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Functional Analytic Psychotherapy and the treatment of Obsessive Compulsive Disorder.

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Abstract: This paper argues that Functional Analytic Psychotherapy (FAP) can contribute to the treatment of Obsessive Compulsive Disorder (OCD). FAP is a behavior analytically informed approach to talk-therapy, developed by Kohlenberg and Tsai. It uses natural occurrences of clinically relevant behavior in the client-therapist relationship to promote therapeutic change. A selection of vignettes of client-therapist dialogs involving two clients with OCD is discussed. The examples show how natural interactions between therapist and client can be used to bring therapeutic technique closer to the natural occurrences of obsessive-compulsive behavior. Furthermore, the fragments illustrate that FAP can encompass exposure and response prevention. Therefore, the in-vivo learning during the session as promoted in FAP can be an asset in the treatment of clients with OCD, and it deserves attention in future treatment research.

Key-words: Behavior therapy; Obsessive compulsive disorder; Functional analytic psychotherapy.

Functional Analytic Psychotherapy

It is possible to practice psychotherapy from a radical behavioral frame of reference when one adopts a functional analytic account of how relationships change people. Functional Analytic Psychotherapy (FAP) is a treatment approach, developed by Kohlenberg and Tsai (1987; 1991), building on a behavioral analysis of why and how clients can improve in intense therapeutic relationships. It describes strategies that can help build such relationships and how to handle them as instruments of healing. In contrast to what typically happens in applied behavior analysis (e.g. Hanley, Iwata, & McCord, 2003), FAP does not rely on contrived or analogue contingencies. Difficulties concerning the generalization to real-life situations of what a client learns in an artificial didactic setting that have haunted applied behavior analysis (Stokes & Baer, 1977), are circumvented as Kohlenberg and Tsai (1987) pointed out that the relationship between therapist and client is in itself a natural environment in the same right as relationships between the client and other significant people in his or her daily life. At once, this insight has lifted the ban for radical behaviorists on working with the fine-grained interpersonal processes that are the stuff traditional psychotherapies are made of.

FAP happens by working in-vivo on what is actually happening between client and therapist, as opposed to role-play or discussion of what happens in other relationships outside the session. Focusing on what happens between client and therapist as interacting persons, and expanding the functional analysis to include the therapist's reactions to the client make it possible to detect occurrences of both problem-behavior and clinical improvement during sessions and to consider the functional relations they are imbedded in on a moment-by-moment basis. Occurrences of problem-behavior or of improvement constitute the opportunity to conduct treatment in-vivo. Functional analytic psychotherapists continuously compare what happens in the client-therapist relationship with their case formulation concerning the client's problems and goals in the outside world. Based on this comparison they identify what in-session behavior is clinically relevant. The context of the therapeutic relationship allows for behavior that constitutes a clinical improvement to be reinforced naturally by the therapist's reactions to it, and for in-vivo problem-behavior to be weakened. To act therapeutically in this sense, therapists need to be aware of what aspects of their behavior are naturally reinforcing for the client's behavior and they need to note even small improvements in-vivo, lest these go unreinforced or heedlessly punished.

Obsessive-compulsive disorder

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder for which empirically supported treatment has been available since decades (Meyer & Levy, 1973; Steketee, 1993). Current conceptualizations propose that OCD behavior arises from a set of cognitive distortions. Shafran, Thordarson and Rachman (1996) showed that inflated responsibility and thought-action fusion transform intrusive thoughts in obsessions and motivate compulsions.

Wegner (1989) highlighted a positive feedback-cycle of suppression and expression in which efforts to suppress unwanted thoughts result in a rebound-effect. The subsequent increase in thoughts prompts more suppression and leads to an escalation in the rebound-effect. Generally, contemporary models attribute the OCD process to (1) inflated responsibility and overestimation of threat; (2) perfectionism and intolerance of uncertainty; and (3) exaggerated beliefs concerning the importance and danger of intrusive thoughts and their content (Salkovskis, 1985; Rachman, 2003; Clark, 2004). The evidence that each of these three factors have main effects on OCD symptoms (Taylor, Abramowitz & McKay, 2005), rather than interact among each other to produce OCD, supports state of the art cognitive-behavioral treatments that are tailored to the individual client's specific dysfunctional beliefs, like danger ideation (Jones & Menzies, 1998) and appraisal of the need to suppress (Freeston & Ladouceur, 1998), as well as the use of alternative procedures that focus the way the client gives meaning to his or her experience (e.g. Hallam & O'Connor, 2002).

As the picture becomes progressively more complex, different types of interventions may be thought of to address different pieces of the puzzle. Research on the OCD process highlights aspects as diverse as a deficit in security motivation (Szechtman & Woody, 2004), intollerance of the feeling that something is just not right (Coles, Frost, Heimberg & Rheaume, 2004), memory distrust (van den Hout & Kindt, 2003; Tallis, Eysenck & Mathews, 1991), overactive action monitoring (Ursu, Stenger, Shear, Jones & Carter, 2003), and fear that intrusions might reveal bad or immoral traits of one's character (Ferrier & Brewin, 2005).

Considering this literature, a first impression may be that FAP has little to offer for the treatment of OCD. This may explain why a PSYCLit search in September 2005 yielded no hits for OCD and FAP. However, as Steketee (1993) and Rachman (2003) commented, the state-of-the-art treatment of OCD in itself can become a ritual or an object of obsessive thoughts, in which case clinically relevant behavior is markedly present in the session. It is also hard to imagine that the emergence in-vivo of interpersonal issues may be avoidable during treatment of OCD. Hand (1992) pointed out that Exposure and Response Prevention (ERP) can represent an intense intrusion upon the client's autonomy. To challenge rituals can be experienced as lack of caring. In such cases, a client's angry or defensive reactions to interventions look to therapists as signals of deficient motivation for change or lack of collaboration. But they may be actual samples of interaction-patterns that make it possible for people with OCD to execute their rituals.

Although authorities in the field have observed that OCD behavior can impose itself on the therapeutic relationship, the important possibilities that this opens up for treatment have stayed largely unexplored. As it has not been considered in outcome studies concerning OCD, the purpose of this paper is to present arguments for the role FAP may play to enhance treatment of this disorder.

Method

The paper pretends to argue its case describing applications of this approach with clients presenting OCD. Fragments of therapist-client dialog have been selected to illustrate the principles of FAP. They are discussed with regard to the implications FAP can have in the treatment of OCD.

Miss A is a 22-year-old single woman. She lives with her mother, maternal grandparents and aunt. After onset of OCD at 6, her school performance continued excellent till she was 14. Then she dropped out of school and never persevered in any of the courses she took from then on. She has a long record of psychiatric and psychological treatments and when she started the treatment from which the fragments are presented, she had most of her day tied up in a variety of rituals, experiencing high levels of anxiety and was unwilling to leave the house unaccompanied.

Miss B is a 29-year-old female unemployed university graduate, living with her parents. The OCD behavior - that started in childhood - got worse after she broke up with her boyfriend, and during the three following years she progressively restricted her social contacts and activities. Often she thought someone might get harmed or that something may go terribly wrong if she would not execute her compulsions. The latter included systematically avoiding turns to the right. Due to this limitation, she often had to walk or drive long distances to places that actually were close by. She often returned to places where she had turned right, in order to compensate with a left-hand turn. Another compulsion of hers was insisting to be explicitly pardoned for the slightest offense or discomfort she imagined to have caused.

Vignettes and Discussion

Compulsive questions.

Miss A illustrated her compulsive reassurance-seeking with examples like the following: "I asked my mother if I look like X [an actress]. And she told me I did. But my sister said my hair is different. Does that mean her hair is more beautiful than mine? I called upon my aunt, to decide who was right, but in the end I got more confused still and I wanted to know if I was more beautiful than X. They said I was, because they are afraid I would get angry again. So, I did not believe them and I knew I would not sleep without knowing for sure. I had to spend the night on the telephone, calling everyone I know to ask them if X is more beautiful than me."

In the next fragment she tells about an obsession concerning her body odor: "My sister denied she smelled anything. But she could be lying, because she wants me to feel good. So I had to ask my mother, who was outside in the street. But I didn't believe her either, and I had to ask this boy I didn't know. It was embarrassing, but I had to put this question to him. He looked surprised and said he didn't smell anything. I ended up feeling less sure than when I started out. Can you smell me now?"

Therapist: “Do you remember we discussed this kind of questions? You make me feel uncomfortable asking them.”
Client: “But everybody always answers.”
Therapist: “And does that help you in any way?”
Client: “Aren’t you supposed to help me? My mother helps me, all my friends help me by answering my questions.”
Therapist: “And don’t they get uncomfortable, the way I do, and frustrated when you keep repeating questions they answered before?”
Client: “But I can get nasty if they don’t answer.”
Therapist: “So what is happening now? You keep asking. And with every answer you get, you want more. I, like most people, get frustrated about this. But when someone refuses to continue answering, you threaten, to make us continue, and you continue feeling unsatisfied.”

At the next session, Miss A sets out saying: “How can anyone take pleasure in refusing to answer a simple question like this?”
Therapist: “How do you think you made me feel now?”
Client: “I brought you a list of questions you can fill out for me. So you won’t have to answer any question twice. Next time I’m in doubt I will look at the list.”
Therapist: “Then you will start obsessively checking the list.”
Client: “This is torture. You are supposed to help me. I’ve been in treatment with so many professionals and never anyone made fun of my problems the way you do. You want to make me worse”
Therapist: “So I feel bad now. I feel like I’m uncaring and I made you dislike me.”
Client: “Doctor X [her psychiatrist] would fill out my list for me. He is like a father to me.”
Therapist: “And don’t you make other people, like your mother and aunt feel as though they were uncaring, when they don’t answer your questions? I think this is the way you feed your OCD. You make people feel bad when they don’t help maintaining your rituals.”
Client: “Feed, feed. You don’t want to answer? Than let me tell you about all the good things that happened this week. I’m going out on my own again. I take the bus alone to almost anywhere.”
Therapist: “I saw you were alone in the waiting room. Are you going back on your own after the session?”
Client: “I am. And I’ll take a walk in the mall on my own before going home.”

Discussion:

In the first fragment Miss A described how she pressured others into collaborating with the questioning ritual. Her coercive strategies evoke questionable answers from others that on their turn evoke more questions. Her report of what happened in a situation outside treatment ended up in in-vivo compulsive behavior. Typical FAP interventions by the therapist include explicitly sharing the feelings these strategies evoke in him and offering his interpretation of the ongoing behavior. The people she pressured to answer in daily life situations did not share the negative feelings this evoked in them. The delayed consequences of the strain she put on people, may include loss of social reinforcers, but people’s immediate reactions tended to maintain her coercive behavior. Telling her about the impact her behavior has on him, the therapist allows the behavior to contact a natural consequence that in her daily life situations cannot influence her behavior because it

consists of feelings most people don't tell her about. As the coercive strategy remains unsuccessful, Miss A ends up telling about her progresses during the week and the therapist picks up on this conversation (natural reinforcement). Note that the question is not answered and no form of reassurance is allowed to occur. Miss A leads the conversation to another topic, without having found out whether the therapist can smell her or not.

Undoing right-hand turns.

The following dialog took place after Miss B and the therapist had agreed on an exposure exercise, in which they would walk about the clinic-corridors, only taking right-hand turns from the office to the outside door. While leaving, the therapist accidentally looking back sees her unobtrusively hiding her purse in the room.
Therapist: "Do take your purse with you. We're not coming back."
Client: "I'm not going to carry this about the clinic."
Therapist: "I'll carry it for you."
Client: "You can't do that. You are a man."
Therapist: "Well, then you'll have to carry it."
Client: "If you don't let me return to this room before leaving the building, I can never come here again."
Therapist: "You thought you'd come back to fetch your purse and then you'd get away to the left, is that right?
Client: "I'm not going with my purse. I'll first leave it with the receptionists at the entrance. Wait for me here."
Therapist: "Are you going to escape and leave me here feeling foolish?"
Client: "Would you feel like that? How sweet of you! I'll go with you and with my purse. And afterwards I'll go all the way back without you and with my purse."
Therapist: "After our walk through the corridors, I'll accompany you to the entrance hall and I'll say goodbye there. I thrust you do what we agreed upon. If not, all our effort negotiating this walk will be lost."
Miss B quietly accompanies the therapist through the corridors, always turning right, until reaching the hall. She schedules her new appointment with a receptionist and walks out the building smiling back. The therapist waves goodbye.

At the end of another session, the therapist mentions that his car was getting fixed and that he would have to walk from the clinic to the university building. Miss B spontaneously offers him a ride, complaining she would have to turn right several times to get there. The therapist accepted the offer and Mrs. B, after dropping him off continues straight home the shortest way, turning right at the first crossroad.

Discussion:

Miss B's plans to return to the therapy room are clinically relevant behavior. If she had been able to compensate for all the right-hand turns with left-hand turns, the relationship between Miss B and the therapist would have been a vehicle for OCD behavior. FAP interventions used by the therapist include blocking the coercive behavior and explaining how the way Miss B treated him, affected him. Miss B ends up doing what was agreed upon, tolerating the transgression of her safety-rules, which in itself is an in-vivo improvement. That she spontaneously gives the therapist a ride, breaking her rules concerning right-hand turns, is another example of in-vivo improvement in the context of

the interpersonal relationship between her and the therapist. In all these cases, the new behavior makes it possible to succeed in tasks like doing what she agreed upon, or helping a person, that would not be possible if she had engaged in OCD behavior.

Responsibility for the other's feelings.

In another session, Miss B starts out saying: "Here in Brazil people are more welcoming. People are warmer and more hospitable. But I didn't mean you. You are a foreigner. Have I offended you? Pardon me. Please, pardon me. Please. You won't pardon me, will you? But why not? It's simple. Just say it."
Therapist: "You were talking about Brazilian hospitability. Go on. I was interested."
Client: "First you have to pardon me."
Therapist: "I won't do that. I want you to stop ordering me what to say, remember?"
Client: "But this is different. This is not OCD. I really hurt your feelings. So you should pardon me. Isn't that true? Aren't you even a little bit annoyed? I know you are."
Therapist: "Yes. I felt annoyed when you implied foreigners are less hospitable. So what?"
Client: "I made you feel unhappy. I don't want you to feel unhappy. Anyone who will hear about this will agree you are wrong in not pardoning me."
Therapist: "Do you know why I don't want to?"
Client: "You don't want to feed my little tiger [a metaphor for anxiety]?"
Therapist: "Ah, the tiger!"
Client: "But Brazilians are more hospitable. At least I think so."
Therapist: "Go on, go on, what were you going to tell me about that?"

Coming in for a session Miss B says: "Your car was in my parking space and I had to leave mine in another street. That's very nice of you. Very nice indeed."
Therapist: "Do you have a parking space of your own in front of the clinic?"
Client: "No, I'm sorry. I should not have gotten annoyed, or I should not have told you."
Therapist: "Why not? If I made you park somewhere else?"
Client: "What are you doing? I said I'm sorry. I was joking. You have to say it's fine."
Therapist: "But I won't."
Client: "I'm sorry. I'm sorry. I'll never make a joke again.

The next session, she starts out saying: "That was not your car at all, in front of the clinic last week."
Therapist: "My car was out there."
Client: "But it was not the one in my parking space. That was someone else's car. You made me believe that the little red one was your car. Just to see me angry."
Therapist: "I can't guess which parking space you were calling yours."
Client: "Oh yes, you cheated and you lied. That's very nice of you. Very nice indeed."
Therapist: "What do you mean?"
Client: "Oh, I'm sorry! Forgive me. Is that what you want to hear? Well I'm not sorry."
Therapist: "That wasn't pleasant to hear."
Client: "No, you are not feeling hurt, because you know I was joking. And even if I you feel hurt it is only a little and that would even serve you well."
Therapist: "You are very funny."
Client: "Ha, ha. Here's my homework chart."
The therapist receives the chart and examines it with Miss B.

Discussion:

During the conversation on hospitality, Miss B tries to capture the therapist in her ritual. Refusing to comply, the latter intensifies exposure by honestly sharing his annoyance. Miss B ends up maintaining her opinion, while tolerating herself to cause subjective harm. The in-vivo improvement consists in continuing the conversation without neutralizing her harm-related inferences. In the interaction concerning the parking space, she ends up arbitrarily accusing the therapist and belittling possible discomfort she might be causing with her accusation. These new behaviors may not seem overly aggressive or immoral to a neutral observer, but proceeding without obtaining reassurance that she did not hurt the therapist's feelings is unacceptable from the point of view of Miss B's obsessive concerns. The most natural reinforcement for this behavior was for the therapist to comply with the task she offered and work on the chart she hands him over.

Conclusion:

Interference of OCD symptoms with the collaborative relationship, often considered an impediment of progress, can be opportunities to intensify treatment. When OCD behavior imposes itself on the treatment process, the FAP therapist will not interrupt treatment to eliminate the interference in order to be able to continue with the application of techniques. Trying to coerce the therapist into answering compulsive questions (Miss A) or into unnecessarily pardoning (Miss B) are functionally equivalent to what the client often does outside the session and are part of the behavior patterns that treatment should target. From the perspective of FAP, these events constitute invaluable in-vivo learning opportunities. As in-vivo improvements can come in the form of reduced responsibility, or carelessness about the therapist's feelings, the therapist needs to pay attention not to unwittingly punish them.

The above fragments are examples of using genuine problems that occur in the client-therapist relationship as in-vivo learning opportunities. The classically prescribed focus on symptom-triggers in daily-life settings, must be complemented with a focus on the relationship, that will increase the therapist's awareness and preparedness to detect moments that offer in-vivo treatment opportunities. Examples of situations that provoke OCD behavior are physical proximity, which leave Miss A insecure whether the therapist may be able to detect her body odor; locomotion, which evokes Miss B's concerns about having to turn right; expressing opinions, which includes the danger of annoying the conversational partner. All of these situations are common in other kinds of interpersonal transactions and thus are potentially relevant for the client's daily-life problems.

The intense relationship offers in-vivo learning opportunities concerning inflated responsibility for the therapist's feelings (Miss B), and concerning tolerance of uncertainty (Miss A). Both clients experienced that thought contents to which they had accorded exaggerated importance, could be ignored. Both had the experience to act without trying to neutralize uncertainty (Miss A) or possibly immoral aspects of her own behavior, like hurting someone's feelings (Miss B). The fragments show that FAP is not incompatible with the rationale of empirically sustained treatments for OCD, like Exposure and

Response Prevention (ERP). Following the principles of FAP, the clients directly contact interpersonal situations that evoke clinically relevant behavior. This is entirely coherent with traditional in-vivo exposure. The escape behavior, like demanding doubt-relieve (Miss A), undoing turns to the right-hand side with turns to the left and demanding guilt-relieving pardon (Miss B) is blocked as the therapist does not provide opportunities for successful escape. This type of intervention can easily be understood as ERP. In the process, the clients are exposed to feared consequences, like continued insecurity (Miss A), obviously annoying a conversational partner and turning right without expectancy of coming back to undo the act (Miss B). The interpersonal situation also allows for alternative behaviors (like task-focus or spontaneous change of conversational topic) that are incompatible with OCD behavior to go naturally reinforced.

FAP, rather than interfering with ERP, may actually enhance its application. It brings therapeutic technique closer to natural occurrences of obsessive-compulsive behavior and the fabric of its interpersonal contexts. As FAP implies in systematically taking advantage of spontaneous interactions between therapist and client, it can increase the density of therapeutic interventions during the session. Therefore, the potentials of working through an intense therapeutic relationship, as proposed by FAP, is an issue that deserves the attention of future OCD treatment outcome research.

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