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THEORETICAL ARTICLE

Interpersonal Behavior Therapy (IBT), Functional Assessment, and the Value of Principle-Driven Behavioral Case Conceptualizations

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Abstract

We introduce interpersonal behavior therapy (IBT) in the context of a brief history of evolving paradigms of psychotherapy research and the rise of the third-wave behavior therapies facing the challenges of the introduction of middle-level terms in the service of their dissemination. The article focuses on IBT as a response to the evolution of functional analytic psychotherapy (FAP) and its movement away from behavioral principles and functional assessment. IBT is proposed as a contemporary behavioral treatment whose focus is on interpersonal distress, emphasizes the need for a functional assessment to conceptualize client problems, and utilizes behavioral principles to specify the mechanisms of the problem and mechanisms of clinical change. Largely a retooling of the original proposals in FAP, IBT explicates the mechanism responsible for clinical problems and the corresponding mechanism of clinical change. Moreover, as a behavioral therapy, IBT emphasizes the need for functional assessment in conceptualizing client problems and determining clinical treatments. Finally, we call for a unified return to behavioral assessment across the third-wave therapies. This unified approach may help advance principle-driven treatments for complex forms of human suffering as well as offer a path forward to a program of behavioral science and preserve the longevity of behavioral therapies.

Keywords Functional analysis · Clinical behavior analysis · Interpersonal · Functional assessment · Distress · Mechanism · Research · Behavior therapy

In fits and starts, the progress in psychotherapy research and development has evolved. The important events along the way could be parsed in a variety of ways. One notable period was from Eysenck's (1952) skepticism that psychotherapy was no more effective than a placebo effect or the passage of time, to the Smith and Glass (1977) meta-analysis of 475 outcome studies indicating therapy was better than no treatment, but that there were few if any notable differences between therapies. The expanded report still did not crown a winning type of therapy, so it too was controversial (Smith, Glass, & Miller, 1980).

The publication of *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition (*DSM-III*; 1980) marked the beginning of another era of psychotherapy research. A remarkable period of research on the efficacy of pharmacotherapy and psychotherapy followed. A goal of the *DSM-III* was to redress the low reliability of diagnoses present in the previous two versions of the *DSM*, thereby increasing the likelihood of the *DSM* nosology becoming a useful framework to advance research on mental disorders. The authors of *DSM-III* purported to present an atheoretical nosology, but it was clear that a medical model would eventually emerge (see, Kirk & Kutchins, 1992, chs. 1–6). *DSM-III* did not specifically use the term "disease," but presumed "harmful dysfunction" gave rise to "disorders." The heuristic value and scientific-philosophical implications of harmful dysfunction were debated at the time, but the use of those terms persisted (cf. Houts, 2001; Houts & Follette, 1998; Wakefield, 1998). The study of disorders, much like diseases, should produce information about the etiology, prognosis, course, and response to treatment for a given disorder.

As *DSM-III* and *DSM-III-R* (American Psychiatric Association, 1987) became established, there was a major shift in psychotherapy research. Although the early 1980s started

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with an earnest interest in refining the psychotherapy process and outcome research at the National Institute of Mental Health (NIMH), by 1985 NIMH had been reorganized around diagnoses (Knobloch-Fedders, Elkin, & Kiesler, 2015). This transition saw the emergence of randomized clinical trials (RCT) as the dominant design in funded psychotherapy research programs whose designs often compared two or more manualized treatments for the disorder being studied. Though more comprehensive in scope than subsequent NIMH studies, the prototype for such designs was the NIMH's Treatment of Depression Collaborative Research Program (Elkin, 1994; Elkin, Parloff, Hadley, & Autry, 1985). At the same time, the APA provided support for this transition with the creation of the Task Force on Promotion and Dissemination of Psychological Procedures (1995). In order to be recognized as an empirically validated treatment (EVT), efficacy data from multiple outcome studies that compared at least two treatments and made use of treatment manuals were needed. By 2001 there were 108 treatment manuals that met the criteria for empirical support (Chambless & Ollendick, 2001). Treatment development was primarily organized around diagnostic categories (Chambless & Hollon, 1998).

These "racehorse" designs pitting two or more active treatments against one and other predictably resulted in ties. Though investigators became increasingly sophisticated at designing and conducting RCTs during this period, the result seemed reminiscent of the Smith and Glass (1977) conclusions that treatments comparisons were often equivalent. This led to the (in)famous "Dodo Bird" verdict that "all have won, and all must have prizes" (e.g., Wampold et al., 1997). Shadish and Sweeney (1991) bemoaned the fact that many of the studies included in meta-analyses generally failed to include conceptually meaningful moderators or mediators. Thus, homogenized designs produced homogenized results.

The strategy to apply manualized treatments to disorders implied a treatment protocol would sufficiently treat a disorder. The same treatment X would be effective for everyone with disorder Y. This flight into nomothetic research largely abandoned the behavior analytic tradition of precisely applying bench science principles to contextually specific cases. The application of principles to instances and classes of behavior is an idiographic strategy, but it has little in common with hermeneutic, narrative methods of describing a situation with little intention of relating a principle to an outcome. In fact, the precision of idiographic research is exactly what was missing from the group design RCTs.

NIMH has finally recognized the failure of using the *DSM* as an organizing principle for research and replaced it with the research domain criteria (RDoC; Cuthbert & Insel, 2013). Although RDoC seems reductionistic and only modestly familiar with the nature–nurture debate outside of epigenetics, there is a recognition that research on mechanisms rather than disorders is more likely to produce more useful translational research. In recognition of the lack of progress from earlier research strategies, the former head of NIMH, Thomas Insel, is reported to have said:

> I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs—I think $20 billion—I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness. (Henriques, 2017)

The failure of the *DSM* and diagnostic disorder-based research using the *DSM* was predictable (Follette, 1995; Follette & Houts, 1996). Though the research stages arbitrarily presented above have been less successful than one might hope, much has been learned in the past 35 years of treatment research due to the conscientious efforts of those investigating treatments and dissemination. We now are on the cusp of another change in how one can approach advancing our knowledge of fundamental components of change.

Treatment Research and Development

As a model for the evolution of clinical science, there has been a renewed interest in a return to and expansion of idiographic research to identify and test discreet principles of change with an end goal of identifying underlying therapeutic processes that are components of therapeutic procedures used in treatment. A prominent example is the proposal put forth by Hoffman and Hayes, termed process based therapy (PBT; Hofmann & Hayes, 2019b). They describe therapeutic processes as "underlying change mechanisms that lead to the attainment of a desirable goal. . . . These processes are *theory-based* and associated with falsifiable and testable predictions." (p. 38; emphasis in original). The proponents of PBT describe an elaborate, but unwieldy scheme for how the strategy will unfold (see Hayes et al., 2019, for an overview). Their approach leaves some wondering just where and how to fashion a research program (Teachman, 2019) While we wait for this approach to mature, we note, along with others, that clinical behavior analysis already has principles and strategies that fit the process definition quoted above.

Something Old, Something New, Something Borrowed…

Functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991) was proposed as one of the emergent third-wave

cognitive-behavioral treatments (Hayes, 2004), offering a way to conceptualize and treat complex human problems from a behavior analytic framework (see also Biglan, 2004; Dougher, 1997; Dymond & Roche, 2009; Roche, Barnes-Holmes, Barnes-Holmes, Stewart, & O' Hora, 2002; Stewart, Barnes-Holmes, Roche, & Smeets, 2002, for a sample of others making the case for significant expansions to the scope of behavior analytic treatments). Other third-wave treatments like acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and dialectical behavior therapy (DBT; Linehan, 1993) began to address problems where emotional and cognitive experiences were the focus of treatment. ACT and DBT continue to remain focused on those problems that can be understood as intrapersonal and often considered private events from a behavioral perspective (Skinner, 1957, 1969). On the other hand, FAP began with a focus on interpersonal problems, attempting to help clients develop more effective relationship repertoires and improve their ability to effectively derive expanded, valued social reinforcement.

We are not suggesting that therapists conducting ACT, DBT, or other treatments consider interpersonal relationships to be unimportant in understanding or alleviating human suffering. Indeed, the importance of the therapeutic relationship is acknowledged in many forms of therapy (e.g., Norcross, 2001, 2002; Norcross & Wampold, 2018). FAP conspicuously focused on interpersonal behavioral excesses and deficits that limit successfully accessing social reinforcement. FAP presumed that some important self-assessments are epiphenomena to changeable overt behavior or context. For example, Bem's self-perception theory suggests that one's self-assessment reflect how in concert one's own behavior is compared to behaviors valued when observed in others (Bem, 1978). Therefore, reinforcing a client's interpersonal repertoire that they emit and valued behavior that is reinforced is predicted to alter verbal statements about the self. Likewise, Biglan's (1987) behavior analytic critique of Bandura's self-efficacy theory also implied that increasing one's accuracy in predicting successful outcomes would increase reported self-efficacy. That is, language that might frequently have been considered intrapersonal can be affected by altering overt, generally interpersonal, successful behavior. In some contexts, even such things as mood may be understood as overt social behavior that functions to reduce interpersonal aversive interactions when a more effective problem-solving repertoire is lacking (Biglan et al., 1985).

There is utility in determining which types of problems to address with clients, and both intrapersonal and interpersonal issues can be fundamental in bringing about and sustaining suffering. The third-wave behavior therapies brought both of these domains into the area of treatment and research, offering distinct treatment strategies and an understanding of the underlying mechanism of the problem and the mechanism of change (see, e.g., Follette, Naugle, & Callaghan, 1996). After their inception, several of these treatments sought to explain these mechanisms from a contemporary behavioral perspective utilizing both Skinnerian principles (Skinner, 1969) as well as extensions of Skinner's work such as relational frame theory (Hayes, Barnes-Holmes, & Roche, 2001).

One can argue that FAP is the most idiographic of the third-wave therapies. Most of the research on FAP has not been based on diagnostic categories, and there are no FAP treatment manuals. Rather, behavioral principles and functional assessment in the form of ongoing case conceptualizations guide therapy. In 2017, several prominent FAP researchers summarized the outcome literature (Kanter et al., 2017). Their conclusion at the time was that FAP was promising but the data were not sufficient to claim that there was adequate support for its efficacy for specific psychiatric disorders. This conclusion was not surprising. FAP researchers seemed to struggle with finding a research paradigm that could characterize FAP efficiently and assess the appropriate outcome measures. Though analytic strategies for identifying the relationship between therapist contingent responding and client behavior change had been identified, the coding and analysis were difficult and resource intensive. The work that did analyze therapy process intensively permitted this review to conclude that the therapist as a social reinforcer was stronger.

Many of the studies of FAP used single case designs (SCD) because such designs better fit the idiographic nature of the FAP model. Where data were extensively sampled, the mechanism of change could be tested. Although SCD studies have long been a standard of showing proof of control in an experimental setting. However, FAP was proposed in an era of RCTs and group designs. Though SCDs were recognized as adequate evidence of efficacy by the Task Force on Empirically Validated Treatments, there was not widespread acceptance of such designs.

Only recently have methods for analyzing and combining SCDs become more robust. In 2018, Singh & O'Brien analyzed 20 different SCDs of FAP. The authors concluded that the synthesis of the studies indicated that reliable changes occurred. Using a metric that generated an effect-size estimate of treatment outcomes based on end-state functioning, Swanson's d_{sw}, the authors assessed changes observed in FAP as large and reliable (Swanson, Hoskyn, & Lee, 1999). Although there is evidence in support of FAP's effectiveness, with some sharpening of focus, FAP can be a vehicle for conducting research that can identify fundamental change processes.

At the outset, the authors want to acknowledge and express deep affection, respect, and appreciation for what Kohlenberg and Tsai (1991) have brought to behavior therapy in the form of FAP. Both authors (blinded) have built much of their careers, their clinical practice, and their approach to training and supervision on the foundations laid out in FAP.

Our interests have increasingly focused on better understanding the fundamental change processes in FAP, many of which were described in the first presentation of FAP (Kohlenberg & Tsai, 1991). We are also interested broadening the study of known behavior analytic processes that promote or impede behavior change such as behavioral momentum, delay discounting, and schedule effects (see Waltz & Follette, 2009, for an initial discussion). It is also important to better define how to conduct and be guided by an iterative case conceptualization in the tradition of a functional analysis (cf. Davison, 2019; Hayes & Follette, 1992; Hofmann & Hayes, 2019a). Training FAP remains a difficult and time-consuming task. Nevertheless, identifying the procedures to do so in a manner that maintains veridical ties to the basic science is fundamentally important.

The evolution of FAP still includes ties to basic behavior analytic principles, but has introduced some departures from a more purely behavioral treatment to also target its own larger goals including community engagement and environmental responsibility (Tsai, Kohlenberg, Bolling, & Terry, 2009). These are laudable goals, and embracing them has introduced some assumptions and technical dissemination procedures that differ from the initial FAP agenda. These departures are significant. As FAP continues to explore a variety of agendas, we discuss how this process has inadvertently moved researchers of clinical behavior analysis away from the fundamental task of understanding and evaluating mechanisms of change. We offer a retooling of the original ideas discussed in FAP as a return to behavior analysis with a specificity of variables that benefit both clinicians and researchers investigating the clinical processes of change.

As the developers of third-wave behavioral therapies began to disseminate these treatments to practitioners and proponents of the treatments, they faced the problem of how to disseminate the principles and strategies using terms that would communicate both methods and procedures as well as an appropriate science behind the terms, to as many people as possible. One of the challenges that emerged early in this dissemination process took the form of determining how practitioners who did not have a foundation in behavioral case conceptualization could be trained in these treatments.

Although some adherents to FAP and ACT have remained dedicated to developing and teaching behavioral case conceptualization (e.g., Villas-Bôas, Meyer, Kanter, & Callaghan, 2015), a more popular vernacular began to take hold to help new practitioners understand both the value of these treatments and how to engage them without having been trained behavior analytically. These dissemination efforts encountered difficulties. In the first edition of Russ Harris's (2009) book, *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment therapy*, he tried to present a simple description of functional contextualism, applied behavior analysis, and relational frame theory in Chapter 3, "The House of ACT." One can find the original version of his attempt online (https://thehappinesstrap.com/upimages/the_house_of_ACT.pdf) with the following introductory comment on the draft: "In the textbook, most of the chapter got deleted as a) *it was considered too complex* and b) we ran out of space" (emphasis added).

The problem of disseminating technical material is a significant concern, and the epistemic barrier of conceptualizing complex human suffering from within a behavioral framework is also real (e.g., O'Donohue, Callaghan, & Ruckstuhl, 1998; Skinner, 1975). However, the cost of shifting the focus away from behavioral principles to more vague terms is substantial. The introduction of constructs not operationalized in behavior analytic or functional contextual language does not allow practitioners or researchers to effectively approach their subject matter with precision. Often called middle-level conceptual terms, these terms are appealing to those who do not know behavioral language and principles. However, they are not tied to any known mechanism of change, thereby creating problems with advancing a coherent body of scientific research (see Barnes-Holmes, Hussey, McEnteggart, Barnes-Holmes, & Foody, 2016, for a more thorough discussion of problens with middle-level terms).

Two approaches (or their combination) often emerge to guide the choice of middle-level terms. The first is to use terms that have little current social meaning so the learner has no history with the term other than that supplied by the trainer. For example, in the dissemination of ACT, "defusion" is not a word that appears in the dictionary. It implies the therapeutic process, but the term itself has no other competing history for someone learning ACT. Other middle-level terms for ACT are not readily understood outside of the training community. Likewise, "self as context" is not a phrase that brings with it a history of being reinforced by the verbal community prior to its introduction while being taught ACT. Though this approach seems to address the issue using terms "contaminated" by differential reinforcement by multiple verbal communities, the solution is only temporary and is subject to distortion. As a group of people use a novel term, its use is sustained by being understood by others when used in the same or similar conditions. As time passes, different subgroups of people learning ACT may share a different history for using a particular middle-level term, resulting in a drifting of meaning for that concept. Moreover, this problem does not address the adequacy of the middle-level term as a representation of the science tied to a therapeutic process.

In FAP, the middle-level terminology that emerged included "awareness," "courage," and "love" (Tsai, Kohlenberg, Kanter et al., 2009). These constructs have a pop psychology appeal and may have served to bring those less familiar with FAP to workshops or written material, but they do not in any way specify the mechanism of change for this interpersonal therapy nor how to engage that mechanism. In fact, at the very

least they cloud the mechanism, and at the worst introduce a construct, "love," that not only has multiple meanings but functions as problematic or even harmful language with some clients (Muñoz-Martínez & Follette, 2019). This is not to say that these terms could not be operationalized or translated into behavioral language; the problem is that these constructs are used as if they were psychological principles. Conceptualizing client problems using these nonspecific or middle-level terms fails to guide a therapist in determining more precisely the controlling variables for the problems a client has. More than that, a concern is that without psychological principles, therapists may venture into treatments that are unnecessary or even unethical because of the established stimulus functions that these words have as a result of their usage in other contexts. Finally, we argue that the movement toward an a-priori identification of client problems using middle-level terminology betrays the very core of FAP as a behavioral therapy by removing the role of functional analysis in determining clinical problems and the corresponding treatments.

Interpersonal Behavior Therapy

The tension between dissemination using a more common vernacular and a focus on behavioral principles does not seem easily resolved. Two distinct ways of conceptualizing and talking about how we intervene with those issues have emerged among those who focus on interpersonal client problems. In particular, this difference is in the emphasis (or lack thereof) on the central role of functional analysis and specifying mechanisms of behavior change. To that end (and in an effort to avoid gracelessly repeatedly criticizing FAP), we introduce here the specific terminology of *interpersonal behavior therapy* (IBT) to describe a contemporary behavioral treatment with a focus on interpersonal distress, the need for a functional assessment to conceptualize client problems, and the use of behavioral principles to specify the controlling variables of the problem and mechanism of clinical change. As it has evolved, FAP still resides with third-wave behavioral treatments and is an interpersonally focused treatment. FAP can be seen as having different goals than IBT with respect to the conceptualization of client problems (Bonow, Maragakis, & Follette, 2012), and its deemphasis of a behavioral understanding of the mechanisms of problems and change. In this way, IBT respectfully revisits some of the original ideas offered by Kohlenberg and Tsai (1991) and attempts to specify them in the service of returning to a more principle-driven behavioral therapy.

The Mechanisms of the Problem and Change in IBT

IBT and FAP both focus on human suffering as a function of problems with interpersonal relationships. As FAP developed, the mechanism[1] of the problem was characterized as specific repertoire excesses and deficits under environmental control (e.g., Callaghan, 2006a; Callaghan, Naugle, & Follette, 1996; Follette et al., 1996). That is, from a behavioral framework the interpersonal problems humans have are specific repertoires that have emerged based on the learning history of contingent reinforcement. These often narrow repertoires result from a history of negative reinforcement or punishment and are sustained by a social community (in addition to being sustained by intrapersonal variables such as the escape and avoidance of aversive events experienced in social interactions).

The mechanism of the problem for IBT focuses on complex interpersonal repertoires to allow us to conceptualize behavior that has been shaped through contingencies of reinforcement. This explication allows us to specify which client behaviors may be problematic and the conditions under which those behaviors occur and can be modified. For example, consider a client who self identifies that they "can't connect with others." Upon further discussion we learn that this client is not able to express strong feelings (including affection) to another person. As we move toward a behavior analysis of this inability to "connect with others" we may identify a history that shaped this repertoire and the current identifiable consequences for engaging in that behavior. In specifying the mechanism of the problem, we can acknowledge the possible role of more distal variables that occurred in the client's past as well as those more proximal variables impacting and controlling the client's behavior currently, allowing both an opportunity to express empathy for what has occurred and a chance to help alleviate distress with behavior change. By bringing precision and behavior principles to our description of which behaviors we think are important for understanding a particular client's suffering, we can specify those behaviors and generate hypotheses about why the client may be doing those things that seem to maintain their suffering. More than that, we can move toward specifying what can be done to help alleviate those problems.

The mechanism of clinical change follows from the mechanism of the problem of learned behavior shaped and maintained by natural contingencies. From an IBT perspective, the mechanism of interpersonal behavior change is the differential reinforcement of more effective client repertoires in large part by contingently shaping client behavior in-session. That is, it is the therapist's job is to help the client learn more effective ways of interpersonally relating. From a behavioral

[1] We use the term "mechanism" to simplify communication. Our perspective is a functional contextual view rather than a mechanistic perspective (Pepper, 1942). Using the rubric of Hofmann and Hayes (2019b) the reader can understand the relationship between mechanism and therapeutic processes as follows: "Therapeutic processes are the underling change mechanisms that lead to the attainment of a desirable treatment goal. . . . These processes are theory-based and associated with falsifiable and testable predictions. . ." (p. 38).

framework, the therapist has direct access to the contingencies that occur in session between the client and the therapist, and many of the client's interpersonal behaviors can occur with the therapist in a treatment session (Kohlenberg & Tsai, 1991).

A proportion of any psychotherapy involves talking about events that occur outside of the therapy hour. An IBT therapist will also talk about those outside problems and relationships and make suggestions for modifying behavior out of session to produce more effective repertoires for the client. Using behavioral principles, however, the challenge with focusing only on behaviors that occur outside of session is that the behavior shaped in session may simply be a verbal repertoire related to or describing to the goals of change but not the actual repertoire of interest. In other words, we may help clients learn how to talk about their relationships differently if we focus on those issues outside of session, but the behavior of interest is actually engaging in more effective interpersonal repertoires that can be more efficiently shaped as the behavior occurs in-session with the therapist. The goal once this behavior begins to be shaped by the therapist is then to transfer the repertoire to relationships outside of therapy.

This differential reinforcement of more effective client behaviors by the therapist requires the therapist to specify those particular repertoires that are problematic for the client and are targets for therapeutic treatment. This assessment is tailored to the individual and focuses on the unique functions that the behavior serves for the client (i.e., what is both the response cost to the client to engage in the behavior and what it gains the client). This functional assessment focuses on the context in which the particular behavior occurs as well as an understanding of both immediate and more distant consequences that follow the behavior. (The role of functional assessment and functional analysis is discussed in the section that follows). It should be emphasized that the behavior of interest needs to be operationalized so that the therapist would know with what in particular the client is struggling (including examples of the form it might take) and how a more effective repertoire would function.

Using our example above, we move from seeing a client as having problems because they "can't connect with others" to specifying what the client does when feeling a need or desire to relate to others. For instance, the client may engage in a repertoire that is overly demanding of others when they need support. On the other hand, the client may have an intact and effective repertoire for requesting support but feels that they "can't connect" due to a repertoire of escape or avoidance of interpersonal conflict (i.e., a negatively reinforced repertoire of escape in the context of aversive experiences). It is not hard to imagine how either repertoire could have been shaped over time by a social community. That said, by specifying the repertoire the therapist can engage in strategies for changing that repertoire.

To continue the example (and consistent with early FAP rules; Kohlenberg & Tsai, 1991), the therapist would both watch for and evoke client behaviors that serve the function of decreasing opportunities for social reinforcement (e.g., reducing a "sense of connection with others," "getting support"). The therapist would then prompt and reinforce successive approximations of a repertoire in-session that are more effective in meeting the client's stated goals. In other words, the therapist watches for problematic behavior that occurs with the therapist, provides feedback about the challenges of that behavior, and attempts to shape more effective interpersonal responding during the therapy hour. Once a reasonably consistent repertoire is established, the therapist will help the client select opportunities to flexibly practice that same set of behaviors with others outside of therapy. An assessment of the social community identifies individuals and situations that will more likely reinforce and sustain that developing repertoire. This assessment of multiple exemplars of situations and people who reinforce behavior change, is central to efforts to generalize the repertoire to relationships beyond therapy.

In order for the therapist to differentially reinforce improved client behaviors, the therapist must also have a sufficiently intact repertoire to effectively provide that reinforcement in-session. This is more potentially complex than it seems because it is not always clear how interpersonally skilled a therapist must be to effectively conduct IBT (or arguably any other interpersonally focused psychotherapy). In more precise terms, it remains an empirical question what repertoires are required by a therapist to effectively respond to and differentially reinforce more effective client behaviors. This remains another point of departure for IBT and FAP. As FAP has evolved, it has increasingly emphasized the topography of therapist (and client) intimacy and disclosure. Although creating a more effective therapist repertoire for genuine disclosure of emotional response to clients can be a goal for IBT therapist, there remains the need to determine whether how that repertoire affects any given client. Rather than state a therapist should be more genuine, open, or present to a client, the goal is to have the therapist learn to discriminate his or her impact on clients as well as trying new and different strategies with clients that may be more effective. By adhering to a behavioral framework, it is possible to specify and then assess what behaviors an IBT therapist would need to engage in to be effective. This can be done in the same way we specify the interpersonal behaviors clients emit to become more effective in their relationships. The specification of both client behaviors and therapist behaviors is done in the spirit of a functional analysis of those behaviors in an effort to create a working understanding of client problems as well as targets for improvement. An assessment system that attempts to identify and specify the necessary skills for IBT and FAP therapists can be found in the *Functional Assessment of Interpersonal Skills for Therapists* (FASIT; Callaghan, 2006a).

The Role of Functional Assessment and Functional Analysis in IBT

A principle-driven analysis of the mechanism of the problem and mechanism of change is essentially at the root of all clinical behavior analytic therapies. This behavior analysis takes the form of a functional assessment of the target behavior and leads to the conceptualization of the client's problems. A functional assessment seeks to specify the behavior of interest and the contingencies that give rise to and maintain that behavior and to generate hypotheses about these relationships. One way to accomplish a functional assessment is by talking to the client and asking them about specific problems, clarifying when the behavior is more likely to occur, and determining the observed consequences of that behavior.

In addition, a functional assessment can occur with the observation of clinical events in-session. Consistent with some of FAP's original five rules (Kohlenberg & Tsai, 1991), IBT maintains a focus on those behaviors that occur in the context of the therapeutic relationship and requires the therapist to observe instances of both problems and improvements as well as actively elicit these from the client. This requires the therapist to notice the impact the client is having on the therapist and what functions that impact has for the client. The goal in this process is to specify the complex social situations (along with client intrapersonal experiences) that give rise to the client engaging in specific repertoires and the consequences for doing so. This behavioral precision allows the therapist to document the specific targets for behavior change, to present those to the client, and track their change over time. In other words, the functional assessment offers a detailed theoretically consistent roadmap for both the client and therapist to follow as they work on changing complex repertoires.

For example, the therapist may determine that a client has a repertoire of social disengagement that has been negatively reinforced due in part to hypersensitivity to social feedback. In this example, the therapist may have learned about this client's difficulties with others in several ways. The client may have told the therapist that they tend to withdraw when feeling like others are being critical or mean, even though the client recognizes that others were not actually making especially negative comments. The therapist can also observe moments in-session when the client becomes quiet, withdrawn, or otherwise disengaged from the therapist when the client experiences the therapist's comments as punitive or unkind. In this assessment, the therapist needs to determine the client's ability to accurately discriminate when others (including the therapist) are being punitive toward the client as opposed to responding more neutrally or even positively. This is not to discount the client's experience of feeling hurt. Instead, the therapist acknowledges an opportunity to recognize and empathically respond. The functional assessment may allow the therapist to recognize the client has a history where any type of feedback is experienced aversively, prompting an escape response that takes the form of disengaging from others, withdrawing, or becoming quiet. The essential feature of recognizing that the client may not be able to discriminate or is hypersensitive to feedback suggests different opportunities for helping develop an improved behavioral repertoire in this context. The client may need to learn how to more accurately discern when, from whom, and which type of feedback is critical, how to engage others when feedback occurs, and even how to more effectively experience and express the emotions that occur when the client feels distress.

Aside from self-report data and in-session observations, a functional assessment can include a functional analysis, the direct test of the hypothesized relationships among variables that have been specified in the conceptualization (Haynes & O'Brien, 1990). The functional analysis can help determine whether the target variables have been identified correctly, and whether change occurs when the therapist attempts to alter the contingencies that give rise to or reinforce that behavior. Conducting a functional analysis requires the demonstration of the relationship between the hypothesized contingencies of behavior developed in the functional assessment, providing evidence of the ability to change that behavior. This is certainly the goal of IBT, but the reality of clinical work often requires therapists to conduct a functional assessment as they work toward implementing a change process, ultimately attempting to demonstrate that functional relationship. One of the key advantages of specifying a functional analysis is that it can help document the clinical change process idiographically and become a central part of gathering data about a clinical treatment to establish evidence-based practice.

Conducting a functional analysis was initially central to FAP and is two-thirds of the FAP acronym, *functional analytic* psychotherapy. However, as briefly discussed, FAP's evolution toward the topographically defined constructs of awareness, courage, and love broke from the requirement of conducting a functional analysis or even functional assessment. Despite the advantages of broader dissemination to those without behavioral training, the costs of FAP focusing on poorly defined constructs rather than specific behaviors outweigh any gains when one's goal is to understand mechanisms of change. In particular, without a functional assessment, the behavior therapist cannot possibly know with precision what repertoire is a focus for treatment, the client would likely not understand the goals of therapy, and there is no clear specification of the mechanism of change that could be tracked over time to demonstrate the efficacy of that intervention.

Further, this move away from functional assessment or analysis does not allow the broader development of a program of science testing the efficacy of a principle-based interpersonal therapy. By retaining behavioral precision, the principle-

driven identified function of the problem, and mechanism of change, the therapist can remain focused on the specific targeted repertoires. The therapist can explain these clearly to clients, track changes in those behaviors over time, and provide evidence and accountability for the treatment. This specificity allows a program of science to emerge to identify and study specific processes hypothesized by IBT to create clinical change. That body of research can provide evidence for the success of those IBT processes to relieve human suffering mediated by interpersonal relationships.

The idiosyncratic identification of each individual client's problems can yield a correspondingly unique description of the myriad interpersonal difficulties that people exhibit. To this end, the *Functional Idiographic Assessment Template* (FIAT; Callaghan, 2006b) provides a structure for assessing client problems and a descriptive terminology rooted in behavioral principles. The FIAT lists five domains of behavioral repertoires commonly seen in IBT and indicates how to assess for their presence. The assessment focuses on the contextual cues and discriminative stimuli that give rise to interpersonal repertoire problems as well as the different forms the repertoire may take. The FIAT system includes questions the therapist can ask in-session, suggestions for behavioral observation, and psychometrically tested questionnaires to help determine which problems clients may have (Darrow, Callaghan, Bonow, & Follette, 2014).

Efforts are currently underway to revise and expand the FIAT system to clarify some of the categories of clinical problems, more explicitly describe prosocial behaviors as targets of treatment, and include a formal assessment of the verbal and social community. This final element, missing from the original FIAT, is being developed with international colleagues in Brazil and offers a central element to a functional assessment of client problems. This assessment of the social community helps determine with whom, when, where, and even possibly how problem behaviors are maintained. It also helps specify situations in which clients may safely practice their emerging, effective interpersonal repertoires that would likely be reinforced and sustained outside of therapy. The goal of the FIAT system is to provide a structure and common language for the behavioral case conceptualization of clients treated with IBT.

A Larger View of Clinical Behavior Analysis and Third-Wave Behavior Therapies

It is important to note that the functional assessment of client problems in IBT presupposes that the client has problems that are primarily interpersonal (as is true of FAP). We imagine most therapists would agree that some clients do indeed have problems that center on their interpersonal repertoires, but the key phrase here is "*some* clients." We want to point out that the role interpersonal repertoire difficulties play with clients is determined entirely by the functional assessment. The corresponding case conceptualization includes interpersonal targets—if necessary. Not *all* clients have interpersonal difficulties or need IBT. In behavior therapy, our goal is to fit the treatment to the client, not the other way around. We start with a client's problems and bring our strategies to meet those; we do not start with the treatment and make the client fit that model of therapy.

It can be argued that this can occur with any of the third-wave behavior therapies because they have come to dominate the field of psychological treatments. For example, it may also challenge some ACT therapists to remember to assess for the presence of escape or avoidance behaviors under the control of contingencies of negative reinforcement if the therapist believes all clients should be treated with ACT. Instead, we want to be sure that following a functional assessment, the client treated by an ACT therapist is indeed a client with problems that are addressed by the processes of ACT. In the same way that not all clients need treatments that focus on interpersonal problems, not all clients need intrapersonal therapy focused dominantly on the avoidance of experiential events. Rather, we know which clients need a particular treatment by functionally assessing and then selecting the therapy that matches those problems.

Pointing out the lack of a functional assessment-driven conceptualization is not to discount the value of any of the third-wave behavior therapies or their contribution to alleviating suffering. If anything, it is a call to return to the initial core values of these behavioral treatments. These values align with a behavioral specification of the mechanism of change and a precision of functional assessment that determines the treatment best suited for a particular client. By beginning with a functional assessment (ideally leading to a functional analysis), we can determine what the best treatment will be for any specific client based on the processes of the therapy. The specificity of that assessment from a behavioral framework allows us to determine the therapeutic approach and how to engage each unique client. This, in turn, allows for the choice among multiple therapies with their own unique focus on inter- or intrapersonal behavioral problems to be used to address those identified problems.

ACT, FAP, DBT, and IBT can coexist as approaches to address specific types of client problems, but therapists must remain explicit about how they understand those behavioral targets and what the mechanism of change will be to alleviate the identified suffering. This is equally true for cognitive therapy, mindfulness-based strategies, narrative therapies, and other treatments that utilize sometimes difficult to specify, construct-laden processes purported to create behavior change. It is not impossible to create a behavior analysis of, for example, the role of narratives in psychotherapy (Snycerski, Laraway, Gregg, Capriotti, & Callaghan, 2018).

Operationalizing these constructs may sometimes change how the therapy is implemented, but it can potentially broaden our tool kit of strategies for working with different kinds of client problems. This is not to say that the behavior therapist is suddenly doing (in this example) narrative therapy as originally outlined by early proponents (e.g., Brown & Augusta-Scott, 2006). Instead, we can understand why talking about a complex change in associated (or derived) verbal repertoires can be important to understanding and alleviating aspects of human suffering (Hineline, 2018; Snycerski et al., 2018).

This understanding of different psychotherapies as approaches to alleviating suffering allows for a critical reframing of our role as clinical behavior analysts and behavior therapists as well as the role of these psychotherapies as institutions. If as therapists we begin with a functional assessment of client problems and attempt to bring to bear strategies to address those problems understood by specific processes, we may be in a unique position to address multiple client repertoires under different kinds of contingent control (including those that are inter- and intrapersonal). These strategies not only may vary among different clients but by each problem evidenced by the individual client. For example, we may find that we can conduct a functional assessment and generate a behavioral case conceptualization that determines whether, and in what way, a specific client may benefit from addressing experiential avoidance, focusing on problems with interpersonal distress, and working on strategies for emotional regulation.

Conclusion

Remaining behaviorally focused can bring precision to our clinical work while maintaining a clear program of research to study complex behavioral problems and treatments. Studying these processes can allow us to continue to develop best practices that are empirically supported and principle driven. Behavior therapists may find themselves practicing a variety of behavioral strategies based on those problems that clients bring to therapy as defined in a functional assessment. In this way, we are not therapists of one brand of therapy or another but behavior therapists who use a variety of demonstrated change processes in the service of our clients.

All of that said, we still have much work to do to return to and maintain focus on the precision of our language, the utilization of functional assessment, the development of behavioral case conceptualizations, and the application of idiographic and nomothetic strategies to demonstrate the efficacy of our approaches. Although FAP began as a compassionate and thoughtful method of looking at complex interpersonal behavior problems, IBT represents a retooling of those ideas and a move towards keeping that focus behavior analytic. IBT also asserts a step in the direction of a broader construction of a fourth wave of behavior therapies (Callaghan & Darrow, 2015) where all treatments are unified under a single set of psychological principles rather than fragmented by theories or target populations.

Remaining behaviorally focused in IBT requires that our community determines how we make certain that therapists are sufficiently trained to be able to conduct a functional assessment in order to provide IBT. If this is shared by proponents or practitioners of other behavioral principle-driven therapies, those therapists will necessarily share similar tasks. Of course, this would be the case if we mount an agenda of moving toward an approach to a unified principle-driven psychotherapy. This is no small task, but it is one that other helping professions have approached with success (e.g., the behavior analytic treatments for those struggling with complex developmental repertoires diagnosed as problems on the autism spectrum). In behavioral psychotherapy, our job is to determine the amount and kind of education that would provide practitioners with the skills to be not just behavior technicians but true behavior therapists. The community that created ACT, FAP, and DBT is beginning to recognize the scope and complexity of disseminating a principle-based therapy that allows clinicians to identify events in therapy and select processes that solve clinical problems in ways that are consistent with the underlying science behind therapy without needing to know excessively technical language and research. The consequences of doing so successfully are enormous. The cost of inadvertently decoupling science from practice presents significant threats, not only for our clients and practitioners of behavior therapy, but also jeopardize the credibility of our discipline as a science of human behavior change.

Compliance with Ethical Standards

Conflicts of Interest Both authors declare no conflicts of interest regarding the writing and content of this manuscript.

Research with Participants or Animals This article did not involve research with human participants and/or animals, and so did not involve informed consent.

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The FIAT and associated assessment approach discussed can be found in the corresponding publication and by request to the first author.

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