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Focusing on the Client-Therapist Interaction

Functional Analytic Psychotherapy: A Behavioral Approach

ABSTRACT

Therapeutic approaches that attend to the client-therapist interaction typically are based on psychodynamic theories of behavior. In this paper we describe a behavioral theory of therapeutic change in which the client-therapist relationship is at the very heart of the change process. This approach, Functional Analytic Psychotherapy, is guided by radical behavioral philosophy and was built on a behavioral analysis of the outpatient psychotherapy environment. This paper presents the central principles of radical behaviorism, discusses how this leads the therapist to focus on the client-therapist relationship, and points out how this approach can help with some difficulties in cognitive therapy. A segment of a case example is presented to show how some of the strategies of a functional analytic approach can be applied with a client.

The Origins of Functional Analytic Psychotherapy

As practicing clinicians, Drs. Kohlenberg and Tsai noticed that some of their clients, who were being treated with traditional behavior therapy techniques, showed dramatic and pervasive improvements that far exceeded the goals of treatment. In these cases, they also observed that the client-therapist relationship was particularly intense. They used Skinnerian concepts to account theoretically for such effects, and to delineate the steps therapists can take to facilitate intense and curative relationships (Kohlenberg & Tsai, 1991, 1994b). The result is a treatment called Functional Analytic Psychotherapy, or FAP. FAP focuses on maximizing the therapeutic benefits of using the evocative and reinforcing aspects of the client-therapist relationship.

Functional Analytic Psychotherapy is built on the foundation of radical behaviorism, the conceptual framework described in the writings of B. F. Skinner (e.g., 1953, 1957, 1974). FAP itself is derived from a Skinnerian analysis of the typical psychotherapy environment. Although FAP is a type of behavior therapy, it is quite different from traditional behavior therapies, such as social skills training, cognitive restructuring, desensitization, and sex therapy (Dougher, 1993; Kohlenberg, Tsai, & Dougher, 1993). These traditional behavioral treatments tend to be problem-focused and time-limited. Instead, FAP techniques are concordant with the expectations of clients who seek an intensive, emotional, in-depth therapy experience. It is well suited for clients who have not improved adequately with traditional behavior therapies, who have difficulties in establishing intimate relationships, and/or who have diffuse, pervasive, interpersonal problems commonly known as "personality disorders." In order to deal with these in-depth problems, FAP leads the therapist into a caring, genuine, sensitive, involving, and emotional relationship with the client while at the same time capitalizing on the clarity, logic, and precise definitions of radical behaviorism.

Principles of Radical Behaviorism

Radical behaviorism (radical in the sense of root or fundamental part rather than extreme) is a rich and deep philosophy of behavior that tries to get to the root of human behavior. An essential foundation of a radical behavioral approach is that it employs a functional analysis of behavior instead of analyzing behavior in terms of its formal properties or topography. In other words, there is more emphasis on the question of "what are the functional relations between behavior and its contextual antecedents and consequences" than on what behavior looks like. Radical behaviorists are deeply invested in developing a complete account of human experience. Unlike other behaviorists, radical behaviorists study all aspects of human experience including topics such as slips of the tongue, metaphor, the self, suicide, phylogenic behavior, and spirituality (e.g., Hayes, 1984, 1992; Kohlenberg & Tsai, 1995; McCurry & Hayes, 1992; Skinner, 1957, 1981, 1984).

Three principles underlie this philosophy, namely that: 1. knowledge is contextual; 2. behavior is nonmentalistic; and 3. even the most private verbal behavior (thinking) has its origins in the environment. Let's examine these principles briefly (for more complete coverage, see Hayes, 1987; Kohlenberg & Tsai, 1991). ➔

1. Knowledge is contextual

In the constructivist tradition, radical behaviorists emphasize context and meaning. Take something out of context and it becomes meaningless. Put it in a new context, and it means something different. Problems – mental or otherwise – do not exist in isolation. They are ascriptions of meaning that arise within a particular tradition, and have meaning only within that tradition. The behavior of striking a person in the face is a serious problem in a marriage but results in prize-money in a boxing match. Radical behaviorist attempt to account for behavior by describing the context, which includes both the immediate context and the behaving person's reinforcement history. Language and previous experiences shape even experiences that people consider purely physical. Pain, for instance, is not simply the firing of nerve endings. It is part sensation, part fearful ideation – a package of interpretations surrounding sensations (Efran, Lukens, & Lukens, 1988).

2. Behavior is nonmentalistic

Radical behaviorism explains human behavior in terms of *function in context* instead of entities or structures inside the mind or brain. Explanations of behavior are incomplete if they do not trace its antecedents back into the client's history as far as necessary to determine the functional relationships between the behavior and its effects. Radical behaviorists are continually engaged in a search for "controlling variables." Antecedents and effects (consequences) are considered controlling variables when they are perceived to be related functionally to behavior (that is, they maintain or change the likelihood of its occurrence). This process of searching for the controlling variables for a behavior by tracing its antecedents is known as functional analysis.

In the context of a psychotherapy case, this past is referred to as the client's reinforcement history. For example, a client may say he yelled at his spouse because he was angry. This explanation may be useful for many purposes. It is not satisfactory, however, as a functional analytic explanation. The functional analytic explanation would require information about the past contingencies that account for 1) getting angry, and 2) yelling. That is, not all spouses get angry under these circumstances; and even if they do become angry, not all spouses will yell because of it. The functional analytic explanation addresses these issues.

A note on private events:

Radical behaviorists object to things that are mentalistic, not to things that are private. Private events such as thoughts, perceptions, feelings or emotions, and dreams, are considered to be as real as typewriters, trees, typhoons, or train trestles (see Boring, Bridgeman, Feigl, Pratt, & Skinner, 1945; Skinner, 1945). Private events, however, are not given any unique status other than their privacy – that is, they are directly available only to a single individual.

Whether public or private, perception is considered to be behavior. In fact, most of the time it is easiest to view perception as something private because only one person can participate in a single act of observation. Thus, perceiving is private behavior cut from the same cloth as public behavior, and is subject to the same discriminative and reinforcing stimuli that affect all behavior. It follows, then, that a client's private response (such as a perceiving, thinking or feeling) can have as much or as little causal effect on subsequent behavior as can a public event, depending on circumstances of reinforcement (context, including reinforcement history).

3. Even the most private verbal behavior has its origins in the environment

Although the phenomena related to human verbal functioning range from the most intimately personal to the most publicly social, all language is shaped into effective form by the action of a verbal community outside of the speaking subject. In matters of human communication, of spoken and written language, the verbal community is the primary controlling variable. What factors lead a speaker to say what he or she does? To know thoroughly what has caused a person to say something is to understand the significance of what has been said in its very deepest sense (Day, 1969). For example, to understand what a man means when he says "I just had an out-of-body experience", we would search for its causes (or controlling variables). First, we would want to know about the stimulation in the body that was just experienced. Then we would want to know why a particular bodily state is experienced as "out-of-body." That is, we would look for environmental causes going back into the man's history, including the circumstances he encountered as he was growing up that resulted in his saying "body," "out of," "just had," and "I." As soon as we knew all of these, we would understand deeply the significance of what was meant, and we would have tracked down the controlling variables in the environment. This approach to verbal behavior is central to understanding FAP, as psychotherapy itself is an art involving verbal behavior and its functional analysis.

Individuals are encouraged (by the verbal community) to talk about what they have seen and felt. Radical behaviorists recognize that the individual's report is an interpretation that is a function of the individual's history. The verbal community expects that what people see and feel will come to exert an increasing influence

on what they say. This is referred to as increasing contact with the world. Improved contact is desirable in the whole range of human endeavors including: science, politics, medicine, and social community. It is also a need for most clients who are seen in psychotherapy. For example, the client who does not express emotions often avoids contact with situations that evoke emotions. Because of this, such people often have difficulties in intimate relationships.

A Note on Diagnosis and Treatment: There are a variety of ways to construct a diagnostic system and many reasons for diagnosing behavior. The prevailing diagnostic systems (e.g., the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), American Psychiatric Association, 1994) base their diagnostic categories primarily on topography of behavior. In other words, a diagnostician will assign the label of Dysthymia, Major Depressive Disorder, or Depressive Personality Disorder if the client reports sadness or anhedonia, problems with sleep, appetite and eating patterns, and cognitive performance (concentration and decision making). The temporal pattern and intensity of the symptoms determines the severity of the "disorder." In this system of topography based diagnosis and treatment, you find different disorders treated with the same method and the same disorders being treated with different methods (Gavino, Godoy, Rodriguez-Naranjo, & Eifert, 1996). This confusing state is a symptom of problems with the current approach to classifying client's presenting problems. When using a diagnostic system based on a topographical analysis, you end up with descriptive categories that provide little or no information about the functional relationships maintaining the behavior and thus, little information to inform treatment from a behavioral viewpoint. Gavino et al. (1996) claim that a consequence of this approach to classification "has little known benefit as measured by improved treatment outcome" (p. 108; cf. Hayes, 1995). The prevailing view has been that a single diagnostic system could be developed that would be useful for multiple purposes: making treatment, administrative, and legal decisions; facilitating communication among clinicians and researchers; and guiding scientific inquiry. The belief that a single classification system could be developed to serve diverse purposes relies on the premise that there is a common underlying disorder entity that explains a wide range of problematic behavior. Our behavioral orientation leads us to reject that premise and instead rely on explanations in terms of the problem behavior's context and function. Many people in the mental health field have discussed a variety of problems with the current topographical or syndromal approach to diagnosis (Clark, Livesley, & Morey, 1997; Follette, 1997; Follette & Houts, 1996; Gavino et al. 1996; Hayes, 1995; Houts & Follette, 1998; Koerner, Kohlenberg, & Parker, 1996). The primary complaints are the heterogeneity of patients in the same diagnostic category and the overlap of different categories. An alternative approach to diagnosing clinical problems is to apply a functional analysis in order to understand the patient's problems. This type of assessment would provide information about functional relationships of the client's behavior that would guide the clinician in selecting treatment strategies to directly address the functional aspects of the client's problem (e.g., Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Koerner et al.). For example, Hayes et al. (1996, Hayes & Wilson, 1993), through a functional analysis of language, have derived the functional category of "Emotional Avoidance" and have developed a treatment (Acceptance and Commitment Therapy, ACT) that targets this problem. Although criticisms and alternatives to the current diagnostic systems are inchoate at best, we hope that the field will move toward functional analytic systems that will better serve the purpose of improving the outcome of psychotherapy.

A Functional View of Psychotherapy

Evocative Aspects of the Psychotherapy Environment

Early behavior therapists assumed that adult outpatients had problems in their daily lives that did not directly occur in the therapy session, and so could not be observed, specified, quantified, or differentially reinforced. This assumption logically precluded a behavioral approach to adult outpatient psychotherapy. At first glance it seems that the psychotherapeutic session does not resemble the natural environment outside the clinic, and therefore direct work with client behaviors would not generalize to the client's life outside the session. Kohlenberg and Tsai, taking a functional approach, reasoned that the occurrence of problems during the session is evidence for its functional similarity to daily life. A functional approach compares the environments on the basis of the behaviors they evoke rather than on the basis of their physical characteristics. If the environments evoke the same behavior, then they are functionally similar. Variables that control a problematic client behavior must exist in the therapy session itself if that behavior occurs in session. The FAP view is that the client-therapist relationship is a real social environment that has the potential to evoke and change actual instances of the client's problematic behavior. For example, a client who has difficulty forming close relationships might have similar problems forming a trusting relationship with the therapist. In FAP terminology, the client's pro-

blems that also occur in the session with the therapist are *Clinically Relevant Behaviors* (CRB; there are other types of CRB, discussed below). CRB are actual occurrences of problematic behavior during a session and are *not to be confused* with the in-session behavior brought about by role-playing, behavioral rehearsal, or social skills training.

In FAP, the occurrence of CRB is viewed as an important opportunity for producing significant therapeutic change. Maximal therapeutic benefit and generalization to daily life occurs when these occurrences are real interactions, so comparable benefits are not to be expected from role playing, behavioral rehearsal, or skills training. Goldfried (1982) described these special opportunities as in vivo behavioral work, which is known to be "more powerful than imagined or described [situations]" (p.71). In watching for and deliberately evoking problematic behaviors in-session, FAP therapists capitalize on the evocative aspects of the psychotherapy environment.

Reinforcing Aspects of the Psychotherapy Environment: Within-Session Contingencies

A well-known aspect of reinforcement is that the closer in time and place that consequences follow behavior, the greater will be the effect of those consequences. It follows, then, that treatment effects will be stronger if a client's problem behavior and improvements occur during the session, where they are closest in time and place to the available reinforcements. For example, if a client states that she has difficulty trusting others, the therapy will be much more powerful if her distrust is actually evoked in the therapeutic relationship where it is reacted to immediately by the therapist, as opposed to talking about incidents of distrust that occur with other people between sessions. From this point of view, significant therapeutic change results from the contingencies (contingent consequences) that occur during the therapy session within the client-therapist relationship. In many ways, the FAP approach parallels that of traditional applied behavior analysis (usually practiced in institutional settings) where the client's problematic behavior (e.g., head-banging, incorrect naming of objects) is directly observed and is subject to consequences by the behavior analyst. In being aware of the ways that therapist behavior and the therapy environment itself may affect relevant client behaviors, FAP therapists take conscious advantage of within-session contingencies.

The focus on within-session contingencies warrants a note on arbitrary versus natural reinforcement. Radical behaviorists argue that it is less effective, even counterproductive, to use arbitrary reinforcement (Ferster, 1967; Kohlenberg & Tsai, 1991; Skinner, 1982). For example, if a client tells the therapist it is frustrating when the therapist interrupts him and he feels put down by that, the therapist can make effusive compliments for the client's forthright communication skills saying "I'm really glad you told me that. It's great that you are able to express your frustration with me and it shows how much progress you are making in therapy. That was great. Well done." This type of response is not likely in typical social interactions. A more likely response might be, "oh, sorry. I'll watch for that." and subsequently the therapist interrupts less. The first response is obviously contrived and is more likely to reinforce the specific behavior of telling the therapist something like this than the more general behavior of telling others when their behavior is intrusive or demeaning. The second response is more typical of reinforcement in the natural social environment and is more likely to generalize to other situations.

The Behavioral Structure of FAP Interactions

In teaching and supervising FAP in clinical applications, interactions are discussed in terms of certain types of client behavior and therapist behavior, all occurring during the therapy session. The client behaviors are his or her problems, improvements, and interpretations. As mentioned above, we term these CRB, for Clinically Relevant Behaviors. The therapist behaviors are therapeutic methods that include evoking, noticing, reinforcing, and interpreting the client's behavior. These are emphasized as five rules for therapist behavior.

Everything a therapist can do to help clients occurs during the session. To the radical behaviorist, the therapist's actions affect the client via three stimulus functions: 1. eliciting, 2. discriminative, and 3. reinforcing. *Elicited behavior* is reflexive (respondent behavior), and is commonly called *involuntary.* A *discriminative stimulus* refers to the stimulus conditions (context) under which certain behaviors were reinforced and thus are more likely to occur. For example, we are more likely to be quiet when we are in a church or library than when at a ball game. Most of our behavior is under discriminative control and is commonly known as voluntary behavior (operant behavior). The *reinforcing function* refers to consequences that affect behavior, either increasing or decreasing its likelihood in the future. Every action of the therapist can have one or more of these three effects. For example, the therapist might ask, "What are you feeling right now?" Its *discriminative* effect is, "It is now appropriate to say how you are feeling." The question might be aversive to the client, thus punishing (reducing the likelihood of) whatever behavior immediately preceded the therapist's question: This would be a *reinforcing function* of the question (there could also be positive reinforcing func-

tions). The *eliciting function* might make the client turn red, sweat and experience other private bodily states such as a pounding heart. The reasons for the client's reactions are found in his/her history. Client improvements also must take place during the session so reinforcers naturally present in the session may affect them. The reinforcers are mainly the therapist's actions and reactions to the client.

FAP provides a guiding framework that emphasizes working with the natural relationship that develops between the client and the therapist, therefore its structure involves only a few rules or formal protocols. In brief, therapists are instructed to watch for three kinds of client behavior, Clinically Relevant Behavior (CRB), and to act in accordance with five rules for therapist behavior. The three kinds of client behavior, or CRB, are: 1. CRB1, *client problems that occur in session*; 2. CRB2, *client improvements that occur in session*; and 3. CRB3, *client interpretations of their own behavior.* The five rules for therapists relate to these clinically relevant in-session behaviors variously through the discriminative, eliciting, and reinforcing functions mentioned above. The rules are: 1. watch for CRBs; 2. evoke CRBs; 3. reinforce CRB2s; 4. observe potentially reinforcing effects of therapist behavior regarding CRBs; and 5. give interpretations of variables that affect client behavior. Please note that although we mention these rules and will refer to them in the case example, the details, caveats and implications of their use are too extensive to describe here. Interested readers may consult Kohlenberg & Tsai (1991).

A Functional Analytic Account of Cognitive Therapy

A fundamental formulation in cognitive therapy is that clinical problems (e.g., depression or anxiety) are a result of faulty or irrational cognitive responses to life events. This formulation can be represented by the A>B>C model that links the environmental or activating event (A) to the emotional consequence (C) by the intervening (B), or cognition (e.g., belief) (Beck, Rush, Shaw, & Emery, 1979). As cognitive theory developed, it became apparent that the exact meaning of B, cognition, was unclear (Beidel & Turner, 1986).

Cognition According to Cognitive Theory

In an effort to remedy the "confusing terminology regarding human cognition" Hollon and Kriss (1984, p. 36) turned to basic cognitive theory to clarify what is meant by cognition. They identified three types of cognition: cognitive products, cognitive structures, and cognitive processes. Our analysis is not affected by the additional concept of cognitive processes and we will discuss only products and structures. Cognitive products are directly accessible, conscious, private behaviors, such as thoughts, self-statements, and automatic thoughts. This meaning of cognition corresponds with Ellis's (1962, 1970) formulation and seems to be used in day-to-day cognitive treatment in which the therapist tries to change the client's dysfunctional automatic thoughts, irrational beliefs, or maladaptive self talk. Cognitive structures, such as schemas, are defined as the underlying organizational entities that play an active role in processing information. Structures operate at an unconscious level since their content cannot be known directly and must be inferred from the products.

From the Hollon and Kriss perspective, the causal factor in the ABC formulation is the cognitive structure, whereas the cognitive products (irrational thoughts, self-statements, automatic thoughts) constitute "signs or hints of the nature of one's knowledge structures." Hollon et al. and others (e.g., Beck, 1984; Safran, Vallis, Segal, and Shaw, 1986) suggest that any clinical interventions that change cognitive products are merely symptomatic treatments.

Difficulties Encountered Within the Cognitive Approach

Although necessitated by deficiencies in the original ABC hypothesis (e.g., the fact that C's sometimes occur in the absence of a B and that cognition was inconsistently defined, see review by Beidel & Turner, 1986), the shift in focus from products to structures has produced a theory-practice schism. The same cognitive therapists who reject the causative role of cognitive products are the ones who provide treatment manuals and clinical examples that focus on changing cognitive products. For example, Beck, Emery, and Greenberg (1986) stated that the therapist "must be able to communicate clearly that anxiety is maintained by mistaken or dysfunctional appraisal of a situation" and "gives this explanation...in the first session and reiterates it throughout therapy" (p. 168). In addition, Guidano and Liotti (1983) stated that first important step in therapy occurs "when patients understand that their suffering is mediated by their own opinions" (pp. 138-142).

From a FAP view, the theory-practice schism in cognitive therapy makes sense. Since clinical interventions are always limited to the behavioral realm, such as the client's thinking, feeling and talking (i.e., products), it is impossible to devise treatments that focus on nonbehavioral entities (i.e., structures) that cannot be directly contacted or observed by the therapist. As one cognitive researcher described it, a schema is like "the holy grail" (Zuroff, 1992, p. 274) of cognitive psychology. Thus, it has been difficult for cognitive therapists to

create interventions aimed at structures that are substantially different from those aimed at products. For example, Beck et al. (1979) stated that "the cognitive and behavioral interventions (used) to modify thoughts...are the same as those... used to change hidden assumptions" (p. 252). It appears that the only procedures that differentiate the clinical treatment of products from structures is that the latter must first be inferred (i.e., the therapist must abstract or deduce the existence of the structure). Once identified, however, the same therapeutic methods used to change products are applied. Directed by theory to change a nonbehavioral entity (the underlying structure) while restricted to working with the behavior (products) of the client, the cognitive therapist is in an untenable position. These theoretically posited difficulties in changing schemas and the tenuous link between theory and how change occurs have been termed a dilemma by Hollon and Kriss (1984, pp. 46-48). Thus, it is not surprising that the actual nuts-and-bolts practice of cognitive therapy mainly operates according to an ABC model in which B refers to cognitive products.

The wholesale application, however, of an ABC formulation involving products to the exclusion of other possibilities leads to questionable clinical procedures. If clients reject the ABC model by claiming they experience no conscious B that precedes the C, or they report a B that is inconsistent with a C (e.g., "I intellectually accept I don't need to be loved by everyone, but I am still devastated when I'm rejected") cognitive therapists usually will continue to carry out an ABC treatment plan by questioning the client's logic or sincerity, or by proposing that there are additional, unconscious cognitions to be discovered. Challenges to the client can also be indirect, such as giving additional homework or assumption-testing assignments. Such nonacceptance of alternative paradigms is found in the cognitive therapy of Beck et al. (1979) even though Beck (1984) rejects the theory implied by the ABC model. For example, Beck suggested that clients who say that they intellectually "know" they are not worthless, but who do not accept this on an emotional level (i.e., cognition occurs but does not influence subsequent feelings or behavior) need more cognitive therapy because the dysfunctional feelings can occur only when they do not "truly believe" the rational thought (Beck et al., 1979, p. 302). From our perspective, a client's objecting to cognitive interventions could be desirable, that is, a CRB2. If such a client were seeking help with becoming more assertive or more confident with opinions, then objecting to the therapist's ABC theory would be an improvement that should be reinforced by the therapist's acceptance and not punished by the challenges.

The need for more flexible models is demonstrated by the tendency for cognitive therapists (as well as other types) to persist in their approach even though the client is not progressing (Kendall, Kipnis, & Otto-Salaj, 1992). Given the complexity of human behavior, the exclusion of coexistent, noncognitive mediated explanations as demanded by the ABC model seems unreasonable.

A Radical Behavioral Analysis of Cognitive Products and Structures

The FAP model, in contrast, allows for clients whose experience matches the ABC paradigm as well as for those that do not. Our analysis is based on Skinner's (1974) distinction between rule-governed and contingency-shaped behavior, which seems to capture much of what is meant by the product / structure distinction in cognitive theory. This view retains the clinical usefulness of that distinction, but avoids the problems of the original ABC cognitive hypothesis. In our revision of the ABC paradigm, cognitive products are conscious verbal behaviors such as thinking, believing, choosing, reasoning, categorizing, labeling, or self-talking of which the client is aware. In behavioral terms, cognitive products are private verbal behavior that can serve as rules. Rules are defined as verbal statements that describe contingencies and can instruct or guide behavior (cf. Poppen, 1989; Reese, 1989; Skinner, 1969). For a client this may take the form of "don't trust others, I'll just get hurt." Depending on whether or not an individual has been reinforced for following rules, the B (e.g., self statements, automatic thoughts, beliefs) may or may not affect subsequent acting and feeling (Hayes, Kohlenberg, & Melancon, 1989; Kohlenberg, Tsai, & Dougher, 1993). The ABC formulation represents the case in which B does have rule-governing properties and does influence C.

Hollon and Kriss' (1984) account of structures as "constructed from information received and processed . . . in the past [and] strengthened when similar information is repeatedly processed" (p36) fits with Skinner's description of contingency-shaped behavior established by way of a reinforcement history. Viewing cognitive structures as contingency-shaped behavior also allows for the client's experience represented by a direct AC relationship. In this instance, the client has problems but doesn't consciously think, plan or attribute beforehand. It may also be the case that both B and C are evoked by the same A, are correlated, and have no influence on each other. In this later case, C is contingency-shaped and is directly evoked by A.

In other words, within the FAP framework, the degree of control exerted by thinking over clinical symptoms is on a continuum. Cognition (as products) can play either a major, minor, or no role in the client's problems. Correspondingly, cognitive therapy methods will be of varying effec-

tiveness with different clients depending on the role that cognitive products has in the clinical problem. At one end of the continuum, the client's problem is primarily rule-governed, and treatment would be aimed at changing self statements, beliefs and attitudes using cognitive therapy techniques.

At the other end of the continuum the symptom has been shaped purely by contingencies. Although it is possible for a client with a deeper, unconscious contingency-shaped problem to improve when given a cognitive interpretation, less favorable outcomes are more likely. This is especially true for clients who grew up in dysfunctional families where they were abused, neglected, negated, or otherwise punished for expressing their feelings. Children who are repeatedly told, either directly or indirectly, that "there's no reason for you to feel or think that way" mistrust their feelings and are unsure of who they are. Suggesting to such clients that their beliefs are dysfunctional or irrational can replay the contingencies associated with the invalidation and alienation they experienced while growing up.

As a result of focusing on the client's cognition in the ABC paradigm cognitive therapists usually focus on behavior occurring in the client's daily life thereby avoiding or preventing therapeutic opportunities provided by the therapist-client interaction. With certain notable exceptions (Goldfried, 1982; Jacobson, 1989; Linehan, 1993; Safran, 1990a, 1990b; Safran, McMain, Crocker, & Murray, 1990; Safran & Segal, 1990; Young, 1994) cognitive behavior therapists traditionally have not attended to the therapeutic relationship. For example, in a discussion of "technical problems" in doing cognitive therapy for depression, Beck et al. (1979) raised the problem of a client who says, "You are more interested in doing research than in helping me." First, Beck wisely pointed out that even if nothing is said, a client who is in a clinical research project might secretly be harboring such thoughts. However, the reason such thoughts occur, according to Beck, is that depressed clients may be distorting what the therapist does. He then suggested that the therapist inquires if any such notions are present and put these worries to rest. According to Beck, the therapist should avoid such problems in the first place if possible, by anticipating their occurrence and giving complete explanations to the client.

Our functional analysis of that situation would be somewhat different. A depressed client who feels unimportant to the therapist highlights the fact that the therapy situation could be evoking the same problem that the client experiences with others (for example, not acting worthy and not asking for what she wants). This would not be viewed as a technical problem to be disposed of but as a situation that provides an important therapeutic opportunity. This is an instance of Rule 1: watch for CRBs. In FAP, it would not be assumed that the client is distorting, just that the therapist and the client are contacting different aspects of the situation. It is even possible that the research actually is more important to the therapist than the client is, and in that sense, the client would not be "distorting." The notion that the client might be secretly harboring such ideas rather than telling the therapist suggests the clinical problem of the client not being direct, open, or assertive during the session. (Rule 1 again: watch for CRBs.)

We have briefly outlined the three CRBs and five rules for therapist behavior. In the following case example we note occurrences of each of these so that the reader may get a sense of how these technical events play out in an actual psychotherapy setting.

CASE EXAMPLE

The following example of the treatment of a depressed person illustrates the immediacy of the therapeutic relationship and its potential for altering a negative self-concept, a verbal behavior that is deeply ingrained. We note occurrences of each of the three CRBs and the five rules for therapist behavior so that the reader may get a sense of how these technical events play out in an actual psychotherapy setting. These portions of verbatim transcript were selected from the third author's work with MC, a healthy, attractive, and articulate Caucasian female in her late twenties. She came to therapy asking for help with her depression and for her concerns about how she interacts with others. Feelings and thoughts of being ugly, not being good enough, and being a failure often plagued her. She recoiled from seeing herself in a mirror. MC reported an extensive history of aversive control. Her mother was very critical and abusive throughout MC's childhood, a pattern that continued at the time MC entered therapy. A central theme of therapy was working on her "self hatred" and pervasive negativity in thoughts and feelings about herself.

In the following example, the therapist had asked MC to try writing out an autobiographical outline or timeline. He explicitly said that anything MC could write would be fine; even a rough draft of an outline. If she wanted to write more, that would be fine too.

Despite the therapist's lenient instructions, during the next session MC was unvaryingly self-critical about not writing enough. Clearly, she was out of contact with the contingencies of the current situation. Following Rule 1, (watch for CRBs), the therapist hypothesized that this was functionally similar to problem interactions in other areas of her life and was a CRB1, a problematic client behavior occurring in session. In this excerpt the therapist addresses the effect of the self-deprecating behavior on him and checks to see if MC is aware that her self-criticism affects other parts of her life.

➔ *1. T: OK… OK… Um, anything else that comes to mind? [MC: Um, um, no] I wonder if you had any thoughts or feelings about coming into session today? (Here, the therapist is eliciting thoughts and feelings about therapy and the therapeutic relationship, bringing the focus of therapy onto the session itself, following Rule 2: evoke CRBs.)*

1a. MC: I don't know. I just wish I could've written more. (MC's "I don't know" indicates unwillingness or inability to contact private responses to the situation--a possible CRB1.)

2. T: You wish you could've written more? (Therapist inquires into the immediate self-criticism or statement of inadequacy, probing further to determine whether her wish is based on her private experience or is based on public cues.)

2a. MC: Yeah, like, a lot of it I feel like I can't remember, like, junior high school, I can only remember a few things. (Reason-giving, attributing the supposed shortcoming to a memory deficit. This is a CRB3, the client's interpretation of her own behavior.)

3. T: What do you mean, you wish you had written more? (Continued probe for public or private control over the wish to have written more, following Rule 2: evoke CRBs.)

3a. MC: Oh, I just wish I hadn't – well, some things, I think I'd have, like, tons to write about, but I wish I had written more, but I didn't.

4. T: I see. I wondered if you were feeling that I might have a reaction to you having not written more. (Rule 2: evoke CRBs; also Rule 4: observe potentially reinforcing effects of therapist behavior, e.g., will the client comply by directly answering the question, or will she avoid compliance? The therapist probes for the possible interpersonal function of MC's description of her shortcoming, bringing the interaction explicitly into the here and now of the relationship.)

4a. MC: To not have written more? [T: Yeah] Probably. (MC admits, tentatively, that she is concerned about the therapist's reaction. The therapist notes this, following Rule 4.)
[A portion of the transcript is skipped here for the purposes of continuing our illustration.]

5. T: I wonder when you're thinking about, you know, me, and you having not written enough about that. Was there a sense of having not done that well enough? (Therapist probes for enduring interpersonal behavioral pattern around performance, not specifying either cognition or feeling, but leaving it ambiguous with "sense." Rule 2; also Rule 5: give interpretations of variables that affect client behavior.)

5a. MC: Yeah, I just kinda felt like I failed. I chose to go hiking instead. (MC says "I failed" following work on the assignment, even though the assignment was without standards for judgment. She further reports leaving the situation, which may be an avoidance move, or it may be a positive move toward self-assertion and away from public control of her actions, or "people-pleasing." The therapist would need to determine the function of this behavior in the context of the case conceptualization and his knowledge of her history. If a similar or parallel client behavior occurred in session or with reference to him, he could follow Rule 3 and reinforce such behavior if it is an improvement (CRB2), or note it as a CRB1 if it is not – all the while observing the effects of his own behavior, following Rule 4.)

In the next excerpt, the therapist pursues this topic and describes the paradoxical position he is now experiencing as a result of MC's self-critical report on the assignment he had given her. By reflecting on his own reaction to the situation, the therapist models both in-vivo self-monitoring and the open (not publicly-controlled) reporting of private experience and verbal behaviors (feelings and thoughts). Furthermore, he probes for the presence of a pervasive or generalized pattern of behavior, stated as "I never do well enough."

6. T: Well, um, I noticed, OK, I'm gonna mention something I'm thinking of and then we'll come back to some other things. [MC: OK] But, I notice feeling like I'm in kind of a jam with the autobiography thing. Cuz, I'm wondering, in a way it has become another opportunity for you to do something not well enough. Does that make any sense?

6a. MC: Yeah, but everything's like that. (MC admits the pervasiveness of the pattern. Such a way of constructing reality signals the possibility of longstanding contingency-shaped behavior that has generalized. The therapist's sense of in-session instances of self-deprecation as CRB1 appears to be right on track.)

7. T: And, I remember – how I remember presenting it, is like, anything you can do, anything you're willing to do, it's completely in your court how you do that. I don't have a standard. I'm not going to grade it. I'm not going to expect – I don't have expectations. You didn't have to do anything. You could've just written [your name] on it and said, "That's all I feel like doing. I'm not into this." (Therapist presents actual contingencies again, in an attempt to shape her response here in session. The immediacy is palpable.)

7a. MC: Yeah, but that's not fair. (Hints at a way the basic construct has been elaborated in her life.) ➔

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8. T: And, when I say I feel like I'm in a jam, by saying that, I saw yet another thing for you to not do right. I don't know if you can follow that. I might have to clarify that. (Modeling reporting private responses, and following Rule 5, giving an interpretation of variables affecting the client's behavior.)

8a. MC: No, I follow it, but I don't think . . . (Tries to avoid by mollifying–another CRB1?)

9. T: But, by saying, you know, something about you feeling like you didn't do it right, well, that's not doing it right maybe. Do you see the Catch-22 sort of? (Blocks avoidance and again presents actual consequences in the form of his response to MC's self-criticism.) [MC: Yeah.] OK. So, what do you mean it's not fair? (Probing for elaboration of the construct, actually asking client to state consequences she has experienced in the past, in order to determine the function of her problematic behavior.)

These excerpts illustrate the ongoing assessment of functional relationships, one of the therapist's fundamental tasks. Second, they show the therapist focusing on the here and now, watching for CRB1 and evoking CRB 1, 2 and 3, reinforcing CRB2 by encouraging the client to self-monitor by modeling as well as by direct request; constantly being aware of the effects of therapist behavior and

➔ interpreting the variables that affect client behavior, following the five rules for FAP. In sum, they show the therapist beginning to shape a deeply ingrained contingency-shaped client behavioral pattern through the natural consequences of interpersonal behavior within the therapeutic relationship.

Current Applications And Research

Functional Analytic Psychotherapy is being applied and studied with increasingly diverse clinical settings. Follette et al. (Callaghan, Naugle, & Follette, 1996; Follette, Naugle, & Callaghan, 1996) are developing a fine-grained analysis of process during therapy. They have recently developed a process measure based on a functional analysis of therapy sessions (Callaghan, 1998) that is now being applied to supervision of therapists in training (Follette & Callaghan, 1995; Ruckstahl, Callaghan, & Follette, 1998). Paul Holmes, University of Chicago Department of Psychiatry, and Thane Dykstra, Trinity Services in Joliet, Illinois, have begun using FAP in their work treating patients with psychoses and schizophrenia and are developing a research project (personal communication, May, 1998). They have noticed the occurrence of disordered speech and psychotic behavior influenced by social contingencies of therapist-client interactions. Brandao and Conte, University of Londrina, Brazil, have a line of research studying FAP and have worked with adult outpatient clients, children, adolescents, families, and group psychotherapy (Brandao, 1998, personal communication, November, 1998; Brandao & Torres, 1997). An additional line of research that has emerged from the Functional Analytic approach is exploring Kohlenberg and Tsai's theory of self (1991, 1995). We are developing the Experience of Self Scale (EOSS, Parker, Beitz, & Kohlenberg, 1998) to study one of the theory's main hypotheses; that individuals will differ on their degree of public versus private stimulus control and that there will be a predictable difference between clinical populations. We hypothesize that an assessment of a client's degree of public versus private stimulus control will be a useful indicator for intervention strategies.

Robert Kohlenberg, Mavis Tsai and Neil Jacobson at the University of Washington are currently working to test the viability of adding Functional Analytic Psychotherapy strategies to Cognitive Therapy, a protocol we refer to as FAP enhanced CT or FECT. We have developed an adherence measure (Therapist In-session Strategy Scale, THISS, Parker, Bolling, & Kohlenberg, 1996) for this study and we are in the process of developing a competency scale. The adherence measure has demonstrated reliability and validity and is proving to be useful in the training of therapists during our project funded by the National Institute of Mental Health.

It is our hope that a functional analytic approach has much to offer the field of psychotherapy. The outlook appears promising as clinical behavior analysts accrue empirical evidence for the effectiveness of functional analytic strategies. However, there is much work to be done and many problems to be faced in the forthcoming programs of research and application of functional analysis. ➔

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