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Intervention based on functional analytic psychotherapy in a case of panic disorder with agoraphobia

Intervenção baseada na Psicoterapia Analítica Funcional em um caso de Transtorno de Pânico com Agorafobia

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Resumo

Estratégias terapêuticas descritas como eficazes em transtornos de ansiedade envolvem procedimentos comportamentais e cognitivo-comportamentais de exposição à enfrentamento de situações aversivas. Entretanto, considerando-se que o padrão comportamental comum a estes transtornos é a esquiva fóbica, o uso de tais estratégias pode dificultar a adesão ou promover fuga/esquiva do e no processo terapêutico. A Psicoterapia Analítica Funcional surge como alternativa para manejo dos comportamentos de esquiva e para promoção de respostas de enfrentamento. Este estudo de caso apresenta a análise da relação terapêutica de um caso de Transtorno de Pânico com Agorafobia. A intervenção baseada na FAP foi adotada para auxiliar no

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manejo do padrão de esquiva do processo terapêutico apresentado pela cliente. Os resultados demonstram a efetividade dos procedimentos adotados e confirmam a possibilidade de utilização da FAP para aumento da eficácia de terapias empiricamente baseadas.

Palavras-chave: Transtorno de Pânico, Agorafobia, Psicoterapia Analítica Funcional, Terapia Comportamental, Relação Terapêutica.

Abstract

Therapeutic strategies described as effective for anxiety disorders include behavioral and cognitive-behavioral procedures of exposure and coping with aversive situations. However, considering that the behavioral pattern common in anxiety disorders is the phobic avoidance, the application of these strategies may make adhesion difficult or promote escape and avoidance of the therapeutic process. Functional Analytic Psychotherapy is an alternative for dealing with these avoidance/escape behaviors and can promote coping responses. This case report describes an analysis of the therapeutic relationship of a client with Panic Disorder and Agoraphobia. The FAP-based intervention was considered to help dealing with the avoidance behavior in the therapeutic process. Results show the efficacy of the procedures adopted and confirm the possibility of using FAP for improving the effectiveness of the empirically based psychotherapies.

Key-words: Panic Disorder, Agoraphobia, Functional Analytic Psychotherapy, Behavior Therapy, Therapeutic Relationship.

Introduction

Panic Disorder is an anxiety disorder characterized by sudden and recurrent panic attacks, followed by worrying about further attacks and their implications and/or significant behavioral alterations related to the attacks (APA, 1995; Kaplan, Sadock & Grebb, 1997). In many cases a panic disorder is followed by agoraphobia, the fear of being alone in public places, which aggravates the condition and is a clinical concern as it is incapacitating, seriously limiting the social and occupational lives of the individuals who have developed it (Kaplan et al., 1997; Rangé & Mussoi, 2007).

Treatments considered more effective to improve symptoms, mainly when associated, are pharmacotherapy and cognitive behavioral therapy (Kaplan et al.; 1997; Rangé & Mussoi, 2007; Roy-Byrne, Craske, Stein, Sullivan, Bystritsky, Golinelli, & Sherbourne, 2005). Some behavioral techniques, such as exposure and response prevention, systematic desensibilization and social skills training, have been utilized and described as strategies for the treatment of anxiety disorders (Simão, 2001).

However, even though the use of these techniques has allayed symptoms, it is necessary to reflect and proceed with care to attain therapeutic success and population reach. This is so because, as Zamignani (2001) points out, the application of procedures, when it is isolated from functional analysis and focuses on the variables of a covert nature, may overshadow the role of other relevant environmental

variables. Furthermore, the aversive nature of some procedures can result in patients' unwillingness to take part in the therapeutic process and in difficulties in following the treatment (Zamignani & Banaco, 2005).

Coêlho and Tourinho (2007) concur as to the limitation of interventions that emphasize only a part of the relationships involved in anxiety. According to these authors, there are several definitions for the concept of anxiety within the analytical behavioral perspective. As a result of these definitions, different interventions in case the of anxiety are proposed and put into practice: some highlight body condition aspects, others focus on operant nonverbal relationships, whereas others aim at modifications in operant verbal relationships (Coêlho & Tourinho, 2007). According to these authors, such focused interventions, notwithstanding a certain range, are not able to intervene in the wide spectrum of relationships involved in a complex phenomenon such as anxiety.

A way to increase intervention effectiveness, considering the highest number possible of variables, was proposed by Zamignani and Banaco (2005). In the analysis suggested by these authors, one should consider: I) a) establishing operations (deprivation and aversive stimulation conditions), b) pre-aversive discriminative stimuli and c) covert responses - composing the previous context for the occurrence of a response; II) anxiety responses (compulsion, checking, escape and avoidance), which would be followed by III) a) negative reinforcement consequences, such as elimination or postponement of aversive stimulation and b) positive reinforcement consequences. In addition, IV) stimuli and responses present at any point of this analysis could establish generalization or stimulus equivalence relationships and could elicit or evoke anxiety responses.

The difficulty in sticking to the treatment, when it is restricted to the use of exposal to aversive stimulation techniques - such as exposure and response prevention, systematic desensibilization and combating the avoidance of aversive situations - can be explained with this analysis. Aversive contingencies present in the techniques can result in establishing operations and evoke avoidance responses in the therapeutic process (Zamignani & Banaco, 2005). Since the behavioral pattern common to anxiety disorders is phobic avoidance - emission of responses that eliminate, soften or postpone the occurrence of a threatening or uncomfortable event (Zamignani & Banaco, 2005), a high rate of treatment avoidance based solely on these techniques can be predicted. Roy-Byrne et al. (2005), for example, describe a 31.9% (38 among 119 patients) absence rate at three or more sessions of the six offered in a research on the effectiveness of using Cognitive Behavioral Therapy and Medication for the Treatment of Panic Disorders. It is also necessary to inquire whether the data found in other surveys on treatment success restricted to standardized procedures refer only to the data gathered from clients taking part in the treatment, disregarding dropout rate, which would question its real level of effectiveness and population reach.

Preventing aversiveness in coping with anxiety situations, we suggest: 1) following procedures making the therapeutic process less aversive, such as previously notifying the client of the procedures that will be adopted, and non-punitive audience, and 2) the development of a strengthening relationship between therapist and client before the beginning of applica-

tion (Zamignani & Banaco, 2005). Another approach is being based on the very therapeutic relationship as an intervention strategy following the Functional Analytic Psychotherapy proposal: FAP) in order to implement client's participation and effectiveness of other implemented procedures, as described by Vandenberghe (2007) in reports of intervention to two cases of obsessive-compulsive disorder.

Functional Analytic Psychotherapy (FAP) is prescribed precisely for clients who do not stick to or do not respond adequately to traditional therapies (Follete, Naugle & Callaghan, 1996; Kohlenberg, Tsai, Parker, Bolling & Kanter, 1999). Among these clients are, e.g., those who avoid intimate interpersonal relationships (García, Aguaio & Montero, 2006), which hinders complaint clarification and the formation of therapeutic alliance and the effectiveness of traditional intervention strategies. According to Kohlenberg et al. (1999), Follete, Naugle and Callaghan (1996), Kohlenberg and Tsai (2001), FAP is based on the principles of Radical Behaviorism of reinforcement, stimulus generation, and functional analysis of verbal behavior and stimulus equivalence relationships. This therapeutic proposal considers the therapist-client relationship is a real interaction that has the potential to evoke and change client problem behaviors (Kohlenberg et al., 1999). Under the FAP perspective, clients tend to reproduce in the therapeutic context the same pattern of problematic responses found in other general life relationships, giving the therapist the possibility to consequence their emission in a contingent and natural form and to progressively create more adequate responses (Follete, Naugle & Callaghan, 1996; Kanter, Landes, Busch, Rusch, Brown, Baruch & Holman, 2006). To decrease problem behaviors, the therapist stops reinforcing them, creates more effective concurrent behaviors or occasionally punishes them when they are unpleasant in the client's interactions with other people (Follete, Naugle & Callaghan, 1996).

The cases described by Vandenberghe (2007), in which FAP procedures were used for intervention in cases of obsessive-compulsive behavior, led him to find that: the anxiety disorder symptoms observed in the therapeutic interaction, frequently deemed as hindrances to the treatment process, can be used therapeutically. This author concluded that FAP is not inconsistent with rational or empirically based therapies to handle anxiety symptoms, such as exposure and response prevention, and can even increase their effectiveness.

Thus, it is suggested that FAP can be an effective strategy to deal with behaviors regarding sticking to the therapeutic process in clients whose selected behavioral repertoire was an escape and avoidance pattern, as with anxiety disorders. With these considerations in mind, our aim is to present an analysis of therapeutic intervention and FAP-based intervention in a case of panic disorder with agoraphobia.

Case report

Virginia (fictitious name), female, 47, separated for three years, mother of two sons and two daughters between 20 and 26 years of age (with whom she lived), public servant. At the first therapy session, Virginia reported:

- *"Sometimes I want to go out, but I can't do that." It is hard to leave home every morning, I get sick in the morning, I think it is because I'm afraid. This is my struggle, but then I up and leave."*

Throughout the sessions, it was possible to find that these and other client complaints were consistent with the diagnosis of panic disorder with agoraphobia: (a) panic attacks (sudoresis, tachycardia, trembling, nausea, hand tingling) at public places and in public transportation, which were later avoided; (b) worry about other attacks; (c) fear of leaving home followed by retching; (d) difficulty eating and taking medication due to constant nausea.

Data collection and complaint clarification procedures, constituting a functional analysis of the case, were conducted according to the description by Brandão, Pezzato e Oshiro (2010). In short, they involved: 1) a survey of initial hypotheses from the theoretical conceptual corpus of behavior analysis, 2) data collection from the report on contingencies present in the client's daily life, 3) investigation of the client's background and 4) direct observation of the client's behavior during sessions.

As can be seen in Table 1, the data surveyed by procedures 1, 2 and 3 allowed us to identify contingencies present in Virginia's daily life responsible for the establishment and maintenance of her complaint. Such contingencies involved especially the emission of operant responses of escape or avoidance of aversive situations - situations that elicited anxiety respondents or demanded a coping response emission, as problem solving, behavioral repertoire development and social exposure.

The direct observation of client interaction with the therapists contributed to identifying and illustra-

Table 1: Functional analysis of daily contingencies present in Virginia's case, according to the diagnostic procedure described by Brandão et al. (2010).

Context	Antecedents	Responses	Consequents
Loss of people in her social group (R+) who solved Virginia's problems (R-)	- situations demanding performance or signaled panic episodes or kidney colic (S conditioned: stomachache, stomach discomfort, public transportation, crowds, invitations to get out, etc.)	- corporeal anxiety - describing symptoms - staying at home or delaying getting out - getting off the bus - turning down invitations to get out - asking people to solve her problems (e.g., her daughter should buy a car)	- escape from corporeal anxiety/avoidance of its intensification (R-) - social support: approaching people (R+) and help in problem solving (R-) (e.g., friend's visit, sisters' call, son takes her to the movies). - escape/avoidance to cope with aversive problems and to be evaluated in the search of reinforcers (R-)

Table 2: Clinically relevant problem behaviors (CRBs1) observed during sessions and their correspondents outside of sessions.

CRBs 1	CORRESPONDENTS OUTSIDE OF SESSION
- avoiding talking about oneself (e.g., talking about the weather, the traffic, other people, asking questions about the therapists' lives) - avoiding getting in touch with feelings (e.g., changing subjects when negative feelings come up, smiling while narrating such events) - avoiding conducting and reporting requested observation tasks (e.g., saying she could not do them, mainly by reporting failure due to anxiety symptoms "I didn't do them because I haven't felt well this week"). - describing symptoms in light of solving problem questions (e.g., the therapists suggest that Virginia face problem situations and go out with her children. She describes a situation in which she did not feel well). - requesting a magical solution ("I would like to have a magic wand for me to wake up tomorrow and have everything sorted out"). - not presenting for therapy	- difficulty establishing new intimate relationships (e.g., talking only about superficial topics or professional topics that do not demand much effort, such as making invitations, paying somebody a visit or making a call). - avoiding solving problem (e.g., taking out a driver's license, looking for fun, seeking medical assistance, investing in friends and emotional relationships, etc.) - describing anxiety symptoms by justifying avoidance and producing family support and a friend's bonding.

ting the behavioral pattern of escape and avoidance to cope with problem situations at the therapy sessions. The demand established by the therapists along the sessions was proved to be aversive to the client, causing the emission of responses as: absences, symptom description in light of problem solving questions, denial to conduct observation and contingency description tasks, request for magical solutions involving no effort (e.g., "magic wand"), avoiding talking about herself and getting in touch with feelings (e.g., laughing when describing a divorce or parents' death).

These escape and avoidance responses of the therapeutic process prevented the utilization of traditional procedures, as the high frequency of absences and the inconsistent execution of tasks and strategies proposed did not allow shaping contingency description responses, using desensibilization techniques and creating conditions to learn new pro-

Table 3: Clinically relevant behaviors pertaining to improvement (CRBs2) observed during sessions and its correspondents outside of sessions.

CRBS 2	CORRESPONDENTS OUTSIDE OF SESSION
- speaking about herself - getting in touch with feelings (e.g., talking about aversive topics and showing feelings consistent with them, such as crying, being moved) - building close relationships with the therapists (e.g., talking about her life, her difficulties, hugging, kissing) - engaging in the therapy and in complaint solving problems (e.g., attending every session, carrying out observation tasks, analyzing her life contingencies, thinking about and describing strategies to face difficulties).	- building new close relationships (e.g., speaking about oneself, being affective, making invitations, calling friends and family) - engaging in problem solving and skills development (learning to drive, learning to dance, seeking medical assistance) - seeking intrinsic and social reinforcers irrespective of symptoms (arranging to meet friends and outings with children when feeling well, going to places where she can meet people, dancing, traveling, etc.)

blem solving and reinforcer obtention responses. Such a repertoire was considered a class of clinically relevant behaviors (CRB1), as they occurred in the therapeutic relationship and corresponded to the behavioral pattern observed in daily life, which contributed to maintaining the complaint.

Intervention

The intervention process was based on the procedures proposed by Functional Analytic Psychotherapy (Kohlenberg & Tsai, 2001) to handle clinically relevant (CRBs) problem (CRBs1) and in-session improvement (CRBs2) behaviors. The procedure of differential reinforcement was proposed based on the previously described contingency analysis: avoidance blocking, differential reinforcement of other behaviors (DRO) and therapeutic relationship analysis in face of CRBs1; natural positive reinforcement of CRBs2 and positive reinforcement of client in-session analyses (CRBs3).

Examples (T1= therapist 1; T2= therapist 2; C= client):

"T1: We brought a couple of statements on paper slips that you made at previous sessions and we would like to reflect on them. I will give them to you so can you read them.
(The client reads them silently)

C: Well... I will discuss the statement: I would like to have a magic wand to sort everything out. I think this statements shows my impatience... you know... sometimes I don't see what I've gotten from therapy and I feel like quitting. But I think I'm improving a little... even though it's hard, I go to work every day... But I still observe myself little and I know that's important (she describes the relationship that she has just observed between drinking soda and having stomach ache).

T1: That is right!!! Virginia, what connection do you see between observing yourself little and wishing for a magic wand to solve your problems?

C: I think it is because it's fast. To solve them quickly... I suffer a lot with these feelings...

T2: But is it only a matter of time?

C: I don't know. What do you think?

T2: It looks like it is difficult for you to observe.

C: For me it really is, it's just that I start thinking, observing, I see things from my past I don't like. Things I quit doing, for example, driving, swimming... and that really frustrates me.

T1 describes the process of experiential avoidance, how it applies to Virginia and general coping procedures.

C: Interesting... I do avoid that... It is bad because I see I have to act. I've never been a go-getter.

T1: How does that relate to the magic wand?

C: Because I won't need to do those things!

T1: Exactly!

T2: Good for you you can see the relationship! And how do you intend to deal with these avoidance behaviors?

C: I'm thinking... I don't know yet if I want to do the things I wanted to: driving, riding a bicycle, swimming. You know... sometimes I think: Anyway, I don't have much to live! (avoidance CRB1)

T2 discussed the consequences of these behaviors. The client once more showed avoidance behavior (CRBs1) saying that it wouldn't make a big difference in her life to do those things.

T2: But what are the consequences for your feelings?

C: Frustration. And I feel that riding the bus reminds me of my frustrations... that I don't have a license...

T2: Wow... that is hard... so it looks like today's situations remind you of your past frustrations.
C: Exactly.

T1: But look, Virginia, you're not doomed to keep suffering because of these frustrations. We are here to help you along the way.

T2: And dealing with difficulties has to do with the second phase we've selected for you. That is, you've been working to achieve that. (Statement: I'm keeping control over my own life"). Right after that T2 asks Virginia what she thinks about it.

C: Oh... I don't know... It's so hard... I don't know how to deal with it... (CRB1)

T2: Maybe it's not that hard, maybe it's only a matter of you observing yourself and noticing that you've already got control of a few things.
At this moment T1 reminded Virginia of the gains that she has already had, such as the close relationship she built with the therapists. (DRO)

C: I know I've changed... I feel empty, but I do agree that I was very closed and now I'm better...
The therapists signaled to Virginia the importance of looking at her gains and of thinking of strategies to have her life under control. They praised her for the conclusions she made during the session.

T2 praises Virginia's engagement in the therapy by saying that coming to therapy, even when it is difficult and you don't feel like coming, is an important coping mechanism (CRB2).

C: Right, but you know it is difficult to come sometimes. But then I leave with a good feeling, feeling I'm getting somewhere."

At the next session, T1 mentioned that at the previous week they had engaged in important but very difficult discussions and she would like to know how the client felt after the session.

"C: Well... you really got me with the magic wand thing...

T1: And have you reflected on it?

C: Hmm... I always want everything very quickly and I can't wait for it... then I consider quitting therapy...

T1: And we saw that besides speed the magic wand meant other things, right?

C: Right... because there are many things I can't do, like , riding a bike, swimming... and I feel very frustrated...

T1: And if you can't do these things, what does the magic wand mean?

C: Hmm... it means I don't need to take chances, right?

T1: But what are the pros and cons of using the magic wand?

C: The pro is I don't have to think about the things I can't do... you know, sometimes frustration comes over me, you know? But I know that means I'm not facing the challenge, right?

T1: That is great, Virginia! Your description was great!

C: And you know... when I think I'll have to take chances, take the first step, the first thing that comes to my mind is: "I won't go to therapy".

T1: We are glad you are telling us that."

Results

The results showed a decrease in CRBs1 and an increase in CRBs2. The client started describing contingencies, talking about herself, about her difficulties and feelings and showing positive and negative feelings consistent with the events she narrated, as well as reporting she feels confidence in the relationship with the therapists (CRB2), pointing out to the building of close relationships.

"C: I'm very closed... but here with you I'm not sure... I think it's really great to trust someone.

T1: That is what we want to show... this relationship we're building here at therapy can be extended to other people..."
Symptoms were no longer described at the request of the therapists and were replaced with reporting the need to seek reinforcers and face aversive situations. Notwithstanding her statement regarding how difficult it would be and that she would need to gradually face her difficulties, Virginia stopped skipping sessions, she described a few tasks she could pursue and agreed to the analysis of wishing for a magic wand, which illustrated her difficulty in coping with the problem situation. Example:

"T1: Virginia, remember you said you would think about you like now?

C: I know, but I didn't think about it. I know that what I enjoy now is to be with my children. But you know, I don't think I want to pressure myself... my thinking is: what I'm going to do 5 years from now, I have to think about the long run. Because if I think: I'm going to get my driver's license this year... then I get stuck, it can't be like that.

T1: But Virginia, when we asked you to think about what you like, it didn't need to be something major.

C: Right, I always tell my daughters I need to do something for myself. Something I would maybe like to do is to take up dancing. I can picture myself dancing." (CRB2).

Discussion

The analysis of the therapeutic relationship and FAP procedures demonstrated effectiveness not only as an intervention instrument, but also as a strategy to cause the client to stick to the therapeutic process. The escape and avoidance behavioral pattern shown by Virginia, common in anxiety disorders (Kaplan et al., 2002; Zamignani, 2001; Zamignani & Banaco, 2005) hindered data collection for complaint clarification, since describing loss and failure situa-

tions and expressing feelings seemed aversive to the client, who gave escape responses to the therapists' questions.

The therapeutic bond getting stronger by means of nonverbal (smiles, hugs) and verbal (compliments, conversations about topics seemingly agreeable to the client) responses by the therapists as well as non -punitive audience contributed to keeping the client at the therapy. However, the high frequency of escape/avoidance responses of observation, contingency description and aversive situation coping tasks hindered the engagement in the process and the patient's clinical improvement. Thus, the use of positive reinforcement contingent to the initially few coping responses of the client (CRBs1) and differential reinforcement of other behaviors (DRO) with respect to escape/avoidance responses (CRBs2) can be considered effective necessary intervention strategies. The analysis with the client of the in-session escape/avoidance pattern (the magic wand) and its consequences also seemed efficient to clarify the analysis of contingencies involved over the course of the sessions (escape/avoidance patterns) and its later correlation with the contingency analysis described in daily life, previously avoided by Virginia.

The cases are consistent with those described by Vandenberghe (2007) insofar as the anxiety disorders symptoms observed in the therapeutic interaction, frequently deemed as hindrances to the treatment process, can be used therapeutically. They are also consistent with said author's analysis of compatibility and possibility to use FAP to aid in conducting undoubtedly efficient therapies, such as Cognitive Behavioral Therapies. However, the reservations about an aversive potential of certain procedures in clients with an escape/avoidance behavioral pattern established and maintained by positive and negative reinforcement in daily life must still be voiced, as is Virginia's case. Although the present report is restricted to the initial procedures that aimed at keeping her presenting for treatment, data collected in other research on FAP (Garcia et al., 2006; Kohlenberg et al., 1999) suggest that clinical improvements tend to become general. Therefore, the coping pattern that started to be positively reinforced and became more frequent at the sessions can occur outside of therapy and promote coping with aversive situations in the client's daily life, obviating the need to follow artificial procedures of exposure to aversive situations in the context of therapy.

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