he has reasoned that if we are to really understand the phenomena of psychotherapy we need to step out from research focusing exclusively on outcomes and start paying more attention to common factors and processes of change (Messer & Wampold, 2002). Some have suggested that the impact of the alliance on outcomes is greater than that of active bona fide treatments packages (Messer et al., 2002). These claims and the methods used to arrive at them are controversial and have sparked considerable debate (e.g. Siev, Huppert, & Chambless, 2009; Wampold, Imel, & Miller, 2009) but there is no doubt that the therapeutic alliance has emerged as an important aspect of modern research into psychotherapy and has been conceptualized as an alternative to the exclusive emphasis in outcomes of the literature.

A disturbing aspect of the current literature is that attempts to train therapists to have better alliances with their clients have not yet been proven to be successful. There is no clear evidence that adherence to alliance guidelines enhances therapy outcomes (Crits-Christoph et al., 2006) – indeed there is some evidence that it rather produces negative attitudes toward clients (Henry, Schacht, Strupp, Butler, & Binder, 1993). This suggests that the understanding of the therapeutic relationship is not yet sufficient to lead to manipulable features that reliably improve outcomes. Perhaps as a reflection of this concern well-known therapeutic alliance researchers have argued that the field needs to put more emphasis on the theoretical development of the therapeutic alliance as a construct. Horvath (2005) when speaking to the challenges of the therapeutic alliance research stated that:

> "Firstly, we need more theoretical debate about the construct of the relationship. The relatively brief period between the initial theoretical/conceptual formulation and the development of measuring procedures that in practice defined the construct for research that followed likely foreclosed the opportunity to examine the implications and possible limitations of the concept as first presented by LUBORSKY (1976) and BORDIN (1979)." (p.4)

In a somewhat different vein, Bordin argued that the fact that many authors took the therapeutic alliance construct as a "pantheoretical" approach cut off from its psychoanalytic roots, limited the theoretical development that might have occurred.

One alternative to investigate scientifically the therapeutic alliance is the model proposed by some behavioral clinicians. FOLLETTE, NAUGLE AND CALAHHAN (1996) proposed that the basic operant conditioning model (SKINNER, 1957) and Relational Frame Theory (HAYES ET AL., 2001) could account for the alliance factors proposed by the alliance research. In their view a behavioral analytical account that focuses on therapist-client interactions could be more adequate. However, behavioral proponents have had a limited impact on the empirical literature in the area.

At this point empirical methods to develop the therapeutic relationship are very limited. BALDWIN ET AL. (2007) recommended validation techniques drawn from Dialectical Behavior Therapy (LINEHAN, 1993); SAFRAN ET AL. (1994) suggested managing and dealing with client-therapist ruptures as a way to nurture the alliance; LAMBERT ET AL. (2003) advocated for monitoring systems of client-therapist alliance ratings; and finally ACKERMAN AND HILSENROTH (2003) pursued the systematic identification of therapist qualities that foster the therapeutic relationship. Some of the suggestions entail adoption of different empirical traditions than mainstream empirical clinical science. For example, WAMPOLD (2006) proposed that a viable venue for the study of non-specific factors is anthropology and the cultural aspects of the psychotherapy process. As we have argued elsewhere (VILARDAGA & HAYES, 2009), some of these changes would risk losing the psychological unit of analysis, which is the prediction and change of the behavior of the individual in a historical and situational context. There are no examples we know of in which such a form of science has proven useful to psychological intervention.

All in all, the scientific and empirical investigation of how to foster the therapeutic alliance is still in its early stages. For research in this area to be successful, conceptual clarity, methodological creativity, and a coherent focus on the development of useful approaches are necessary.

The ACT Therapeutic Relationship Stance

ACT as a model of intervention revolves around the notion of psychological flexibility, a functional diagnostic dimension and model of psychopathology. The ACT model argues that the core of human suffering lies in entanglement with the literal qualities of human cognition resulting unwillingness of individuals to remain in contact with particular private experiences (Hayes, Wilson, Gifford, & Follette, 1996, p. 1154), inability to maintain flexible and voluntary contact with the present, excessive attachment to a conceptualized self, and the failure to engage in flexible and committed values-based action. Evidence for the importance of psychological flexibility and its components in a variety of clinical problems and their mediational role in clinical trials is increasing (Hayes et al., 2008; Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Pierson and Hayes (2007) described the therapeutic relationship stance with an analysis of the ACT processes at the levels of a) client, b) therapist, and c) their relationship. In their account of the therapeutic relationship from an ACT point of view they laid out the importance of psychological flexibility in all of its different dimensions and how that guides the decision making process in ACT.

We will take a slightly different approach in the present paper. ACT is a model of clinical intervention but it is also part of a larger effort that can be useful in understanding the therapeutic relationship and its potential. ACT is one aspect of a deliberate strategy of scientific development that we have come to term *contextual behavioral science* (CBS; Hayes, Levin, Plumb, Boulanger, & Pistorello, 2008; Levin & Hayes, 2008; Vilardaga et al., 2009). Contextual behavioral science emphasizes the use of multiple fronts of exploration as a way to strengthen the epistemological power of our observations and thus to increase our chances to build more progressive and useful technologies.

CBS is not a series of steps because its aspects are not linear or sequential. Rather it is an inductive, iterative, reticulated development strategy with several simultaneous distinct fronts, among them philosophical refinement, development of more useful basic processes, development of clinical processes linked to a basic account, organization of processes into a broadly useful clinical "operating system," process research, component research, exploration of breadth of outcome, dissemination and training, and the creation of a developed community of practitioners and researchers. CBS *per se* is not the focus of the present paper, but we will review a few of its key aspects as they become relevant to the present purpose. In this paper we will examine the role of the therapeutic relationship using three different dimensions of the ACT model as a form of contextual behavioral science: its philosophical assumptions, its basic theory of language and cognition, and general aspects of ACT as an operating system of clinical intervention.

The ACT Therapeutic Relationship Stance at the Level of Its Philosophical Assumptions

In order to understand ACT as a model of intervention, it is helpful to start with its philosophical foundation (Vilardaga, Hayes, & Schelin, 2007), which is known as functional contextualism. Functional contextualism begins with the assumption that the world is an undivided and undistinguished whole which we partition by virtue of interacting in and with it (Hayes, 1993). Away from a solipsistic ontological stance functional contextualism takes the view that the world is "real" in the sense of being one world, but as living creatures live in and with it, it becomes non-arbitrarily structured in a plurality of ways.

Historically contextualism has had a difficult time not devolving into elemental realism on the one hand, or mysticism on the other. If utility is justified by an appeal to ontology, the former is likely because if the structure of reality is the basis of workability, truth is not a matter of consequences per se but of its foundation in what is pre-organized and real. That idea, leads directly to elemental realism. If utility is justified by an appeal to personal sense of appreciation of the whole (see Hayes, 1993), the latter is likely. This can lead to an initial phase of pointing out the assumptions underlying all claims to knowledge (as in post-modernism), but ultimately one begins to feel that *any* knowledge claim violates contact with the sense of the whole. True knowledge thus means saying less and less about more and more: those who know do not speak; those who speak do not know. That is a core assumption of mysticism.

In all forms of contextualism "truth" is any analytic division or formulation of the world that is useful, but as a philosophy of science "useful" needs to be linked to assessable claims. Functional contextualism is based on a refinement in this area: What is useful or pragmatic is precisely that which allows us to achieve our analytic *goals*. Goals must be established *a priori* since they make sense of any epistemological effort to build knowledge and produce change. In the absence of clear pre-analytic goals, successful working collapses into the behavioral concept of reinforcement and the evolutionary concept of survival. These concepts do indeed help explain how living creatures partition the world, but they are inadequate as scientific guides since they fail to deal with the social and verbal nature of science and its attempt to maximize contact with the world and limit the role of idiosyncratic histories in the determination of the utility of verbal knowledge (the central purpose of "the scientific method").

The particular goal of functional contextualism is prediction and influence with precision, scope, and depth. The goals and values of the researcher and practitioner of trying to manipulate and influence the world are central in functional contextualism but in addition ways of speaking are sought that allow these analytic purposes to be accomplished with specificity, that are broadly applicable, and that do not contradict useful ways of speaking at other levels of analysis.

The specification of analytic goals provides a middle path for contextualists. Workability need not be caught up in truth by correspondence ontological claims, and it can be sensitive to the purposes of the analyst and still be stated and shared.

Functional contextualism gives coherence to the ACT model of intervention. It provides an overarching philosophical framework that allows ACT therapists to flexibly apply the model without taking it to be "true" in a traditional ontological sense. This is helpful in maintaining a functional approach. ACT is a set of principles not a set of techniques. For example, one of the metaphors frequently employed by the ACT model is the *Man in the hole* (see HAYES ET AL., 1999). This metaphor provides a verbal context that increases the likelihood that the client will contact how unfruitful are his/her attempts to control and change uncomfortable thoughts, feelings, physical sensations and wants. However there is nothing in the ACT model that prevents the practitioner using any other metaphor in order to produce the same result, since we need to take into account that given that every individual has a different history and circumstances, certain metaphors might evoke responses that are contrary to the ones we expected (i.e., an individual that has a history of phobia to close and dark places). Similarly, a therapist's particular history of learning might cause the presentation of a particular metaphor less likely to be effective.

A functional contextualist stance deemphasizes form over function by orienting the therapist to the fact that any technique or concept is just one method to partition the world in order to help the client and therapist accomplish their goals. This idea also has implications for how we conceptualize the therapeutic relationship in ACT. Like all concepts, the notion of the "therapeutic relationship" is not solidified or static. At most, it is a way of speaking that orients the therapist or researchers to talk about a particular kind of phenomena in a way that is useful.

The "ideal" therapeutic relationship in ACT can be anything from a superficial and straightforward relationship, to one that is more intimate and profound. Both sides of the spectrum are legitimate forms of therapeutic alliance, since for the functional contextualist, it is not the form or topography of a particular relationship, but the fact that it functions to satisfy the goals and values of both participants of that relationship. The resulting effect of lack of clarity in the goals and values of the therapist and client is chaos and confusion. A "world" (or therapeutic relationship) in which the therapist and client do not share the same therapy goals, is a world in which the differentiation and interpretation of psychological events is probably not going to serve the purposes of both individuals.

BORDIN'S (1979) influential conceptualization of the therapeutic alliance, later on adopted by most researchers in that area, seemed to favor some of the assumptions of functional contextualism. This author underscored the importance of the agreement on goals between therapist

and client, and as mentioned earlier, the goals of the therapist and client orient them to *what* is it that they are predicting and influencing. This philosophical framework organizes the therapists' experience in the process of predicting and influencing behavior. By emphasizing the goals of client and therapist we avoid "cartoon" versions of the alliance in which for example we ought to feel "connected". Instead, "connectedness" is always a function of *what matters* for client and therapist, regardless of form.

This approach provides more flexibility to the specific ways in which we *ought to behave* when relating to clients. We do not need to suppose that we always need to be intimate and close, nor that this kind of relationship must be inherently therapeutic in and of itself. What's therapeutic instead is that the client and therapist build a common set of goals and values and based on them they construct their own therapeutic relationship around them.

The ACT Therapeutic Relationship Stance at the Level of Its Basic Theory

Along with behavioral principles, Relational Frame Theory (RFT; HAYES ET AL., 2001), a scientific theory of human language and cognition, is the core basic analysis that underlies the ACT model. RFT has shown that it is helpful to think of language in terms of a core behavior called *arbitrarily applicable relational responding* that consists in abstracting types of relations between two events and bringing them under the control of arbitrary contextual cues. For example, if we learn that when someone says "house" we might then see a HOUSE, we may also be able to derive the spoken response "house" upon seeing a HOUSE. When a number of functional sets of relational responses are abstracted, they form what are called relational frames. The example presented above could be an example of "coordination framing," but there are other types of framing such as hierarchical framing, distinction framing, comparison framing, etc.

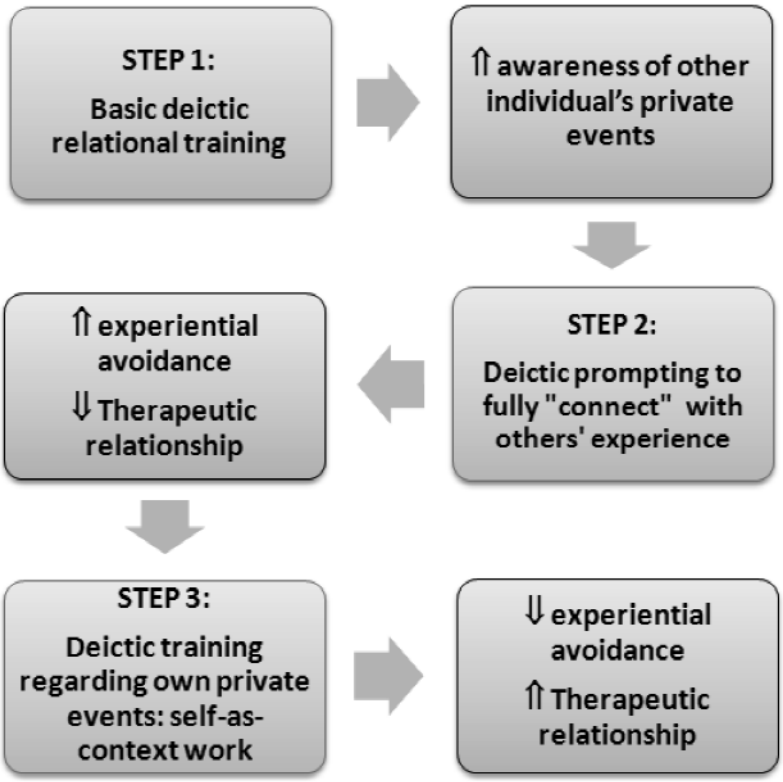
One kind of relational framing that is particularly relevant for the therapeutic relationship is deictic framing. This type of relational responding specifies some sort of relation in terms of the perspective of the speaker. During a clinical session, if a client says "my car is broken", the therapist will have to derive a deictic relation of I-YOU in order to respond effectively to the frame of coordination "car is broken". "My" in that case refers to the perspective of the client, and not to the therapist's. But notice that the words "my", or "mine" or "I" or "you", unlike other kinds of words, do not have a stable physical correlate. Their meaning will always depend on the perspective of the speaker.

Deictic framing thus, is constantly mediating our daily social interactions, and we have reasons to suspect that when we use the words "relating to another person," the kind of *relating* that we are referring to is literally a form of deictic framing. An emerging body of literature suggests that this process is associated to a variety of complex phenomena such as social anhedonia

(Villatte, Monestes, McHugh, Freixa i Baqué, & Loas, 2008), empathy and stigma (Vilardaga et al., 2008), schizophrenia (Villatte, Monestes, McHugh, Freixa i Baqué, & Loas, 2009), Theory of Mind performances (Rehfeldt, Dillen, Ziomek, & Kowalchuk, 2007), and false belief and deception (McHugh, Barnes-Holmes, & Barnes-Holmes, 2004). The link between deictic framing and the therapeutic alliance seems arguably clear, and we would expect that the strength of our operant ability to derive deictic framing relations will be directly associated to the strength of the therapeutic alliance between client and therapist.

A theoretical path to explain the role of deictic framing in fostering the therapeutic relationship can be viewed in figure 1. In this diagram we distinguish three different kinds of deictic processes and their psychological effects. Suppose that in step 1, basic deictic relations are strengthened. A procedure to achieve that would be to ask multiple variations of questions such as "If I were you where would I be?" or more complex forms such as "if I were you and here was there,

Figure 1. A three levels path to increase psychological flexibility and foster the therapeutic relationship



where would I be if I were there?" Decitic relations of this kind seem to result in an increased ability to take the perspective of others. In step 2, deictic questions would be presented to help the individual produce emotional responses. These questions would be variations of "How would you feel if you were Kate?" or "How would it be like to be your brother?" Those questions would prompt individuals to apply perspective taking skills to what another person feels, which could result in a change in the targeted subject's ability to experience more intense emotions towards others. This second step seems necessary; since being aware of someone else's private experience (i.e., acknowledging that someone is sad) is not the same that privately responding to them (i.e., feeling sad for someone else's sadness). However, training this ability, as a result, might lead to a variety of responses, depending on other skills. For example, empathy toward others could easily lead to experiential avoidance or client depersonalization: Feeling everyone else's pain is something that most people might want to run away from or minimize and reduce its importance. For that reason we hypothesize that a final step 3 in necessary, which consists in helping the individual to take perspective with regards his own uncomfortable private events, which is one of the aspects addressed by ACT under the rubric of self-as-context.

These three levels of intervention might suggest a new path not only to reducing therapist's depersonalization of their clients and increasing their empathic concern, but also to the fostering of psychological flexibility and general well being.

In order to understand the significance of this process we need to address the notion of self-as-context, which is a key ACT concept. Technically speaking, self, from a behavioral perspective, refers to one organism's discrimination of its own behavior. Skinner, in his writings, introduced the notion of self from a behavioral standpoint (e.g., Skinner, 1974). If an organism responds to situational events as a function not only of antecedent stimuli but also of his own previously displayed behaviors (i.e., picking the green light to obtain food as a function of having picked the red light before), we can assume that a discrimination of his own behavior has occurred. The organisms' own behavior becomes an antecedent stimulus for a subsequent response that will be more likely to be reinforced. But the process of self-discrimination occurs in a different fashion among humans (Dymond & Barnes, 1995; Dymond & Barnes, 1997): A human organism is "not simply behaving with regard to his behavior, but is also behaving verbally with regard to his behavior" (Hayes et al., 1993, p.297).

Self discrimination of our own behaviors, thoughts, feelings, wants and body sensations, over deictic relations of *time* and *space* (I-YOU-HERE-NOW, I-YOU-THERE-NOW, I-YOU-HERE-THEN, I-YOU-THERE-THEN), might lead to the formation of not just of one's identity or self as an individual but also to that of others (YOU). Our self-awareness is made of the constant stream of this self-discrimination process. Based on the different levels of self-discrimination of our own behaviors, thoughts, feelings, wants and bodily sensations (which for the sake of simplicity we

will call from now on "private events"), the ACT model has distinguished three different kinds of self: self-as-concept, self-as-process and self-as-context. A more detailed description of those different kinds of self can be found elsewhere (e.g., BARNES-HOLMES, STEWART, DYMOND, & ROCHE, 2000; HAYES, 1984; HAYES & GREGG, 2001). As reasoned in the ACT literature, self-as-context involves the highest levels adaptability to the environment, since the "object" of discrimination is a constant, but ineffable perspective that is dependent neither on the momentary stream of private events nor on current overt actions. The implications of this approach are that an inductive scientific analysis of human behavior provides the basis of ideas of self that are cohesive, parsimonious, and susceptible to empirical investigation (HAYES, 1984).

In summary: RFT suggests that when we *relate* to our clients we engage in a form of relational responding called deictic framing that can be trained at three different levels of complexity. Secondly, the "what" or content of what is related are both our sense of self and our sense of others, in other words, our self/other-discriminations of behaviors and private responses.

RFT informs the ACT model by suggesting that in order to enhance the therapeutic work and our relationship with our clients, it is of vital importance that a functional discrimination of our own thoughts, feelings and body sensations and that of others be established, since this is the substance (what's being *related*) of interpersonal relationships. That is why the ACT community has from its inception encouraged practitioners of that model to participate in experiential and not merely didactic trainings. These training events are designed to empower the clinician by setting up an appropriate context in which he/she will be more likely to self-discriminate his/her own behavior and private events (and that of other individuals) and contact a more stable sense of self or self-as-context that can be linked to greater psychological flexibility.

As indicated earlier in this paper, some studies have shown that the therapists' report of alliance with their clients was more predictive of outcome than the client's report of alliance with their therapists (BALDWIN ET AL., 2007). In line with this finding, and based on our knowledge of RFT, the exercise that we display in Figure 2 provides an example of how this idea might be applied. This exercise can be used at the beginning of each session and should not take more than 4 minutes. The exercise is a visualization task based on what we know of our client (or in the absence of that, on our intake information or brief telephone note). Each instruction consists in taking a series of perspectives that begins with our client's life, and transitions to the therapists' life. Instruction 1 consists in contacting the client's spatial perspective (YOU-HERE-THERE). Instruction 2 is a verbal prompt to contact the client's private experience. Instruction 3 consists in contacting the client's temporal perspective (YOU-NOW-THEN). Instruction 4 prompts the therapist to contact the client's other-as-context. Instruction 5 prompts the therapist to contact some of his own verbal barriers to empathize with his client (I-HERE-NOW). Finally, the content of those is used in instructions 6, 7, 8, 9 and 10 to guide the therapist

through parallel deictic framing manipulations in order to achieve a higher level of therapeutic flexibility or alliance with his particular client.

Figure 2. A deictics framing exercise to foster the therapeutic relationship previous a therapy session*.

This is an exercise that should take between 1-4 minutes. Before starting the exercise, try to find a quiet place (like your therapy room), and relax. The questions are not necessarily intended to have a response; instead we encourage you to think through them. After each question, please keep track of them marking the box on the left.

1. Take a few seconds and imagine you are your client on his/her way to the session. What would he/she see, hear and smell on his/her way here? What would it be like sitting on the waiting room before starting the session?
2. From this perspective of being your client, imagine what thoughts, feelings and judgments he/she is having (if this is your first session, think about his/her presenting problem).
3. Notice the historical nature of these reactions. He/she has had those thoughts, feelings and judgements for months or years, and in many different places, and they are likely to happen here, today.
4. In addition to his/her thoughts, feelings and judgements, see if you can connect with his/her sense of conscious awareness that is more than the content of his/her suffering.
5. Try to recall some emotions, thoughts and judgments that you have had about your client in the past (if this is your first session, think about his/her presenting problem).
6. Recall other times when similar thoughts, feelings and judgments have come up for you in different therapy rooms or locations (maybe with different clients), months or years ago, and notice how they are happening here, in this very moment.
7. In addition to these thoughts, feelings and judgements, see if you can connect with your own sense of conscious awareness – you are more than the content of your reactions.
8. Now bring your attention back to when you decided to be a therapist. What were your thoughts and feelings about being a therapist? What are your thoughts and feelings about being a therapist now?
9. If you were transported five years into the future, what would you like this client to have taken from the work the two of you have done?
10. Now bring your attention back to the room. Take a moment to just notice your different bodily sensations … the various sounds… and the objects around you.

*Developed by Vilardaga, Levin and Hayes, 2007

The ACT Therapeutic Relationship Stance at the Level of its Operating System

The ACT model can be usefully viewed as an "operating system" that allows the practitioner to apply principles and behavioral theories investigated at a more basic level to clinical phenomena of higher complexity. One way of representing the ACT model is with a hexagon in which each corner contains one psychological process. The six processes are: defusion, acceptance, present-moment, self-as-context, values and committed-action. The purpose of this model is to orient the clinician towards phenomena of clinical interest. Those processes are not highly precise terms, nor highly abstracted categories; instead they are middle-level terms, allowing a transition from highly precise behavioral principles and theories into more abstracted categories that facilitate their application (VILARDAGA ET AL., 2009). The effect of enhancing those six processes through therapeutic work is psychological flexibility, which is the overall goal of ACT interventions. A more detailed account of the ACT operating system and its components can be found elsewhere (HAYES ET AL., 2006; HAYES, STROSAHL, & WILSON, in press).

The notion of psychological flexibility is key to understand the ACT therapeutic relationship stance. It influences all the different aspects of the therapeutic relationship: the goals that client and therapist have agreed upon, the tasks that they will put themselves to work, and the resolution of eventual ruptures in their relationship.

Psychological flexibility can take the form of different psychological processes. For example, psychological flexibility is present when the therapist or client is able to be fully aware of the noises, colors and smells of the therapy room while at the same time being aware of the movements and oscillations of his private experiences (emotional reactions, random thoughts, wishes and desires, etc.). When the therapist or client is also fully aware of each other's reactions, gestures, physical properties, etc., ACT calls that process *being in the present moment.*

Psychologically flexible is also the willingness to have uncomfortable thoughts, feelings and judgments towards our clients, or the client's willingness to have uncomfortable thoughts, feelings and judgments towards us. This form of psychological flexibility can be seeing as *being accepting*. When the client or therapist do not get caught by the credibility and appearance of ultimate reality provided by particular judgments (i.e., about themselves or the client or therapist), they are able to take a relative stance towards them and remind themselves that they are just part of their experience (i.e., as for example by telling themselves that in the same way that they have arms and legs, they also have constantly changing thoughts and feelings towards their therapist or client), the ACT therapist can label this process as *being defused*.

If the client and therapist are in contact with what they care about the most in life, and that translates into being aligned on what they have agreed with each other to work towards to in their therapeutic sessions, that itself is an aspect of psychological flexibility: *contacting chosen*

goals and values. In addition, if the client and therapist not only know what they care about, and hold the same therapeutic goals, but also actively engage in them both within the room and/or outside of the session, that form of psychological flexibility is called *being committed.*

Finally, when client and therapist perceive themselves and each other not as the contents or form of their body, or private events, nor as to their succession or change, but instead they perceive themselves as a constant and invariant perspective that notices and experiences them, the ACT therapist might call this form of psychological flexibility as *being in a state of self/other-as-context.*

The above paragraphs contain all the ACT middle-level terms in a nutshell. Since ACT is a principle based therapy and not the application of a set of techniques, the ACT processes described above can be flexibly used with the purpose of describing and defining the ACT therapeutic relationship without violating its theoretical and philosophical coherence.

One aspect of the ACT model that also informs the therapeutic relationship refers to the way ACT conceptualizes the notion of suffering. ACT assumes that suffering in one form or other is a ubiquitous phenomenon that affects both clients and therapists. The RFT account of human language and cognition supports the above statement. Verbal behavior once learned is very resistant to extinction. Skinner actually argued that extinction barely occurs, and that under the appropriate contextual factors, private events never experienced for years can promptly emerge in full form (Skinner, 1957). The notion of derived relational responding gives a more technical account of that process, and shows that events or objects never experienced can evoke uncomfortable thoughts, feelings and memories in virtually any situation. Suffering thus, is embedded in what makes us more human, which is language and cognition.

Suffering contacted willingly is a source of life information that enhances our ability to connect with our clients. ACT views clinical work as a collaborative effort. In that sense it is not different from the overall cognitive behavioral tradition, but ACT goes one step beyond by encouraging the therapist to achieve the same psychological flexibility that he asks from his clients and to use his own suffering to fuel the six ACT processes in himself. Among other reasons, that is why ACT is called an *experiential* approach.

An intervention that is sometimes used at the beginning of therapy is the *Two mountains* metaphor. The therapist, after clarifying its role in the therapeutic process and emphasizing how the experience of suffering is shared with the client, might say:

> "It's like you're in the process of climbing up a big mountain that has lots of dangerous places on it. My job is to watch out for you and shout out directions if I can see places you might slip or hurt yourself. But I'm not able to do this because I'm standing at the top of your mountain, looking down at you. If I'm able to help you climb your mountain, it's

> because I'm on my own mountain, just across a valley. I don't have to know anything about exactly what it feels like to climb your mountain to see where you are about to step, and what might be a better path for you to take." (TWOHIG, 2004, p.4).

This quote taken from an ACT protocol for individuals diagnosed with obsessive-compulsive disorder is fully representative of the ACT therapeutic relationship stance. It sometimes happens that therapists adopt the attitude of mere professional providers of techniques or strategies to ameliorate their client's suffering. However, regardless of the fact that it is true that we need to be professional in our work with clients, it is also truth that our duty as clinicians are nevertheless to be genuine and authentic in our interactions with them. Pain and suffering is an undeniable part of the human experience and embracing these phenomena can be a powerful boost of the therapeutic alliance. The claims of the common factors literature summarized at the beginning of this paper support the utility of this aspect of the ACT therapeutic relationship stance.

Summary and Conclusions

The ACT therapeutic relationship stance is not an ad-hoc component of this model of intervention. Instead, it emerges as the natural result of the converging effect of its philosophical assumptions (Functional Contextualism; HAYES, 1993), a scientific theory of language and cognition (Relational Frame Theory; HAYES ET AL., 2001), and finally, the characteristics and guiding principles of the ACT model as an operating system for clinical intervention (Acceptance and Commitment Therapy; HAYES ET AL., 1999). Those different fronts of exploration constitute a form of scientific inquiry: contextual behavioral science (HAYES ET AL., 2008; LEVIN ET AL., 2008; VILARDAGA ET AL., 2009).

The ACT therapeutic relationship stance encompasses a broad range of therapeutic relationships; flexibility as to what is a proper and adequate therapeutic relationship between client and therapist is central. In that regard, agreement on goals and values between client and therapist is key, because those are defining features of the kind of relationship that will be built between two individuals. Chaos and confusion emerges in the absence of clearly defined goals and values. Second of all, a *relationship* between two individuals can be better understood as a form of relational responding called deictic framing. The notion of deictic framing has profound implications for our understanding of human interactions because they might be at the core of what human interactions are, which is the act of *taking perspective* regarding other individuals and ourselves. Deictic framing can be devised as a powerful heuristic to develop new interventions to foster the therapeutic relationship and research it. Furthermore, it can also provide a new venue for the scientific investigation of the formation of our identity as individuals

and their implications for psychopathology. Finally, the ACT model, as an operating system of clinical intervention contains elements that are allies of the therapeutic relationship, such as its emphasis on the ubiquity of human suffering and its radically (at the root) collaborative stance.

Overall, the ACT therapeutic relationship stance converges with the guidelines and recommendations presented by the therapeutic alliance movement (Horvath, 2001; Horvath, 2006) and the recent emphasis on the non-specific or common factors of psychotherapy (Messer et al., 2002; Wampold, 2007), but without abandoning an experimental and outcome focus. Wampold criticized the existence of different psychotherapy models or schools on the grounds that they are all equivalent in terms of outcomes (Wampold et al., 1997). He also argued that the reason for the existence of specific treatments for specific problems is that psychotherapy has been subsidized by the medical model (Messer et al., 2002; Wampold, 2005). But the ACT model could hardly be considered as derivative of the medical model (e.g., Hayes, Walser, & Follette, 1995), and although it is a distinct model of therapeutic intervention, it is not precisely of the kind that considers that only specific technological components can address specific syndromal problems. Instead, it is meant as a unified model of human behavior change and psychological growth. With very few modifications it has shown to be effective for a variety of problems such as depression, anxiety, substance use, psychosis, borderline personality disorder, trichotillomania, epilepsy, weight maintenance, and diabetes management (Bach & Hayes, 2002; Dalrymple & Herbert, 2007; Gratz & Gunderson, 2006; Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007; Hayes et al., 2004; Lillis, Hayes, Bunting, & Masuda, 2009; Lundgren, Dahl, & Hayes, 2008; Woods, Wetterneck, & Flessner, 2006; Zettle & Hayes, 1987).

That would conform with some of Wampold's claims, but not because we think that common factors have any magical effect on people's lives. Rather the source of the breadth is the fact that human language and cognition in involved with all complex forms of human behavior and useful concepts in that domain inherently spread across various problem areas. ACT is grounded in a scientific tradition that has shown to have a broad impact in a variety of problems of human concern such as education (e.g., Johnson & Layng, 1992; Layng, Twyman, & Stikeleather, 2004), organizational management (e.g., Glenn & Malott, 2004; Malott, Shimamune, & Malott, 1992), autism and special education (e.g., Charlop-Christy, Carpenter, Le, LeBlanc, & Kellet, 2002; LeBlanc et al., 2003), and behavioral economics (e.g., Hursh, 1984; Jolls, Sunstein, & Thaler, 1998). The scientific strategy followed by ACT and contextual behavioral science is the one of attempting to develop a comprehensive and scientific account of human functioning that generates rules or principles of generalization with enough precision, scope and depth to be able to be applied to a variety of problems in a variety of ways. That goal is not justified by an a priori claim that the world is so organized as to make this possible. None of us know how the world is organized beyond our interactions in and with

it, and these interactions are always limited by history and purpose. It adds nothing to the usefulness of scientific ideas to claim that the reason they are useful is that they correspond to the way the world is organized, but it also adds nothing to the usefulness of scientific ideas to fail to seek the kind of utility we most deeply desire. ACT and the CBS tradition is attempting a new way forward that is both bold and humble. This approach to the therapeutic relationship we hope is an example.

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