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Reinforcement matters: A preliminary, laboratory-based component-process analysis of Functional Analytic Psychotherapy's model of social connection

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ABSTRACT

A therapeutic model of social connection derived from Functional Analytic Psychotherapy (FAP) that applies to both the client's outside-of-therapy relationships and the psychotherapeutic relationship is explored in two studies. The model integrates established behavioral principles with existing research on the reciprocal process of self-disclosure and responsiveness that occurs during development of intimate relationships to highlight a promising therapeutic process. In this process, self-disclosure ("courage" in FAP's model) is evoked by the therapist and then reinforced with therapeutic responsiveness ("love" in the FAP model) resulting in improved self-disclosure and more connectedness in the therapy and other relationships. Study 1 included a sample of 77 undergraduate participants who self-disclosed responses to a series of closeness generating questions to undergraduate research assistants trained in responsiveness. Findings indicated that social connection increased following this full procedure. Study 2 included a sample of 99 undergraduate participants and provided evidence that the responsiveness of the research assistant is key to promoting increased feelings of connectedness and also improves the depth of disclosure.

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1. Introduction

The terms *social relationships*, *social connection*, *social functioning*, and *social support*, as well as converse terms such as *loneliness, troubled social relationships*, and *social isolation* refer to a broad realm of human functioning that has been studied extensively across different domains of science. The public health significance of successful behavior with respect to this domain of human functioning, which we will refer to as *social connection*, is massive. Social connection, in fact, may be our most important public health priority, proving to be equivalent to cigarette smoking and stronger than alcoholism, physical activity, obesity and hypertension as a predictor of mortality risk (Holt-Lunstad, Smith, & Layton, 2010; Wilkinson & Marmot, 2003).

The need for social connection is fundamentally human. Converging lines of scientific inquiry, from evolutionary biology (Bugental, 2000), psychology (discussed below), and neuroscience (reviewed in Cacioppo & Patrick, 2008) suggest that humans are hard-wired to seek social connection and to dysregulate when it is lost or unavailable. Thus, social connection is often a target of psychotherapy, as it has been shown to be related with a host of depressive, anxiety, and other psychiatric disorders (Wetterneck & Hart, 2012).

Social connection is also relevant to the process of psychotherapy itself. While psychotherapy researchers may debate the exact requirements and nature of the therapeutic relationship necessary for therapists to do their work, the general consensus is that a strong relationship, alliance, or bond is required, or at least beneficial, in producing positive therapeutic outcomes (Norcross, 2011; Tsai, Kohlenberg, & Kanter, 2010). It is generally regarded as the most important of psychotherapy's non-specific or common factors, and meta-analytic reviews of alliance research have concluded that relationships characterized by a strong therapeutic alliance are important for psychotherapeutic outcomes.

The current research explores a therapeutic model of social connection derived from Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991) that applies to both the client's outside-of-therapy relationships and the psychotherapeutic relationship. Emphasizing the three terms "awareness," "courage," and "love,"

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this contextual-behavioral clinical model is a direct extension of a well-researched interpersonal-process model for how close relationships develop (Reis & Shaver, 1988). The potential benefit of this particular articulation of the model is that it is both contextual behavioral and clinical. It explicates the key processes in both behavioral and clinically user-friendly terms, thereby producing a clinically beneficial research strategy that focuses directly on the therapeutic behaviors necessary for client growth at any moment (Hayes, Barnes-Holmes, & Wilson, 2012).

The current two studies present a laboratory-based, experimental component-process strategy (Levin, Hildebrandt, Lillis, & Hayes, 2012) for researching this model in analog, non-clinical settings. The first study served as a demonstration of the basic process, replicating and extending earlier findings (Aron, Melinat, Aron, Vallone, & Bator, 1997; Reis et al., 2010). The second study dissected the process into its basic components from a contextual behavioral perspective, providing a model for future explorations of this process.

2. FAP's clinical model of social connection

FAP suggests that the psychotherapy relationship is a real, genuine relationship involving trust, vulnerability, and attachment. Therefore, the process of psychotherapeutic relationship development is influenced by the same factors as the other important relationships in the client's life. As such, the psychotherapeutic relationship can be used as a context in which improved connection-related behavior can be encouraged and nurtured, and these improvements will generalize to the client's outside relationships (Kohlenberg & Tsai, 1991; Tsai et al., 2009). At a very basic level, regardless of the specific content focus of a therapy session, the therapeutic encounter can be seen as an interpersonal process of client self-disclosure and therapist responsiveness that leads to the development of intimacy and connection between the two individuals.

FAP's model of social connection incorporates three constructs —awareness, courage, and love—in an interactional sequence. This sequence is consistent with previous literature on the development of intimate relationships (Aron, Melinat, Aron, Vallone, & Bator, 1997; Reis & Shaver, 1988), with previous behavioral analyses of intimacy (Cordova & Scott, 2001), and with an operant functional analysis of the behavior of interest, client vulnerable self-disclosure. With respect to the client behavior of interest, although the current formulation focuses on "vulnerable self-disclosure," the FAP model can be applied to almost any client behavior that occurs in session. Previous FAP writings have used the purposely unspecific term "clinically relevant behavior" rather than specifying that the target of therapy is self-disclosure per se. Nonetheless, there is much research to support the specific therapeutic target of authentic, vulnerable, emotional self-disclosure of difficult content that otherwise would be avoided or suppressed when the goal of therapy is improved social connectedness and intimate relating (Baddeley & Singer, 2009; Brunell et al., 2010; English & John, 2013; Graham, Huang, Clark, & Helgeson, 2008; Reis et al., 2010).

The FAP model of the full process is outlined in Fig. 1. The model clarifies the therapist's functions in the process (Panel A) which begins with providing antecedents for/evoking the client self-disclosure (A). This could be as simple as asking "How are you feeling?" or it could be more specifically related to asking for specific responses from the client. After the client behavior (B) occurs, the key therapeutic behavior is providing effective consequences by responding to the resulting disclosure in a reinforcing way (C). The FAP view of the therapist response as reinforcing is seen as a clarification of the function of

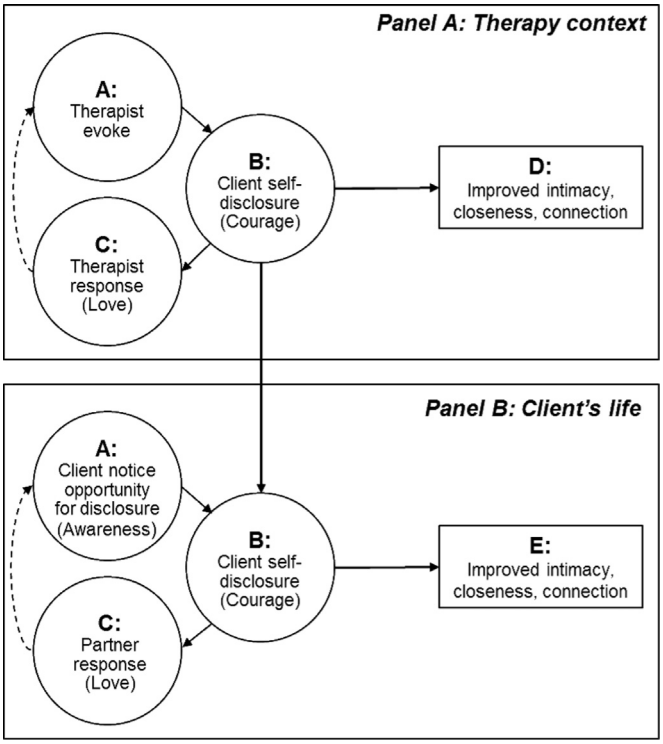

Fig. 1. FAP's clinical model of social connection.

"responsiveness" in the interpersonal process model of Reis and Shaver (1988). Note that, in traditional FAP terminology, the therapeutic behaviors of evoking and responding to client behavior, respectively, have been referred to as Rule 2 and Rule 3, respectively (e.g., Kohlenberg & Tsai, 1991). In the current formulation, consistent with more recent FAP writings (Tsai et al., 2009), we also have added the clinical terms "courage" as a label for the client self-disclosure and "love" as a label for the therapeutic response. Thus, clinically, it may be said that the therapeutic task is to respond to client courage with love (for more discussion of this, see Kanter, Holman & Wilson, 2014 and Kanter et al., 2015).

The dotted arrow from C (responding) back to A (evoking) in the model suggests that this process is replicated multiple times throughout a therapy session and over the course of therapy (analyses of FAP sessions suggest approximately 10 cycles per session during a FAP research protocol with a client with positive outcomes; Busch et al., 2009). If the process is indeed responsive/reinforcing, then it is predicted that both the frequency of client vulnerable self-disclosure (B) will increase in session and (D) there will be an increase in experienced closeness, intimacy, and connection in the therapy relationship. Importantly, in contextual behavioral terms, the prediction that vulnerable self-disclosure will increase in frequency during the session is a direct statement of FAP's presumed mechanism of action—reinforcement of target behavior will lead to an increase in the frequency of the target behavior. The increase in experienced closeness and intimacy (D) that is predicted in the model can be seen as an important respondent that occurs during the interaction.

A key prediction of the FAP model is that the frequency of vulnerable self-disclosure will increase in session and this behavior will generalize to the client's out-of-therapy relationships (B in Panel B in Fig. 1). To help with this generalization, an important element of the FAP model is increasing client awareness of opportunities for connection (A in Panel B) which facilitates evocation of the behavior. When the self-disclosure occurs, when the other individuals in these relationships respond to the disclosures well, increases in the frequency of self-disclosure (B) and

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