A Functional Analytic Approach to Group Psychotherapy

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Abstract

This article provides a particular view on the use of Functional Analytical Psychotherapy (FAP) in a group therapy format. This view is based on the author's experiences as a supervisor of Functional Analytical Psychotherapy Groups, including groups for wo men with depression and groups for chronic pain patients. The contexts in which this approach emerged are presented. With the help of the terms technique and tactic, an attempt is made to pinpoint how exactly the tasks of the therapist in conducting FAP are put into practice in the group. During the explanation of these ideas, a series of examples of how FAP can work in the group setting are given. These contributions are aimed at stimulating divergent thinking about, and experimentation with, FAP in group settings.

Keywords : Functional Analytical Psychotherapy; Group therapy; Therapist-client relationship.

More than two decades ago, Kohlenberg and Tsai (1987) published the first book chapter on Functional Analytic Psychotherapy (FAP), an approach to psychotherapy that is based on the functional analysis of the therapist-client relationship in the individual talk therapy setting. Over time, FAP has consolidated its place among third wave behavior therapies. Third-wave behavior therapy is a strand of treatments that builds upon many of the acquisitions of first-wave (exposure-based) classical behavior therapy and second- wave (based on modifying thoughts and beliefs) cognitive behavior therapy, but differs from them in its distrust of verbal control and its focus on contextual meaning. These differentials give the third-wave behavior therapies an experiential flavor which is strongly evident in FAP. Relying on a client case conceptualization, the FAP therapist observes clinically relevant behavior when it occurs in-session. When it does not occur, he or she evokes it. The curative process depends on the therapist's allowing natural, direct consequences to affect these clinically relevant behaviors in-session. In addition, the therapist monitors and when necessary, promotes generalization. These tasks are interwoven to produce FAP`s approach to the healing potential of a relationship.

While FAP was developed mainly as an approach to individual psychotherapy, there have been translations into group therapy (e.g. Gaynor & Lawrence, 2002; Hoekstra & Tsai, in press). The present paper presents one such translation. It suggests that, when properly understood, FAP necessarily leads to a type of group therapy that is pragmatically quite different from traditional behavioral group therapy. How could we describe this difference? Since its early days, behavioral group therapy has been distinguished by its teaching technology, including training activities and streamlined learning modules (e.g. Rose, 1977). Group therapies in the cognitive mainstream of behavior therapy (e.g. Free, 1999; Bieling, McCabe & Antony, 2006) tend to maintain this characteristic, through activities such as lectures and structured exercises. Even when, for example, exposure for social phobia is done in-session, the programmed teaching focus is maintained (Becker & Heimberg, 2002). When we apply FAP to the group setting, however, it comes much closer to Group Psychotherapy, which has often focused on unexpected experiences and outcomes (Yalom, 1975; Rutan & Stone, 1984). However, group FAP is not a compromise between these two traditions. The combination of a flexible focus on spontaneously evolving

interactions with a functional contextual approach to the healing nature of relationships adds a new dimension to group therapy.

The aim of the present article is to discuss how this dimension works. For that purpose, personal experiences in supervising FAP in group therapy will be described. These groups functioned as free-of-charge services for socially disadvantaged patients. First, some points of inspiration for conceptualizing the work in the groups will be presented. Then, it will be described in an informal way how a group can be transformed into a network of healing relationships. It will be shown how this can be done on different levels of analysis, namely that of long-term strategy, of in-session tactics and of moment-to-moment technique. Finally, the transformation of unplanned events into in-vivo learning opportunities will be illustrated with a series of short examples.

The chronic pain group experience

Our first group, described by Vandenberghe, Cruz and Ferro (2003) was formed at the initiative of the two latter authors with the intention of helping people referred from a nearby pain center. These were patients who did not respond to medical treatment for chronic orofacial pain. The group started in August 2001 as the first in what would become a long series of FAP groups for chronic pain (e.g. Vandenberghe, Ferro & Cruz, 2003; Vandenberghe & Ferro, 2005; Martins-Queiroz & Vandenberghe, 2006).

The evidence that chronic pain is in many ways related to stress (Melzak, 1998) prompted our interest in client behavior linked to the hustle and bustle of daily life and otherwise stressful interpersonal patterns. The choice of an interpersonal brand of behavior therapy like FAP permitted us to target these variables. The seminal work by Fordyce (1976) that defines pain as part of communication between people provided us with an operant view of pain behavior. The literature also sensitized us to other targets for treatment such as fear of pain (Vlaeyen, Kole-Snijders, Boeren & Van Eek, 1995; Crombez, Vlaeyen, Heuts, & Lysens, 1999) and catastrophizing (Turner, Jensen & Romano, 2000; Thorn, Boothy & Sullivan, 2002). Experiential avoidance (Luciano, Visdómine, Guthiérrez & Montesinos, 2001) attracted our attention as behavior to be targeted for change when we observed that in trying to control pain, the client gets locked in a permanent fight with the pain and more important life issues are not attended to, so that ever more stressful contexts are created (Martins-Queiroz & Vandenberghe, 2006). From a FAP perspective, we saw all of these (dealing with daily life hustles, communication through pain, catastrophizing, fear and experiential avoidance) as patterns that also occur in the treatment setting. And this meant they could be influenced in-vivo.

As the literature (e.g. Curran, Sherman, Cunningham, Okeson, Reid & Carlson, 1995) had led us to expect, a significant number of participants in the chronic pain groups reported histories of trauma. In many cases, these histories produced extensive repertoires for controlling negative sensations by means of avoiding interpersonal proximity. Kohlenberg and Tsai's (1994) work on the healing intimacy of the relationship served as a model for our trauma work, which centered on promoting intimacy among group members.

Soon, the burgeoning literature concerning the role of positive emotions in resilience and coping (Frederickson, 2000; Folkman & Moskowitz, 2001; Zautra, Johnson & Davis, 2005) provided us with new sensitizing concepts that were helpful in mobilizing client resources and working on emotion regulation. A focus on emotional awareness was already present in the 2001 group (Vandenberghe, Cruz & Ferro, 2003) and subsequent groups developed this focus by integrating formal mindfulness exercises (Ferro & Vandenberghe, in press) as well as acceptance and diffusion tactics (Martins-Queiroz & Vandenberghe, 2006).

The depression group experience

Early in 2004, a treatment group for depression was started up as a free community service in a disadvantaged suburb. Eight depressed women, who had responded to an ad in a local church newsletter, were selected. The group would meet two hours per week over six months (Oliveira & Vandenberghe, submitted).

Interpersonal psychotherapy and cognitive therapy furnished many of the ideas for the work. The interactional and interpersonal literatures describe relevant behaviors of depressed clients, such as inadequate reassurance-seeking, discouragement of other people`s helpful attitudes and inducing counter-productive reactions in others (Coyne, 1999), as well as issues, such as interpersonal conflicts, role transitions or interpersonal deficits (Klerman, Weissman, Rounsaville & Chevron, 1984). Interpersonal therapy emphasizes supporting the client in working out solutions to the problem areas identified as relevant to her depression.

We observed that this pragmatic approach to therapy tends to evoke the targeted problems in-vivo during the sessions in ways that can be dealt with using FAP. In the process of working out solutions together with the therapist and the other group members, the participant will often experience the same difficulties that underlie her interpersonal conflicts, and she will display the same problem behaviors that make it difficult for her to deal with changes or relate to people in daily life. For instance, when the group tries to help a member to stop discouraging people`s helpful attitudes in her daily life environment, she reacts in a similarly discouraging way to the group`s efforts. As another example, discussing the dysfunctional ways in which a client deals with interpersonal conflicts in other environments, can lead to conflicts between the client and the group members who are prompting her to change. This makes it possible for the therapist to influence the relevant behavior in-vivo.

Kohlenberg, Kanter, Bolling, Parker and Tsai (2002) lay out how the therapist using cognitive therapy can zoom in on how the client's problems occur in the interaction with the therapist. They also show how the latter can respond contingently to the relevant client behaviors. We started out by reframing cognitive group therapy protocol in terms of FAP tactics. For instance, cognitive restructuring in a group (White, 2000a; 2000b) often begins with the participants sharing the daily thought registers they filled out during the week, or by selecting a thought or belief that surfaced during the session. The group then gathers evidence for and against these thoughts or beliefs while the therapist facilitates interactions by throwing out questions such as: Are there other ways to look at this situation? Did anyone else experience something similar? How did you deal with it? At the start, the therapist leads the cognitive restructuring,

but gradually, participants learn to discuss more freely. This practice offers a great variety of in-vivo learning opportunities. While engaging in these group activities, participants will need to give and take criticism, obtain help from others, deal with conflict or stand up for their needs.

As another example, the traditional cognitive-behavioral way of using homework assignments offers in-group learning opportunities, both in the session in which the assignment is chosen and in the session in which the results are reported. When each participant chooses an activity for the week (White, 2000a; 2000b) based on an idea the group produced, behaviors that can be targeted for development include proposing an assignment, discussing and sometimes defending a plan and accepting suggestions from others. Reporting on completed homework often evokes relevant emotions in-vivo, and offers opportunities to learn receive and give criticism, to deal with others' evaluations and to publicly negotiate one's interpretation of the events reported.

The 2004 group (Oliveira & Vandenberghe, submitted) made intensive use of in-session activities and games to promote emotional intensity, to evoke the clients' problems during the sessions and to give them opportunities to deal directly with them. Some tactics described in the present article illustrate how this can be done. In many cases, one client's difficulties provided in-vivo learning opportunities for another client, as when one participant is excessively critical while another has difficulties in dealing with criticism. When this occurs, the therapist transforms the problem into a unique in-vivo learning opportunity for many group members at once by prompting both participants to give each other feedback and by asking other group members to give their bystander perspectives on what happened between the two protagonists.

How to transform the group process into FAP

Assessment. In the preliminary individual interview or during the first group sessions, therapist and client seek to understand how the client's daily-life goals and problems function interpersonally. They describe client behaviors that maintain problems and others that may help solve the problems and bring the goals closer. Both types of behaviors are defined in terms of their effects in relevant interpersonal contexts. Functional category sets like Callaghan's (2006a) Functional Ideographic Assessment Template (FIAT), which incorporates assertion of needs, bi-directional communication, conflict, self disclosure and closeness, can help in this task. The therapist uses a worksheet in which the target behaviors are specified, together with the entire caseformulation, as in individual FAP (Kohlenberg, Kanter, Bolling, Parker & Tsai, 2002).

Relevant client strengths and resources are identified because they help build new daily life repertoires. Reasons and explanations the client gives for his or her difficulties are also assessed because they can either prolong problem behaviors or facilitate changes. The client's learning history is a necessary aspect of the case conceptualization. It clarifies the functions that shaped the problem behaviors and explains why more adequate behavior did not develop. Therefore, it shows which classes of consequences are likely to reinforce these behaviors. Rounding out the case conceptualization, long-term treatment goals are set out for each individual participant and these are broken down into more specific

goals, so that during any session the therapist has a clear view of what learning opportunities would be relevant or what behaviors may be evoked and influenced.

The worksheets help therapists to quickly identify relevant events. They allow them to simultaneously attend to the often very different functions that similar behaviors of different participants may involve. For instance, criticizing another participant may be an in-vivo improvement for one client and an in-vivo problem behavior for another. Without the individual case conceptualization, the therapist will be at a loss as to which behavior to strengthen or which to block. On the other hand, observing the client's interpersonal behavior in-vivo will also provide clues to hitherto unidentified problem areas and thus furnish new information that must be written down on the worksheet. The therapist's actions to promote in-vivo change need to be based on a thorough review of the client's case conceptualization, which may need frequent revision.

With the help of a good case conceptualization for every individual participant, the therapist will be able to adopt FAP as a group strategy by organizing the context, structure and content of the sessions in such a way as to make in-vivo learning opportunities frequent. The consequences of behavior in-session must be examined to see if it belongs to the same functional class of behavior that contributes to the daily life problems the client seeks treatment for. FAP strategy also means monitoring reactions the client evokes in the therapist and in the other group members so that these can be used to shape relevant daily life repertoires.

Tactics. Throughout the course of therapy, FAP strategy unfolds through sequences of tactical moves. A tactic is a course of action taken by the therapist in order to promote a specific in-session goal. Tactics may be infinite in number, and they constitute an aspect of treatment in which the therapist can be highly creative

Introducing a contract that specifies rules is an example of how simple standard procedures evoke clinically relevant behaviors. A client whose instability creates problems in relationships and work environments may at first agree but then not comply. At the opposite end of the spectrum, excellent compliance may be expected from a client whose daily life problems are related to rigid rule following. Proposing a contract may offer opportunities to target behaviors such as expressing disagreement. Changing some aspect of the established contract can evoke behavior that is targeted for development, such as listening, negotiating, taking the perspective of the other into account, or standing up for one's rights.

The modeling activities often used in behavioral group therapy can be tactics for shaping imitative repertoires. Again, the client's case conceptualization will determine whether getting better at imitation is an improvement or the opposite. Also, discussing one's own performance after role play or imitation, giving feedback to other members or receiving feedback may be in-vivo learning opportunities for some clients.

Sometimes important improvements are too weak to affect group members and may be extinguished amidst the ongoing interaction. The best tactic in these cases is to fish those improvements

out of the stream of ongoing interaction and then allow natural reinforcement to do its job. For example, the first time Peter proposed a topic for discussion, he did so with so little enthusiasm that the group ignored him. The therapist said: "Listen to this. It's something different." Peter then restated his proposal more convincingly and the group adopted it.

Encouraging participants to give real-time feedback on the effects another member's behavior is having on them is a typical tactic to allow them to influence this behavior. When Mary provides irrelevant feedback because she is not good at picking up interpersonal messages or is not sensitive to others' behavior, the therapist can check with the other clients to see if the behavior under discussion affected them in the same way as it affected Mary. If this is not the case, Mary may use the others' answers as clues for improvement. As another example, when a group member gives accurate information in a hurtful way, the therapist can ask other participants how this way of giving feedback affected them. Hearing others' reactions to her treatment of a fellow group member turns the situation into a learning opportunity for her.

Techniques. Techniques are the therapist's habitual ways of acting from moment to moment throughout sessions. They are consistent ways of addressing what is happening. Their habitual nature can at times be recognized when therapists unwittingly use them in other settings, for instance when teaching classes. The main techniques of FAP include observing, evoking, reinforcing, blocking and extinguishing clinically relevant behaviors (Kohlenberg & Tsai, 1991). These will be briefly summarized in the following paragraphs.

The therapist observes clinically relevant behaviors and the effects of his or her own behavior on client behavior. In addition, the therapist observes group members' effects on each other. These observations are guided by questions derived directly from the worksheets, e.g., Is she reacting to the other participant's challenge in the same way as she reacts to her partner's challenges at home? What happened that led to this participant's increased expression of emotion? Are the consequences that the new behavior had in the group relevant for this particular client problems and goals? Is this class of consequences available in her daily life environment? Will this particular behavior lead to the same results in her daily life setting as it does in-session?

Evoking behaviors means acting in ways that make it more probable that the client will emit a target behavior. Most often, the therapist will prompt a behavior that was targeted for development, but in certain cases it will be necessary to prompt a problem behavior first to be able to create a learning opportunity. Also, one participant's problem behavior or in-vivo improvement often evokes behavior in another participant and chains of clinically relevant behaviors may occur in the group.

Reinforcing behaviors means reacting to client behavior in ways that will increase the probability of similar behavior happening in similar situations. The opposite technique, namely extinguishing a behavior, means withholding the relevant reinforcement each time the target behavior occurs. Extinction requires that the behavior is executed freely by the participant, but reinforcing consequences are prevented by the therapist.

Blocking can be defined as making it impossible for the behavior to be executed in a complete enough form to allow it to contact a reinforcing consequence. For instance, blocking can be done by interrupting the client, by confronting the client with the problems caused by that behavior or by insisting on an activity that makes avoidance or escape ineffective. Blocking is more complex in the group setting than in individual FAP. One client may facilitate another's inadequate behavior. When this happens, the therapist needs to consider the case conceptualization of both participants. The skillful interruption of the counterproductive sequence should happen by prompting more adequate alternatives, thus creating in-vivo learning opportunities for both participants.

As can be seen, there exists no one-to-one relation between tactics (which we defined according to their topography) and techniques (which were functionally defined). When the therapist shares his or her thoughts or feelings, this may punish, reinforce, evoke or block clinically relevant behavior. Proposing a change in the contract may weaken problem behavior for a client who rigidly insists on following rules. Alternatively, it can reinforce improvement, as when it is the therapist`s response to a client who asserted needs that were not being met under the prevailing arrangements.

Discussion

Why use groups for doing FAP? The above examples of in-vivo learning opportunities illustrate that the group may offer a higher density of learning opportunities than would individual therapy. Core aspects of the participants' daily life problems may pop up quicker in the interpersonal micro-cosmos of the group because of the great variety of challenges inherent in having to deal with a variety of people. Also, a broad variety of any particular class of clinically relevant behavior is bound to be evoked in a group. And this provides richer opportunities for responding contingently to this behavior.

Why use FAP when working with groups? A group is an ideal environment to observe our impact on others and, if needed, to try something different. It is a real-world environment in which participants deal with the therapist and other group members as real persons in real relationships. The complexity of these challenges makes it hard for daily life problems not to be evoked. And when they are evoked, with their can we let the opportunity for promoting change go by unused? These characteristics of FAP continuously invite an in-vivo interpersonal approach in which conditions favorable for influencing clinically relevant behavior are present. All group members, not only the therapist, can share the effects that others' problem behaviors and improvements have on them, creating richer feedback loops than are possible in individual therapy, and making all participants, to a certain extent, each other's therapists.

Future directions

A specific conceptualization of functional analytic group therapy has been described. To evaluate whether it is a useful addition to the existing stock of functional analytic group approaches (e.g. Gaynor & Lawrence, 2002; Hoekstra & Tsai, in press), its strengths and weaknesses will need to be determined. The present paper represents a first step in the construction of a principle-driven protocol that defines the match between client problems and target behaviors on the one hand and strategies, tactics and techniques on the other.

The first item in the future protocol must prescribe the development of an individual case conceptualization for every candidate, based on pre-group assessment. Even knowing that this conceptualization will continue evolving during treatment, the group must start out with a thorough case formulation for every client. This is needed, not only because a good preliminary case conceptualization will allow the group leaders to select participants, but also because the therapist must from the start avoid reinforcing client problem-behavior and weakening in-vivo improvements. Starting with a new group is a challenging situation for many clients. It typically evokes some of their daily-life problem patterns, but by the same token, it also offers valuable in-vivo learning opportunities. Without a good case formulation, the therapist may miss these initial opportunities. He or she will lack the needed direction to decide how to respond to the client's behavior in the first group sessions. The established FAP assessment procedure for individual therapy (Kanter, Weeks, Bonow, et al., 2008) may serve as a model for preparing the individual case conceptualization. As has already been pointed out, Callaghan's (2006a) FIAT can be used to identify and categorize the often complex interactions that will be included in it.

Further, the protocol will need to specify tactics and techniques. How these match client problems and target behaviors will need to be operationally defined. A list of the most frequent tactics and their targets must be established, based on existing experience with FAP groups. This may be done, for instance, by submitting a large number of session recordings to open categorization. Good exemplars of tactic-goal dyads will need to be chosen to serve as inspiration for the therapist. The list will necessarily be limited in relation to the probably unlimited variety of possible tactics. An example of a tactic in the present paper is to fish weak improvements out of the stream of group interaction in order to have the group respond contingently to them. Another example is to change an item in the group treatment contract in order to evoke reactions in a rigidly rule-following participant. More important will be working out criteria for devising tactics that match target behaviors.

Traditional FAP rules provide guidance in matching techniques to targets (Kohlenberg & Tsai, 1991). The present article also describes how observing, evoking, reinforcing, extinguishing, and blocking can be done in a group session. But to draw up a group therapy protocol, more operational rules that describe the match between each technique and its targets in more detail need to be prepared. Up to now, clinical rules of thumb have worked well in deciding, for instance, which behavior is to be extinguished and which is to be blocked. However, research can help establish the criteria that best define the ideal client behaviors and situational conditions for each of these techniques.

At the level of general FAP strategy, treatment integrity implies the group must offer a context that makes tactics productive. It must promote the deployment of tactics throughout the sessions. Each tactic used must be related to the creation and/or productive use of a specific in-vivo learning opportunity. At the technique level, treatment integrity will depend on matching target behavior with the prescribed contingent responding by the therapist. Each client's individual case conceptualization will serve as the touchstone for deciding whether that particular client's in-session behavior is to be strengthened or weakened. When scrutinizing session recordings for treatment integrity, Callaghan's (2006b) Functional Assessment of Skills for Interpersonal Therapists (FASIT) can be used to classify techniques into categories of therapist behavior and break strategies into functionally defined skills so that their adequacy in relation to the client target behaviors can be directly evaluated.

Evaluating the effect of treatment will also require an idiographic approach. At the end of treatment, the behaviors targeted for development in the client's case conceptualization need to have become sufficiently frequent and to have come under sufficient situational control to affect the client's daily life problems. A new assessment using the FIAT categories will make it possible to check if these changes have occurred. In addition, the client's subjective evaluation of the changes in his or her daily life, resulting from what was learned in the group will help determine treatment effectiveness.

An empirical question concerns the criteria by which the preliminary case conceptualizations should inform the allocation of clients to a group. The 2004 depression groups (Oliveira & Vandenberghe, *submitted*) were homogeneous as far as the functional categories targeted in their case conceptualization were concerned. Similar behaviors, such as interpersonal approach and bi-directional communication, were targeted for development in all participants. The clients' case conceptualizations singled out similar behaviors to be weakened, e.g. passive avoidance behavior. The groups' presenting problems, gender and background were also homogeneous. In contrast, the first pain groups (Vandenberghe, Cruz & Ferro, 2003; Vandenberghe, Ferro & Cruz, 2003) were exceptionally diverse on all these dimensions , although all participants presented a chronic pain component and a number of participants were abuse survivors.

A clinical hunch worth investigating is that homogeneous groups are more straightforward to conduct and will therefore be more effective. Homogeneous groups aid the work of the therapist because the same type of challenges will be in-vivo learning opportunities for all group members. Setting up this type of group allows the therapist to evoke and strengthen similar clinically relevant behaviors in different participants simultaneously. More effective planning on the part of the therapist may be possible and tactics will affect all participants in similar ways. On the other hand, a group of people who share the same interpersonal deficits and the same difficulties in relating to others is often difficult to get going. The therapist often needs to be more active and provide more challenging activities to overcome the resulting inertia (Oliveira & Vandenberghe, *submitted*).

However, we have observed that heterogeneous groups are more dynamic. They tend to demand less complex strategy and fewer tactical interventions from the therapists. The participants tend unwittingly to create a greater density of in-vivo learning opportunities for each other through their clashing interaction styles. Groups with more diversity also tend to produce more and richer feedback on in-session problem behavior and improvements. On the other hand, a participant may provide a more deeply meaningful response to the clinically relevant behavior of another participant with whom she shares relevant life experiences. The question may thus turn out not to be whether homogeneity is preferable to heterogeneity but rather which of these is preferred under particular conditions and on which dimensions homogeneity and diversity should be considered. Research will be needed to determine which criteria for constructing groups should be included in the future protocol.

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