THE THERAPEUTIC ALLIANCE IN ACCEPTANCE AND COMMITMENT THERAPY

LA ALIANZA TERAPÉUTICA EN LA TERAPIA DE ACEPTACIÓN Y COMPROMISO

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Abstract

Acceptance and Commitment Therapy (ACT) is a process-based intervention that promotes psychological flexibility by implementing six core processes. These include acceptance and awareness as well values and behavior change processes. Still, the primary vehicle for implementing these processes is the therapeutic relationship. Underscoring the importance of the relationship is paramount – it is the context in which the interventions emerge, allowing the therapist to shape psychological flexibility directly. We argue that the therapeutic alliance (TA) is co-created and is a critical factor contributing to the effectiveness of ACT. This paper focuses on the TA as a vital part of ACT treatment. We discuss the therapeutic alliance from an ACT perspective, explore different roles in implementing ACT, and conclude with a clinical case illustration. We more specifically focus on how the TA alliance and the therapeutic relationship can be a vehicle of change in ACT.

Keywords: *therapeutic alliance, therapeutic relationship, ACT, acceptance and commitment therapy*

Resumen

La Terapia de Aceptación y Compromiso (ACT) es una intervención basada en procesos que promueve la flexibilidad psicológica implementando seis procesos centrales. Estos incluyen aceptación y conciencia como también procesos de valores y cambio conductuales. Sin embargo, el vehículo primario para implementar estas intervenciones es la relación terapéutica. En este trabajo discutimos que la Alianza Terapéutica (TA) es co-creada y es un factor crítico que contribuye a la efectividad de la implementación de ACT. Este artículo se enfoca en la TA como una parte vital del tratamiento ACT. Desarrollamos la alianza terapéutica desde la perspectiva de ACT, exploramos los diferentes roles que ocupa en la implementación de ACT y concluimos con un ejemplo clínico. Mas específicamente mostramos cómo la alianza terapéutica y la relación terapéutica pueden ser un vehículo de cambio en ACT.

Palabras claves: *alianza terapéutica, relación terapéutica, ACT, terapia de aceptación y compromiso*

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In the traditional behavioral literature, an essential part of therapy can be overlooked, or at least under-appreciated – the therapeutic relationship and the alliance that emerges from it. Efforts to evaluate and integrate the therapeutic relationship's importance within behavior therapy are more recently emerging. Yet, much work is to be done. We maintain that the relationship between the therapist and client and the therapeutic alliance that grows between the two is vital in producing effective therapy outcomes – an assertion supported by years of research (Nienhuis et al., 2018). The therapeutic relationship is not only an essential part of treatment; it also can be the vehicle for promoting client growth and transformation. Specific to our approach, the alliance in acceptance and commitment therapy (ACT; Hayes et al., 2012) is the conduit for fostering psychological flexibility and the context for change.

Psychological flexibility in ACT is cultivated by helping clients contact the present moment, developing awareness of emotions, thoughts, and sensations while choosing to engage in behaviors that reflect personally held values (Hayes et al., 2012). There are three main pillars in ACT that encompass the process. These are opening to experience (open), living with awareness (aware), and committing to values-based living (engaged). The three pillars contain six core processes implemented to support healthy change. These are (see below for more thorough definitions): 1) willingness; 2) defusion; 3) present moment; 4) self-as-context or perspective taking; 5) values clarification or ways of living; and 6) committed action. Varied and numerous exercises, metaphors, and techniques are used to support clients in learning to engage these processes in their lives. These processes are used to address psychological *in*flexibility (avoidance, fusion, living in the past or future, self as content, lack of values clarity, and inaction or impulsive behavior). However, building psychological flexibility is not only about the techniques and exercises used to support these processes in general; the heart of the ACT model is also about evoking, shaping, and reinforcing this inside of a relationship that instantiates the model itself. The therapist, reflecting the model is psychologically flexible, responding to the client from a stance of openness while holding them as a whole being capable of change linked to meaning.

As a therapy that comes under the umbrella of cognitive-behavioral approaches, the work in ACT is to implement processes and techniques that target problematic behavior(s), modifying behavior in the service of healthy change. However, as with other behavioral and cognitive approaches, ACT can fall prey to a more technique-oriented intervention focusing on the alliance only when there is a rupture. In this *first* approach to the alliance, the ACT core processes contributing to psychological *in*flexibility (i.e., avoidance, fusion, etc.) are the main focus of the case conceptualization. These are then targeted for change by the psychological flexibility processes, with therapists mainly attending to the context of the client. Although this is undoubtedly a part of the work in ACT, oversimplification of the approach and a narrow focus on the client leads to less interpersonal sensitivity. It is important to remember that an advanced, richer therapy benefits from recognizing that the therapeutic relationship and alliance are critical factors in contributing to the effectiveness of ACT. This is not to say that well-planned techniques cannot serve as a respectable intervention. However, interpersonal factors may still mediate the results even with robust techniques. As with other behavioral therapies, ACT can be enhanced when the therapeutic alliance as a context or even a vehicle for change is built-in

More recently, a focus on the alliance with a move to include interpersonal factors has changed for cognitive and behavioral models, with the therapeutic alliance playing a more prominent role (Gilbert & Leahy, 2007). Integrating these interpersonal factors as a focus of therapy is a *second*, more connected approach to the alliance. The therapeutic relationship and TA are enriched by these factors, supporting the relationship as a context for change. Here, interpersonal factors may be viewed as either interfering with or facilitating change. These factors might include the role of emotional sensitivity, empathic understanding, mindfulness, compassion, validation, and irreverence. Once lacking or given very little recognition, the importance of these interpersonal factors in the therapeutic approach is now being considered and more broadly implemented. Using these components in building the relationship and a robust therapeutic alliance, the therapist can enhance meaningful and transformative experiences for the client.

As a therapy method, implementing these factors relies not only on the skill to employ the factors themselves but also on the therapists' ability to personally engage the ACT processes in the service of enhancing the therapeutic bond. The latter means that the therapist consistently behaves psychologically flexibly, modeling openness, awareness, and engagement. Modeling in this manner creates the context for learning and change and builds a mindful, compassionate, and empathic bond.

The third approach, suggested here as the most important, involves an even greater level of participation by the therapist - building awareness of intrapersonal and interpersonal processes across the arc of therapy. The relationship between the therapist and client reflects a natural dialectic where the relationship acts as both a means to make the treatment work while also acting as the therapy itself apart from any technique. This third approach focuses on the interpersonal behaviors occurring in session as the means of change.

For example, Functional Analytical Psychotherapy (FAP; Kohlenberg & Tsai,1995), a behavioral therapeutic model, asserts that the relationship is the lead mechanism for facilitating change. The direct experience between the client and the therapist is the behavior of interest. The additional learning history acquired by interacting with the therapist during treatment leads to modification of behavior. Problem behaviors that clients emit in session (e.g., emotional avoidance, mistrust, assertion deficits) are of the same general class of behaviors they emit with others and are addressed with behavioral principles directly. The same happens with growth behaviors. The therapist responds in session contingently to behaviors by recognizing their relevance, evoking growth behaviors, reinforcing them, and facilitating generalization outside the therapeutic room.

As with FAP, the relational interaction is also fundamental to the theoretical foundations of ACT. Behavioral principles come alive inside this context with both therapist and client evoking responses, including helpful (e.g., supportive behavior) and, at times, unhelpful (e.g., avoidant behavior), in one another (Walser et al., 2019). Responding to these behaviors contingently, we can facilitate the change we are targeting. As a therapy method, the therapeutic relationship again relies on the therapists' ability to personally engage the ACT processes in the service of enhancing the therapeutic bond. As with the second approach, the therapist consistently behaves psychologically flexibly, modeling openness, awareness, and engagement, creating a context for learning and change while building a mindful, compassionate, and empathic bond. However, if the therapist uses the relationship as a vehicle for change, recognizing which ACT process to use when, the therapist needs to be aware of the kind of relationship the client and therapist are co-creating in the moment. Is the relationship nurturing flexible behaviors or not?

For ACT therapists focused on technique and what is happening for the client, the flexible implementation of ACT tucked inside a relational bond that nurtures flexible behaviors may prove more elusive. Including interpersonal factors can expand therapeutic acumen and augment the alliance. However, co-creating an intrapersonally and interpersonally informed process as well as a dynamic bond across ACT treatment can truly enrich the therapy. However, it will mean learning to monitor and observe, in an ongoing way, the moment-by-moment relational processes that are being co-created by the client and therapist in a kind of "togetherness" designed to promote meaningful change.

In the following sections, we begin to look at this issue by exploring the therapeutic alliance, considering the role of the relational bond in behavior therapy, and focusing on relevant basic principles. We then clarify the therapeutic alliance in ACT and its different roles. Finally, we further develop the therapeutic alliance's power as a means of change, concluding with clinical cases Illustrations.

The Therapeutic Alliance: An Overview

The therapeutic alliance, or alliance, is a construct that attempts to define the collaborative elements of the interpersonal relationship between client and therapist during psychotherapy. The term "therapeutic alliance" is commonly used to refer to the most significant aspects of the relationship which impact gains in therapy (e.g., Gelso & Carter, 1994). Clinicians from many theoretical orientations acknowledge the importance of the relationship between the client and the therapist in effecting change (e.g., Bordin, 1979; Horvath & Luborsky, 1993; Rogers, 1957; Wright & Davis, 1994).

A positive therapeutic alliance (TA), or "working alliance," refers to the collaborative, mutually respectful, caring partnership that characterizes a productive patient-therapist relationship (Horvath, 2001). However, it can be conceptualized more accurately as a multifaceted construct consisting of several areas of emphasis (Bordin, 1979; Greenson, 1965). These areas have included an agreement on the goals and tasks of therapy, a commitment to treatment, and the perceived bond between the client and therapist, among others (e.g., Horvath & Greenberg, 1989).

Research on the therapeutic alliance in adult psychotherapy has been fairly robust and in support of the alliance as a mechanism of change in psychotherapy (Crits-Cristoph et al., 2013; Flückiger et al., 2018). In addition to the definitions underpinning the alliance, the alliance itself is considered an active therapeutic ingredient independent from any psychotherapeutic technique (Horvath and Symonds, 1991). The alliance is also thought to be a common change process in psychotherapy regardless of theoretical orientation (Wampold & Imel, 2015).

Given the data and research indicating that clients tend to emphasize the importance of therapist warmth and emotional involvement (Gilbert & Leahy, 2007), it can be argued that establishing a good relationship is necessary from the first stages of therapy. Furthermore, as therapists tend to judge the initial quality of the relationship in terms of clients' active participation and collaboration, the objectives for the first stage in the relationship might include empathy, intentions, and hope.

The second stage of the relationship involves carrying out therapeutic activity. A deepening of the therapist-client relationship often accompanies this stage but may also include challenges to the relationship shifting it into the third stage. These challenges may involve misunderstandings, conflicts, activation of defenses, negative reactions, and ruptures. Maintaining the quality of the relationship through the various stages of therapy involves therapists ensuring they are appropriately responsive to their clients and able to recognize and seek to repair ruptures in the relationship.

Maintaining this complex developing and changing connection requires therapists to individualize their responses to specific aspects of clients' needs and relating styles. Therapist understanding and appreciation of contextual factors are also crucial. Research suggests that the blending of these various skills makes for a good therapeutic relationship, influencing the outcome for the client (Gilbert and Leahy, 2007)—again, establishing the importance of the therapeutic relationship as a mediational factor in psychotherapy.

The Relational Bond in Behavior Therapy. Whereas the therapeutic alliance is a defining feature of psychodynamic and humanistic/experiential approaches (see Horvath & Luborsky, 1993 for a detailed historical account), its role in behavior therapy has been explicated less clearly (Lejuez, 2005). Behavior therapists have traditionally assumed that specific therapy techniques largely account for treatment outcome variance with notable exceptions (Brown & O'Leary, 2000; Hyer et al., 2004; Klein et al., 2003). The therapist-patient relationship is generally a "neutral stimulus" that has minimal relevance toward assessing treatment efficacy (cf. Kohlenberg, 2000).

It could, however, be argued that ignoring the role of the therapeutic relationship and alliance in behavior therapy may not only be problematic on a practical level but may also be inconsistent with basic principles that underlie behavior therapy (Kohlenberg et al., 1998; Raue et al., 1997). Indeed, Follette et al. (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. However, in contrast to a client-centered perspective, they do not assume that "unconditional positive regard" or wholly noncontingent responding are sufficient conditions in therapy to bring about change. Technically speaking, the therapist's general support and acceptance of a client's effort to change is better understood as contingent responding. The class of behaviors reinforced by the therapist is necessary for therapy to occur.

In more recent accounts of a new generation of behavioral therapies such as FAP (Kohlenberg & Tsai, 1995) and ACT (see Hayes & Hofmann, 2018), exploring the behavioral processes between therapist and client has been given serious consideration (Vilardaga & Hayes, 2009; Walser et al., 2019). Specifically, the therapeutic relationship and the strength of its alliance depend on a process of mutual influence. The therapeutic alliance is a mutual shaping and learning (Follette et al., 1996; Lejuez et al., 2005) process. The therapist works to influence clients' responses, and clients also impact therapist behavior (Walser et al., 2019).

From a FAP perspective, for instance, the therapeutic relationship is where clients engage in problem behaviors and learn new, more effective ways of responding. The consequences of behavior emitted in the client-therapist relationship are the key to healthy outcomes. For therapy to be effective, the clinician needs to identify problem behaviors and shape more functional behaviors during the session. The target is interpersonal functional classes of behavior. The therapeutic alliance should approximate intimate social relationships as closely as possible so that the client can easily generalize treatment effects from the session to the natural environment.

Equally important, a FAP therapist must be invested in creating an authentic and close therapeutic alliance. FAP would be impossible without a therapeutic relationship that is caring, genuine, sensitive, involving, and emotional (Kohlenberg & Tsai, 1987). The therapy rests on the supposition that a client will interact with the therapist in much the same way they behave with peers and loved ones.

The Therapeutic Alliance in ACT

ACT (Hayes et al., 2012) is a behavioral intervention focusing on reducing rigid, non-varying, and non-adaptive behavior by encouraging and reinforcing psychological flexibility. The intervention focuses on decreasing experiential avoidance and fostering willingness of private experiences in the service of healthy living based on values. The six core components use acceptance and mindfulness processes and commitment and behavior change processes to produce change. The processes are interrelated and instituted inside of and through the therapeutic relationship.

More thoroughly defined than above, the six core components use acceptance and mindfulness processes and commitment and behavior change processes to produce change. Willingness increases flexibility by bringing the individual into contact with previously avoided private experiences such as negative emotions and unpleasant sensations. Clients learn to feel emotions and sensations as they are and not as what the mind makes them out to be. Cognitive defusion decreases the behavioral regulatory effect of thoughts by increasing contact with the process of thinking instead of the products of thinking. Clients are taught to observe the ongoing flow of thoughts while also discovering that words do not exist inside the objects they refer to (e.g., the sound apple refers to the object, it is not the object itself). Encouraging contact with the present moment enhances the person's awareness of external and internal events (e.g. be in the moment observing what is here now). Strengthening a transcendent sense of self (self-as-context) decreases attachment to the conceptualized self. This sense of self is consistent with the I, Here, Now perspective. Becoming more aware of this transcendent sense of the self empowers other processes supporting the pillar of openness to experience. Values are chosen qualities of personal meaning (i.e., loving, caring, etc.) and guide living. Values are continuously present and never obtained as concrete objects. Encouraging committed action builds ever-larger effective behavior patterns linked to chosen values. Finally, ACT includes numerous techniques focused on each component area, but the model, not the technology, defines the intervention.

Most importantly and relevant to the argument here, ACT incorporates the therapeutic relationship as a significant component of treatment. Although several ACT goals may be intrapersonal in nature, the means are decidedly interpersonal. That is, they hinge upon the trusting and collaborative nature of the therapeutic alliance.

The alliance in ACT is complex and reflects many different qualities, most necessary for building awareness of intrapersonal and interpersonal processes across the arc of therapy. First, ACT is non-hierarchical, client and therapist are both human, and each has their own measure of pain and joy. The therapist does not "sit above" the client.

Second, the therapist and client are engaged in a collaborative process of mutual influence. The therapist impacts clients' responses, but clients also affect therapist behavior. The alliance in ACT emerges as the natural result of the converging effect of its philosophical assumptions (Functional Contextualism; see Hayes, 1993), a scientific theory of language and cognition (Relational Frame Theory, RFT; see Hayes et al., 2001), the characteristics and guiding principles of the ACT model as an operating system for clinical intervention (Hayes et al., 2012), and finally the moment by moment mutual influence that is co-created in the interpersonal field.

In contrast to a more topographical understanding of the alliance as something a therapist "has" or "does not have" with a client, ACT places its emphasis on what a therapist and client are expected to "do" in building the alliance during treatment. Such a behavioral emphasis has several consequences for studying the alliance in

ACT as a mechanism of change.

First, a behavioral understanding of the alliance requires a therapist to be practicing ACT – they are open, aware, and engaged inside the relationship. Second, the behavioral emphasis has the effect of placing the responsibility of monitoring and maintaining the various areas of the alliance on the therapist as part of the intervention despite knowing that it is co-created with the client. Third, any failure in various areas of the alliance can be subjected to a rupture-repair process (Walser & O'Connell, 2021). Therapists and clients agree that it is a priority in treatment to address any behavior on the part of the therapist or client that interferes with the effective delivery of the intervention. The importance of therapy-interfering behavior is an explicit acknowledgment that the therapeutic relationship in ACT is a genuine, real relationship. Still, there is a commitment to serve and support change.

Pierson and Hayes (2007) note that other broad qualities speaking specifically to the multiple dimensions that guide decision-making in reinforcing psychological flexibility inside the relationship. Change is reflected in the clients moving from rigid behavioral responses to flexible responses. The intrapersonal process is brought into the therapy. What is happening inside the client as well as the therapist during the session is entirely relevant (Walser et al., 2019). What is happening within the therapist in the moment-to-moment interaction is revealed if functionally appropriate.

The qualities of therapeutic interactions also play a role (Pierson & Hayes, 2007). Interactions that are empowering assist the client in taking healthy risks in the session and in their lives outside of the session. This is executed through the processes themselves. For instance, an empowering interpersonal relationship is also a loving relationship - values unfold in the therapy room. A defused relationship is creative and playful, and an accepting relationship makes room for all emotion and sensation experiences. Relating from the perspective of self-as-context, both therapist and client detect a sense of transcendence. Neither is the content of their life, and both are more than their histories. Finally, the present moment is alive and connected to during the session with action linked to change folded in. More simply, behaving flexibly is instantiated and embodied using the ACT processes in the relationship and throughout the therapy's ongoing arc.

The therapist using ACT at the third level of approach to the alliance effectively builds awareness of intrapersonal and interpersonal processes across the therapy in the service of psychological flexibility. Here, the therapist should be supporting, modeling, evoking, shaping, and reinforcing psychological flexibility allowing the client to vary and adapt behavior to suit the relevant context.

Therapists implementing ACT in this way seek to optimize the therapeutic relationship's conditions maximizing the therapeutic bond's effectiveness – a concept we have referred to as, togetherness. 'This can include responsiveness, warm engagement, genuineness, and self-disclosure – with self-disclosure creating a sense of a "real" relationship. In addition, the balance of acceptance and change manifests as a dance between behavioral expressions of autonomy and control. The relationship holds that the client feels accepted but is also expected to change.

Expectations for change as an interpersonal position that the therapist adopts include unwavering centeredness balanced by a sense of compassionate flexibility. Along this dimension, the therapist finds equilibrium between unwavering consistency in the implementation of the therapy and responsiveness to the client's current experience. Movement between these two poles communicates simultaneously that the therapist believes in the therapy and is attentive to the client as an individual. Additional expectations for change include therapist qualities along the dimension of nurturing and benevolent demanding. Nurturing behaviors—coaching, aiding, and strengthening the client—create a relationship in which the client understands they will have support and compassion from the therapist. Nurturing is balanced with the attitude that the client can and must care for themselves. The therapeutic relationship is characterized simultaneously by genuine empathy and support and a firm belief in the client's capability to care for themselves.

Finally, expectations for change involve shaping more flexible client responses and broadening their interpersonal repertoire. The therapist first shapes responses that establish new, more flexible client behaviors inside the relationship. This transforms the relationship into a true alliance, which models, evokes, shapes, and reinforces psychological flexibility. When this aspect of the relationship does not occur, the interaction can inadvertently produce an ineffective client response repertoire, increasing the future probability of less effective behaviors. Thus, it is essential to focus on behaviors in the relationship that are more relevant to the treatment goals identified and then responding contingently, differentially reinforcing specifically targeted client behaviors. Contingent responding means that the therapist responds to client behavior as it naturally impacts the therapist. If the client emits a behavior the therapist finds particularly effective during the session, the therapist responds accordingly. If the client is ineffective, the therapist experiences whatever aversive properties occur and responds in a way that indicates the natural effect this client's behavior had on them, working with the client to figure out how to produce the effects the client actually desired. The therapist successively shapes more useful behavior by the client by reinforcing approximations of client improvement. This analysis implies that the therapist's behavior functions to increase effective responding on the client's part and according to the client's stated values.

A Functional Contextualist Caveat to the Alliance. Deeply connected relationships formed through the ACT processes can promote well-being of all kinds. However, we do not need to presume that therapists always need to be intimate and close, nor that this kind of relationship is inherently therapeutic in and of itself. Instead, it is vital to monitor, moment by moment, how the relationship is co-constructed, analyzing whether it is supporting psychological flexibility. Therapists in ACT can learn particular strategies that can enhance the bond as well as repair the bond when it is perceived to interfere with psychological flexibility (Walser & O'Connell, 2021). An essential question arises: Is the alliance that is being co-created at this moment in the service of psychological flexibility?

From the ACT perspective, the noted way of creating the alliance then is not merely a matter of being supportive, positive, or empathic. It is not supposed that the relationship need always be intimate and close, nor that this kind of relationship must be inherently therapeutic in and of itself. Instead, it is a matter of being present, open, and effective intrapersonally, interpersonally, and across time. These qualities set the context for processes to flow in ACT. Nonetheless, the 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 creating the therapeutic alliance. This is the case since functional contextualism is not about the form or topography of a particular relationship; instead, it is about the function of a behavior. Creating psychological flexibility by targeting the function of behavior allows for several ways to interact or relate with clients.

Co-Creating in ACT

The relationship and the alliance can be used as a powerful change engine through deeply connected relationships that empower clinical work. Even so, we attempt to go a step beyond the agreed-upon point that the relationship matters. We argue that the alliance, co-created through monitoring moment by moment how the relationship is constructed, analyzing if it supports psychological flexibility, can be a vehicle for long-lasting change. From our perspective, the alliance in ACT is understood as both a mechanism that facilitates change as well as a source of change. Two main questions arise from this approach, 1) what alliance is being co-created at this moment, and 2) is this alliance supporting psychological flexibility in context?

The alliance in ACT is functionally beneficial when the relationship is constructed around the goal of psychological flexibility on the client's behalf with the therapist supporting, modeling, evoking, shaping, and reinforcing the same through a class of intrapersonal and interpersonal psychologically flexible repertoires. If we trace an equivalent functional class between the intrapersonal and interpersonal behaviors occurring in session, we can work in the interpersonal field using our contingent interpersonal responses to promote change.

For example, a client avoiding contacting painful feelings may show avoidance repertories interpersonally by arguing and fighting with the therapist; viewing these avoidance behaviors occurring in session as equivalent functionally to other avoidance behaviors can prove helpful. When the avoidance behaviors occur within the relationship, the therapist focuses on acceptance work that includes responding to these behaviors contingently; this can then be generalized to the intrapersonal field. In this sense, as with FAP, the therapist can recognize relevant interpersonal behaviors that are equivalent functionally to intrapersonal behaviors (avoidance/acceptance, fusion/defusion, etc); or they can evoke equivalent interpersonal behaviors and reinforce psychologically flexible ones. These can then be generalized to the intrapersonal field. This can be seamlessly implemented through frames of coordination (see Villatte et al., 2015). Questions can be asked during the session such as, "How is what is happening here and now between you and me the same in terms of what is happening in your relationship with pain?" or "What have you learned between us that can be useful for your relationship with pain?"

This co-created process provides the client with the opportunity in therapy to address inflexible interpersonal and intrapersonal behavioral patterns, setting the stage for more flexible behaviors between the client and therapist and promoting psychological flexibility and useful practice for situations outside of therapy.

Psychological flexibility can be created in this fashion as it is relational; it is the way we relate to what is happening: more or less rigidly or flexibly. These same classes of rigid and flexible behaviors show up in the interpersonal field. Responding in the here and now in the interpersonal field can be a more robust learning experience for clients. From this perspective, the relationship and the alliance become the therapy itself, paying close attention to the interpersonal field co-created moment by moment.

Clinical Case Illustration of TA in ACT

The clinical case illustration below is presented and modified based on a role-played interaction of therapist and client from a clinical course. The three ways an alliance can be approached from the ACT perspective will be demonstrated: 1) Technique-oriented with little regard for the therapeutic relationship and only applying the core processes, 2) doing act accented with interpersonal factors implemented in the relationship as a context that permits ACT to flow, and 3) enhancing ACT by intertwining intrapersonal and interpersonal relational behaviors in an arc across time. The same clinical example will be used for each. In the third approach, psychologically *in*flexible and psychologically flexible behaviors in the context of the interpersonal field are presented.

Case. Maria is a 55 years old woman who had a close relationship with her husband. She reported that she was doing what he expected from her to maintain the relationship. She never dared to engage in activities she loved because her husband would not approve. Her husband died recently, leaving Maria a widow. Maria entered therapy stating that she "can't stand being alone." She reported feeling anxious and and a sense of anguish. In contrast, she also noted that she should learn to be by comfortable alone.

The first section below opens the dialogue, setting the stage for the three approaches:

T: Maria, what would be important for us to focus on today?

M: (*talking rapidly*) I feel lonely all the time, and I can't stand it. I'm alone at home and everywhere. But then I invite people to my house, and they start asking for help and don't even think about what I need. It doesn't work. I feel awful again. What can I do?

T: Let's slow down just a little bit. You feel lonely, and you don't like that. I noticed that you had a look on your face when saying that you invite people home. When you invite people, you are not alone…and still your face seems lifeless? Not excited or relieved. Have you noticed that?

M: (*shrinking in her seat*) Yeah…

T: Let's take a few moments to notice what you feel here.

M: Well, I can't stand feeling alone, but when I invite people, they start asking me for help. They ask me to do things…and they don't wash the dishes and then….

T: (*gently interrupting*) Let's slow down again … what is happening for you right now?

M: I can feel that I have a problem and that I need to solve this problem. Maybe I need to learn to be alone, and that's it. Is that right? Is it what I should do?

Approach 1 -Technique-oriented with little regard for the therapeutic relationship and only applying the core processes (each of the ACT core processes could be used in treating Maria; however, for this demonstration, the focus is on the values process):

T: What would it mean for you to solve the problem? What would happen to you if you were able to solve it? What are you looking for?

M: I would be able to go for a walk on my own…maybe taking the dog out. [pauses]. I would feel empowered…that I'm doing this for myself, that I can take care of myself.

T: Can you notice how your face has changed now? It looks like taking care of yourself, and that quality of empowerment is really important for you.

Approach 2 - doing act accented with interpersonal factors implemented in the relationship as a context that permits ACT to flow (the therapists expands into fostering a genuinely loving and supportive relationship):

T: What would it mean to solve the problem? What would happen to you if you were able to solve it? What are you looking for?

M: (*sitting up just a little*) I would be able to go for a walk on my own… maybe taking the dog out. [pauses]. I would feel empowered…that I'm doing this for myself, that I can take care of myself.

T: Let's stop here for a little bit and notice. Something has changed for you. Do you notice that? You seem to sit up a little more as you talk about feeling empowered. Like something is growing within you. I am wondering if we can work on what this is together?

M: Yes, I would like to. Can you help me with that? Because I need help.

T: Yes. I'm here for you. We can work together to learn ways to help feel the qualities of empowerment, bringing them into your life more fully. We can work together as you learn to take care of yourself.

Approach 3: enhancing ACT by intertwining intrapersonal and interpersonal relational behaviors (that would be evolving and extended across time if fully *represented):*

T: What would it mean to solve the problem? What would happen to you if you were able to solve it? What are you looking for?

M: (*sitting up just a little*) I would be able to go for a walk on my own… maybe taking the dog out. [pauses]. I would feel empowered…that I'm doing this for myself, that I can take care of myself.

T: Let's stop here for just a moment. Something has changed in you. Do you notice it?

M: Yes…

T: You moved from that kind of face that shows up when you talk about inviting people to your house to new face…I can see that something has lightened up. Can you see it ….feel it? How does it feel for you?

M: It feels different, more room. I can be myself in this place. But I need help from you. You need to help me with this because I can't do it on my own

T: *(reading that Maria's lack of contact with her values – being independent, empowered - is because she looks for approval from others just like she tended to do with her husband. The same behavior in her relationship with her husband shows up in the therapy relationship – she needs approval or believes she „can't do it herself)* Do you notice that you are asking me what to do? I am a little confused. In which way do you feel I can be most supportive to you?

M: I don't know.

T: If I help you as you asked, do you feel that same sense of empowerment that you experienced a few moments ago?

M: No, [pauses] not that much. It feels more like when I invite people to my home.

T: (*focusing on changing the quality of the relationship to support Mari's values through a mutual influence process*) So…is there a way that you and I can relate that will help you feel empowered?

M: Well, you know [the client leans over and closer to the therapist to whisper a secret] I can imagine myself going out on my own. I didn't dare to do that before when my husband was alive. I think if I did those things, he would think I was a little bit crazy. I would….

T: (*gently interrupting to comment on the process*) Can you feel what's happening here between us? Something seems different…it is like we are partners in crime [they both laugh] like I'm your confidant, not the one who tells you what to do. Do you feel that?

M: Yes! [giggles,face softens]

T: Can you feel it on your face? [Maria nods yes] So maybe this is a way we can support this "new face" in your life. Does this feel different for you?

M: Yes, very much, it is lighter, and I feel freer.

T: Does it feel different from the usual way you relate with others?

M: Yes…[nodding].

T: Is it possible for you to try this way of relating to others during this week while you move in this empowered direction we found today?

M: Yes! I would love to try it out!

As noted, each approach can function to assist the client. Nonetheless, in approach three, the inflexible and flexible repertoires are shown in the client's interpersonal field. Through the relationship and the alliance, the therapist promotes change by evoking, shaping, and reinforcing flexible behaviors. For this to happen, the therapist needs to understand the function of the client's behavior, taking into account her context, recognizing how the client's behavior functions interpersonally, while also understanding what is needed intrapersonally. Here, inside this interpersonal field of understanding and alliance created, the relationship not only supports change but also becomes the vehicle for change.

Conclusions

In ACT, the core processes contributing to psychological *in*flexibility (i.e., fusion, avoidance, self as content, etc.) are the main focus of the case conceptualization. These are then targeted for change by the psychological flexibility processes (i.e., defusion, willingness, self as context, etc.), with therapists largely attending to the context of the client. Although this is undoubtedly a part of the work in ACT, oversimplification of the approach and a narrow focus on the client leads to less interpersonal sensitivity. Integrating interpersonal factors can lessen the narrow focus and improve interpersonal sensitivy. However, it is essential to remember that an advanced, richer therapy benefits from recognizing the intertwining of the interpersonal and intrapersonal in a behavioral field that is dynamic and evolving across time.

We have considered three approaches to the therapeutic alliance in ACT. Each has its own level of effectiveness and therapeutic sensitivity. Our hope in presenting these approaches is to invite clinicians to enhance their clinical work by considering a more vivid and memorable experience for both the client and therapist. By approaching the therapeutic relationship as a vehicle for change, assisting learning in the moment by consequating equivalent behavior according to its function, growth is possible. Through this process-oriented interpersonal engagement, intrapersonal and interpersonal change takes place.

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