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Functional Analytic Psychotherapy (FAP) for Cluster B Personality Disorders: Creating Meaning, Mattering, and Skills

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Abstract

There are ten identified personality disorders, broken into three clusters: A, B, and C. Individuals with a cluster B diagnosis may demonstrate marked displays of emotional instability, erratic and disruptive patterns around interpersonal relationships, a myopic and restricted range of affect, a pronounced lack of empathy and insight, barriers around the ability to take the perspective of others, and extensive challenges related to effective communication. Functional Analytic Psychotherapy (Tsai, Kohlenberg, Kanter, Kohlenberg, Follette, & Callaghan, 2009) is a contextual cognitive behavioral therapy that focuses on the importance of developing effective interpersonal skills via the therapeutic relationship, and posits that contingent responding by the therapist to in vivo client problems and improvements provides the mechanism for change in psychotherapy (Tsai, Kohlenberg, & Kanter, 2010). Although termination and poor reported outcomes are problems of particular importance and impact in working with clients with an Axis II diagnosis (Hilsenroth, Holdwick, Castlebury, & Blais, 1998), there is evidence that behaviorally-oriented techniques can improve clinical practice with regard to personality disorders (Nelson-Gray, Lootens, Mitchell, Robertson, Hundt, & Kimbrel, (2009). This article is a brief summary discussion around the application of Functional Analytic Psychotherapy in the treatment of cluster B Personality Disorders.

Keywords

personality disorder; Axis II; behavioral health challenges; cluster B; personality disorder treatment; treatment interventions, clinical strategies, narcissistic personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality disorder; therapeutic alliance, therapeutic relationship, Functional Analytic Psychotherapy

INTRODUCTION TO CLUSTER B

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision* (DSM-IV-TR) (American Psychiatric Association [APA], 2000), the standard nosology for diagnosing psychopathology and related conditions, there are ten personality disorders classified on Axis II, with individuals identified under the broad umbrella of these disorders sorted into one of three sub-categories, or "clusters." These groupings are delineated as clusters A, B, and C, and although the categorization into sub-types provides the framework for differing symptom pictures, personality disorders are a complex and fascinating class of diagnosis (Fowler, O'Donohue, & Lilenfeld, 2007), and as a whole are among the more controversial and problematic within the diagnostic manual (Widiger, 2007). Individuals with cognitive, affective, and behavioral features related to the diagnosis of a personality disorder have deeply ingrained and pathological patterns of thoughts, feelings and behaviors that can be traced back to adolescence or early adulthood (Kraus & Reynolds, 2001); yet the body of empirical literature is scant when it comes to scientific investigations of how to treat these long-standing, characterlogical disorders found on Axis II (Callaghan, Summers, & Weidman, 2003). Notably, premature termination and poor reported outcomes are problems of particular importance and impact in working with patients diagnosed with a personality disorder (Hilsenroth et al., 1998).

There is general consensus that individuals with disordered personalities demonstrate pervasive and extensive interpersonal difficulties. Further, maladaptive and inflexible patterns of interacting with others can lead to functional impairment (APA, 2000). Due to space limitations, discussion within this paper will be specific to features of individuals with diagnostic patterns related to cluster B, which includes the diagnoses of Borderline Personality Disorder, Narcissistic Personality Disorder, Histrionic Personality Disorder, and Antisocial Personality Disorder. These cluster B "dramatic" personality disorders are all associated with pushing boundaries (Bender, 2005), and as such, clinicians must develop effective clinical formulations and make decisions on how to work with patients within the context of their particular personality organization and style (Kraus & Reynolds, 2001). The cluster B client, who may present with tendencies toward chronic self-harm, theatrical engagement in conflict, labile emotional states, dangerous antisocial sociopathy, or hyperbolic and intense displays of cognition and affect, can be challenging to manage clinically because their behaviors of interest are intrusive across domains of life functioning, including during the therapy session.

FUNCTIONAL ANALYTIC PSYCHOTHERAPY

Functional Analytic Psychotherapy, FAP (Tsai et al., 2009), is a contextual cognitive behavior therapy with roots in radical behaviorism. Briefly stated, FAP is a behavioral treatment that

utilizes the therapeutic relationship to improve interpersonal difficulties (Nelson-Gray et al., 2009). FAP therapists endeavor to create vital, organic, meaningful, and dynamic therapeutic alliances (for an interpretation of FAP therapeutic alliance see Tsai et al., 2010) that progress and expand based on the therapist's conceptualization of the client's in-session behaviors, or clinically relevant behaviors (known in FAP terminology as "CRBs"). FAP conceptualizes that the mechanism of change occurs within the context of the therapeutic relationship, as the therapist shapes the client's CRBs via the process of contingent responding. The therapist pays careful attention to the communication patterns that the client exhibits, focusing on excesses and deficits in the client's interpersonal repertoire; and through the establishment and maintenance of the alliance formed via this therapeutic relationship and communication exchange, comments contingently upon the occurrence of CRBs in an effort to mold more useful skills and interactions.

Because personality disorders are associated with significant impairment in interpersonal relationships, special issues and problems arise in the formation of a therapeutic alliance in the treatment of individuals with these disorders (Bender, 2005). FAP assumes that the interpersonal problems that clients have in relationships outside of therapy will also occur in the context of the therapeutic relationship (Callaghan, Follette, Ruckstuhl, & Linnerooth, 2008), and that the same features that led the client to seek treatment will inevitably intrude into the treatment itself (Hilsenroth et al., 1998). Particular attention is given within FAP in conducting a functional analysis of the client's problem behaviors, by detecting and organizing these behaviors into classes of interest. From a FAP theoretical framework, there are five core classes of interpersonal skills from which FAP therapists identify CRBs. (Due to space limitations please see Callaghan, 1998, for further discussion of these classes). Given the complexity and salience of CRBs in the cluster B client, FAP may be of assistance with this population as it has been hypothesized that identification of problematic response classes and the use of functional analysis techniques are likely to maximize success with this challenging population (Nelson-Gray et al., 2009).

A fundamental practice of FAP is the identification, reinforcement, evoking, and shaping of CRBs with the goal of practicing emergent behaviors in session that the client can then generalize into their outside life. Discussion of CRBs is at the core of the client change agenda, and because clients with cluster B characteristics have repertoire or motivational deficits in areas important to good interpersonal relationships (Callaghan et al., 2008), the practice of "evoking" or stimulating in-session discussion around CRBs is essential to effective practice of FAP. For classification purposes, these in-session client problem area CRBs are delineated in FAP shorthand terminology as "CRB1s"—or clinically relevant weaknesses. In-session clinically relevant strengths or improvements are termed CRB2s in the vernacular of FAP. The FAP therapist assists the client in developing and maintaining CRB2s in the interpersonal domains with which they are struggling and to reduce the usage of CRB1s. A final type of clinically relevant behavior is the CRB3. CRB3s are functional interpretations of the client's problem and improved behavior that are specific to identification of the variables that gave rise to, and are responsible for, sustaining these behaviors (Callaghan et al., 2003).

Early on in therapy, the FAP therapist assists the client in detecting and recognizing their CRB1s and CRB2s; and works to simultaneously expand and reinforce the client's approximations of CRB2s while working to consequate the behaviors falling under the CRB1s category. Examples of CRB1s are context dependent, and specific to the client, but might include for example, that the client frequently interrupts the therapist, has a high level of self-involved talk to the detriment of the listener, gets stuck in redundant "story telling" at the expense of subjects they are avoiding, or tells the therapist defiantly upon intake that "I fired my last therapist so you better do a good job." All of these behaviors function to create barriers to communication with the therapist and are illustrative of how the client comports themselves in other life domains. Conversely, CRB2s are also specific to client and context; and as an example, perhaps a client asserts an opinion in session when usually it is problematic for them to do so. In this instance, the behavior of speaking up is a CRB2, or relevant strength or improvement that is emerging. It is important to note, however, that the same behavior would be a CRB1 for a person who presented to therapy with an aggressive verbal stance and frequently makes antagonistic statements to the therapist. The FAP stance here is that such hostility most certainly occurs in other domains in their life and functions as an impediment to communication, and therefore is a behavioral excess, and a target for change, or CRB1.

The core assumptions around client change within FAP is laid out for the cluster B client early on by the therapist in what is known as the "FAP rap," which outlines the central thesis that the CRB1s the client experiences with the therapist within the therapeutic relationship are most likely the same issues that have arisen for them in their "outside of the room" world. For example, a client may arrive to therapy with issues related to marital discord. The person might report that he is very depressed and that his marriage is failing because he and his wife cannot communicate. The therapist might notice that while he is discussing this content area and he is asked questions for clarification, he cuts off the therapist, is tangential, makes condescending facial expressions, and seemingly ignores feedback. A fifteen minute sample of this behavior would be fruitful for the therapist to note that it is most likely relevant to the client's marital and/or relationship issues in general and is indicative of the client's difficulties with emotional expression, bidirectional communication, and challenges with interpersonal closeness.

CHOOSING CRB1 DISCUSSION WISELY

To assist the FAP therapist in deciding how to organize cluster B client problems and repertoire concerns, the therapist can apply the concept of a "virtual reality" *Therapeutic Bubble* (see figure on page 120) that is conceptualized around the therapist and the client, within a "therapeutic space" that is spatially contained and dependent upon cooperation and movement by both parties, in a sort of seesaw manner, with willingness as a fulcrum. The seesaw is a metaphor for the alliance between the FAP therapist and client in that the "seesaw" is the therapeutic relationship as the dyad engages in communication. This metaphor underscores the process of give and take in effective

communication and highlights the necessity of the therapeutic bond when working with cluster B clients. It also reminds the therapist that the process is a collaborative one, despite clients who may present with puzzling and perplexing confluences of behavior. Individuals within cluster B have broad and eclectic concerns, and can exhibit a scope of behaviors ranging from narcissism and self-absorption to potentially dangerous actions and suicidal and homicidal ideation. The therapeutic bubble is a focused framework that directly addresses the struggles some clinicians may feel sitting in the room with a cluster B client. Specifically, the cluster B client can feel "overwhelming" to the therapist via therapy interfering behaviors and/or a bulk of content topics that are "dumped all at once" on the therapist. To counteract the sense that the cluster B client is "taking up all the space in the room" via their behaviors and communication style, and or resisting/manipulating, or avoiding--the FAP therapist can invoke the Therapeutic Bubble to envision from their point of view a virtual reality "dashboard" that appears on both the right and left sides of the client, as well as to the right and left side of themselves, with running lists of ideas and concepts related to the client's clinical targets and potential therapist relevant behaviors. This process underscores the complexity of content (or "story") the cluster B client presents, and invites a context of movement toward active choices on the part of both individuals, and an organic but directive flow of communication.

As outlined in the Therapeutic Bubble diagram on page 120, the FAP therapist can imagine a virtual running list of "content areas" that they are targeting with the client, e.g., substance abuse, anger, etc. (symptoms and habits and diagnoses, etc.) to the right of the client, and a floating list of CRBs to the left of the client. This type of "virtual reality" case conceptualization aids the therapist in characterizing every turn of conversation that occurs in the room, and to carefully craft contingent responses that increase the utility of interactions. Cluster B clients can manifest a bewildering array of behaviors, so for proactive motives the therapist must be aware of their own clinically relevant behaviors as well and can visualize over to the left of themselves a list of therapist clinically relevant weaknesses and strengths (TRB1s and TRB2s). These TRBs can be client specific; and/or related to more "meta TRBs" with respect to the clinician's behavior across clients and even with regard to relationships in their own lives.

Finally, to bolster the sense of momentum and strategy in the FAP session, to the right of themselves, the therapist can imagine what is called "the *Shelf*." The Shelf is important because it is here where the therapist makes decisions to either evoke (attempt to bring forth) or block (punish) a CRB1. The therapist does not want a bulk of information "left on the shelf" as if it is "on the shelf," it is therefore not being processed via FAP techniques and strategies and therefore not subject to feedback, shaping, and change. However, the therapist does not desire to dump the entire contents of the shelf on the cluster B client at once because it is potentially aversive and alienating. The cluster B individual may be hypersensitive and defensive, and as such, the shelf is the virtual area where the FAP therapist can choose wisely what leads in terms of CRB content and what CRBs to evoke, reinforce, and/or punish.

Notably, having a sense of "the shelf" helps the therapist balance the placement of feedback in an idiographic (client specific) manner, per the client's repertoire (and the therapist's), and as per their case conceptualization. The therapist can titrate the CRB1s in and weave them, "pulling" (setting the stage) for CRB2s as they go. The shelf helps the therapist avoid "dumping too much" on the client, while still supporting the therapist's case conceptualization and processing of targets. The shelf holds the CRB1s that are "in queue," and provides a virtual reminder for the therapist that the CRB1s need commentary. For example, if the therapist has a TRB1 around discussion of sexuality, and finds themselves avoiding discussion of the topic and relegating it to the shelf, the process of noticing this avoidance or lack of skill set on the part of themselves is a reminder that the issues are relevant and intrusive for the client, and that the therapist is doing the client a disservice if they do not attempt to bring the issues to light for discussion. Being aware of TRBs can encourage the FAP therapist to seek consultation and training.

PAGE 120 IS AN EXAMPLE OF A THERAPEUTIC BUBBLE FOR AN AXIS II CLUSTER B CLIENT

It is not an understatement that the client's CRBs are incredibly germane to their current state of distress and most likely, their historical issues. The FAP therapist is aware that the onus in on themselves to be willing to address CRBs in a competent and caring manner, and to titrate information that is both sensitive to capitalizing on the value of the client's time, but balanced by not pushing them just for the sake of pushing or dumping too much in a way that is ineffective. This process is essential to the craft of practicing FAP artfully and with direction. A core component to an effective Therapeutic Bubble is a thoughtful analysis of CRBs based on FAP response classes. An overarching FAP case conceptualization is developed based on these five repertoire classes and is the guiding formulation by which the majority of the Therapeutic Bubble is conceptualized and FAP therapy is conducted. As such, the Therapeutic Bubble provides a framework that captures the essential elements of the intervention in a cohesive way.

ESTABLISHING A THERAPEUTIC RELATIONSHIP WITH INDIVIDUALS WITHIN CLUSTER B

Cluster B individuals can present with unstable relationship patterns that are typified by the propensity to seek attention, a carelessness with others, a pervasive, prevalent, and long standing history of social punishment, and a distorted lens around receiving and accepting feedback. Cluster B clients can possess the sense that they are "extraordinarily special," present with CRBs from multiple classes, and can have difficulties understanding and receiving feedback. They may trigger the therapist via transference through provocative, deviant, or outlier behaviors. These behaviors can be extremely aversive and have been negatively reinforced and strengthened over time through consistent use and a rising imperviousness to shaping. A central facet of FAP is identification and strengthening of CRB2s, however, with cluster B clients, this process can be daunting.

Rapport building with individuals who fall under the cluster B umbrella starts with "capturing their attention." For many clients outside those with disordered personalities, the therapist is

THE THERAPEUTIC BUBBLE

In session CRBs
(Clinically Relevant Behaviors)

CRB1s (Weaknesses) (examples)

Unable to identify needs
Excessive acquiescence

Rejects feedback

CRB2s (Strengths) (examples)
Open range of emotion
Highly verbal
Good eye contact

****Remember to comment on instances of**
→ Client reports of CRBs "outside of session"

O1s (example—blew up and fought with boss)
O2s (example—chose to be emotionally vulnerable with wife)

Case Conceptualization
Treatment Targets

For example:
Depression/ substance abuse
Exhibits some bipolar features, specifically mania

Has some chronic health issues
Marital discord, issues at work, no friends
Inability to identify values
Fused with negative self thoughts
Issues with tolerating distress and regulating emotion

***Above I conceptualize both traditional targets as well as contextual targets e.g., lack of ability to tolerate distress, emotionally avoidant, fused with negative thoughts about childhood, etc.**

In session TRBs
(Therapist Relevant Behaviors)

TRB1s (examples)
Difficulty evoking when client is silent
Difficulty giving feedback around certain topics
Issues keeping clients on topic
Avoidance of certain topic areas
TRB2s (examples)
Earnest, directive
Can ask for interpersonal closeness
Models vulnerability
Good instances of self disclosure

"On the Shelf"

(Based on conceptualization—things held off on; but then titrated in organically)

Examples:
Client states "I want a perfect life" (hyperbolic)
Client notes "Everyone is out to get me" (paranoia)
Client appears to be editing some topics but it is unclear at this point why
Client shrugs off praise
Client minimizes blame for themselves and maximizes blame for others
Client won't take responsibility for their own actions

already primed to be a salient and potentially reinforcing stimulus, as they come to therapy with a direct plan for change in their life. Notably, the cluster B individual may not reflect whatsoever upon the therapist and see therapists as interchangeable objects and have no plan for change. They may have had multiple therapists and have found repeated frustration with their attempts at "therapy." Further, the therapist may have the sense that the client is speaking *at* them instead of *with* them, or telling tangential stories with long involved "reasons," with tendrils of righteous indignation rather than meaningful conversation that involves taking turns. The cluster B client may interrupt the therapist and tell them that they are "wrong," or comb over minute details that the therapist says in an effort to "catch them in a lie," e.g., "I never said *that*, I said *this*." All of these behaviors function to create interpersonal distance with the therapist.

Beginning to build hypotheses around ways to establish the therapist as a different and relevant stimulus is vital during a FAP intake. Traditional ways of building rapport often do not work with cluster B individuals because of the repertoire problems noted above. In general, with regard to the treatment of individuals with personality disorders, clinicians need to consider the patient's characteristic way of relating in order to select appropriate interventions to effectively retain and involve the patient in treatment (Bender, 2005). History gathering with Axis II cluster B clients can be an exercise in futility or frustration. It may be characterized by storytelling and can function in session to feel like the client attempting to garner attention or control and/or to gauge the depth of the therapist's willingness to sit through such demonstrations. It is important to note that there may be an honest lack of insight about these behaviors in a subset of cluster B clients and an inaccurate impression, or *tact*, on the client's part that they are "working hard to be real with you." However, the opposite is true with a portion of cluster B clients who are calculated and formulating plans with which to manipulate the therapist. They may ask intrusive personal questions, make sexual innuendos, or remain steadfastly silent with a fixed and angry mask. These clients may draw borders around topics, indicating "I'm never going to talk about topic X so don't even ask," or insist that they are "different and special and that their story is a case study in abnormality," or tell you that they "like to think that they are offering themselves for you to study so that their case can further the state of the field of psychology." Given such hyperbolic utterances, the FAP therapist must make instantaneous decisions about what potential CRBs are at play and act accordingly to establish themselves as someone who will react differently and contingently than the individual's social environment. It is of further note that a subsection of individuals identified on cluster B, specifically individuals presenting with features of Antisocial Personality Disorder, may be dangerously non-interested in *any* change agenda, and working an agenda antithetical to true progress. The FAP therapist must be aware and cognizant that social reinforcement and punishment are *not* always salient to every client seated in front of them. It is a grave mistake to believe that all individuals respond in a manner consistent with behavioral shaping, or that all clients automatically are primed to find the therapist's feedback meaningful to them. If the FAP therapist senses that APD spectrum features are present, it is prudent to be alert to discerning, and responding contingently to, the therapist's perception of what the client's true agenda is. Care must be taken to discuss these matters safely and competently. The author is presently preparing another paper on this topic.

INTAKE SESSION: INTRODUCING THE "TWO PLATES" STRATEGY AT INTAKE

Traditionally across psychotherapy modalities, intake sessions can be heavy on gathering historical content. However, the cluster B client may take this opportunity to go on a long diatribe about various content areas in their lives and history. If unchecked, this endeavor can take up a large portion of the session time and lack direction. It is important in a FAP intake to get the broad strokes around historical issues, but weave the session topics in such a way to get a concrete and immediate sense of what interpersonal issues the person is struggling with in the "here and now." The FAP therapist need not "hear *about* it" they need only to witness the client's in-session behavior to make hypotheses around what types of issues the client is struggling with. In this manner, the client is *showing*, not *telling*; and this information is much less edited and more organic than the heavily practiced and emotion laden content areas. For example, the cluster B client may present and say "I'm depressed and I hate my boss." One strategy for traditional treatment intervention might be to then "climb into the content matter," with questions around work and what the depression "looks like." Those questions are important and should be asked. However, strategically, the FAP therapist would be also paying attention to the *delivery* of this content. Perhaps it is punctuated with swearing, aggressive body language, and a swaggering attitude that does not exude vulnerability and sadness; but rather distain. The FAP therapist might then be considering what sorts of CRBs are contributing to a) the client's depression and b) the client's work environment—which of course are interrelated. The FAP therapist might then, based on this information, instead of continuing to hear multiple stories about work, switch gears and ask something like "I'm wondering what part of your issues at work are related to things you are struggling with in other areas of your life." The cluster B client then understands experientially that the therapist will hear content and "roll it into" discussion about interpersonal issues. This primes the FAP client early for a) discussion around communication patterns, b) learning insight around and taking responsibility for their part of interactions, and c) sets the stage for a therapy that encourages client discrimination of issues and how they participate in maintaining problem areas via their communication patterns. Here, therapy-continuing questions are molded around the client's responses rather than asking another for another example about content areas.

This manifests in a FAP session via the "*Two Plates*" strategy, whereby the therapist is poised and listening to the client, aware of potential CRB1s and CRB2s, and upon the occurrence of a CRB1, comments from the perspective as if they are metaphorically holding two plates with verbal content in front of them, one in each hand, prepared to "hand them over" to the client, one after the other concurrently. For example, the "right-handed plate" (or *reinforcing* and *evoking* plate) might sound like, "You know, I appreciate that you are telling me that you are trying to

hear what I am saying, and I see your eye contact and body language that indicates you are listening. (These statements function to alert the cluster B client that the therapist is paying very close and detailed attention to them. It will automatically call their awareness to the therapist's words because of the nature of their issues around self). (Now the therapist switches to the "other plate" –the left plate (*FAP CRB1* and *ask for change*)—"And, I wonder if also you notice that you tend to shrug your shoulder and look down when I try and offer a compliment to you?" "I wonder if you are having a hard time hearing my praise?" (Therapist has established that they will be noticing and commenting on client behavior, but the therapist choses a CRB1 that is hierarchically not the most intimidating or potentially aversive to hear. This exchange is meant to simply set the stage for many long chains of "Two Plates" in the future, when much more salient and potentially disruptive CRB1s will be attended to and commented on. The FAP therapist then "switches plates" again by pulling for, (or asking for through contingent responding) for a new and alternative behavior, (e.g., a CRB2) "I'd love to give you feedback and have you accept it in some manner without shrugging it off, perhaps either sitting and hearing it, or acknowledging it verbally, what do you think?" (Here, the FAP therapist is checking in with the client to see if they are willing, and offering an alternative behavioral choice). Often client behavior is habitual, like the shrugging, so this can take time. Any approximation of willingness or attempt to try is reinforced.

It is important to note that after a "two plates" discussion, the cluster B client might either agree with the therapist, or vehemently disagree. At this juncture, the FAP therapist must avoid falling into the trap of arguing with, or attempting to change the client's perception; but instead comment on the process--for example--"I like that we can really 'go there' in here." (This systematically points out to the client that there is an assumption on the part of the therapist that the dyad can go to difficult emotional places. This can establish that the therapist does not see them as a "broken person" but one that is *capable*, and finally, and very importantly, it sets the tone and tenor for a therapeutic process that will continually push the envelope and ask for change; and in effect, challenges the client to be willing and proves that the therapist will not be deterred from the task they described in the FAP rap). This is a profound way to begin a relationship with someone who most likely has significant interpersonal issues. The traditional ways in which rapport is built may be less effective with cluster B clients. The therapist must establish mattering about the process first and be ready to reinforce behaviors that are alternative to CRB1s.

THE CHALLENGES WITH ADDRESSING CRB1S WITHIN THE CLUSTER B POPULATION

A central FAP target when working with individuals with cluster B diagnoses is increasing *capability*. The true cornerstone to psychological health is a capability in interpersonal relationships. The therapist for example, may find that some clients are simply incapable at intake at conducting communication exchanges at a fluid and successful level. Their CRB1s may be serious enough that they are experiencing pervasive and long term relationship patterns that are toxic in nature and leave them feeling empty and depressed, or drug seeking to avoid the emotional pain. Setting up the client to succeed would include attempting to build capability, as often repertoire cliffs (discrimination errors based on excesses and deficits) are very steep. The cluster B client may not be able to make intuitive leaps as to the "how" of this process. FAP identifies at the level of theory and technique how to increase repertoire strength and scope by attending to therapy interfering CRB1s courageously and zealously and endeavoring to cultivate and nurture CRB2s. The FAP therapist crafts a case conceptualization, and in doing so, finds a "true north" and can stick to it experientially, even in the face of sessions that can be sometimes ripe with intense and/or aversive behaviors on the part of the client.

A preliminary strategy for the FAP therapist to prepare to tackle CRB1s with cluster B clients occurs before the client is even in the room. This means embracing and understanding that CRB1s are dysfunctional coping strategies on the part of the client, and that no matter how undesirable and destructive, they are representations of how the client fosters meaning in their lives and how they have "survived emotionally." It is from this stance profound and sustained empathy for cluster B challenging clients can arise, and the "voodoo that they do" can be understood through a lens of compassion. The intense and detrimental CRB1s that are barriers to therapy can be hypothesized as long term coping skills that are ineffective, rather than as triggers for therapist frustration and burnout. At the very least, the client CRBs are unproductive; and blocking them from getting their needs met within interpersonal relationships. At the other end of the spectrum, behaviors can be dangerous boundary violations and demonstrate a complete disassociation from a synthesized sense of self. No matter where they manifest on the continuum, CRB1s can be handled via a combination of brave, active, and attentive observations on the part of the FAP therapist. However, again it is of import to note that behaviors falling as outliers related to sociopathic and manipulative designs on the part of the client must necessarily be of note to the therapist, who must be tracking how the client is functioning on them and aware of the client's potentially dangerous agenda. Consultation with advanced FAP practitioners is advised in these situations.

LEADING WITH CRB1S IN THE CLUSTER B POPULATION

FAP is practiced with varying strategies in terms of technique, depending on the idiographic needs of the client. There is no set formula. For some clients, it may be prudent to focus on CRB2s primarily, and then to begin to bring the discussion around to CRB1s. For cluster B clients, there is an argument that beginning with CRB1s in an effort to "clear the room" is crucial and necessary. For the majority of cluster B clients at intake, the instances of CRB1s are often very predominant. If the therapist is not completely prepared in a stance of attention, they can find themselves distracted by the client's affect and storytelling. In this situation, if no parameters are set up early, the tone and tenor of therapy can be stalemated before it even begins. The therapist may be stymied by the client's interpersonal impediments. Notably, in these situations it is impossible to progress fruitfully.

However, sometimes discussing CRB1s can be a difficult task for the therapist. Within cluster B individuals, the client's CRB1s may range on a spectrum from simply therapy interfering (e.g.,

the client who repeatedly says "I don't know,") to CRB1s that are dangerous (e.g., the client who tells the therapist that they hate them and wants to harm them.) Cluster B client CRB1s are often apparent during most every utterance and the therapist may find themselves distracted by content. Certainly, clients who fall outside the range of Axis II demonstrate the above CRB1s as well. However, the level of intrusive and negative interpersonal excesses and deficits is amplified and ubiquitous in the cluster B client.

What is most at risk to the FAP therapist if you do not comment on CRB1s early on in therapy with cluster B individuals is that you risk negatively reinforcing the behavior (most likely like the rest of their world does). If the therapist does not block CRB1s fairly immediately as they arise, and simply waits for instances of CRB2 behavior and then reinforces it, the experience from the perspective of both parties can feel "really slow." The cluster B individual might ask "Why didn't you bring this up before?" or be so lacking in insight that when the therapist reinforces a CRB2 they are unaware that they are even being reinforced and have no context in terms of how to take that feedback, or even why they should care. Further, unless the therapist outlines for the client through a really concise FAP rap e.g., "what we are doing in here," it can sometimes take cluster B clients a lengthy time to even emit a CRB2 at all. If a FAP therapist avoids commenting on CRB1s, or ignores them in hopes that avoidance will function on the client as punishment and thereby extinguish the behavior (this might work in other populations but cluster B clients are often particularly insensitive to social punishment), they are avoiding commenting on behavior that is interfering with the client's ability to develop and maintain meaningful relationships. The FAP therapist must understand as well that the use of an amplified "two plates" technique is crucial and imperative at this juncture. Meaningful attention to CRB1s *must* be accompanied by asking for alternative behavior and then reinforcement of such attempts (differential reinforcement of alternative or other behavior). This strategy is critical because commenting on CRB1s may be seen as punishment, so the therapist must be prepared for long strings of a) evoking CRB1s, b) commenting on CRB1s, c) asking for CRB2s, and then d) reinforcing approximations of CRB2 (ish) behaviors. The author adds the "ish" here to make the point that the FAP therapist must be poised to attend to sometimes extremely subtle shades of approximations whereby the client's behavior moves in small incremental ways. If reinforcement of these nuances are missed, the therapist risks missing an opportunity to reinforce clinically relevant change.

The client has come to therapy for reasons that are complex but almost always related to lack of functioning fully in their lives. The FAP therapist strives to model emotional willingness and being present in the room. Commenting on CRB1s is the most elemental and proactive way in which to demonstrate this. This is especially relevant if the client's CRB1s are excessive or if they are hungering to understand "why" their lives are so disruptive and unsatisfying to them. If the therapist can provide honest and candid feedback via contingent responding, the client can then begin to grapple with their interpersonal issues with the therapist and eventually, generalize this to their outside-the-room lives. Commenting fluidly on CRB1s and CRB2 in concert should be part of the rapport building process with cluster B clients, not independent of it and "following rapport building." It is problematic to try and repair moments where the therapist brings a CRB1 to the client's attention in a later session, independent of ever commenting on CRB1s up to that point, as the client may be confused and frustrated. The FAP therapist who is working with cluster B individuals must comment early on CRBs and build rapport around the shared journey together, working through it as a team, building on willingness as the fulcrum of the seesaw of working for change together. FAP has been discussed as a sacred journey (Tsai et al., 2010), and an essential part of this process is being genuine, brave, and earnest. There is no greater moment of putting this to the test than a CRB1-filled FAP session. However, there is satisfaction for the client and therapist when they both sense the progression of therapy. The client can be alerted through the FAP rap that the therapeutic process is much like a waltz, and that commenting on instances of behavior that are interfering with their quality of life will indeed be the "first step forward" in the journey. With that said, a risk presents itself in bringing CRB1s to the cluster B client's attention sooner rather than later, as there is a danger of alienating the client. It is context dependent and that is why the FAP therapist must decide carefully and hierarchically what CRB1s they are going to comment on first. Beginning initially with less potentially punishing CRB1s primes the client for process conversations and gives them opportunities to practice gaining insight and CRB2ing. (The FAP community at large at times discusses CRB2s in this informal manner, e.g., as a verb the client is said to be"*CRB2-ing*," thus it seems relevant to introduce this information to a wider audience at this point given that cluster B client behavioral changes may be *very* subtle and therefore it is appropriate to highlight for a new practitioner to FAP that CRB2s need not be "completely opposite" of the CRB1s but may initially emerge in CRB2 "ish" or "esque" manners, e.g., paying attention to shades of behavior is extraordinarily important throughout the FAP session).

CONCLUSION

Interpersonal relationship issues are extremely relevant to the cluster B client's primary concerns and distress in life functioning. As such, the FAP therapist has a profound opportunity to assist the client in learning to create healthy and vital relationships via the contextual space developed through FAP principles and techniques. The relationship that deepens between the client and therapist will expand the client's skill set and set them up for successful interactions and patterns of effective communication both in session and across the client's life domains. Key components in implementing FAP with cluster B individuals include the following: The therapist must establish themselves immediately as an important catalyst within the room through active structuring of both non-verbal and verbally communicative responses. A FAP therapist strives via directed contingent responding to the client's CRB1s, CRB2s, and CRB3s to stimulate motivation and competence in communication exchanges. "Clearing the air" of the client's CRB1s should be the "first step forward" strategically in terms of process, for rapport and alliance building reasons as well as to generate paths to discuss

content matters. Commenting early and with care on the client's CRB1s is essential, and can be implemented via a "two plates" technique whereby the client's CRB2s are reinforced and alternative behaviors are introduced and reinforced. Understanding how to conceptualize a virtual "therapeutic bubble" for each FAP client will aid the therapist in developing a case conceptualization and organizing the client's CRBs into understandable and easily accessed chunks of information. The FAP therapist must have a plan, feel confident in the process, and engage a very proactive and therapeutic stance that pays close attention to address the often defiant, demanding, and chaotic presentation of cluster B clients.

Ultimately, the significant clinical matter at hand is that cluster B clients possess a long standing inability to form attachment bonds, and regularly exhibit limits around interpersonal capability. These tendencies are often extraordinarily difficult to intervene on therapeutically. A FAP therapist's consideration and awareness that the client's CRB1s emanate from historical circumstances of emotional suffering and subsequently are dysfunctional coping strategies, can aid the therapist in discovering a place of empathy and encouragement from which to work. Seeing the client via this lens can bring clarity of treatment vision to the therapist and re-frame the often confusing and distracting "noise" that the cluster B client generates in session via CRB1s, thereby increasing the effectiveness by which the therapist delivers FAP. This is fundamental to client outcomes, given that the greater the degree the client understands the function of their behaviors on themselves and others, the more likely they are to express themselves effectively. Consequently, as these skills grow, others in their lives may notice and they will very likely begin receiving positive feedback around changes, thereby reinforcing their efforts and underscoring a willingness to continue. Through the development and expansion of a FAP therapeutic relationship that targets the increase of meaning, mattering, and skills within interpersonal interactions, the cluster B client can learn to enhance supportive relationships and with practice, subsequently experience a decrease in subjective distress and other behavioral health issues.

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