

## THE CONCEPTUALIZATION OF CLINICAL CASES FROM FUNCTIONAL ANALYTIC PSYCHOTHERAPY

Rafael Ferro García<sup>1</sup>, Luis Valero Aguayo<sup>2</sup> and Miguel Ángel López Bermúdez<sup>3</sup>

<sup>1</sup>Clinical Psychology Centre (CEDI), Granada. <sup>2</sup>University of Málaga. <sup>3</sup>Psychology Centre, Bailén (Jaén)

*Functional Analytic Psychotherapy forms part of what has been called third-generation behaviour therapy. It focuses on the contingencies that occur in the therapeutic context itself, on natural reinforcement and on shaping. The proposal is for a form of conceptualizing clinical cases which helps the therapist to focus on the patient's goals and problems. It includes: problems in everyday life, any relevant background or history, problems that arise during the session, cognitive concepts, and goals both in everyday life and in the session itself. Three clinical cases of personality disorders are presented: a "borderline personality disorder", a case of "unstable self", and a "schizotypal personality disorder". We describe the conceptualization schemas for each case, together with the clinically relevant behaviours and the goals to be achieved both in clinical sessions and in everyday life.*

**Key words:** Functional Analytic Psychotherapy, Personality Disorders, Case Conceptualization

*La Psicoterapia Analítica Funcional forma parte de lo que se ha denominado la terapia de conducta de tercera generación. Pone énfasis en las contingencias que ocurren en el propio contexto terapéutico, en el reforzamiento natural y en el moldeamiento. Se propone una forma de conceptualizar los casos clínicos que ayudan al terapeuta a centrarse en los objetivos y problemas del cliente. Incluye los problemas de la vida diaria, la historia relevante, los problemas durante la sesión, los conceptos cognitivos, los objetivos en la vida diaria y los objetivos en la sesión. Se exponen 3 ejemplos de casos clínicos de trastornos de personalidad: un "trastorno límite de personalidad", otro con un "yo inestable", y un "trastorno personalidad esquizotípico". Se describen los esquemas de conceptualización de cada caso, las conductas clínicamente relevantes, y los objetivos a conseguir en la sesión y en la vida diaria.*

**Palabras clave:** Psicoterapia Analítica Funcional, Trastornos de Personalidad, Conceptualización de un caso

**F**unctional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991; Tsai, Kohlenberg, Kanter, Kohlenberg, Follette & Callaghan, 2009) forms part of what has been called third-generation behaviour therapy (Hayes, 2004; O'Donohue, 1998; Pérez Álvarez, 2006), together with other therapies: Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999), Behavioural Activation (Martell, Addis, & Jacobson, 2001), Integrative Couple Therapy (Jacobson & Christensen, 1996); and Dialectical Behaviour Therapy (Linehan, 1993).

FAP (Kohlenberg & Tsai, 1991) emerged at the end of the 20th century as an alternative to classical behaviour therapy and cognitive-behavioural therapy. It shares with other therapies of this generation the features that have emerged from the study of behaviour: equivalence relations between stimuli, rule-governed behaviour and the functional analysis of language; also like them, it has important implications for the understanding of cognitive behaviour and emotional behaviours (Fernández Parra & Ferro, 2006).

According to Kohlenberg and Tsai (1991), FAP addresses those clients who have failed to improve with the more traditional behaviour therapies, who have difficulties for establishing intimate relationships, and/or who present the type of diffuse and generalized interpersonal problems typified in Axis II of the DSM-III-R and DSM-IV.

Philosophically, FAP is based on the principles of radical behaviourism and on contextualism. It places emphasis on the contingencies that occur during the therapeutic session, on the therapeutic context itself, on the functional equivalence between the clinical setting and the client's everyday situation, on natural reinforcement and on shaping (Kohlenberg & Tsai, 1991, 1995). It uses the therapeutic relationship itself as a form of promoting change in the client, focusing on the here and now, on what occurs within the clinical session, on both the problems of the client and his or her improvements, and is adapted to each particular patient. Rather than being constituted by a set of techniques, it is a conceptual framework whose purpose is to guide the activity of the therapist and create intensive and curative therapeutic relations (Ferro, 2006). An important aspect of FAP is the delimitation of

Correspondence: Rafael Ferro García. Centro de Psicología Clínica C.E.D.I.. Avda. Constitución 25, 7º Izda. 18014-Granada. España. E-mail: [rferro@cop.es](mailto:rferro@cop.es).  
Web site: <http://www.cop.es/colegiados/GR00777>

two basic elements: on the one hand, the contingencies present during the therapist-client interaction, especially verbal interactions, and the nature of these contingencies; and on the other, the context in which these relations occur, with analysis of the functional equivalence between the clinical setting and the client's everyday situation (Kohlenberg & Tsai, 1991, 1994a, 1994b, 1995).

Moreover, it is not only a psychotherapy in itself, but can also be combined with any other therapy, producing synergic results (Kohlenberg, Tsai, Ferro, Valero, Fernández Parra, & Virués, 2005). FAP can improve any clinical intervention without the need to change the form of that therapy. Its integration with other therapies is yielding good results (Apsche, Ward & Evile, 2003; Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004; Gaynor & Scout, 2002; Kohlenberg, Kanter, Bolling, Parker & Tsai, 2002). For a fuller review of its concepts we recommend some works in Spanish by the following authors: Fernández Parra and Ferro (2006), Ferro (2006); Ferro and Valero (1998), Kohlenberg, Tsai, Ferro et al. (2005) and Pérez Álvarez (1996a, 1996b, 1998).

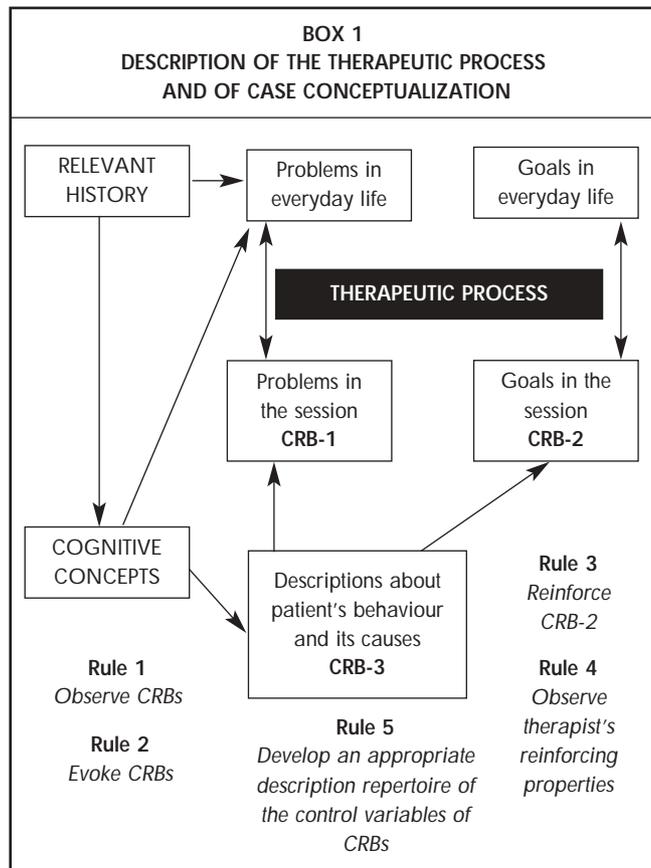
As far as the latest developments are concerned, we refer the reader to Ferro, Valero and López (2007) and Ferro (2008).

In the present work we present an analysis of the therapeutic process considering its proposal for the conceptualization of a clinical case. We have also selected three cases with complex sets of problems and in which the classification has normally been that of a personality disorder. These cases serve to illustrate how three different therapists with different experiences would work in the context of FAP.

### ANALYSIS OF THE THERAPEUTIC PROCESS FROM FAP

The therapeutic process from FAP is based fundamentally on what the client does and says in the actual clinical session. The client's behaviours are anything that the person does: talking, thinking, feeling, seeing, hearing, remembering, etc. (Kohlenberg & Tsai, 1994a). These behaviours have been called Clinically Relevant Behaviours (CRB) (Kohlenberg, Hayes & Tsai, 1993; Kohlenberg & Tsai, 1991, 1994a, 1994b, 1995; Kohlenberg, Tsai & Kanter, 2009). Three types of CRB have been defined. Type 1 CRBs are those problems of the client that occur during the session, and which the therapy must try to reduce. They are under the control of aversive stimuli, and tend to have functions of escape and avoidance. Type 2 are behaviours considered as being improvements of the client that occur during the session. Type 3 are the client's interpretations of his or her own behaviour and what he or she thinks is its cause – that is, observations and descriptions of one's behaviour and of the reinforcing, discriminative and eliciting stimuli associated with it. These may in fact also be Type 1 or Type 2 CRBs, since explanations can be a problem or an improvement.

Also taken into account in the therapeutic process is what the therapist should do. There are five Therapeutic Rules (Kohlenberg, Hayes & Tsai, 1993; Kohlenberg & Tsai, 1991, 1994a, 1995, Kohlenberg et al., 2005; Tsai, Kohlenberg, Kanter & Waltz, 2009). According to Rule 1, it is necessary to develop an observation repertoire of possible CRBs during the therapeutic session. Rule 2 demands the building of a therapeutic context that evokes CRBs, both of Type 1 (to be reduced) and of Type 2 (to be increased). Rule 3 refers to organizing the positive reinforcement of the client's improvements (Type 2 CRB). Rule 4 proposes the drawing up of a repertoire for observing the reinforcing properties of the therapist's



behaviour in relation to the client's CRBs. Rule 5 refers to generating in the client a repertoire of description of the functional relations between the control variables and the behaviours (Type 3 CRB).

As can be seen in Box 1, the therapeutic process involves some variables that are related to one another, that define it and that interact continuously during the sessions. The relevant history plays a key role in the genesis and maintenance of people's problems, both in everyday life and in the therapeutic session itself. The past should not be overlooked in attempting to understand a person's problems. There are dispositional and motivational factors that have a historical origin, such as situational events that affect the problems in an indirect way, as we shall see below. The main goal of the therapeutic process is none other than the transference of effects between the clinical and everyday contexts of the client. It is a case of establishing a functional equivalence between clients' everyday life problems and their problems within the session (Type 1 CRB), so that through the observation and evocation of these behaviours (Rules 1 and 2) such transference takes place. At the same time, the client's improvements within the clinical session (Type 2 CRB) are to be transferred to everyday life, through natural reinforcement, and their effects seen in future interactions (Rules 3 and 4). As Box 1 shows, also of relevance are clients' interpretations and explanations of what happens to them (Type 3 CRB), which may be correct or problematic (Types 1 and 2 CRB), as already mentioned. These interpretations tend to be influenced by cognitive concepts or ideas about what happens to a person, and even about their conception of psychological health or wellbeing, happiness, etc. In the majority of cases it is necessary for the therapist to generate in the client a repertoire of description of the functional relations between the control variables and the behaviours themselves, through models or indeed directly through their shaping (Rule 5).

Among the dispositional factors given least attention in psychotherapy manuals are so-called *Situational Events*. Such events or factors are complex conditions that occur concurrently with the behaviours which influence them indirectly and are based on past interactions between the organism and the environment (Durand, 1990; Whaler & Fox, 1981). Situational events can be: *Biological* (such as illnesses and their symptoms, hormonal changes, direct and/or secondary effects of medication and drugs, eating

and sleeping habits, or fatigue); *Social* (meetings with friends, family, difficulties related to tasks or demands, people in the waiting room, the therapist him/herself, etc.) or *Physical* (such as the physical environment, furniture/decoration, temperature, light, or noise). For example, in the case of a couple with problems who attended therapy, the woman complained that he tended to become aggressive after things she said; however, this problem did not arise during the sessions. This aggressive behaviour appeared sporadically when she made some criticism of her husband. The husband was a frequent drinker, and one biological situational event was found to be the hangover after excessive drinking the previous night. In other cases, the actual *rapport* may function as a social situational event – the consulting room itself, the therapist's image, and so on. Such factors evoke CRBs (Rule 2), and may function as motivational *establishing operations* (Dougher & Hackbert, 2000; Michael, 1993), leading to a motivational change and thus increasing the probability of occurrence of a particular behaviour. The FAP manual describes situations that can evoke CRBs, mentioning that some of them can function as such situational events (the very time structure of the therapy, the therapist's holidays, ending the therapy, the fees, the therapist's errors, silences in the conversations, the therapist's characteristics, unusual events, etc.).

In psychotherapy, the most important CRBs are those with multiple causes. In the manual itself, Kohlenberg and Tsai (1991) offer an analysis of the client's verbal behaviour. Multiple causation refers to the client's descriptions concerning at the same time the clinical situation and everyday life, and also the requests or demands that have a disguised or hidden intention. These types of demand are of capital importance in FAP insofar as they serve to correctly identify CRBs and are a form of promoting generalization and the functional equivalence between the two contexts, the clinical and the everyday one. This would be the case, for example, of a client who at a morning appointment says: "Today I didn't want to get out of bed at all; I didn't think I could do it". In such a case, therapists must ask themselves whether, although the client is describing the difficulty of getting up, he might not actually be referring to a behaviour of avoiding coming to the session, because of what might be spoken about that day, or for other reasons. When the behaviour in question is weak or not strong enough, it could be said that this is due basically to a poor conditioning history; that is, it has not been

sufficiently reinforced and/or it has been punished. It may also be that the stimuli which control that response are not clear at that time. Let us imagine an audience that reinforces and punishes the response at the same time. Examples of this type are given in the formation of "Problems of the Self", as maintained by Kohlenberg and Tsai (1991, 2001). The Audience affects behaviours with multiple causes. Where there is multiple causation, Skinner, in *Verbal Behaviour* (1957) defined supplementary stimulation as that which could evoke this weakened response. It could be defined as a way of strengthening responses that are historically weak and have multiple causes. According to Skinner (1957) there are different types of this. When the therapist knows the possible response they are called *prompts*; when the response is not known they are called *probes*. These can be divided, in turn, into: formal (when there is formal correspondence between stimulus and response) and thematic (related to the content of that response). The majority of weakened responses are unknown to the therapist, and for strengthening them he or she uses probes, both formal and thematic. An example of a formal type would be the case of the therapist saying a word that evokes the same verbal response from the client. If the therapist knows the response – in a case of abuse, for example – and the help was thematic, the example of supplementary stimulation would be a prompt. These situations, without being abundant, do occur in therapy, and it is important to take them into account not only when the therapist knows the response, but also when, without being sure of it, he or she makes an assumption about what it is. A possible example of thematic probing would be the use of projective tests such as the TAT or Rorschach. This would be the case, for example, of a client who avoids talking openly about his homosexuality but who at the same time has given the therapist clues about it, such as always using the neutral term "partner" rather than referring to his "girlfriend". An example of thematic probing would be the description by the therapist of the case of another client, a strategy that is widely used and of great clinical value, as shown in Ferro, Valero and Vives (2006).

As we have seen, the importance of multiple causation is clear throughout the therapeutic relationship. As Catania (1998) maintains, humour is a clear example of multiple causation. This could also be extended to any affective state, be it depression, anxiety, joy, melancholy, etc., and it would depend on the individual's case history.

### CONCEPTUALIZATION OF THE CASE FROM FAP

We shall continue by describing a form of conceptualization of the clinical case recently proposed from this therapeutic approach (Kohlenberg & Tsai, 2000; Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002; Kanter, Weeks, Bonow, Landes, Callaghan & Follette, 2009). It consists in an open record including the description of variables assumed to be key for the analysis of a clinical case. It would involve the description of relevant behaviours and the continual search for hypotheses over the course of the therapeutic process. This serves three purposes: First, to generate a way of seeing how the client's history has led to his/her current everyday problems, and also to see to what extent the problems are adaptive and would form the bases for the client's being able to learn new forms of behaviour. Second, to try and identify the cognitive phenomena potentially related to the current problems. And third, to identify and predict how the CRBs should occur in the therapeutic relations during the clinical session (Kohlenberg, Kanter, Boling, et al., 2002).

This record consists of the following sections (see Table 1):

1. The *problems* the client has in his/her *everyday life*. These are the problems he or she has to deal with daily, as conceptualized by the therapist.
2. His/Her *relevant history*. This section includes a description of the relevant events in a person's life that are involved in the aetiology and maintenance of the problems.
3. The *problems* that emerge in the *clinical session*. These would be Type 1 CRBs, and as already indicated, they are functionally equivalent to the problems that occur in everyday life.
4. The *cognitive concepts* of the patient that interfere with the treatment (automatic thoughts, code of beliefs, ideas, assumptions) and which should be the object of therapy. Among these concepts are the values held by the client in relation to a wide variety of aspects that in some way affect the problem and its solution. Among others we could include: the concept of psychological wellbeing, happiness, the fairness of one's life, etc. Also included in this section are what Beck's Cognitive Therapy (Beck, Rush, Shaw & Emery, 1979) calls cognitive distortions (over-generalization, magnification, arbitrary abstraction, etc.)
5. His/Her *everyday goals*. That is, what it is attempted to achieve and to generalize to that person's life, and the progressive changes the client aims to achieve, conceptualized by the therapist.

6. The *goals* within the session itself that the therapist would set himself. That is, Type 2 CRBs, the changes it is hoped to achieve in the clinical session.

Below we present three examples of conceptualization of three clinical cases developed in the course of treatment by three different therapists, as examples of the development of this schema; all three cases were successfully treated. For technical reasons related to the publication of the article they are presented without using the schema shown in Table 1.

### Case 1. MARÍA

Woman aged 26. University student. Presents emotional disorders and has difficulties relating to others. Diagnosed as "borderline personality disorder" by a psychiatrist who saw her previously. She was treated for a period of over two years by one of the authors, by means of Behavioural Activation and FAP, as well as metaphors and ACT exercises.

#### 1. Problems in everyday life

- ✓ Sporadic crises (aggressiveness, self-harm, weeping, irritability, self-disparaging thoughts, sadness, insulting others, occasionally aggression against objects) when she is alone, and always triggered by recurring thoughts about her past.
- ✓ Poor results in her studies. She still has many courses pending. She passes only 1 to 2 subjects per year.
- ✓ She is unemployed.
- ✓ She still lives with her mother.
- ✓ She has had several partners; the relationships have generally been problematic, and brief.
- ✓ When she has conflicts with other people (according to her they made her look foolish, "they insulted her") she presents strange behaviour, isolation and outbursts of verbal aggression and violence.
- ✓ She has self-disparaging thoughts, and continual thoughts about her history, which she relives all the time, and these make her feel bad (situations experienced with her mother, her father, other colleagues, boyfriends, previous therapists, etc.). These thoughts can be triggered by the smallest thing (especially when she is alone). After half an hour recalling such things she becomes irritable and angry, starts crying and attacks people and objects.
- ✓ Abuses the telephone and Internet.
- ✓ Sporadic binge-eating.

#### 2. Relevant history

- ✓ Parents separated.
- ✓ Possible history of abuse by her mother.
- ✓ Poor relationship with her parents:
- ✓ Serious conflicts with her mother.
- ✓ Lived for a while with her father, and claims that he did not pay her much attention.
- ✓ Problematic employment record. Walks out of many jobs due to problems with co-workers because, according to her, they abuse, criticize, and look down on her continually.
- ✓ History of various courses of treatment by psychiatrists and psychologists.
- ✓ Admitted to acute unit several times after episodes of violence or self-harm at her mother's house.
- ✓ Receiving pharmacological treatment since then (antidepressants, sleeping pills, antipsychotics).
- ✓ Previously dropped out of psychological treatment due to improvements. Reason for seeking help on that occasion was problems with studies and being unable to get up in the mornings. Duration was one year.
- ✓ History of various treatments and self-help groups (including pseudo-religious and pseudo-psychological groups). Gave up treatment because she felt she was ignored, insulted and denigrated more.
- ✓ Seeks help this time after crises involving self-harm and aggression.

#### 3. Problems in the session. CRB-1

- ✓ She always tells the same stories about what happened with other people. Continually repeats the same type of memories and episodes in which she is hurt and made to look foolish.

TABLE 1 SCHEMA FOR THE CONCEPTUALIZATION OF A CASE BY AREA	
Name:	Date:
1. Problems in everyday life	
2. Relevant history	
3. Problems in the session. CRB-1	
4. Cognitive concepts (automatic thoughts, beliefs, assumptions)	
5. Goals in everyday life	
6. Goals in the session. CRB-2	

- ✓ Complains about lack of self-esteem, lack of initiative, not feeling like doing anything, etc.
- ✓ Does not follow the therapist's instructions (does not keep records, does not do the activities agreed, etc.).
- ✓ Always approves of what the therapist proposes; always says "yes... of course, that's what I have to do," but never does it.
- ✓ When there is aversive content in the conversation, she smiles in an exaggerated fashion, but does not speak about it.
- ✓ Does not express her emotions well, and acknowledges how absurd her reactions are. Laughs about this, but still fails to express them.
- ✓ During moments of silence, always waits for the therapist to take the lead or to continue the conversation.
- ✓ Is dependent upon the therapist. Tells her stories and waits for the advice; asks explicit questions such as: "How can I do such-and-such,... what do I have to do..."

#### 4. Cognitive Concepts

- ✓ Continual negative thoughts about herself, her lack of worth, how she has been hurt, her low self-esteem, her lack of personality, etc.
- ✓ Considers that her partners use her or have used her.
- ✓ Has notions that others use her, insult her, make her look foolish and denigrate her.
- ✓ Attributes her improvements to medication, not to therapy.

#### 5. Goals in everyday life

- ✓ To reduce emotional crises.
- ✓ To improve relationships with her mother and her brother.
- ✓ To pass the subjects she still needs for her university qualification.
- ✓ To establish and maintain more positive social relationships.
- ✓ To get a steady partner.
- ✓ To find goals in her personal life.
- ✓ To reduce her impulsiveness (abuse of Internet and telephone, binge-eating)
- ✓ To get a part-time job and keep it.

#### 6. Goals in the session. CRB-2

- ✓ To talk more and express her emotions more.
- ✓ To reduce her inappropriate smiling when she is talking about something problematic.
- ✓ To reduce inappropriate comments.

- ✓ To try not to talk constantly about the same stories.
- ✓ To talk about her past without this triggering a crisis.
- ✓ To accept that others do and think differently from her.
- ✓ To reduce her dependence on the therapist; to make her own decisions and draw her own conclusions.
- ✓ To behave in a socially more positive way, modifying her tone and manner of speaking, increasing eye contact, etc.
- ✓ To describe positive episodes that occur in her life and positive emotions she has.

#### Case 2. BERTA

Woman aged 19, the eldest of three children. University student. She lives in a student flat, not with her family. According to the therapist who treated her she presented a mild disorder of the self ("Unstable self"), in line with the criteria set down by Kohlenberg and Tsai (1991).

##### 1. Problems in everyday life

- ✓ She is afraid of looking foolish and of what others might think of her.
- ✓ Is highly sensitive to criticism.
- ✓ Is afraid of criticism.
- ✓ Avoids social situations.
- ✓ She freezes in social situations, doesn't know what to say, thinks she is being observed, doesn't know how to move.
- ✓ Has problems with her partner. She does not feel loved by him. They argue over this. She doesn't dare break up because she is afraid of being alone. She feels he doesn't love her, and has doubts about whether she really loves him or whether she only stays with him for fear of being alone.
- ✓ Frequently asks her friends what they think is happening to her.
- ✓ Says and does what her friends say (when my friend X says something, that's final).

##### 2. Relevant history

- ✓ Is going to study in another city because she wants to break with her environment and get to know new people (as a way of solving her problem).
- ✓ Has a history of problems in relating to other people.
- ✓ Her mother has had several bouts of depression ("my mother is a lot like me", "things happen to her with other people, like they do to me").
- ✓ Her parents have always compared her to one of her cousins.

- ✓ Her parents have never acknowledged what she does well, and only talk about her mistakes.

### 3. Problems in the session. CRB-1

- ✓ Complains about herself and her failings (I don't know how to feel good; I would prefer to be alone; When I listen to my friends I try to be like them, and I can't; I can't get interested in anything).
- ✓ Wants a "psychological" explanation of what is happening to her. "What I really want to know is what's wrong with me".
- ✓ Has a very poor self-concept; considers herself ugly (she is attractive), useless, stupid.
- ✓ Frequently criticizes herself.
- ✓ Cannot exercise introspection; is incapable of it ("I just can't..."); opens her eyes, etc.
- ✓ Always speaks well of her family (but theoretically they must have affected the formation of her Self).

### 4. Cognitive Concepts

- ✓ In relation to the causes of her problems and their solution, she believes:
- ✓ That she lacks self-esteem. As something necessary to be able to live and put right what is wrong with her.
- ✓ In the need to give herself heart: "I want to pluck up courage".
- ✓ In the need to feel superior to others: "I need to feel I am better than others in order to feel good – I heard that on a course".
- ✓ Problems of self-concept:
- ✓ "I haven't found myself".
- ✓ "I don't know how to be myself".
- ✓ "I don't recognize myself".

### 5. Goals in everyday life

- ✓ To not be affected by others' criticism and to not be afraid of it.
- ✓ To not simply accept others' criticism of her.
- ✓ To cope with social situations and behave naturally.
- ✓ To be able to break up with her boyfriend.

### 6. Goals in the session. CRB-2

- ✓ To cope with the therapist's criticisms.
- ✓ To increase responses such as "I + X personal responses" (*I feel.. I want... I think...*)
- ✓ When she is better, to be able to recognize it.
- ✓ To not psychologize her problems.
- ✓ To exercise introspection, and not to avoid it.
- ✓ To talk about her problems regarding the relationship with her parents referring to herself.
- ✓ To talk about what she is like.

- ✓ To know what is happening to her and what has happened to her.

### Case 3. JUAN

Man aged 30. The eldest of 3 children. Currently living with his parents and unemployed. Met the criteria for a diagnosis of "schizotypal personality disorder", according to the DSM-IV criteria (APA, 1994).

#### 1. Problems in everyday life

- ✓ Has been sleeping little and badly for a month.
- ✓ Is socially isolated: avoids social contact, avoids giving explanations about himself, avoids talking to his parents, and hardly replies, even to simple questions.
- ✓ Spends all the time at home in his parents' house, locked in his room without doing anything, much of the time crying.

#### 2. Relevant history

- ✓ He is 30 years old and his girlfriend has just left him.
- ✓ Currently unemployed.
- ✓ Has given up all his previous jobs without giving an explanation.
- ✓ Has failed to do or finish important activities and tasks (studies, paintings and drawings, bank matters, card and document renewals, etc.).
- ✓ Highly problematic social and family relations with periods of isolation.
- ✓ Frequent behaviours intended to punish others, especially his family (episodes of anger, of scorn or of ignoring people, refusal to attend family events).

#### 3. Problems in the session. CRB-1

- ✓ Comes to the consulting room wearing dark glasses, and at the first session does not remove them at all.
- ✓ Does not maintain eye contact with the therapist.
- ✓ Is excessively serious, with very rigid posture.
- ✓ Is distracted in his communication, changes the subject and avoids answering the questions put to him.
- ✓ High frequency of the phrase "I don't know...".
- ✓ Fails to finish sentences, and when pushed to do so, becomes blocked or goes silent.
- ✓ Refuses to fill out questionnaires or tests, using avoidance tactics and giving vague reasons.
- ✓ Fails to comply with the therapist's instructions, even though he commits himself to doing so. When he is asked, and promises to bring written documents about the facts relevant to why he is the way he is, he still fails to bring them. The reasons he gives in justification of this are incoherent.

- ✓ Gives incorrect explanations about the causes of his behaviour.

#### 4. Cognitive concepts

- ✓ Has over-generalized ideas: "I can't find a practical outlet for my creativity; if art is not important in this world, what use am I in it?"
- ✓ Has delusions of grandeur: "The thing is that people don't understand me. I'm a really quick thinker, and people aren't at my level".
- ✓ Blames his father for what is happening to him: "If there's someone to blame for everything that's happening to me, it's my father".
- ✓ Has exaggerated ideas about what will happen: "I can't go out into the street here because memories come flooding in and trap me".

#### 5. Goals in everyday life

- ✓ To reduce avoidance behaviours.
- ✓ To increase the rate of potentially reinforcing behaviours.
- ✓ To complete the tasks and activities left half-done, including the therapy itself.
- ✓ To increase the verbal repertoire, which would make more likely the establishment of appropriate causal relationships.
- ✓ To increase positive social relationships.

#### 6. Goals in the session. CRB-2

- ✓ To not give up the therapy.
- ✓ To maintain eye contact.
- ✓ To reduce blocked communication ("I don't know") and silences.
- ✓ To finish the sentences he starts.
- ✓ To establish appropriate functional relationships as regards things that occur.
- ✓ To increase his basic social repertoire, in relation to things such as greeting and saying goodbye.
- ✓ To maintain a natural relationship with the therapist; to express what he likes and what he doesn't like in a natural manner.
- ✓ To complete the therapy in an appropriate fashion.

### CONCLUSIONS

We have presented an analysis of the therapeutic process according to FAP, analyzing the variables involved in it. Furthermore, we have described the variables and the form of conceptualization of a clinical case recently proposed, using a schema that summarizes the information and serves as a guide to the professional about the behaviours on which to focus, the equivalence

between the problems outside and within the session and the person's arguments about his or her own behaviour. We have also presented the outline of three clinical cases with different diagnoses, and which have in common the diffuse nature of these problems and their extensive history and chronification, which imply a long history of learning in these cognitive and emotional repertoires.

This schema helps the clinician focus on the behaviours that occur within the session itself and which it is considered should be increased, as well as on those which it is necessary to reduce and on the client's verbalizations about functional relations between his/her behaviour and others. From there, a relationship is established between these behaviours and the problematic behaviours in the everyday life of the person. It should not be overlooked that the clinical relevance of a behaviour observed in the session must be appraised in relation to the set of problems the client presents, and hence the importance of the conceptualization of the case.

As described, FAP is a powerful treatment in itself, as well as being an integrative approach that can be combined with any kind of therapy (Kohlenberg, Tsai, Ferro, et al., 2005). This strategy of synthesis of a clinical case helps clinicians to analyze the information, structure their therapeutic goals and focus on the changes that are produced throughout the process. The demonstration of its greater or lesser utility is an empirical question, regardless of the therapist's clinical training, but in our professional experience so far it has certainly shown itself to be useful.

In all three cases there were improvements. In Case 1, that of María, various improvements occurred after the treatment: she has passed some of the subjects on her university course, she has more relationships with friends, and has sporadically had partners; also, there have been fewer episodes of emotional crisis. Family relations have improved. A miscarriage in the past year scarcely affected her, by comparison with the way previous equivalent events had. She has travelled, has managed to avoid entering into casual relationships with so many men, and helps a little around the house. In Case 2, that of Berta, after the treatment she succeeded in doing the introspection exercises without escaping or refusing, she behaved naturally with her group of friends, she completed her university course, she talked about the influence of her family relationships on her problem, and she was able to take criticism, in some cases even standing up to it, giving her opinion. In the third case

there was a considerable reduction in avoidance behaviours and becoming blocked, both in the clinical context and in everyday life, with improved quantity and quality of social and family relations; moreover, the client found a job that he still had eight months after the end of the therapy, and he said he was now painting only as a hobby.

In everyday clinical practice our team is applying this form of conceptualizing the case from this therapeutic approach with problems such as: depressive disorders, personality problems, obsessions or generalized anxiety. This analytical schema has also been applied to other cases involving persistent specific anxiety, study problems, relationship problems, problems between parents and children and problems related to what have traditionally been called social skills. In all such cases it has been of great utility. Moreover, it has been applied to students and to recently qualified therapists, improving their knowledge, understanding and training background.

We agree with Whaler and Fox (1981), who maintain that the analysis of situational events is crucial for the effectiveness of treatment, with regard to both the initial behaviour change and the generalization and maintenance of the change.

As Martell, Addis and Jacobson (2001) argue, it is impossible to understand all the contingencies that have brought about and maintained a particular behaviour. History plays a fundamental role in the entire process. The alternative procedure is provided by the description and classification of types of behaviour, organizing them in this conceptualization of the case.

Our experience suggests that the choice of CRBs, both in the conceptualization of the case and in the actual application of the therapy, depends on the learning history and on the repertoire of the therapist him/herself, and more specifically on his or her beliefs about psychopathology and psychological wellbeing, and even on his or her values, and it is in this respect that differences emerge between the therapists applying the therapy. Without doubt, this approach can be of value for other clinicians working with "diffuse" or poorly defined psychological problems, can aid decision-making about treatment goals and the handling of therapeutic sessions, and can also serve as a useful aid in training students to work with cases. With only the initial groundwork completed, further work is necessary, but in our view it is an approach of great practical utility.

## REFERENCES

- American Psychiatric Association (1994). *DSM-IV. Manual diagnóstico y estadístico de los trastornos mentales [Diagnostic and Statistical Manual of Mental Disorders]*. Barcelona: Masson.
- Apsche, J.A., Ward, S.R. & Evile, M.M. (2003). Mode Deactivation: A Functionally based treatment, theoretical constructs. *The Behavior Analyst Today*, 3, 4, 455-459.
- Beck, A. T., Rush, A.J., Shaw, B. F. & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Catania, A. C. (1998). *Learning*. Fourth Edition. New Jersey: Prentice Hall.
- Callaghan, G.M., Gregg, J.A., Marx, B.P., Kohlenberg, B.S. & Gifford, E. (2004). FACT: The utility of an integration of Functional Analytic Psychotherapy and Acceptance and Commitment Therapy to alleviate human suffering. *Psychotherapy: Theory, Research, Practice, Training*, 41, 195-207.
- Dougher, M.J. & Hackbert, L. (2000). Establishing operations, cognition, and emotion. *The Behavior Analyst*, 23, 11-24.
- Durand, V.M. (1990). *Severe Behavior Problems. A Functional communication Training Approach*. New York: Guilford Press.
- Fernández Parra, A. & Ferro García, R. (2006). La Psicoterapia Analítico-Funcional: una aproximación contextual funcional al tratamiento psicológico [Functional Analytic Psychotherapy: a functional contextual approach to psychological treatment]. *Edupsykhé*, 5, 2, 203-229.
- Ferro García, R. (2006). La Psicoterapia Analítica funcional: estableciendo relaciones terapéuticas intensas y curativas [Functional Analytic Psychotherapy: establishing intense and curative therapeutic relationships]. *Psicología Conductual*, 14, 3, 343-359.
- Ferro García, R. (2008). Recent Studies in functional Analytic Psychotherapy. *International Journal of Behavioral Consultation and Therapy*, 4, 2, 239-249.
- Ferro García, R. & Valero, L. (1998). Psicoterapias conductistas: nuevos enfoques clínicos [Behaviourist psychotherapies: new clinical approaches]. *Psicologemas*, 12, 31-62.
- Ferro García, R., Valero Aguayo, L. & López Bermúdez, M. A. (2007). Novedades y aportaciones desde la Psicoterapia Analítica Funcional [Innovations and

- contributions from Functional Analytic Psychotherapy]. *Psicothema*, 19, 3, 452-458.
- Ferro García, R., Valero, L. & Vives, M.C. (2006). Application of Functional Analytic Psychotherapy: Clinical Analysis of a patient with Depressive Disorder. *The Behavior Analyst Today*, 7, 1-18.
- Gaynor, S.T. & Scott, P. (2002). Complementing CBT for depressed adolescents with learning through in vivo experience (LIVE): Conceptual Analysis, Treatment description, and feasibility study. *Behavioral and Cognitive Psychotherapy*, 30, 79-101.
- Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and third wave of behavioral and cognitive therapies. *Behavior Therapy*, 35, 639-665.
- Hayes, S. C., Strosahl, K. D. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy. An Experiential Approach to Behavior Change*. New York: The Guilford Press.
- Jacobson, N.J. & Christensen, A. (1996). *Acceptance and Change in Couple Therapy*. New York: Norton.
- Kanter, J. W., Weeks, C. E., Bonow, J. T., Landes, S. J., Callaghan, G. M. & Follette, W. C. (2009). Assessment and Case Conceptualization. In M. Tsai, R. J. Kohlenberg, J. W. Kanter, B. Kohlenberg, W.C. Follette, & G. M. Callaghan, G.M. (Eds). *A Guide to Functional Analytic Psychotherapy. Awareness, Courage, Love and Behaviorism* (pp. 37-59). New York: Springer.
- Kohlenberg, R.J., Hayes, S.C. & Tsai, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. *Clinical Psychology Review*, 13, 579-592.
- Kohlenberg, R.J., Kanter, J.W., Bolling, M.Y., Parker, C.R. & Tsai, M. (2002). Enhancing Cognitive Therapy for Depression with Functional Analytic Psychotherapy: Treatment Guidelines and Empirical Findings. *Cognitive and Behavioral Practice*, 9, 213-229.
- Kohlenberg, R.J. & Tsai, M. (1991). *Functional analytic psychotherapy. Creating intense and curative therapeutic relationship*. New York: Plenum Press.
- Kohlenberg, R.J. & Tsai, M. (1994a). Improving cognitive therapy for depression with functional analytic psychotherapy: Theory and case study. *The Behavior Analyst*, 17, 305-319.
- Kohlenberg, R.J. & Tsai, M. (1994b) Functional Analytic Psychotherapy: A Radical Behavioral Approach to Treatment and Integration. *Journal of Psychotherapy Integration*, 4, 174-201.
- Kohlenberg, R.J. & Tsai, M. (1995). Functional analytic psychotherapy: a behavioral approach to intensive treatment. In W. O'Donohue & L. Krasner (Eds.), *Theories of behavior therapy. Exploring behavior change* (pp. 637-658). Washington: APA.
- Kohlenberg, R. J. & Tsai, M.. (2000). Radical Behavioral Help for Katrina. *Cognitive and Behavioral Practice*, 7, 500-505.
- Kohlenberg, R.J. & Tsai, M. (2001). Hablo, luego existo: una aproximación conductual para entender los problemas del yo [I talk, therefore I exist: a behavioural approach for understanding problems of self]. *Escritos de Psicología*, 5, 58-62.
- Kohlenberg, R. J., Tsai, M. & Kanter, J. W. (2009). What is Functional Analytic Psychotherapy? In M. Tsai, R. J. Kohlenberg, J. W. Kanter, B. Kohlenberg, W.C. Follette, & G. M. Callaghan, G.M. (Eds). *A Guide to Functional Analytic Psychotherapy. Awareness, Courage, Love and Behaviorism* (pp. 1-19). New York: Springer.
- Kohlenberg, R.J., Tsai, M., Ferro García, R., Valero, L., Fernández Parra, A., & Virués-Ortega, J. (2005). Psicoterapia analítico-funcional y terapia de aceptación y compromiso: Teoría, aplicaciones y continuidad con el análisis del comportamiento [Functional Analytic Psychotherapy and Acceptance and Commitment Therapy: Theory, applications and continuity with behaviour analysis]. *International Journal of Clinical and Health Psychology*, 5(2), 37-67.
- Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.
- Martell, C. R., Addis, M. E. & Jacobson, N. S. (2001). *Depression in context, strategies for guided action*. New York: Norton.
- Michael, J. (1993). Establishing operations. *The Behavior Analyst*, 16, 191-206.
- O'Donohue, W. (1998). Conditioning and third-generation behavior therapy. In W. O'Donohue (Ed.). *Learning and behavior therapy* (pp. 1-14). Needham Heights: Allyn and Bacon.
- Pérez Álvarez, M. (1996a). *La psicoterapia desde el punto de vista conductista [Psychotherapy from the behaviourist point of view]*. Madrid: Biblioteca Nueva.
- Pérez Álvarez, M. (1996b). *Tratamientos psicológicos [Psychological treatments]*. Madrid: Universitas.
- Pérez Álvarez, M. (1998). La Psicología Clínica desde un

- punto de vista contextual [Clinical Psychology from a contextual point of view]. *Papeles del Psicólogo*, 69, 25-40.
- Pérez Álvarez, M. (2006). La terapia de Conducta de tercera generación [Third-generation behaviour therapy]. *Edupsykhé*, 5, 2, 159-172.
- Skinner, B. F. (1957/1981). *Conducta Verbal [Verbal behavior]*. México: Trillas.
- Tsai, M., Kohlenberg, R.J., Kanter, J. W., Kohlenberg, B., Follette, W.C. & Callaghan, G.M. (2009). *A Guide to Functional Analytic Psychotherapy. Awareness, Courage, Love and Behaviorism*. New York: Springer.
- Tsai, M., Kohlenberg, R.J., Kanter, J. W., & Waltz, J. (2009). Therapeutic Technique: The Five Rules. In M. Tsai, R. J. Kohlenberg, J. W. Kanter, B. Kohlenberg, W.C. Follette, & G. M. Callaghan, G.M. (Eds). *A Guide to Functional Analytic Psychotherapy. Awareness, Courage, Love and Behaviorism* (pp. 61-102). New York: Springer.
- Whaler, R. G. & Fox, J. J. (1981). Setting events in Applied Behavior Analysis: Toward a Conceptual and Methodological Expansion. *Journal of Applied Behavior Analysis*, 14, 3, 327-338.