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Importance of the Therapeutic Relationship: Efficacy of Functional Analytic Psychotherapy with Different Problems

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A B S T R A C T

Functional Analytical Psychotherapy (FAP) is a third generation and contextual therapy. It is based on therapeutic interaction, verbal and emotional client-therapist relationships. It also uses functional analysis of behaviour, and live on-going modification of clinical problem behaviours. The aim of this research was to study the efficacy of FAP with different types of psychological problems (anxiety, depression, obsession, sexual, personality, emotional control). An intra-group design (10 participants, 36 years old average) was used with pre-post and follow-up measurements. Different questionnaires have been used as common assessment tools for all clinical cases. The results showed a statistically significant change in all the standardised questionnaires, with a considerable size effect (*d* from -2.01 to -3.80) and maintained one year later. Also, as clinical change, the participants had improved in their daily lives. We conclude on the efficacy of FAP, focusing on the therapeutic relationship, regardless of diagnostic categories.

La importancia de la relación terapéutica: la eficacia de la psicoterapia analítica funcional en distintos problemas

Palabras clave:
Relación terapéutica
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R E S U M E N

La Psicoterapia Analítica Funcional (FAP) es una terapia contextual y de tercera generación que se basa en la interacción terapéutica y las relaciones verbales y emocionales cliente-terapeuta. También utiliza el análisis funcional del comportamiento y la modificación en vivo de los comportamientos clínicos problemáticos. El objetivo de esta investigación es estudiar la eficacia de la FAP ante diferentes tipos de problemas psicológicos (ansiedad, depresión, obsesión, sexual, personalidad, control emocional). Se utilizó un diseño intragrupo (10 participantes, con un promedio de edad de 36 años) con mediciones previas, posteriores y de seguimiento. Se han utilizado diferentes cuestionarios como herramientas de evaluación comunes para todos los casos clínicos. Los resultados mostraron un cambio estadísticamente significativo en todos los cuestionarios estandarizados, con un efecto de tamaño considerable (*d* de -2.01 a -3.80) que se mantenía un año más tarde. Además, como cambio clínico, los participantes habían mejorado en su vida diaria. Concluimos sobre la eficacia de la FAP, centrándonos en la relación terapéutica, independientemente de las categorías diagnósticas.

Functional Analytic Psychotherapy (FAP) (Kohlenberg & Tsai, 1991; Tsai et al., 2012, 2009) is a contextual therapy that is part of the so-called third generation therapies (Hayes, 2004; Pérez-Alvarez, 2012). One key feature is to reconsider the therapeutic context itself as the fundamental interaction for a change in behaviour to occur. The functional analysis of the therapeutic relationship is proposed as fundamental as it assumes that the clinical setting is a natural condition where a client's problems may occur, and also an opportunity for the client to make improvements. FAP is an idiographic therapy, which is based on the principles of functional analysis of a client's behaviour during the session. It includes contingencies of natural reinforcement and shaping that happen within the clinical session itself. In addition, FAP establishes the functional equivalence of the behaviour in the context of a session with other outside behaviours, which occur during the daily life of an individual (Kohlenberg & Tsai, 1991, 1995).

The change process focuses on a client's direct behaviour, what the client does and/or says within the session (including talking, thinking, feeling, seeing, hearing, remembering, emotional responses, etc.), which are the so-called "clinically relevant behaviours" (CRB). There are three types of these behaviours, which the therapist must learn to identify as therapeutic goals (Kohlenberg & Tsai, 1991, 1994, 1995; Kohlenberg et al., 2009). CRB type 1 are the client's problems that are revealed during the session, usually complaints and problems that cause him/her to suffer, and whose frequency should

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Table 1. Characteristics and Problems of all Participants

	Age	Sex	Diagnostic	Sessions	Follow-up (month)
1. Ángela	28	Female	Anxiety, Depression, Choke phobia	11	11
Problems	She had anxious, depressed-type behaviour, and choking phobia. She avoided all kinds of solid food, places where she had to eat in public, and even did not let her young son take anything solid. Loss of weight (20kg).				
2. Antonia	36	Female	Anxiety, Depression, Specific phobia	16	11
Problems	She had anxious and depressive behaviours, ruminations about going to the toilet in inappropriate situations. Avoidance of social situations and long trips. Marital Conflicts. She left all projects unfinished.				
3. José	58	Male	Depression, Anxiety	18	13
Problems	Depression, sick leave, self-induced disabling ruminations about his job and his future. Social withdrawal, sadness, not getting out of bed, and continuous crying.				
4. Antonio	31	Male	OCD, Depression, Sexual problems	24	14
Problems	Obsessive and compulsive behaviours, rituals about slowing down, contamination and checking. Social avoidance. Sexual identity problems, impulsive sexual episodes.				
5. Leticia	26	Female	OCD, Spaces Anxiety	14	10
Problems	Obsessive and ruminant problems, constant “what if” phases. Social avoidance, never going out alone, anxiety in open contexts and with people. Fear of abandonment. High level of anxiety in general.				
6. Miguel	24	Male	Anxiety, OCD	12	10
Problems	Obsessive and ruminant health-related problems, anxiety in social situations, self-concept problems. Avoid social situations. Self-invalidating thoughts. Anxiety in general.				
7. Juan	42	Male	Anxiety, OCD	16	12
Problems	Obsessive and ruminant health-related problems, continuous medical readings and consultations.				
8. Manuela	34	Female	Obsession, Anxiety	13	12
Problems	Obsessive thoughts related to hurting someone, thoughts on fulfilment. Social withdrawal, avoiding personal and intimate relationships.				
9. Carlos	59	Male	Anxiety, Sexual relationships	16	12
Problems	Anxious and depressive problems. Episodes of anger. Withdrawal and avoiding social situations, intimate relationships. Problems with the partner and sexual relations.				
10. Verónica	29	Female	Depression Anxiety	22	15
Problems	Anxious and depressive problems. Social withdrawal. Abandonment of responsibilities, family, studies, tasks, commitments, etc. Self-invalidating thoughts.				

be reduced by the therapist. They are under the control of aversive stimuli and often have an avoidance function. CRBs type 2 are the client’s improvements that are made during the session, which should occur progressively over the course of the therapy. CRBs type 3 are the client’s interpretations of his/her own behaviour and what he/she believes causes it. Therefore, they are sentences about functional analysis in his/her own words. They involve observations and descriptions of a client’s own behaviour, and the reinforcing, discriminatory, and eliciting stimuli associated with it.

Additionally, FAP takes into consideration what the therapist must do, so it proposes 5 “therapeutic rules” that the professional must always keep in mind during the session. These rules help the therapist to evoke, point out, reinforce, and analyse the client’s behaviours. The first rule consists of observing possible CRBs during the therapeutic session. The second rule proposes building a therapeutic environment that evokes CRBs. Rule number 3 consists of organising the positive reinforcement of CRB-2 in a natural way. Rule number 4 seeks to observe the reinforcing properties of the therapist’s behaviour in regard to a client’s CRBs. Finally, rule 5 tries to generate in the client a repertoire of describing functional relationships between the control variables and his/her behaviours.

Because of its transdiagnostic character, based on therapeutic relationships, FAP has been applied to a wide variety of problems: anxiety, depression, obsessions, sexual problems, relationships with partners, chronic pain, personality disorders, etc. Also, it has been successfully applied in different populations (adults, children, adolescents, abused women, people with chronic problems, etc.), and different modalities (individual, groups, brief applications). Studies about efficacy and effectiveness have increased in empirical literature in recent years. Single-case descriptive studies have been published about FAP (Ferro et al., 2010; Ferro et al., 2012; López-Bermúdez et al., 2010); also there have been studies with clinical cases with single-subject design (Singh & O’Brien, 2018) and with different types of problems and countries (Ansarypour & Abedi, 2019; Aranha & Oshiro, 2019; Muñoz-Martínez, 2018). However, group effectiveness studies are less frequent in published literature, such as those of Gaynor and Lawrence (2002) about adolescents with depression where authors combined cognitive-behavioural therapy with FAP in the interactions of live experiences. Maitland and Gaynor (2012) conducted a first study with 8 participants who were afraid of personal and intimate relationships, showing the efficacy of FAP for those social relationships. Holman et al. (2012) carried out two trials with a short 4-session FAP treatment, one with 7 people and another with 6. The whole process focused on personal and couple relationships and also showed the efficacy of FAP at improving close personal relationships. Also Vandenberghe et al. (2018) and Ruiz-Sánchez and Ruiz-Miñarro (2018) has published a procedure for group therapy with FAP.

Comparative effectiveness studies are also scarce. So Kohlenberg et al. (2002) compared the efficacy of FAP when added to cognitive-behavioural treatment for depressive problems. Combining both components increased the efficacy in all participants, but follow-up showed that the outcomes were better in those who had received FAP. In a study by Gifford et al. (2011) comparing the contribution of FAP, ACT, and Bupropion treatments to smoking cessation, the results were better in both short and long-term for those participants that received a combination of FAP + ACT. The study by Maitland et al. (2016) compared a group of 11 clients who had various anxiety problems treated with FAP, versus another 11 participants on a waiting list. In the results, those who received FAP had better outcomes and greater adherence to the therapeutic relationship. An extensive review of all these studies can be found in Mangabeira et al. (2012), Valero-Aguayo and Ferro-García (2015, 2018), and Kanter et al. (2017).

Because of the idiographic characteristic of FAP, there are few publications with groups, so this study aims to show the efficacy of FAP in a group of clients with different psychological disorders and problems, with different possible diagnoses, and different personal characteristics. The objective is to show that a treatment based on

the direct change of behaviour (using behavioural techniques) in the clinical session, and that uses the client-therapist relationship as a context for that change, can produce clinical and vital effects regardless of the diagnostic category of the problems.

Thus, the aim is to demonstrate the efficacy of the idiographic approach of FAP. The process centres on the therapeutic relationship itself, where the mechanisms of behaviour change are more important than the topography or formal diagnosis of that behaviour. To show this efficacy, FAP has been applied to 10 participants with different problems (anxiety, depression, obsession, sexual problems, personality disorders), who may have different diagnoses, and have behaviours included in several diagnoses at once. For this purpose, an intra-group design has been carried out with pre- and post-treatment measurements, as well as a follow-up assessment one year later.

Method

Participants

Different clients from a private clinical centre were the participants for this study. The total sample consisted of 10 people (5 males and 5 females), with ages from 25 to 59 years old. The inclusion criteria were that they had psychological problems related with private events, emotional disturbances, and cognitive anxiety or personality problems. Given the caseload of problems attending private consultations, these were specifically selected for the study because the problems with private and emotional events made them more suitable for applying FAP, rather than a more traditional approach to other cases. They were informed about the characteristics of treatment and clinical process in the first session, and signed an informed consent to record the dialogues during the sessions, and to use the information and data for research, in all cases the anonymity of that information on publishing being assured. To that end, the names and identification characteristics are altered and disguised. Table 1 shows the fundamental data of those participants, including the number of session treatment and time for follow-up. These are the specific descriptions for each participant, including what problems (CRB1 in daily life) were fundamental as behaviour goals for therapy.

Instruments

For all the participants the same standard questionnaires were applied to assess depression, anxiety, and acceptance behaviours. All participants were different, but the use of the same instruments allowed us to compare the general results of therapy.

Beck Depression Inventory-II (BDI-II; Beck et al. 1996; Spanish adaptation from Sanz et al., 2011). It is a standard for depression assessment widely used from the first version. It has 21 items with a different alternative response for each one. The range score could be from 0 to 63, and according to the original authors and the Spanish adaptation, a score from 20 to 28 indicates mild depression and a score of 29 and over is severe depression. This second version and the Spanish adaptation has a high index of reliability (between .87 and .90) and good diagnostic efficiency (ROC = .91) for depressive and non-depressive people.

Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004; Spanish adaptation from Barraca, 2004). This is an instrument for the measurement of experiential avoidance, when a person is unwilling to experience private emotions, and the opposite concept like psychological acceptance, when a person can observe those private events, especially negative or anxious, without escaping or avoiding them. It has 9 items scored in a Likert scale from 1 (*never*) to 7 (*always*) on the extent to which the description of emotional items is true for the person. The original has an internal reliability of .70 and test-retest reliability of .64. The Spanish adaptation has a Cronbach alpha of .74 and test-retest of .71. They are not cut-off points, but the Spanish sample was a mean of 34.61 and clinical sample was 44.71 points.

Anxiety Sensitivity Index-III (ASI; Petterson & Reiss, 1992; Spanish adaptation from Sandin et al., 2001) is a self-report instrument for the measurement of the sensitivity for anxiety (physical, cognitive, and social concerns). It has 16 items valued in a Likert scale from 0 = *nothing*, to 4 = *enormous anxiety*, with total score range from 0 to 64. It has a good reliability index (from .80 to .91), temporal consistency (from .42 to .85), and some correlations with other scales on negative effect and psychopathological variables. There are no cut-off points and the normative mean sample was 19.01 points.

Design

An intra-group with repeated measures was used in order to test the effects of the treatment on all the participants. Data were recorded at pre-treatment, post-treatment, and follow-up after a year in most cases. Because of the different number of treatment sessions for each person, the time period between measurements are not exactly the same.

Data Analysis

Because of the small sample, we used Student's *t* for small samples with related measures for comparing each questionnaire by pairs. Also, the normal Kolmogorov-Smirnov test for all variables was applied. The comparisons were between pre and post, where it was supposed that significant changes would be found; and later between the post and follow-up results, where it was supposed that changes would never happen because efficacy was maintained over a long period of time. SPSS-22 Mac software was used for data analysis.

Treatment

The same therapist, with more than 15 years of clinical experience, treated all the cases and was formed in FAP working and supervised in-group by other therapist. The process was the same in all the clinical cases. Several textbooks that explain FAP in detail have already been published, both by the original authors in English (Holman et al., 2017; Kohlenberg & Tsai, 1991; Tsai et al., 2012; Tsai et al., 2009), and the publications in Spanish about it (Valero-Aguayo & Ferro-García, 2015, 2018). Readers can find details in those publications about concepts, procedures and application of FAP in numerous clinical cases, with details of dialogues, examples, and helps for therapists.

First session was the general interview, informed consent, and application of different questionnaires. In this session the therapist looked for CRB1 in their behaviour into the clinical context and in their lives. Table 1 summarises main problems (CRB1 in daily life) for each participant. They can receive diverse psychopathological categories, but FAP is an idiographic approximation and use functional analysis to assess main problems and variables that could cause them. All the participants had emotional problems, anxiety, depressive behaviours, and personality problems at same time. A single category could not be used for those cases. Also, FAP could be considered as a transdiagnostic approximation to psychological problems (Ferro-García & Valero-Aguayo, 2017; Wetternet & Hart, 2012).

In that process, with each participant, the therapist made "case conceptualization" (Ferro-García et al., 2009; Tsai et al., 2009) writing a scheme of the principal information: relevant history, live CRB1, within-session CRB1, cognitive statements, within-session CRB2, live CRB2, and possible CRB3.

For example, case 1 (Angela) was a 27-year-old woman, married, with a 2-year-old son, who worked on sales. She suffered from anxious, depressive behaviours, and phobia of choking when eating in public, with an extreme weight-loss (20 Kg), and a history of obsessive-compulsive checking behaviours about somatic complaints. In session she spoke continuously and compulsively about eating, spoke very loudly, ignored the therapist's questions, and asked him for incongruent and off topic questions. The total therapy was over 11 FAP consultations, with a follow-up at 11 months later. In a similar way, case 2 (Antonia), case 9 (Carlos), and case 10 (Verónica) suffered anxious and depressive problems.

Antonia was a 36-year-old woman, married, with an 8-year-old daughter, who worked in a family restaurant. She has also obsessive thoughts about soiling or defecating herself, self-medicated, and avoided social situations and traveling if not strictly necessary because of those worries. She left all projects unfinished. Into the session she had CRB1 like asking for the bathroom or repeated phrases about those preoccupations that was affecting her social and family life.

Carlos was a 59-year-old man, married, with 6 children, who was a businessman, and had also dysphemia, episodes of angers, and withdrawal; his marital relationship had deteriorated and avoided personal relationships because he also avoided speaking with others. In CRB1 within the session he did not speak clearly, gave mysterious answers, and did not complete the questionnaires and episodes of open hostility towards the psychologist. The therapy consisted of 16 FAP consultations, and follow-up took place 12 months later.

Veronica was a 29-year-old woman, single, living with her parents, and preparing state examinations. She had also episodes of withdrawal and total abandonment of responsibilities, tasks, personal care, studies, social relationships, etc. She made continuous self-invalidating statements. Those sentences were also her CRB1 within session; he spoke repeatedly about her past, about her image, or physical appearance. The therapy consisted of 22 FAP sessions, and the follow-up was 15 months later.

Other group of participants have also anxiety and depressive behaviours, the most important being obsessive, ruminative, and compulsive behaviour of different types. Same problems had case 3 (José), case 4 (Antonio), who had a formal diagnostic as OCD by other professionals, similar to case 5 (Leticia), case 6 (Miguel), and case 7 (Juan).

José was a 58-year-old man, married and with three children. He was a manager of an aggregated plant affected by the financial crisis. He had intense depressive behaviour and was on sick leave. He cried and complained continuously about his life, his ruminations were always on the same topic. He was inactive and avoided personal relationships. As CRB1 in consultation, he complained continuously about the financial situation, self-invalidating comments, and demanding care form the therapist. Therapy took over 18 FAP sessions, encouraging activation, and follow-up was al 13 months.

Antonio was a single 31-year-old man, studying for competitive state examinations for judiciary. He had depressive, obsessive, and compulsive behaviours with checking rituals. He had obsessive worries about health and contaminating issues. He declared himself as gay, but with sexual identity problems. He had episodes of withdrawal, avoided social relationships, but sometimes he had impulsive sexual behaviours, dating with strangers, and strong feelings of guilt afterwards. The CRB1 within session were repetitive behaviours like looking at the clock, getting nervous and laughing when answering questions, avoiding touching objects, frequent questions about "control". Therapy was carried out in 24 FAP consultations, and follow-up was at 14 months.

Leticia was a 25-year-old woman living with her partner and working as an office administrator. She felt abandoned by her parents at divorce, and had anxiety attacks and intense fear of been abandoned. She avoided going out alone, and also avoided driving. Among the CRB1 within sessions she had signs of nervousness and repeatedly questioned about what was happening to her, being also hostile towards the therapist at the beginning. The therapy was based on 14 FAP sessions, and the follow-up was 10 months later.

Miguel was a 24-year-old-man, living with his parents and sister, and working in agriculture on a family farm. He had avoidance behaviour related to anxiety and health-related ruminations. He took his blood pressure and pulse rate compulsively. The origin was a sudden heart attack of his uncle that recently died. He had also self-concept problems and social relationships with strangers. As CRB1 he presented difficulties asking questions in a clear and direct way; he made self-invalidating comments and avoided to speak about intimate issues. Therapy took 12 FAP sessions, and follow-up was carried out 10 months later.

Juan was a 42-year-old-man, married, with two children. He worked as a welder in a factory. He had patterns of obsessive behaviour related to health, visited several doctors, consulted the Internet repeatedly about health, read medical reports. In sessions as CRB1 he referred to illnesses with "disguised control" in order to obtain reassuring answers; he complained continuously of pains and discomfort. In the most severe episodes, he isolated himself and avoided social relationships.

Case 8 (Manuela) had also obsessive thoughts, but with self-invalidating statements, thoughts related with hurting someone, avoiding personal and intimate relationships. She was a 34-year-old woman, living with her partner and not working outside home. CRB1 in session was alluding repeatedly to her past and remembering episodes of mistreatment by her mother, looking at the clock repeatedly and showing signs of discomfort. Therapy lasted 13 FAP consultations, and follow-up was at 12 months.

Treatment for each case was idiographic but following the rules of FAP, and applying fundamentally the shaping of CRB1 and reinforcing of CRB2 and CRB3. The therapist created collaborative relationships, validating the person, but analysing the functions of the problems they presented. For instance, looking for the reaffirmation of obsessive-compulsive behaviours, analysis of their avoidance functions. So, the therapist taught the clients to observe and feel the emotions they aroused, but without avoiding them. The therapist shaped the fears and avoidance within the session facing those anxiety thoughts. Also, he shaped and blocked asserts about the past, and the FAP exercise of "writing with the non-dominant hand" was also carried out in order to observe and feel emotions without avoiding them. He blocked statements about the past, guilt of others, past family or work episodes, etc. The therapist always asked about emotional behaviours within the session and their feelings in daily life. As sessions progressed, more CRB2 appeared, which meant improvements in clients' problems. In this way, the therapist reinforced speaking naturally about him/herself and his/her tastes, speaking more confidently, without anger or anxiety. Also, he used some experiential exercises to feel emotions and their functions and, in some cases, he used ACT metaphors about thoughts and literality of words.

In order to create CRB3, the therapist tried to compare continuously the problems in and out the session. Also, progressively, the therapist was reducing the number of complaints and invalidating claims. In some cases, he tried to create new rules or "pliances" about their lives, more congruent with natural contingencies in their families or work settings, and eliminate rigid rules such as "I am…" "I have to… "I must…". At the end, clients made functional analysis about their relationships with families or strangers. The therapist was reinforcing the improvements inside and outside the sessions, validating attitudes and values when they self-exposed to social situations, as well as they managed their emotions and relationships, including intimate and sexual interactions in some of the cases.

Table 2. Direct Scores in Each Questionnaire for all Participants in Pre-, Post-, and Follow-up measurements

	BDI-II				AAQ-II				ASI-III			
Participants	Pre	Post	FU	% Change	Pre	Post	FU	% Change	Pre	Post	FU	% Change
1. Ángela	**34**	14	14	-31.75	**45**	22	23	-36.51	**42**	17	18	-39.68
2. Antonia	**29**	10	11	-30.16	**37**	20	21	-26.98	**28**	16	16	-19.05
3. José	**47**	16	13	-49.21	**33**	19	17	-22.22	**21**	14	15	-11.11
4. Antonio	**43**	4	5	-61.90	29	14	16	-23.81	**23**	11	10	-19.05
5. Leticia	14	6	5	-12.70	**36**	18	17	-28.57	**39**	16	14	-36.51
6. Miguel	**21**	11	9	-15.87	**40**	20	21	-31.75	**36**	15	17	-33.33
7. Juan	**23**	14	15	-14.29	**36**	19	18	-26.98	**32**	16	16	-25.40
8. Manuela	19	4	6	-23.81	30	17	17	-20.63	**23**	12	15	-17.46
9. Carlos	**21**	11	9	-15.87	**40**	20	22	-31.75	**29**	17	19	-19.05
10. Verónica	**48**	19	21	-46.03	**49**	24	25	-39.68	**42**	19	21	-36.51
Mean	29.9	10.9	10.8	-30.16	37.5	19.3	19.7	-28.89	31.5	15.3	16.1	-25.71
SD	(12.4)	(5.0)	(5.0)	(13.65)	(6.2)	(2.7)	(3.0)	(4.83)	(7.9)	(2.4)	(2.9)	(8.63)

Note. BDI-II (Beck Depression Inventory II); AAQ-II (Acceptance and Action Questionnaire-II); and ASI-III (Anxiety Sensitivity Index-III).
Data in black indicate a score above the criterion.

Results

We first describe relevant interactions with each participant during sessions and the improvements occurring in and outside consultation related with the final changes in the day-to-day life of participants. Then, we present the statistical analysis comparing pre-, post-, and follow-up questionnaire data as a complete group.

Clinical Cases

We calculated the percentage of change for each client. In Table 2 all the direct data for each questionnaire in pre-, post- and follow-up assessments are presented. Also, it shows percentages of change that are always negative, because all the questionnaire scores decrease after treatment in all the clients.

In the first assessment 5 participants had depression levels above criteria in BDI-II, also 3 participants above criteria in AAQ-II, and all of them were above the mean of anxiety in ASI-III. After the treatment with FAP, all the participants were within the criteria of normality in depression, all scoring less than 20 points. Similarly, everything was below the criteria for anxiety and experience avoidance in AAQ-II and ASI-III. The general percentage of change was -30.16 in BDI-II, -28,89 in AAQ-II, and -25,71 in ASI-III. In all cases the scores decreased by approximately one-third in their values.

On the other hand, if we observe in Table 2 the values in the follow-ups, these remain at similar levels. There are only slight changes of 2 or 3 points in the questionnaires. All this indicates that in all clinical cases the results of the treatment were maintained in the long term in follow-ups between 10 and 15 months later.

But changes were not only quantitative, but also clinical because they changed their lives. After treatment, case 1, Angela, began to eat solid food and to stop controlling her diet, being able to eat in public places, and decreasing complaints and obsessive behaviour. Case 2, Antonia, learned to speak and make clear request, finishing sentences and tasks, reducing the number of time she went to the bathroom, social relation increased, and various trips by car, bus, and train were planned and achieved without problems. Case 3, Jose, exposed himself progressively to activities and social relationships, and finally went back to work, reducing complaints and invalidating claims, and beginnig to interact with friends and family without falling silent. Case 4, Antonio, was more open to talking about his sexual impulsive behaviours and the shame he felt, he was reducing the frequency of such impulsive behaviours that finally disappeared, he also started talking to his family and friends about his homosexuality, and the compulsive rituals of checking and cleansing were also reduced. Case 5, Leticia, reduced her constant questions about her problems; she began to visit stores and other social situations she had avoided before and developed a more fluid and closer relationships with other persons. Case 6, Miguel, began speaking more confidently, and more sure of himself; he also revealed his doubts about his sexuality, and as result of this openness his anxiety and social avoidances decreased. Case 7, Juan, no longer asked questions and he did not seek confirmations about diseases, managing his obsessive thoughts better, and he did not react emotionally when he had this type of thoughts, all this improving his family life and social relationships. Case 8, Manuela, handled her emotional episodes well, rarely spoke about her past, neither in the consultation nor with her husband, her marital relationships improved, and she had a child. Case 9, Carlos, began to express himself clearly and coherently in his speech; he began to be more open with his wife, and intimacy and sexuality between them improved, and also his mood and social relationships were better. Finally, case 10, Verónica, began to accept her physical appearance and to improve her social and personal relationships, the number of complaints were reduced, and she finally decided to break up with her partner; she also began to keep to her study schedules, without interrupting for excuses, and finally she committed herself to studying hard for her competitive state examination.

Group Results

Student's t showed statistical significance in all comparisons between pre and post in questionnaire BDI-II (t = 5.57, gl = 9, p < .0001), in AAQ (t = 14.93, gl = 9, p < .0001), and in ASI-III (t = 8.12, gl = 9, p < .0001). In accordance with hypothesis, differences do not appear between post- and follow-up measures; for BDI-II, t = .17, gl = 9, p = .864; for AAQ, t = -.93, gl = 9, p = .373; and for ASI-III, t = -1.63, gl = 9, p = .137. That way, the results showed fundamental changes after the therapy and showed stability almost a year after treatment finished.

To value the amplitude of the change gained after treatment, Cohen's d and effect size was calculated for each questionnaire. According to Cohen's (1969) criteria, all the effects were high; for BDI-II was d = -2.01 (95% CI = -3.53, -0.49); for AAQ-II was d = -3,80 (95% CI = -5.27, -2.33), and for ASI-III was d = -2.77 (95% CI = -4.00, -1.54).

That way, results have significance from a group and statistical point of view, the scores in the questionnaires decreased, with fewer depression behaviours and less anxiety, also with less avoidance and more acceptance of emotions, showing more personal value in their life. Simultaneously with those quantitative results, they showed significant clinical changes in their daily life.

The principal CRB1 changed for each participant, and they showed CRB2 with self-exposure and new social repertoires in familiar contexts; clinical changes were evident for the clients themselves and relatives (Figure 1).

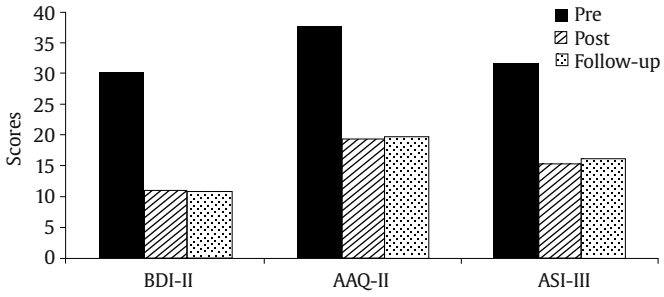

Figure 1. Mean Scores of Questionnaires in the Pre-, Post- and Follow-up Measurements.
Note. BDI-II = Beck Depression Inventory II; AAQ-II = Acceptance and Action Questionnaire-II; ASI-III = Anxiety Sensitivity Index-III.

Discussion

The results of this study, both as a group and as idiographic clinical cases, have shown the efficacy in reducing the initial problems that clients presented in the consultation and in their daily life. Individual results showed these clinical changes, endorsed by family members and improvements in their social, personal, and professional relationships. Cases included in this study would have different psychopathological diagnoses, ranging from anxiety disorder, or obsessive disorders, including obsessive-compulsive disorders, depressive disorders, sexual identity disorders, sexual inhibition, or personality disorders; even several of them would have characteristics of more than one disorder. The FAP approach involves evaluating the individual case, performing a functional analysis of the various problems presented by the client, and applying a treatment based on therapist-client interaction within the session itself. Unlike other cognitive-behavioural approaches, in FAP cognitive and emotional problems are behaviours themselves, and can be changed by the same behaviour modification principles applicable to other habitual behaviours. The difference here, too, is that these principles are applied naturally, so reinforcement and shaping occur throughout therapist-client dialogues. Some of these interactions have been explained in the case descriptions, and examples of dialogues can be found in textbooks (Tsai et al., 2012; Tsai et al., 2009; Valero-Aguayo & Ferro-García, 2015, 2018). Verbal rules of "pliances", metaphors examples, and self-revelations are also used, as are other contextual therapies, in order to change the rules that a client initially brings to the consultation. It is not the "cognitive structures" that are changed, but language and verbal rules that help an individual to govern his or her own life, ceasing to avoid, and facing their fears.

As other clinical case studies with FAP and some studies with groups had shown (see reviews by Ferro-García et al., 2016; Kanter et al., 2017; Mangabeira et al., 2012), the efficacy of this therapy in reducing problems and making the individual a participant in his or her own life is evident. The final results with FAP are not only to reduce the problems, but also to get the individual to be able to relate socially and intimately with others. In this study, 10 different cases have been presented, of different ages and different social contexts, showing this efficacy. Perhaps the fact of selecting the cases in the private consultations, for their suitability to a FAP therapy, having in common the cognitive, emotional and personality problems, can entail a problem in the generalization to other cases. However, FAP is a therapy focused on personal, emotional, and intimate relationships between therapist and client. So, FAP does not aim to be a therapy for everyone and everything.

The possibilities for generalisation are limited to a one-to-one type of consultation, and to a type of lifestyle problems such as those described above. Larger studies would be needed, with larger samples, and especially applied in public contexts that would allow comparison of larger groups, and comparison with groups treated with other common cognitive-behavioural therapies. Thus, an absolute efficacy of FAP cannot be stated, because it has not been compared to control groups or a waiting-list group. However, we must point out the difficulty of working in a private clinical context and doing research at the same time. It would be unethical to leave a group of clients waiting or without treatment; they would certainly leave the practice. One way to add more experimental control in a private context would be to use continuous measurement during the session, especially using observational techniques to record how CRBs change throughout the therapeutic process. Indeed, one question that remains to be answered in FAP is which part corresponds to the relationship (Kuei et al., 2019) and which part to the procedures or techniques that are used (Villas-Boas et al., 2016). In FAP the relationship is the context or the vehicle that allow the natural application of procedures. It remains to be investigated in detail how techniques (i.e., positive and natural reinforcement, verbal rules of "pliances", experiential exercises, differential reinforcement, and shaping) have an effect through this relational process. This is an objective that we are already working on in the research team.

Conflict of Interest

The authors of this article declare no conflict of interest.

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