The definitive version was published in:

Counseling Psychology Quarterly, Volume 23 Issue 1, March 2010.

Vandenberghe, L., Nasser, K. C. F. O. & Silva, D. P. (2010). Couples therapy, female orgasmic disorder and the therapist-client relationship: Two case studies in functional analytic psychotherapy. Counselling Psychology Quarterly, 23(1), 45 – 53.

doi: 10.1080/09515071003665155.

Link: http://www.tandfonline.com/doi/abs/10.1080/09515071003665155#.U-A5v_ldWSo

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ABSTRACT. The present article illustrates Functional Analytic Psychotherapy through two case studies. One concerns a marital crisis and the other a treatment of female orgasmic disorder. Possible curative mechanisms in the therapist-client relationship are discussed. In the first case study, the relationship with the therapists offered opportunities for the woman in the couple to learn to express her needs clearly and to obtain collaboration from the other person in the relationship. It also allowed the male partner to learn to interact in an open, non-defensive way. In the second case study, the therapist-client relationship offered in-vivo learning opportunities concerning the game of give and take that characterises an intimate relationship, including accepting initiatives and challenges from the partner. The case studies suggest that in-vivo learning opportunities in the therapist-client relationship can influence a broad diversity of interpersonal behaviour. Often the therapist needs to look beyond the presenting problems to identify the underlying interpersonal patterns that can be targeted for change by means of an intense and genuine relationship.

Keywords: Functional Analytic Psychotherapy; Marital Therapy; Female Orgasmic Disorder; Therapeutic Relationship.

In-vivo learning opportunities

Emotionally laden exchanges between therapist and client can offer the therapist firsthand opportunities to observe clinically relevant patterns of client behaviour and to respond to them in ways that promote change. These same exchanges may offer clients the opportunity to learn through experience, dealing with their problems while these affect their interactions with the therapist, as opposed to learning about their problems by discussing them with the therapist. Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1987) is a behavioural treatment model that systematizes this process. FAP therapists seek to identify clinically relevant client behaviour when it occurs in-session. When it does not occur, they provoke it. They allow natural consequences to affect clinically relevant behaviour in-session. Finally, they monitor generalization of clinical improvements to daily-life settings and when necessary, they promote it. In the following paragraphs, we will explain these principles based upon Kohlenberg & Tsai (1987) and Tsai, Kohlenberg, Kanter & Waltz (2008).

The notion of natural consequences has been defined in opposition to that of contrived reinforcement. Therapists who prompt for target behaviours like more reasonable self-statements by a depressed client who used to have unreasonably negative views about her self and then use social approval to reinforce these statements would be using contrived reinforcement. Although this is not generally harmful, the FAP critique of contrived reinforcement is that it may cause the therapist to lose track of what is actually happening between him or her and the client. This would entail a real danger that the therapist will inadvertently reinforce behaviour that will make the client's problems worse. To avoid such an outcome, therapists should monitor what category of interpersonal behaviour is being promoted. E.g., when they respond sympathetically to increasingly rational statements from the client, what client behaviour do they reinforce? Adapting her talk to social demands? Complying with expectations? Pleasing the therapist? Are these kinds of behaviour actually improvements in the context of the client's daily life problems? When using contrived social reinforcement in the therapeutic relationship, therapists may unwittingly promote more submissiveness in a client who already has difficulties standing up for herself and dealing with conflict. They may encourage more rigid rule-following in people who already lack spontaneity. Or, as another example of an unintended outcome, therapists may promote more interpersonal superficiality in clients who already have difficulties in building deep, meaningful relationships or in expressing genuine feelings.

How can therapists permit natural consequences of client behaviour to do their job in-session? First, they must identify what types of consequences are available for the target behaviour in the client's daily life situations. Imagine a client for whom expressing her needs more clearly in interpersonal relationships would be helpful in overcoming her depression. Therapists should initially respond to even small improvements in the expression of relevant client needs toward them, e.g. extending the duration of sessions or including new topics in the treatment agenda. They will allow the improvements to have the effects that truly effective negotiation of her needs would have in her daily life situation. Such effects would very rarely be social approval, but would more probably the fulfilment of the particular need expressed. Similarly, a client who would benefit from learning to deal more effectively with interpersonal conflicts may react in a slightly

improved way during a conflict with the therapist, for instance about the agenda of the session or a homework assignment. Again, the therapist should not react with praise, but rather should allow the type of consequence to occur that would be available if the client were dealing effectively with similar problems in the outside world. In this way, spontaneous improvements gradually take shape under the influence of their natural reinforcers.

The examples above illustrate that FAP comes into its own as a treatment approach when three conditions are met. First, the problems for which the client seeks help must also appear within the therapist-client relationship. Secondly, it must be possible for clinical improvement to occur in the context of the session. Finally, the natural consequences of improvements must be available in the therapist-client relationship. This might seem to imply that FAP is adequate as a treatment for a quite limited range of problems. Paradoxically, this treatment model has also been used in the treatment of disorders that seemingly cannot manifest themselves in the client's relationship with the therapist. Two examples are marital distress (Rabin, Kohlenberg & Tsai, 1996) and sexual dysfunctions (de Oliveira Nasser & Vandenberghe, 2005). By way of two short case studies, the present article discusses how the therapist-client relationship can be an instrument of change in the treatment of these problems as well.

Marital distress.

John (37 years old) and Joan (36 years old) had been married for five years. They had a son and a daughter and lived in a middle class neighbourhood of a Brazilian state capital. John had not completed college and was unemployed. Joan had a university degree and ran her own successful business. More than a year before seeking therapy, John had gone to live with his mother after an argument in which Joan tried to pressure him to start a business and to contribute financially to the household. Three months later, he started a small business, and went back to live with Joan, but soon thereafter, closed the business. When Joan pressured him to resume his business activities, he returned to his mother's home and lived there for ten months, after which Joan allowed him to come back to her on the condition that he agree to enter marital therapy.

Joan complained about John's professional and financial irresponsibility and his inability to have a serious conversation with her. He won all their fights by confounding her, by denying what he had previously said, and by making her feel guilty. He dissipated her demands by responding in abstract or metaphorical language even when very concrete questions were concerned. When she tried to pressure him, he repeatedly interrupted her. When she tried harder to make him listen, he would leave the room, or even the house. Joan would tell John specifically what to do. In John’s opinion, however, she did not explain what she needed. She was aware that, in her interactions with friends, family and employees, she often obtained collaboration only through coercive strategies, and her reports indicated that people around her often seemed to be at a loss as to what she really expected from them.

John complained about Joan's constant irritability and complaining. History taking and further assessment indicated that much of his repertoire was shaped through aversive control. In dealing with life's demands, he drew heavily on escape and avoidance strategies. He showed little initiative or approach behaviour in the relationship with Joan. In general, he only became active when she put him under pressure. Even then, his most important goals seemed to go no further than making the pressure cease.

The couple was referred to a free clinic where a male and a female therapist saw them in weekly joint therapy sessions (the latter being the third author of this paper). Treatment goals were agreed upon with the couple. For John, they focused on learning to deal with conflict without resorting to manipulation or any of his other avoidance strategies. For Joan, they focused on learning to express her needs and promote relationships through positive strategies, without coercion. In the following paragraphs, clinically relevant behaviours of the two partners that occurred in the relationship of each with the therapists are described. How such occurrences were used to promote the goals of the treatment is then explained.

During sessions, John soon started to interrupt the therapists when they questioned him or otherwise seemed to expose him. He also answered with metaphoric talk. For example, when the therapists had trouble understanding what John meant by "exercising fatherhood", he explained: "It's like shaving. Have you ever shaved in front of the mirror? That moment is yours. You walk out of the bathroom with your appearance taken care off." He also frequently denied his own utterances when he was questioned about them. For example, in one session he said: "I had a depression, and she doesn't believe it" and few minutes later: "Since our first separation I became a deeply depressed man." When one of the therapists asked how this depression affected the relationship, John answered: "Never did you hear from my mouth that I was depressed. You might have come to that conclusion yourself, but I never said anything like that."

His style made the therapists feel incompetent. Quite often, they forgot about, or abandoned, well-designed interventions. At other moments, they got confused about the goals of the session while trying to work with him. More than once, when the therapists insisted on continuing an activity John had interrupted, he stood up, thanked them for their time and left. A few days later, he would call in to confirm he would come to the next session. After the therapists set some time apart to disclose the aversive effects this behaviour had on them, John stayed away for three months.

Whenever the therapists noticed that Joan tried to avoid negative feelings during the session, they asked her to bring the discussion back to the issues that evoked these feelings. The intention was to use the opportunity for her to increase her tolerance of aversive feelings. During John's three-month absence from therapy, they constructed a relationship with Joan in which they asked directly about her needs in the context of the treatment relationship and gave her feedback whenever they were in doubt or felt a lack of clarity about what she expected of them. Still, it took months for her to state that her real goal in seeking therapy had been to create a space in which she could tell John that she wanted a divorce, a hidden agenda that was at odds with what she had told the therapists and with what she had demanded from John in the first place. This disclosure was an in-vivo

improvement, to which the therapists responded by opening space when John returned to tell him about her wish in the session.

A number of specific changes in the behaviour of the couple interlocked with each other and made a way out of their problem pattern possible. The major difficulty in working with John had been that he dealt with the therapists' interventions using powerful escape strategies. It was only when he faced the challenge of Joan's newly formulated demand that his escape and avoidance repertoires offered no efficient solution. He had to take positive initiatives to have his needs met. By then, Joan permitted the therapists to seek ways to help her achieve her goals, where her usual strategy had been to coerce people into following her instructions. In a similar way, she was ready to accept small improvements by John that she would have found insufficient before, like when he got a job working for a company as an employee instead of running his own business. She also started to express her point of view clearly, waited for a sensible response from him, and stopped paying attention when he talked confusingly.

These changes did not come about suddenly. During several sessions, the therapists encouraged John to be curious about Joan's needs when she did not express them. They also took care to reinforce clearer expressions of his feelings. Among the first improvements that occurred in-vivo during the sessions after his return was that John started answering personal questions by the therapists instead of putting up a smokescreen. When Joan told him that she wanted a divorce, he started to work on finding solutions to her needs in the relationship. This was different from doing literally what she demanded, which had been, in fact, a strategy to escape from aversive control. Taking his own initiatives, he changed the context of the relationship. Joan could now rely on him to take care of issues without needing to give him instructions. Now he had a job, his contribution to the family budget also ceased to be an issue.

Discussion.

Using difficulties in the therapist-client relationship in this way seems at odds with work that shows that partners' agreement about their alliance with the therapist predicts positive results. In particular, early alliance with the man in the couple has been pointed out as a predictor of results due to gender power issues like male resource control (Symonds & Horvath, 2004). Joan controlled the couple's resources and her relationship with the therapists was problematic from the start: Joan did not reveal to the therapists her real intention in coming to therapy. John responded selectively to the pressures and coercive elements in the therapists' communication. He ignored their offer of a collaborative relationship and reacted to their interventions as he reacted to Joan's demands.

Similar to what happened in the Rabin, Kohlenberg and Tsai (1996) case study, the therapist-client relationship was pitched against culturally supported problem behaviour. The difficulties the partners experienced in dealing with each other's needs and the strategies they used in doing so were along the lines of gender role expectancies (Rabin, 1996). Separate work was done on the interpersonal strategies of each partner. There exists a feminist critique of notions like circularity and complementarily that may lead therapists

to make assumptions such as "If she stops pursuing, he will stop escaping", which obscure stronger variables (Rampage, 1995). Targeting the relationship of each partner with the therapist may be an answer to this critique.

Female orgasmic disorder.

Jean was 28 years old when she sought treatment with the second author of this paper. She complained about an inability to reach orgasm and hoped that therapy would help her feel more confident about herself and to get more pleasure out of sex. She lived with a cousin in a poor neighbourhood at the fringes of a Brazilian state capital, earning small and unpredictable sums as a freelance waitress. Her social contacts were superficial and limited to a group of male and female homosexuals with whom she used to go out.

Jean had been born into a large family. She described her father as ignorant and generally absent and her mother as indifferent. She remembered feeling disgust at the violence in her parents' marriage, at the incestuous relations among her siblings and cousins as well as at the promiscuous life her mother led after her separation. She also reported early on rejecting the cultural stereotype of the delicate woman who unselfishly satisfies her lover. She felt deeply ashamed when reprimanded by her parents for seeing a boy expose his genitals and deeply disgusted with herself after a rare attempt at masturbation.

Jean left home and school at an early age. She recalled pain, disgust and fear after her first sexual experience, with an ex boyfriend who was cheating his new girlfriend with her. It took some violence to stop the intercourse. Her second sexual experience involved a girl she disliked, but who was delighted by Jean's sexual technique and later introduced Jean to Jacky, an older woman. After a variety of painful and often abusive sexual experiences with men, Jean would eventually enter a relationship with Jacky. The older woman humiliated Jean during intercourse, repeatedly betrayed her sexually, and involved her in practices that made her feel vulgar and ridiculous. Through this partner, Jean became acquainted with people whose lifestyle and sexual practices she found revolting and was pressured into using drugs and having a breast-reduction operation, which, after a difficult recovery, left her with permanent scars.

After terminating this relationship, Jean had a variety of emotionally insignificant sexual contacts, choosing progressively less experienced and preferably shy women. She would move on to another partner whenever her lover became more active or directive. One romantic relationship with a much younger woman lasted for a longer time, but ended after months of exhausting domestic rows when the woman became more independent and less submissive. Many casual sexual contacts followed. Then, another meaningful relationship with a woman Jean described as delicate and a classical beauty lasted for one year, until once again the fights became unbearable. Finally, she described the new woman with whom she was when she entered therapy as sweet and understanding, but feared the relationship would not withstand Jean's intolerance and bickering.

After history taking, the therapist discussed Jean's current sexual activities. Jean reported fear of feeling feminine and related feminine sexuality to vulgarity. She would initiate sexual intercourse by caressing her partner extensively before proceeding to genital stimulation, and paid special attention to vaginal lubrication, moaning and encouraging talk. On the other hand, she felt ashamed at being watched by her partners. While the partner's signals of pleasure provided positive reinforcement for Jean's behaviour, it also functioned as effective avoidance of initiatives the partner might have taken. When a partner tried to touch Jean's genitals, her feet chilled, she felt overcome with anger and shame, and she stopped her partner's initiative.

The therapist introduced Jean to readings about beauty and sexual attractiveness and they dedicated various sessions to discussing the traps of dominant cultural stereotypes. As she identified Jean’s misconceptions about sex, the therapist offered a series of educational activities, starting with learning to know female sexual organs and orgasm and a stepwise body exploration program providing recordings with guided activities including deep relaxation, body consciousness, muscular control and Kegel vaginal exercises. The readings and Jean’s observations resulting from the exercises were talked through in-session.

During this work, the therapist detected that their discussions were largely theoretical and hardly scratched the surface of Jean's experiences. While at first it seemed reasonable to attribute Jean's avoidance behaviour to the invasive nature of the contents that were discussed, it gradually became clear that the client treated the therapist in a way that resembled how she treated her sexual partners. In both situations, Jean monopolized control and made it difficult for the other to intentionally evoke emotional responses in her.

The therapist thought that sharing this observation would weaken the unproductive pattern. However, the opposite happened. Jean assumed leadership and conducted sessions in an authoritarian way. When the therapist started blocking these escape and avoidance strategies, Jean became gross and defiant. Again, there was a striking similarity to Jean's other relationships, in which she became irritable and aggressive when a sexual partner or friend tried to intensify the relationship or whenever Jean started to lose perceived control over the interactions.

When the therapist insisted in getting through to Jean’s feelings, Jean stayed away during three sessions and came back uncooperative. This was seen as a first important in vivo improvement compared to Jean’s typical daily-life pattern in which she definitely ended the relationship when a partner started to take initiative. Coming to the sessions and dealing in a close relationship with a therapist who was trying to be an active leader allowed her to contact feelings she had refused to tolerate in previous relationships. She protested and complained, but did not interrupt the relationship again. The therapist was able to show the similarity between the fights the client was having with her present partner and had had with several previous partners and friends and what was happening in the therapist-client relationship. This made it possible for Jean to agree to work on tolerating intimacy and allowing initiative from another woman. It was discussed how this corresponded functionally to allowing herself to be touched.

One example of in-vivo learning occurred during the introduction of a new relaxation exercise. Jean first refused, and then cooperated unwillingly, worrying about the therapist's judgments and about looking ridiculous. The therapist told her she accepted and understood these concerns, and encouraged her to trust that she would honestly tell Jean whenever she made any such judgments. The principles of mindfulness (Kabat-Zinn, 2005) were discussed and later practiced to promote acceptance of negative emotional responses during the treatment activities and to increase Jean's willingness to risk being touched.

Another example of in vivo learning occurred when Jean was asked to give a step-by-step account of her most recent sexual intercourse. She laughed, made comments like "I am not going to do this" and finally recited the successive phases of sexual excitement she had studied from a book, early on in treatment. By asking Jean to abdicate control to her during this threatening exercise, the therapist was actually inviting the client to risk feeling ridiculous or vulgar. At the same time, she let her concern about Jean's inner sexual experience be felt. Jean needed to allow the therapist to help her, by making herself vulnerable and permitting the therapist's initiatives.

Starting from this type of experience, Jean opened herself up to the therapist's initiatives in order to allow the latter to take care of her. After experiencing in-vivo during therapy how avoidance and escape were incompatible with intense positive feelings, Jean could commit to acting in accordance with the goals she had set for her sex life instead of prioritizing avoidance of negative feelings. The body knowledge exercises only started to progress when Jean accepted her feelings of shame and her irritation with the therapist's assertive style. This style paralleled the traditional masculine role of taking initiative and introducing, and it pushed Jean into the threatening feminine position of facilitating and expressing feelings.

Discussion

Monopolizing initiative and covering up vulnerability must have been useful skills in the dangerous neighbourhood and in the poverty Jean lived in. However, they did not promote the quality of sexual relationship she wanted. Her uncouth and intolerant responses to the initiatives of the other woman in the relationship invalidated the latter's sexual involvement with her. The meaning of being a woman and the use of her clitoris was constructed in a context of shame and ridicule. The personal history and idiosyncrasies of discovery and exploration of the clitoris affect its use (Waskul, Vannini & Wiesen, 2007), and Jean's way of dealing with her experiences in this realm was to banish it to the most abject corner of her sexuality, trying to avoid it at the cost of making orgasm unviable.

It is clear that a client's growth can be hampered if the therapist promotes traditional gender-role behaviours or unwittingly responds to pulls that are viewed as gender-appropriate but do not correspond to the client's needs (Bartholmew, 2003; Rabin, 1996). However, the therapist's work with Jean was highly focused on promoting *allowing* as a way in which Jean could allow the therapist could attend to Jean's needs. Allowing was not promoted for being a desirable feminine attitude. The therapist focused on negotiating a

more productive definition of their (therapist-client) relationship so that Jean could increase her commitment to the goals she had set for therapy. And this included that Jean should allow the therapist to take initiatives.

What made it hard for Jean to get what she wanted from the therapist was the fact that Jean acted mostly in order to avoid feelings she labelled as vulgar or feminine. She avoided these feelings by blocking initiatives by the therapist that were aimed at helping her reach Jean's goals for therapy. Had the therapist not blocked Jean's avoidance strategies, their relationship would have repeated the same pattern that had characterized Jean's sexual relationships. The therapist, like the other women in Jean's relationships would not be able to provide what Jean was trying to get from the relationship.

Final considerations.

In the case material discussed, the therapist-client relationship offered a context for Jean and for Joan to contact the reinforcing consequences of opening themselves up to a partner (namely to the therapist). Before this, making herself vulnerable had not led Jean to nurturing experiences, but rather to pain and rejection. For Joan, opening herself up had meant losing control over others, particularly over John, who indiscriminately responded to her attempts (and to those of the therapists) to get closer to him with verbal smokescreens and other escape strategies.

Had the therapist accepted Jean's avoidance strategies, and kept therapy on a didactic-rational level, or had the therapists in the other case study avoided a rupture in the relationship with John, in-vivo learning opportunities would have been missed. With the experiential level lacking in therapy, Jean could still have learned a lot about sex and orgasm, but she would have succeeded once again in getting through a relationship without the other woman (the therapist) being able to *touch* her. This would have strengthened her experiential avoidance patterns, which jeopardized her goal of feeling more confident about herself, and would not have contributed to the goal of getting more pleasure out of sex.

Similarly, if the therapists had accepted John's distancing manoeuvres in the therapeutic relationship, he might not have stayed away for months. The open struggle to define the relationship with the therapists gave him the opportunity to reject the therapists' instructions and seeking his own solutions instead. And this change in strategy was followed by his doing the same in his relationship with Jean.

We saw how Jean, John and Jane developed new daily life repertoires in their relationships with the therapists. The therapist-client relationship included the critical elements of Joan and John's marital problems and of Jean's sexual difficulties. As a result, in-vivo clinical change was possible during the sessions. This material illustrates how the therapist-client relationship can be used as an instrument to treat disorders and problems that cannot occur in the client's interactions with the therapist.

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