

An Application of Functional Analytic Psychotherapy In a Case of Anxiety Panic Disorder Without Agoraphobia

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Abstract

Traditional methods of diagnosis are of little therapeutic use when diagnostic criteria are based upon topographical rather than functional aspects of behavior. Also, this sentence in the original seemed rather awkward and a bit unclear. In contrast to this, several authors have put forward experience avoidance disorders as an alternative which takes functional criteria into account. This case study presents the analysis and treatment of an anxiety disorder following the formulation of functional analytic psychotherapy. This psychotherapy is based on a therapeutic relationship which puts particular emphasis on natural reinforcement and eventualities which occur in a clinical context, relating them to a natural context, and establishing functional equivalences. The different stages of the treatment are described and details are given of the therapeutic relationship and the monitoring of the results over a period of 18 months.

Keywords: Functional Analytic Psychotherapy, Functional Analysis, Therapeutic Relationship.

According to the *DSM-IV* (APA, 1994) the disorders that occur with emotional tension and heightened sympathetic activation are classified as anxiety disorders. This system, following formal aspects as criteria for differentiation, classifies up to 12 different disorders within this classification. Despite the function of this “clarification” this taxonomy offers few clues when it comes to the choice, development and establishment of treatment programs.

To treat this type of disorder this is a wide variety of techniques coming from different theoretical bodies (cognitive restructuring, breathing techniques, interoceptive exposure, different forms of relaxation, hypnosis....) The choice of one technique or combination of several is taken on many occasions without considering etiological factors or the maintenance of the disorder in question.

This type of action highlights the eclecticism and the conceptual weakness of diagnostic systems like the *DSM* and the lack of cohesion between the clinical categories derived from them, the possible etiologies, the variables that maintain the disorder and their treatment.

As different authors note (Bisset & Hayes, 1999; Ferro, 2001; Hayes, Wilson, Gifford, Follette, & Stosahl, 1996), these problems presented by traditional classification systems are caused by their origins in structural models of evaluation in which the diagnosis is based on the form or topography of behavior. In contrast to this approach, a diagnostic method is suggested from a

functional perspective which has a potentially larger use, especially if one of the objectives of evaluation is the design of effective treatment programs. (Hayes & Follette, 1992). From this perspective, the same behavior can have different functions and, on the contrary, the same function can be served by different behaviors. (topographically different and functionally equivalent behaviors and vice versa)

Along these lines, Hayes & Follette (1992) describe a type of behavior followed by the escape or avoidance of negative emotional experience. This phenomenon has been called “experiential avoidance”, which refers to cases where a person avoids contact with a series of private experiences and looks to escape, avoid or modify the occurrence of the these experiences and contexts that could produce them. (Ferro, 2000; Friman, Hayes, & Wilson, 1998; Hayes, Strosahl, & Wilson, 1999; Hayes, Wilson et al, 1996; Luciano & Hayes, 2001) These authors have suggested “disorders of experimental avoidance” as an alternative to the traditional diagnostic criteria based on topographic or structural characteristics of behavior.

Logically, with an evaluation that considers functional criteria, the treatment applied should also be governed by the same principles. Therefore, from this perspective, a treatment is suggested that seeks to change the function of the private experiences that the person tries to avoid, rather than to change the form or context of them. In order to do this, alteration of the verbal/social context in which these experiences occur is proposed. Following these principles, and in keeping with a contextual perspective based on recent advances in verbal behavior: bidirectionality, literality of the language, equivalence relations, functional generalization, rule-governed behavior (Hayes S. C., Barnes-Holmes D., & Roche B., 2001), functional analytic psychotherapy has been developed (Kohlenberg & Tsai, 1991).

The framework of this therapy is based on an especially thoughtful client-therapist relationship. The therapeutic session is the context in which the client's problems should appear. Therefore, the therapist should evoke and distinguish the behavioral problems of the client, referred to here as type 1 clinically relevant behaviors. These appear very frequently in the therapy, especially at the outset. Normally, they are under aversive control and they are maintained by negative reinforcement. It is necessary to lessen their frequency and/or modify their function. Also it is necessary to evoke, distinguish, and reinforce the client's improvements, referred to here as type 2 clinically relevant behaviors. These do not often occur at the beginning of the therapy and it is necessary to increase their frequency. The causes or reasons that the client expresses about his/her behavior are another class of behavior, known as type 3 clinically relevant behaviors. The therapist should identify them, evoke them, and help the client to describe correctly the functional relationships between behavior and the variables that control it (Kohlenberg & Tsai, 1991; 1994; 1995; 1998; Kohlenberg, Tsai, & Kohlenberg, 1996).

This therapy emphasises the adoption of criteria that favor the consideration of the clinical session as a natural context where problems arise and psychological change is produced. Therefore, the following criteria of conduct by the therapist are formulated as rules that govern the therapist's behavior (Pérez Alvarez, 1996a). Rule 1 consists of observing clinically relevant behaviors. Rule 2 proposes the creation of a therapeutic environment that evokes these behaviors. Rule 3 reinforces the occurrence of type 2 clinically relevant behavior. Rule 4 observes potential therapist reinforcement of the client's behavior. Rule 5 describes the explanatory relationship between behavior and its sources of control (Kohlenberg & Tsai, 1991;1994; 1995; 1998; Kohenberg et al., 1996).

In summary, this psychotherapy stresses the importance of the therapeutic relationship, emphasizing the eventualities that occur within the sessions, natural reinforcement, the functional equivalence between what occurs inside and outside the therapy, functional analysis, and the shaping of verbal conduct. For further and more precise information, see Ferro & Valero (1998) and the classic texts of Pérez Álvarez (1996a, 1996b)

Below, a case of a panic disorder without agoraphobia according to DSM-IV is described that was treated following a formulation of this psychotherapy.

Method

Client

Julia is a 35-year-old married housewife with an 8-year-old daughter. She sought therapy because she felt very agitated, she had lost 24 pounds in a few months, and she often vomited what she ate. She reported feeling guilty, and cried frequently. She hoped that the therapy would "rid her of her constant nervousness and her obsessions, because sadness doesn't bother me". During the first few sessions were frequent comments such as, "I feel very agitated", "I don't know what to do with this nervousness", "I don't know what's wrong with me", "I feel guilty for not doing what I should", "since my depression my nerves have been damaged", "this is never going to stop", "Why is this happening to me?", "maybe you don't understand me because you don't study this in books.

Four years ago, Julia had become pregnant. She described the pregnancy as “horrible,” with her frequently being sick and constantly uncomfortable. She commented “I knew something was wrong”. In the fifth month, 3 days after she had been trapped in the elevator of her apartment building with her daughter and had experienced a panic attack, she miscarried. She expressed her conviction that the two things were related. She also made reference to a traffic accident where a relative and various acquaintances had died in a bus. When this happened she, in her own words, “fell apart” mentioning that she went to live with her parents “in a state of really deep depression”. She spent the majority of time in bed, she took a lot of medication, on occasion doubling the psychiatrist’s prescription, she barely carried out daily tasks, and in her own words, “life was an ordeal”. During this time, there were periods when she went to accident and the hospital emergency room up to twice a week where she was prescribed tranquillizers and sometimes neuroleptic drugs. She had been admitted to hospital on two occasions, where they various tests were performed, but nothing was found. She was diagnosed as having had “a nervous breakdown”. She didn’t accept this and continued looking for answers and doing more tests, some of which were quite sophisticated and were carried out in the respiratory department of a private hospital, at great financial cost to her.

After a notable improvement she refused to return to the family residence, a fourth-floor flat, saying it was “because there’s something about that flat”. Owing to her insistence, the family acquired a ground floor flat, moving there, according to her, for its comfort and convenience. This had occurred 3 years before coming to the clinic. During this period and up until now, Julia, in her own words, “without being what she had been”, has been able to lead an almost normal life with some relatively infrequent panic attacks. However, her state began to worsen some 2 months before the first session, with more frequent and more intense anxiety attacks and she declared that she couldn’t take it anymore. She also made comments such as these: “I feel very afraid that I’m going to fall again and this time deeper”. And she referred to worrying about her husband and her daughter.

Procedure

The formulation of the case follows the approach of Ferro, Valero & Vives (2000) describing the functional analysis of Julia’s problems, the selection of the behavioral problems, and finally the three phases of intervention.

The treatment took 5 months with a total of 14 sessions of approximately 90 minutes in duration. Furthermore, there was telephone follow-up 6 and 18 months after the conclusion. The first four sessions were dedicated to carrying out the functional analysis and selecting the clinically relevant behaviors. The following intervention sessions made a total of 10 consultations.

The composition of this article is based on the notes the therapist took and on the summaries and transcriptions of some dialogues that took place after each session. Julia met the criteria set by the *DSM-IV* for the diagnosis of panic disorder without agoraphobia; that is to say, she suffered from unexpected anxiety attacks with persistent unease about the implications and consequences that they could have. These difficulties weren’t accounted for by the presence of other mental psychological problems.

She already had experience with practicing different types of relaxation. Training in interoceptive stimulation, progressive muscular relaxation, and diaphragmatic breathing were methods that she already knew, but that reportedly had not worked for her. According to her, when she applied them, they didn’t work and she commented “it made me more nervous and depressed to see that I couldn’t do it”.

Owing to these reasons and others that are not relevant to this article it was decided to conceptualize the case as a “experiential avoidance disorder” and the ultimate therapeutic objective was to establish that the patient would become willing to be open to the risks that she had been avoiding.

Functional Analysis.

The client revealed a low level of social relationships, as she avoided them, spending the majority of her time at home. Subsequently, she received few positive social consequences. Furthermore, some relatives who visited her helped her with her daily chores, reinforcing and sustaining this dysphoric behavior. That is, the family reinforced the dysphoric behavior that she manifested, such as complaints, etc.

She also avoided having sexual relations outside of the period of 4 days before and after her menstruation. She never took any initiative nor was she sexually active outside this interval. Faced with her husband's proposal of having sexual relations, the patient claimed dizziness and headaches, and sometimes vomited. With these disguised mandates (Kohlenberg & Tsai, 1991) or impure tactics with mand functions (Skinner, 1957) Julia tried to prevent her husband from suggesting having sexual relations and avoided her subsequent reactions and her thoughts about a possible pregnancy, a risk that was very aversive for her.

She avoided the possible angry reaction of her husband and she blamed him for her irrational fears. She did not talk to him openly about her fear of becoming pregnant, just as she did not tell him that she did not want to continue living in their home, the fourth-floor flat where they were comfortable and they had friendly relationships with various neighbours.

Julia avoided travelling by bus, despite not having a driving license and often having to travel to a nearby town with hospital and specialized medical services. She only went if it was a sunny day and it was absolutely necessary. Even so, on occasions she didn't turn up to some medical appointments or she arrived late and said she'd missed the bus, and so on.

She avoided closed places, she hadn't been in a elevator again since she'd been trapped, and when she was obliged to go somewhere where she would be for a few hours, she ascertained the size of the toilets beforehand.

Her explanations were also incorrect. She hid the real reason for her behavior and sometimes avoided giving reasons. By these means, for example she gave inexact reasons for changing address, for buying heavy objects so that she was driven to her destinations, and so on.

For these reasons, the physical contexts in which the anxiety appeared extended or diversified and the avoidance behaviors diversified at the same time. That is to say, the discriminative conditions (including the contextual, interoceptive and verbal variables) of the anxiety became progressively more varied and were used in more situations. These responses with avoidance became more frequent because of negative reinforcement and positive reinforcement, such as attention from relatives. The result was the development of a wide repertoire of avoidance behaviors.

After completing the functional analysis, the following clinically relevant behaviors were selected:
Type I clinically relevant behaviours

- Excessive complaining about her life and her past. She frequently complained about what happened to her and why in the sessions. She also complained about what was happening to her at that moment.
- Her way of making requests was dysfunctional. She was generally hostile to others. Through her personal situation she managed to receive help from others and avoided some of her responsibilities.
- She refused to offer suggestions or response to questions that asked her to give explanations. She usually replied "I can't", "I don't know" or "you don't understand me" to the therapist's

questions about why she didn't go out more, why she hardly went to family reunions or celebrations, why she stopped doing daily chores, why she went to bed during the day, and so on.

- She showed avoidance behaviors. She didn't participate in social situations. She didn't talk about what really happened to her. She didn't have sexual relations. She didn't take lifts or buses, etc..
- The explanations about what happened to her were inexact or incorrect. She didn't speak plainly and frequently made reference to her problems to avoid aversive situations for her (family reunions, visits, trips, social activities etc) and also to elude some responsibilities and receive help from others.
- The way she considered what happened to her. She believed that her psychological state was not acceptable. She asserted that everyone else didn't think or feel as she did; they were free of certain thoughts and didn't ever experience emotional states as horrible as hers.

In view of these behavior types the following type 2 clinically relevant behaviors were proposed:

- To accept her past and the aversive experiences that had occurred in her life. Not to show intense emotional feelings when talking about her past, her depression, her suffering.
- To accept her emotional responses of anxiety and her thoughts for what they are. Julia thought that thinking "bad" thoughts was inappropriate for good people. If they were thought about a lot, then they would truly happen. Not to try to control emotions and thoughts.
- To take charge of her jobs and accept the more or less desirable risks that these imply. To accept her responsibilities with her domestic chores, journeys and all that should be done according her own values.
- To maintain satisfactory sexual relations. To say "no" openly without blaming physical discomfort. Not to limit activity to the pre- and post menstruation interval.
- To maintain social relationships. Not to avoid family reunions by blaming to various indispositions.
- To describe correctly the functional relation between behavior and its consequences. To explain openly what is happening to her, what she does and why, without using excuses or incorrect explanations.

Intervention

The description of this phase of the case follows the approach of Ferro, Valero and Vives (2000) & the suggestion of Kohlenberg & Tsai (1995) to divide the intervention into three differentiated phases.

Initial Phase.

This first phase consisted of the first month of treatment and included the first 4 sessions during which information about Julia's problems was collected, the functional analysis was carried out, and the first approach to the clinically relevant behaviors was produced, that were finally proposed.

In this phase an environment of trust and genuine interest in Julia was established [as Kohlenberg & Tsai (1991) suggest] The observation and identification of clinically relevant behaviors constitute an essential part of this phase, in which Julia was shaped into describing what happened to her, why she thought it happened and how she thought her past influenced her present problems. She identified what she had previously done to resolve her problems, what had worked and what hadn't, how she thought she could improve, and what she hoped from the therapist and the therapy.

Clients can come to therapy for various reasons. According to Kohlenberg et al. (1996) the function of asking for or looking for help can be of various types. There are patients who have a personal history of looking for help when they have problems; this is the way to face the problem and solve it. Another function would be that having problems and looking for help has been reinforced in the past by avoiding the real problem and generating another one. And, finally, one looks for help to obtain the care and attention of the therapist, because in the past this manner of having social relationships has reinforced them, generating dependent personalities. We are dealing with a case in which the reason for looking for help falls into the second function. Julia had previously looked for professional psychological and psychiatric help, asking for help for her anxiety and her depression, but she had never talked about her real fears.

In the first session her complaints were very frequent about her health (vomiting, dizziness, and in her own words, "as though I was going to loose my balance", muscular rigidity, heart acceleration, shortness of breath, shivering, etc) She also referred to the behavior of everyone else with phrases like "they don't understand me", "they are angry with me", "they have a go at me" and concerning what happened to her and why, she said, "the doctors haven't found out what's the matter with me", "why won't they make it go away?", and "what I'd like to do is go to bed and wake up a new person." She also complained about herself and her capabilities to do things with expressions like, "I haven't got the strength", "I don't know what to do", "I can't", and "if it happens to me in the street, what could I do?"

She insistently asked what she should do, about how what she had could be taken away, saying, "tell me what's the matter with me and do something so it doesn't happen to me". All these examples and other considerations suggest that having problems and asking for help constitutes a type I clinically relevant behavior.

The stance of the therapist in this moment was, fundamentally, to be a non-punishing audience for her, [as Skinner (1953) suggested], a constant in the whole process, to listen with genuine interest to her problems, and not to generate any doubt whatsoever in Julia and in the credibility that her remarks offered.

In this initial phase, the questions to discover the social verbal context in which these problems occurred were abundant. Such questions included inquiries such as "Why don't you go out?", "Why didn't you go and have dinner with your family?", "Why does it scare you so much being nervous?", and "What do you think you could do in order not to be like that?". One important and emblematic question at that stage was: "if you didn't feel this anxiety would you do very different things from what you do now?" "Do you think you could do them although you feel the anxiety?" The point was to concentrate on what can be done with the way one feels, instead of concentrating on feelings and trying to stop them or eliminate them.

At this time Julia was offered an explanation of her anxiety, of how it was acquired and how it was maintained. She was lead to see that it is an emotion common in all people, including "healthy" people; she was told that probably anybody with similar antecedents to hers would experience something similar and she was asked in various ways why these emotions scared her so much.

From the analysis of Julia's verbal behavior, a very high rate of disguised mands was observed. (Kohlenberg & Tsai, 1991) These functional relations appeared in the form of complaints,

self-invalidating manifestations, and references to physical discomfort. This is called “distressed behavior” by Biglan (1991) and its function is to make the occurrence of aversive risks less likely. A clear example is that the number of complaints or references to physical problems like pains, nausea, dizziness, etc. was significantly higher in situations where Julia noted the possibility of her husband suggesting having sexual relations. The frequency also increased if a family reunion or celebration was imminent, if it was necessary to travel, and so on.

During the sessions Julia also complained. She showed concern and adopted body postures related to suffering and said: “next week it is the communion of my nephew.” The therapist made her believe that he assumed that she would be going to the family reunion, asserting “your daughter will surely have a good time with her cousins!” The therapist believed that this comment would make Julia feel more nervous. On the one hand, she was helped to see that going to communion seemed to be necessary as the most appropriate thing to do, and on the other hand, contacting situations that she feared was shaped. She became more nervous. (Rule 2) From this initial phase, in reference to the above, the following dialogue stands out:

Client (C): “I don’t know if I’ll go”

Therapist (T): “Why wouldn’t you go?”

C: “If I feel like I do now, I’ll definitely not be going.” (disguised mand)

This illustrates the function that, in this case, being ill had for Julia; that is, she used this feeling to avoid exposing herself to risks that she feared.

T: “You’re right Julia, considering how bad you feel you’d be very brave if you went....”

The therapist, with this comment, left the complaint to one side and tried to make it more likely that she would go to the communion and have more social contact (Rule 3)

In the third appointment, some type 2 clinically relevant behaviors appeared at an early stage. Julia told the therapist that she had gone to the communion, thus confirming that the shaping had been effective (Rule 4). The therapist showed signs of surprise and joy and commented: “Don’t tell me that feeling as bad as you did you went to the communion; only you know how much you have suffered and the effort it was for you!! (Rule 3) Julia maintained that she hadn’t had as bad a time as she’d imagined At this moment the therapist took advantage to give examples of occasions where one suffers with thoughts and how different the events can be. (Rule 5)

The most frequent behaviors, however, continued to be of type 1 and more specifically, complaining. The posture that the therapist maintained when faced with the class of functional responses is illustrated through the following dialogue:

T: “What do mean by that?”

C: “Well, I don’t know....”

T: “Could you explain more clearly what you mean?”

C: Crying and suffering posture. “Nobody understands me, I thought you would but I see it’s not like that” (another example of a disguised mand)

C. “Aren’t you going to say anything?”

T : (After a silence) “Is this your usual reaction when you think that your husband or people don’t understand you, you cry and cry and moan...?”

The fact that the therapist insisted that Julia be more precise about what she wanted to say was a way of evoking type 1 relevant behaviors, in this case, and it occurred in this way (Rule 2). With regard to the therapist’s answer to type 1 behaviors it was very useful to relate behaviors that occur within the sessions with those that occur outside. In this way, as Kohlenberg & Tsai (1991) state,

clinically relevant behaviors can be evoked and the establishment of functional equivalents between the therapeutic environment and daily life are encouraged.

The therapist asked, afterwards, about her opinion concerning people who complained a lot, about whether she liked people to ask her for things, and about whether she normally asked for things. Julia admitted that the majority of the time she normally went over the top and that she didn't know why it happened. She also indicated that she didn't realize this at the time, but afterwards felt very bad and quite guilty. She supposed it was because she felt so nervous (relevant behavior types 1 and 3) She also commented that her only two friends told her often that she complained too much and that "I'm a moaner". In this moment she was relating what occurred inside therapy with what occurred outside (Rules 4 and 5; this is an example of the effectiveness of the therapists' shaping.)

She was then asked if she thought one could be nervous and at the same time not be hostile or blame others. Throughout the therapy and in different contexts examples of this relationship "being nervous and not hostile" (sometimes with herself, others with her daughter, or with the therapist) arose with no apparent intention. Relatedly, she was asked to think who she thought was a better person, one who suffers after committing an error, or one who accepts that they have committed the error and then does not worry about suffering. With this posture the intention was to undermine the equivalence of "to be a good person" with "a person who suffers".

In the fourth session, Julia was informed that owing to problems with the diary schedule the appointment would be at a different time and different day than usual. (Rule 2, trying to evoke relevant behaviors) Julia did not show any signs of annoyance (type 2 behavior.) The therapist made her realize that this pleased and delighted him by describing her behavior. (Rule 3)

In this first phase, Julia informed the therapist of the moments of anxiety that she had had during the week. During the time it took to complete the first phase, she had been to the hospital 6 times. She asked the therapist insistently what she could do in order not to feel what she felt. At the beginning of each session Julia was asked how she felt at that moment, and she almost always replied "very nervous" or "really bad, hysterical". The therapist usually replied "you must have made an enormous effort to come!" or "even so, you've come here today!" In the same manner, systematically, at the end of the sessions when Julia showed more signs of being calm, she was asked a similar question again and it was suggested to her that she compare how she felt then with how she had felt when she arrived (a way of evoking clinically relevant behavior). She usually replied "much better now". The therapist, therefore, asked "and what have we done to make you better, to make you feel calmer?"(Rule 5) This type of question disconcerted Julia who replied "well....we've been talking, we haven't done anything special." The therapist reinforced the tact function (Skinner, 1957) saying "exactly, that is what we've done, just talk. We haven't tried to do anything to make you calmer and nevertheless you feel a lot better." In this context, the therapist took the opportunity to shape Julia's verbal behavior in describing the relationship between feeling nervous, running risks, not doing anything to control her anxiety, and realizing she is calmer.

This phase covers sessions 5-9. During this phase, new and important elements were added to the functional analysis that was carried out initially and although some type 2 behaviors appeared, type 1 continued to be the most frequent. Julia showed new behavior that had not appeared before, which could have been seen as type 1 because of its problematic character; however, what appeared was understood as type 2. This is referring to fear of being pregnant as an example of type 1 and talking openly about her fear as type 2 behavior.

As has been described above, what worried Julia the most was her anxiety; she doubted that there was a possible solution. In the first sessions when she asked what she could do, the therapist replied that for the moment there was little that could be done (Rule 2, shaping at the same time not trying to avoid it). She said she felt desperate that it would never go away. In the fifth session, she said "this is never going to leave me; I'm never going to be

cured.” The therapist connected these thoughts to others she had told before about having an awful time in the communion or once she was there she’d had a good time or when she left to come to the clinic in a nervous state and thought she couldn’t get to the building, and so on (Rule 5). Also, it was commented to her that thoughts cannot be controlled at will, and that people cannot take them off like you take off tight shoes that bother you. (Rule 5) Julia said that she understood, but that an acquaintance of hers had been cured in less time (example of a mand in form of a manipulative request to pressurize the therapist, type 1 behavior) The therapist remained silent in an attempt to extinguish the disguised mand. Immediately afterwards, Julia asked what she could do to make herself better and taking advantage of the situation that had been offered, the therapist replied that each person learns to resolve their problems in different ways and described to her how and why her acquaintance had been “cured”, by not avoiding, but exposing herself to her fears. In short, very naturally, a model of behavior had appeared with which she had very probably identified. It is necessary to make clear that this dialogue was conducted with extreme care so as not to betray any professional confidence.

Afterwards, Julia was asked how she thought she had reacted in her life to resolve her own conflicts. She replied, crying, “I haven’t resolved them.” Immediately afterwards she made a review of different periods of her life and of the problems she had had, trying to highlight the way in which she had faced them. She said that now she realized that what she’d been doing was avoiding them and that in the same way as the example that the therapist has given on various occasions, each time they got bigger. The therapist made an observation so that she related what she usually did with the result she had obtained and he reminded her that she was in a psychology clinic. She began to cry and moan and to justify her behavior. The therapist remained in silence to weaken the frequency of the disguised mands in Julia’s repertoire.

Julia telephoned 2 hours before the sixth appointment saying that she wouldn’t be attending. When asked why she replied in tears that “I’m really ill and I don’t see myself getting any better” (again, a manipulative plea, another disguised mand, and a type 1 behavior). The therapist told her that he respected her decision and wished her a speedy recovery in a friendly manner, but without further comment (attempting to extinguish the behavior). Shortly after she called back to say that she would attend the appointment if that was still possible. She was told that it was, and the extinguishing of the behavior pattern was shown to be effective (Rule 4). Julia arrived seeming agitated. The therapist told her that he understood that the previous session had been very hard for her and expressed how pleased he was that she had come in spite of that, adding that this showed an excellent frame of mind for solving her problems, and that it would have been much easier for her to have stayed at home. Nonavoidance was reinforced. (Rule 3). She was grateful, but described herself as being in a mess, cried and said things such as “I don’t deserve this”, and “why does this have to happen to me?” When asked if anything had happened that she thought the therapist ought to know about, she replied that she had spent the night sleepless and vomiting. Asked again if she knew the reason why, she carried on crying and said that she didn’t. She resisted speaking clearly (type 1 conduct). The therapist’s silence encouraged her to show more symptoms of anxiety, crying and hardly maintaining eye contact. Then she broke the silence, saying:

C: last night I felt bad for my husband,... and we made love

T: I’m sorry, Julia, but I don’t really understand why you’re telling me this

C: ... just that we never use contraception ... and I’m really afraid of getting pregnant, ... that’s why I’m like this.

T: Now I understand you. Only you can know how much you’re suffering.

The therapist reinforced her clear expression of her fears (Rule 3).

Her emotional responses to the possibility of becoming pregnant were dysfunctional, a type 1 behavior, but her clear expression of them was taken to be a type 2 behavior, and was reinforced as such.

It should be noted that on other occasions when Julia had been told that she wasn't making herself understood, she complained and felt victimized, whereas on this occasion, her response was to clearly express her fear, and to describe it (Rule 2). The therapist highlighted this fact by showing his satisfaction (Rule 3), to which Julia replied that she no longer complained, it was of no use and that she had discovered that doing it made things worse because each person told her something different that confused her even further (type 3 behavior). The therapist agreed with her, saying that he, too, saw it like that. This type 2 behavior was reinforced and the situation and Julia's more adaptive responses were related to other contexts outside the clinic, and with other responses in more problematic situations. This factor, as previously noted, would contribute to laying the foundation that relating what happens in therapy to day to day situations that take place out of the clinic is of great therapeutic value.

After Julia had shown, for the first time, her fear of a possible pregnancy (type 2 behavior), in the seventh and following sessions, the topic was further investigated. As stated by Kohlenberg & Tsai (1991), paying attention to mysterious responses is a way of identifying behaviors that are clinically relevant. Her husband, with whom she had a good relationship, wanted another child, but she didn't dare tell him that she did not. She avoided telling him this openly because she thought it would disturb their relationship, saying "I don't want to upset him any more" On the other hand, she would convincingly say, "only children aren't happy" and that she saw herself as a bad mother for not giving her daughter a sibling. Aside from all this, she felt under pressure due to her age. In that moment, she was able to identify the fundamental reason why her situation had deteriorated in recent months; her worsening coincided with her husband becoming more insistent that they have another child. As she said, "he regularly wanted us to try". The situation was certainly difficult for her.

Her fears and her thoughts about becoming pregnant became the main focus of this stage of therapy. She made comments such as "if I got pregnant, I'd have to get in the hospital lift and that really would make me ill", "if the mother is nervous during the pregnancy, she'll give birth to a nervous child – the baby will be born with a damaged nervous system or will have nervous problems all his/her life", "if I got palpitations or fainted while I was pregnant, something could happen to the baby", and "several gynaecologists have told me that in order to become pregnant, you have to be very calm and not to become obsessed with it". She would say that she was very nervous, but that at least she wasn't becoming pregnant, a relief for her. That is to say, as paradoxical as it may seem, there were occasions when her distress was a discriminative condition of not becoming pregnant (aversive function) and served as relief, a consequential function of reinforcement.

Once this functional relationship had been established, the therapeutic aim was to break it. To that end, the therapist commented to Julia at the beginning of the eighth session that that morning he had had a thank-you visit from a girl he had treated 2 years previously who had been raped, "imagine how distressed she must have been when that happened,... she became pregnant...". Julia showed signs of distress. When asked about it, she said that she didn't know why she had become agitated. She supposed it was due to what she'd heard.

In that and in following sessions, the therapist took advantage of any opportunities to make seemingly unintentional comments such as "... I'm sorry to have kept you waiting, but I was talking to a friend on the phone. Everyone says she's the calmest person in the world. She's a young girl, more or less your age, and she's been trying to get pregnant for a long time. The gynecologist says that everything's fine... she's so calm that nothing gets to her..." The aim of this and other similar comments was to break the functional relationship previously described and to substitute it for a more adaptive functional equivalent: you can be calm and not get pregnant, and vice versa. The shaping of this rule in Julia's repertoire was understood to be a key aspect in her subsequent recovery.

The same analytic and therapeutic criteria served as a framework to explain other problematic behavior shown by Julia. When determinate stimulative conditions announced contingencies or contexts with aversive functions for her, she would “get ill”, suffering from dizziness, vomiting, pains... These symptoms were interpreted as a function of impure tacts with mand function. (That is to say, now for her, “being ill” was a discriminatory condition of the relief and of the consequential functions of positive reinforcement in the shape of care and attention. It also functioned as negative reinforcement avoiding contingencies she regarded as unwanted and She justified to herself and others that she would avoid these contexts.

This functional relationship also deserved special attention because of the type 1 relevant behavior that was to be weakened. The therapist, with the aim of weakening or breaking it, made comments such as “Remember how good you felt after your nephew’s communion?” “I see that you almost never go to some places because you’re ill, you could not go even if you weren’t ill”... “we can also do things because we feel like it. Additionally, any explanation of a situation in which Julia, without “being ill” chose not to expose herself to a specific contingency was reinforced. In this way, more adaptive type 3 relevant behaviors were shaped.

During the ninth session, when asked if she had noted any progress and how she had noted it, she said that she felt much better, and that she supposed it was due to having relieved her feelings, by saying things for the first time. As Kohlenberg & Tsai (1995) maintain, describing improvement is a way of evoking type 3 behaviors. The therapist explained that expressing with clarity what she felt, what she wanted, would contribute to psychological well-being and that if she had done it this time, she could do it on other occasions outside the clinic. She was invited to evaluate the therapy and to say what she had liked most and least, both about the therapy and the therapist. Julia’s following comment stood out: “what I’ve liked most is that you’ve got to the point...what you’ve done is to scrutinize my problems one by one” (Rule 5)

She also reported that she hadn’t been to the hospital in a month. When asked if this was because she hadn’t had any crises she replied that not exactly, she had had a crisis or two, but that they seemed to bother her less and that she had understood that going to hospital didn’t solve anything (type 2 behavior). The therapist reinforced this new response of Julia and her new emotional perspective.

Final stage

This stage is composed of sessions 10-14, during which new clinically relevant behaviors appeared, some of which verified the modification of determinate functional relationships and were significant in the resolution of the case. The type 2 behaviors that had emerged previously were reinforced and Julia was prepared for the conclusion of the therapy.

At the tenth appointment Julia was satisfied to be able to report that “for the first time in a long time we’ve had a satisfactory sexual encounter and I didn’t get up later to be sick... I even slept really well...yes I thought about pregnancy but it didn’t do my head in like before, and I thought about you and some of the things you say...” Julia was establishing links between therapy and her day-to-day life.

She also said that at that time she felt good even though she wasn’t going to have her menstrual period. That appeared to be a mysterious response and as Kohlenberg & Tsai (1991) maintain, provided a signal to identify clinically relevant behaviors. The therapist asked her to clarify (Rules 1 and 2). Julia replied that before “falling ill with the depression”, she used to feel very irascible and emotionally feeble for the 2 or 3 days preceding her menstrual period, and since her condition got worse, these days were the best of the month, as contradictory as that may seem. Asked about this, she said “that hasn’t happened this month, in fact, I’ve been as angry as I ever was before I got ill”. That is to say that for Julia, the biological and/or hormonal changes associated with

menstruation had been a discriminative condition of reinforcement contingencies, particularly negative ones as they meant she wasn't pregnant.

What Julia was saying at this time was that for her, these biological changes no longer had the same function of relief, possibly because in effect? there was nothing to relieve. This was another improvement (type 2 and 3 behavior) now that she was explaining and developing links between the real controlling variables. The therapeutic answer to all this, as well as reinforcing all that it had meant, included relating how well she was feeling to the new responses that she was making in situations she would have previously avoided. She was also encouraged to relate these consequential functions of positive reinforcement if she were to behave in similar ways in other areas of her daily life. She was told: "...maybe if you acted the same way in other situations you'd feel as good". Once again comparisons were being made between aspects of Julia's life and what happens in a clinical context (Rule 5).

In the eleventh session, Julia said that she felt very good, "too good", "and that scares me, a lot". This is a very significant type 1 behavior, in that it showed that, as Pérez Alvarez (1996 a) states, that for Julia "feeling good" meant a discriminative condition of punishment or aversive contingencies. She said things such as her husband was expecting more and more of her, that he let her take the bus alone, that he didn't seem to help her as much as before, and that her relatives, seeing her much better, thought that she was now cured, and paid her less attention and were harsher with her. She added that "now I know I'm not mad because you've told me so in many ways... but now I don't know what to think because very strange things happen to me". She also said: "I feel like something bad were going to happen... it's difficult to understand and maybe you think that I'm conning you but... I understand myself".)

Julia said that she felt very confused from feeling such contradictory things. The therapeutic answer to this type 1 behavior was to shape and explain that these feelings were normal, not at all pathological, and that they were fitting with her history. She was asked to compare them with her earlier feelings. Julia said that she preferred to feel as she did now and said "what I feel now is laughable when compared with how I felt before, and if I got over that then, I'll get over this which isn't even comparable". This was taken as a type 2 behavior because Julia was showing herself to be ready to accept this feeling defined by her "as if something bad was going to happen to me" without trying to eliminate it, and what seemed of greater importance (her explanation, type 3 behavior) on this occasion, did not appear to be serving an experiential avoidant function.

In the twelfth session, without being asked, Julia volunteered the following: "the feelings I told you about appear sometimes, but they don't bother me as much and I've done what I've wanted to do, I've even used the lift in my sister's apartment block, admittedly it's on the first floor, but every little counts" The therapist replied "You don't say! After you had such a bad time when you got trapped!", he reinforced this type 2 behavior, trying, as always, to do it naturally. Julia replied "I knew you'd be really happy..." We believe that forecasting the therapist's behavior is an improvement in itself. At this point, a review was taken of her achievements: she'd travelled by bus and would do so again if it were necessary and she'd taken an elevator for the first time in a long time and would do it again. She had had satisfactory sexual relations, she was eating more, sleeping better, she said that she was feeling much calmer, she felt neither sick nor faint, "I'm breathing much better and I've hardly had palpitations or that thing in my stomach for a long time", and "I don't go to hospital anymore because I'm not so scared of what I feel, perhaps because I see myself so much stronger.

She was next asked to specify in which other aspects she thought intervention could make her psychological well-being more complete. She said that she supposed there would be more things, but she saw herself as having the strength to deal with them on her own "although I don't want to stop coming to the clinic just like that". A follow-up appointment was made with Julia for three weeks later. In this thirteenth appointment the maintenance of her achievements was confirmed. She was asked to describe the possible reasons behind her improvement, appealing to the therapeutic value and

importance of exposing oneself to the contingencies which are feared as a fundamental part of the recovery process.

In this context, after a certain amount of hesitation, Julia said “I want to tell you something, but it’s really hard...” The therapist said “don’t tell me if you don’t want to... it’s not a problem if you don’t tell me now...” Julia then revealed that she had been subjected to sexual abuse by a direct family member as a child. She added that she didn’t think it had affected her much because it had happened very few times when she had been very young, and perhaps because of that, she hardly thought of it but she wanted to mention it to find out the therapist’s opinion. He thanked her for the trust she had shown in him and reinforced her having confided, despite the shame she had felt, that she had expressed herself clearly and hadn’t avoided her emotional responses.

The fourteenth and last session took place a month later. To begin, the maintenance of Julia’s achievements and related aspects were again discussed. However, for a large proportion of the time, current events were discussed. The therapist noted this with satisfaction. Julia said “now I know myself much better, and as you can see I am no longer unable to talk only of myself and my problems”. She herself proposed that they didn’t make another appointment if the therapist was in agreement, but asked if she would be able to return to the clinic if the situation worsened. This proposal was reinforced and she was told yes.

In the follow-up by telephone 6 months later and again after 18 months, Julia confirmed that everything was going well, that she was 5 1/2 months pregnant and although that fact sometimes caused her some anxiety, she said “it’s different because it doesn’t make me suffer”. She added that she was still taking lifts if it was necessary although “I don’t particularly enjoy it” and also said that she took the bus if she had to without it causing her any problem, even when it was raining.

Results and conclusions

In view of the results obtained, it can be said that functional analytic psychotherapy apparently was useful in the treatment of a client displaying panic disorder without agoraphobia. The functional analysis carried out and the selection of relevant behaviors were also accurate. The results were maintained for a period longer than a year and a half, as confirmed by telephone calls during the follow-up. Furthermore, Julia reported being 5 months pregnant, one of the avoidance behaviors that were propagating her problem. From this and other signs, it was evidence that Julia had adjusted herself to the values and the changes suggested during therapy.

Functional analytic psychotherapy as a theoretical framework from which to operate is based on a particularly thoughtful client-therapist relationship. It is necessary to develop in the therapist a repertoire of observing, identifying and evoking the occurrence of clinically relevant behaviors, The therapeutic response must also include the establishment of functional relationships between the clinical context and daily life. As proposed by Kohlenberg & Tsai (1995), the intervention was divided into three stages.

The authors maintain that in the first stage, by definition the frequency of type 1 behaviors is very high, as in this case. In this period, a genuine and trusting therapeutic relationship was developed, the functional analysis was carried out and clinically relevant behaviors were selected. Through the functional analysis, the individual history was described in relation to her avoidance pattern (Luciano, 2001), that permitted sensitivity to the avoidance behaviors that were to appear in later sessions. In the initial and intermediate stages, type 1 behaviors appeared in the shape of manipulative pleas, complaints etc. with high frequency. The therapist’s elimination of these manipulative requests and complaints was effective. We believe that certain therapy sessions produced a change in Julia’s psychological growth. In the fifth session, a functional equivalent was established between the way a friend solved her problems, and the situation being lived out by Julia, making her aware of how she might solve her problems with the therapist’s shaping. It is fitting to highlight the way in which the therapist shaped and exposed what Julia was actually hiding: the

avoidance of the sixth therapy session and the subsequent intervention, the way that her true fears at having had unprotected sexual relations appeared, or the way that she describes her fear of becoming pregnant for the first time.

We consider it to be particularly important that her fear of pregnancy was evoked and identified. Julia initially failed to mention the topic possibly because she herself didn't know the importance of this subtle source of control in the maintenance of her anguish. Given the clarity with which the etiological variables were identified, the anguish could have been understood to be a respondent without any mistake whatsoever. However, the emotion could also be understood to be a repeated reaction to attempt some change, achieving or avoiding something (Pérez Alvarez, 1996b). The relief she felt at seeing she wasn't pregnant turned out to be a source of control equally as powerful as the traumatic events she had been exposed to, contributing greatly to the anguish experienced by Julia. From the eighth session, Julia's complaints of illness as a disguised mand began to be extinguished and key rules were shaped for her continued therapeutic progress, such as the fact that it is possible to be distressed and get pregnant, just as it to be calm and not become pregnant. From the ninth session evaluation of her improvements began.

The multiple causes of her behavior were taken into account, something confirmed on establishing Julia's improvement following the identification and treatment of the implicated functional equivalents. The flexibility and constant self-evaluation that characterize this style of psychotherapy allowed the addition of new elements to the case. As indicated by Follete, Naugle, & Linneroth (2000), functional analysis is repetitive and self-correcting with pertinent corrections being made in proportion to whether the results are or are not desirable. Perhaps with a structured treatment package of traditional use, this would not have been possible.

In the final stage, type 2 behaviors became gradually more frequent and Julia's explanations of her problems became more functional. Different moments were important in the verification of her recovery. Two of that moments were when she describes the change in function of her menstrual period, and when she talks of having mixed feelings at having felt better for a time and shows herself willing to accept those feelings. Paying attention to this functional relationship and making it a therapeutic objective contributed to the final resolution of the case.

In the thirteenth session, she described sexual abuse from her childhood that wasn't treated as important either by her or by the therapist, but that she described as a sign of recovery. Describing things that had previously gone unmentioned, things which she would probably not tell anyone else, as stated by Kohlenberg and Tsai (1995) are a sign of recovery, and in this case, of change. In that session, Julia describes her achievements and improvements and shows signs of her increasing self-awareness through therapy.

The plurality of problem behaviors that clients show makes it simple to choose a category that contains problem behaviors identified by the psychologist in a given client. However, this plurality means that the choosing of category can be, at the same time, complicated in that none of the proposals would fit the case. That is to say, with reference to this case, according to the problem behavior we chose to highlight, another diagnosis could have been made and situated in another of the categories given by the *DSM-IV*. Noting formal or topographic criteria would not be a mistake either. Should the chosen treatment have been changed? However, two people with identical diagnoses can show different behavior patterns, in the same way that the benefit to each of them can vary considerably. This fact, despite being paradoxical and a criticism of traditional diagnostic systems, represents no contradiction whatsoever for this psychotherapy in which work is focused on functional types of response, not on isolated topographical responses. Julia's avoidance responses were varied, thus the importance of Rule 1, that of being sensitive to Julia's behaviors.

We consider this psychotherapy to be as much a way of working, as a way of practicing psychotherapy in itself. In the sense that it can be used by applying its rules and fundamental characteristics to other ways of practicing psychotherapy such for instance, acceptance and

commitment therapy (ACT), as in the examples of Dougher and Hackbert (1994) and Paul, Marx ,and Orsillo (1999).

We believe the use of questions in the comparison of events in and out of the clinic to be a very effective way of achieving improvements, because it helps clients to establish more appropriate rules about what has really happened and in identifying the controlling variables of the problems. The shaping of Julia's explanations and the therapist's own explanations referring to the problems encourage self-awareness that is, in itself, an objective of this psychotherapy. Furthermore, as has already been stated, the behavioral function of asking for help that the client brings to the clinic can show us the way in which they tend to face their problems, in this case by generating other problems in order to hide the real ones.

We agree with B. Kohlenberg (2000) when he describes the quality of the alliance or relationship between client and therapist as being a very important predictor of the results of intervention. This is something that Skinner (1953) had already realised. We feel that it is necessary to open lines of research in the study of therapeutic relationships and their role in shaping and natural reinforcement, that we believe to be important.

The importance of this study is rooted in the fact that it is one of the few complete descriptions of this psychotherapy. Other authors have described its effectiveness in different disturbances such as depression (Kohlenberg & Tsai,1994) (Bolling, Kohlenberg and Parker, 1999), personality disorders (Koerner, Kohlenberg, & Parker, 1996) in cases of sexual abuse (Kohlenberg & Tsai, 1998), and even in instances of anxiety disorders (Kohlenberg & Tsai ,1995). However, the only application to give a complete description is Ferro, Valero and Vives (2000). We believe it to be necessary to follow this path, describing the interventions carried out in different types of disturbance in order to see the differences and also the different working styles of differing therapists. A subsequent step would then be to compare its effectiveness with other therapies.

The authors accept that the study has limitations in terms of methodology which could have been resolved by taking different measures during treatment. For example, the use of questionnaires such as: Acceptance and Action Questionnaire (AAQ) and/or Beck Anxiety Inventory (BAI).

Despite of these limitations, from the point of view of the authors this work shows us an example of how to carry out treatment from beginning to end from FAP, with examples of CRB interaction and of the Rules in a case of Panic Disorder. Unfortunately there are very few case studies under this therapy and this is one of the points that this case study has to offer.

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