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Expanding the Cognitive Behavioural Therapy Traditions: An Application of Functional Analytic Psychotherapy Treatment in a Case Study of Depression

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Abstract

What can CBT therapists do when interpersonal issues are pertinent to therapeutic change and there is a deficit of CBT literature offering clinicians' guidance on how to address this as part of the therapy process? Do we say "clients are resistant?", "Not ready for change?", or "there is too much secondary gain?" As therapists we may not be familiar with taking personal responsibility for looking at how our own processes also affect the therapeutic journey with our clients. Recent advances suggest that focusing on the process rather than the content in moderate to severe depression is effective and also consistent with the "Third Wave" of CBT as it evolves. The debate about the efficacy of challenging thoughts has also been raised (Longmore & Worrell, 2007). This case study presents the analysis and treatment of depression following the formulation and treatment of Behavioural Activation (BA) and Functional Analytic Psychotherapy (FAP). It is within the context of interpersonal issues arising during BA treatment of depression. FAP uses the therapeutic relationship as a vehicle to promote natural reinforcement and generalisation into the client's daily life based upon functional analysis, radical behaviourism and intimacy.

Keywords

Cognitive Behavioural Therapy, Functional Analytic Psychotherapy, Therapeutic relationship

According to the *DSM-IV* (APA, 1994) Depression is characterised when five or above of the following symptoms have been present for 2 weeks or more including feelings of sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration. It is predicted that within twenty years more people will be affected by depression that any other mental health problem (WHO, 2009). The rationale for a behavioural analytic approach called Behavioural Activation (BA) in this case was based upon multiple factors including: 1) clinical considerations of the growing body of evidence questioning the efficacy in challenging cognitions in moderate to severe depression (Jacobson et al,.1996; Dimidjian et al., 2006), 2) the level of distress presented on assessment and the clients lack of ability to separate from their aversive experiences and in particular their thoughts; 3) client choice of approach; and 4) therapist experience. In the process of treatment it became apparent that the client was experiencing difficulties in connecting to himself and others which pre-disposed the current onset of Depression and identified by the client as maintaining the problem. As a result, the treatment was collaboratively expanded to include Functional Analytic Psychotherapy (FAP).

BA is a contemporary contextual psychological treatment for depression based on a behavioural analytic view of depression as an understandable response to difficult life circumstances (Martell, Addis and Jacobson, 2001). In BA the aim is not to replace the individuals' aversive experiences, but to help the client develop a new understanding of their own patterns of responding to depressed mood, problem solving and other methods to decrease unhelpful patterns of negative reinforcement. Therefore, BA seeks to change the function of the private experiences that the client tries to avoid, rather than to change the context or the form.

Expanding beyond BA, FAP also has its roots within contextual functionalism and radical behaviourism, however; it involves a focus on therapeutic intimacy as part of the treatment (Kohlenberg & Tsai, 1991). FAP highlights the therapeutic relationship as a valuable and unique opportunity for natural reinforcement to occur in session. A collaborative case formulation drives understanding of how the client's avoidances show up in session, how the therapist naturally reinforces client improvements and facilitate generalisation into daily life.

Within the FAP case conceptualisation, clinically relevant behaviours (CRBs) are identified; problematic behaviors in session such as avoidances are typically categorised as CRB1s, and in-session improvements are identified as CRB2s. These CRBs are addressed with the guidance of the five FAP Rules (Kohlenberg & Tsai, 1991; Tsai et al., 2009) 1) Watch for CRBs; 2)Evoke CRBs; 3) Reinforce CRBs Naturally; 4) Observe the Potentially Reinforcing Effects of Therapist Behaviour in Relation to Client CRBs; and 5) Provide Functionally Informed Interpretations and Implement Generalisation Strategies. Within Rule 4, FAP pays attention to T1s (therapist related deficits) and T2s (thera-

Thank you to both the IJBCT and the client who have given permission for this case study to come to life. This is a professional 2. "The way positive reinforcement is carried out is more important than the amount"- Skinner J

pist target behaviors that are likely to evoke and reinforce client improvements or CRB2s).

METHOD

Tim is a 35-year-old single male who works in the e-learning industry. He sought therapy because he was feeling lost, full of angst and a failure within the context of starting a new job 3 months previously. He became reliant on obsessional rumination, self-criticism and engaged in negative judgements about his indecision which stemmed from his inability to tolerate uncertainty and the fear of the unknown.

He expressed a fear of vulnerability, sadness, and guilt as these feelings also were closely related to painful past experiences of physical health problems and being unfaithful in his relationship on one occasion. He struggled to tolerate deadlines and meet project expectations. Tim withdrew from social commitments and friends and avoided emotional intimacy with his girlfriend of 5 years.

Tim is an only child and experienced a lack of parental emotional expression. He developed ulcerative colitis during a critical exam period, did not get the grades necessary to study his first choice of graphic design, and instead obtained a BA in Business. His physical health problems affected his confidence and he did not first kiss a girl until he was 21. He recalled his time at school as very anxiety provoking, and he worried about losing control over his bowels on several occasions.

Tim had demonstrated capacity to establish long term friendships and insight into his avoidance behaviour patterns. His problematic belief systems include "I must achieve to be worthy and accepted"," I am a failure", "If others get close they will see the real me and leave me" and "Uncertainty is bad".

The formulation of the case follows the approach of (Kohlenberg & Tsai, 1991). The treatment took 12 months with a total of 30 sessions approximately 60 minutes in duration. During the course of treatment, sessions were spread out in order to allow time for consolidation and generalisation to occur. This article is based on the notes the therapist took and on the summaries and transcriptions of some of the dialogue that took place within sessions.

The client previously had had 12 sessions of Psycho-Dynamic Psychotherapy and reported that it did not help and resulted in further confusion and worry.

His main problematic belief was "I don't deserve to be happy." For Tim, being happy meant "accepting both his past actions and his imperfections." This belief was related to a one night stand with a colleague while under the influence of alcohol. He regretted it and experienced copious amounts of guilt and shame afterwards. This was a large obstacle to Tim feeling ready to trust himself and his ability to be committed to his relationship. Following the incident of being unfaithful, Tim experienced an increase in his doubts about his partner being the one for him long term. He also questioned many things about his morals, values and behaviour based upon his previous actions. This reached a severe level of obsessionally looking at women on the train while going to work which triggered an internal process of questioning himself repeatedly. Tim also feared success as it could lead to further failure and said that it felt "too emotionally overwhelming and risky."

The variables maintaining his problems included that Tim worked within a "cut throat" environment and a lack of trust in himself to make any decisions. His assets included his capacity to maintain long term friendships, his ability to perform well at previous job for 11 years, his willingness to engage in therapy process, and his warmth and openness.

INTERVENTIONS

The initial phase of therapy was spent going through the BA (Martell, Addis & Jacobson, 2001) model of Depression and building an understanding of the maintenance factors. After carrying out a functional analysis we identified a list of avoidances and agreed to focus on rumination as chosen by Tim. During sessions 1-4, we continued to expand targeting other areas of avoidance including self-criticism and self-care tasks, and continually addressed his rumination as part of this process. In Session 4 we identified that Tim was fearful of having particular uncomfortable emotions in his daily life and used distraction as a coping mechanism. In order to tackle his rumination about the need to be in control, we decided to help Tim move closer to having uncomfortable feelings, one of which was his preoccupation with fear of uncertainty.

The therapist attempted to help Tim orientate himself within his body and introduced cognitive defusion strategies in session. He disclosed in session 4 about his critical incident of being unfaithful and opened up about how difficult it was for him to be kind to himself based upon his past relationship with his body. He described his experience as accepting himself on a surface level and rejecting himself on a deeper level.

On further exploration of his relationships Tim identified as part of his therapy goals to have deeper and meaningful connections with himself and others. The therapist introduced Tim to the FAP rationale ("FAP rap"). In order for FAP to be most effective, it is important that the premise is understood by the client (Tsai et al., 2009). When and how to deliver the "FAP rap" depends on the client.

In this case, the 'FAP rap' went as follows:

> *"Sometimes the difficulties you experience within your relationships may also show up between us within our therapeutic relationship. Functional Analytical Psychotherapy (FAP) is consistent with the BA principles that we have started to work on and it provides a compassionate and explicit therapeutic structure for us to address similar patterns between us when they show up in session. It may help you to generalise improvements into relationships in your daily life." "Is this something you would be interested in?"*

Tim was interested in engaging with FAP and the therapist explained that this approach continues to be goal focused and will be following radical behaviour principles in helping him become more connected to himself and others. He was informed that each session will start and end with a breathing exercise and he was given the FIAT-Q questionnaire (Callaghan, 2006) to complete prior to the next session.

Session 5 began with a 2 minute breathing connection exercise where Tim was encouraged to co-meditate in the flow of

connection and disconnection (Surrey 2005). This involved the therapist leading and observing for a connection in the moment and noticing any obstacles. He initially felt quite awkward as he thought he did not do it right. The therapist conveyed a stance of openness, non-judgment and curiosity for the client to give himself permission to allow his true self to be seen in the session. The observation and identification of clinically relevant behaviours (CRBs) constitute an essential part of understanding how past shaping has influenced current behaviour and are enhanced by the therapist promoting a sacred space of trust and genuine interest. The responses to the exercise were used as a clinically relevant example to ascertain the function of such behaviours. This was followed by the development of FAP Case Conceptualisation and functional analysis. The terms Clinically Relevant Behaviours-in-session problematic behaviours and thoughts (CRB1s) and Clinically Relevant Behaviours-in-session target behaviours and improvements (CRB2) were introduced.

CRB1s. Tim's CRB1s included: monitoring therapist to see if he is being accepted and making sense, laughing or smiling when feeling uncomfortable, difficulty receiving feedback, avoiding eye contact when connecting, over intellectualizing to deflect feelings, /using lengthy philosophical discussion points to distract from any in-vivo opportunities to have an emotional connection, excessive re-assurance seeking that he will get better.

CRB2s. His CRB2s included: being open to moments of intimacy and connection within the therapeutic relationship, taking risks to be emotionally closer to the therapist, assess and assert his needs in session, speaking up more and allowing himself to think about his potential, being more self-compassionate, not taking responsibility for therapist's emotional experience and responses, creating accepting and non-judgmental space for his feelings of discomfort.

Daily Life Goals. These included: be more present and spontaneous, have contact with hobbies and interests, have better work life balance, allow himself to make mistakes and learn from them, take action, ask for help or support if needed. Note that many daily life goals have in-session correlates or CRB2s, such as being more present, learning from mistakes, taking action, asking for help.

Therapy Goals. Tim had many goals for therapy: get to know himself better including his hobbies and interests, become more self-accepting of limitations and focus on his strengths, manage his depression and fear of the unknown, be more care free and spontaneous, follow his ambitions by finishing important tasks, be able to make mistakes, connect to himself more often and process past hurt, guilt, and shame, be more connected in his relationships, propose to his girlfriend, be verbally more expressive about his feelings, develop a new way of relating to his vulnerability, allow himself to be happy.

At the end of the session, Tim was introduced to the idea of an emotional risk log (see Tsai et al., 2009, Appendix N) and was asked to keep a record of the tasks engaged in over the week. He was advised that the intensity of risks taken would increase during therapy.

In session 5 the therapist noted and adjusted her own clinically relevant behaviours *T1s* (Therapist in-session problems) and *T2s* (Therapist in-session target behaviours). FAP therapists are encouraged to keep a list of their own personal in-session avoidances when with clients so that it can maximise their ability to respond effectively (Tsai et al., 2009). In this case the therapist had also discussed her personal avoidances within clinical supervision.

T1s included: dropping eye contact when uncomfortable, being less evocative in session, rushing end of session feedback due to her discomfort with focus being on the therapist, being less open and not being fully present, mirroring client's hesitancy to connect. *T2s* were: taking risks to fully connect, maintaining eye contact for longer periods, evoking and staying with in-vivo experiences and openly sharing her own feelings about the process, openly receiving positive feedback without discounting or rushing on, tolerating her own discomfort so she can stay connected and be more present with their journey of therapy, using plural language in session (e.g., "our journey of therapy", "our meditation today", "the next hour is our time together", "I am feeling really connected to you right now".

Session 6 started with a connection breathing exercise. Tim was observed to be physically more comfortable with the exercise than in the previous session, and he was receptive to feedback that he was more open to the experience and to refocus in the present moment after a busy day at work. An agenda structure was set for the session. Tim brought a comprehensive list and throughout the review he frequently asked, "Did I get it right?" The function of his question as a CRB1 in light of his past experiences was explored. His parents told him growing up to do his best; therefore his self-doubt revolved around whether he had given something his ultimate best attempt. His level of self-doubt was exacerbated by his current depression and difficulty in tolerating uncertainty. He was reassured by the therapist that he would not be judged on his ability to do the task. He appeared to relax and to be naturally reinforced by the therapist sharing how glad she felt that he had committed to trying the task in itself.

Risks taken during week 6 were rated 4 on an emotional risk level of 0-10. These included sitting on the sofa with his partner and practising using his senses to re-orient himself to the present moment and away from rumination themes of failure, and helplessness. The session ended with an agreement for Tim to continue taking emotional risks. In addition, the therapist read an evocative adaption of "The Invitation" by Oriah (n.d.). The reading of this poem by the therapist felt risky and was a T2 because she felt vulnerable sharing powerful language for the purpose of demonstrating an authentic interest in connecting with Tim (excerpt: *"I want to know what you ache for, and if you dare to dream of meeting your heart's longing. I want to know if you can live with failure, yours or mine.")*

Sessions 8-10 focused on a series of in-session exercises including the writing exercise with the non-dominant hand (Tsai et al., 2009, p. 76). This evokes more potent, less ordinary responses that may be difficult to contact and express under normal social conditions. Tim was given the option about sharing his responses with the therapist and decided he did not want to. His CRB2 was naturally reinforced by the therapist through listening and respecting his expressed needs and wishes in that moment. Tim was also instructed to commence writing a list

of 100 positive attributes about himself that would be added to over the course of therapy.

Sessions 10-15, guided by a theme of whole heartedness, focused on building Tim's resources in relating to himself. The therapist increased interpersonal risk taking by introducing the open heart meditation adapted from Deida (2001). Kohlenberg and Tsai (1991) suggest that opening your heart to others risks the greatest vulnerability of all, namely the loss of life itself.

The key areas covered with Tim included: 1) *Courage* to tell his story with his whole heart and the courage to be different, 2) *Compassion* to be kind to self before others, 3) *Connection* to authenticity, and 4) Embracing *vulnerability* with willingness and gratitude for the opportunity. This included tolerating vulnerability for longer periods of time *in-vivo* (CRB2) and noticing behaviours related to detachment (CRB1), for example: dropping eye contact, laughing and grinning that did not match his feelings, and talking over therapist. Talking about these CRB1s explicitly together was an in session CRB2 and T2. Referring back to Tim's case formulation normalised his fears and at the same time bolstered his ability to take risks outside of the session. He could understand that striving for perfection created a relentless feeling of not being good enough and subsequent lack of contact with areas of value, resulting in depression and anxiety.

The therapist offered the evolutionary notion to Tim that as humans we are born to suffer and experience vulnerability at different times, and that one can resist it or compassionately allow oneself to be imperfect, and learn from mistakes knowing that it takes one closer to their values. The therapist self-disclosed here about her own relationship with her imperfections. The idea of open heartedness promoted a powerful in-session moment of connectedness between the therapist and Tim.

Natural reinforcement in session was crucial for Tim as he presented more relaxed, seeking less reassurance and taking regular risks in his daily life including wearing a new hair style at work, feeling more connected to the present moment, able to notice boundaries of responsibilities at work, and letting go of negativity.

The process of trust within the therapeutic relationship improved at this stage with reduction in CRB1s of talking over therapist and writing fewer notes in the session as an indicator of Tim slowly starting to trust his own ability to remember things that are important to his recovery. The sessions ended with both the therapist and Tim sharing appreciations of each other, the function of which was to assist further CRB2s of closeness by sharing honestly in turn.

At session 15, Tim had already been showing significant improvements and his varied activities reflected risks reported at 6 and 7 in his emotional risk log. He had been feeling better for taking risks and embracing uncertainty in moments that he wanted to be seen as his true self. This started with himself, and expanded to his partner, and parents.

At mid therapy review Tim reported that he felt therapy was helping him get back on track with his life and that his depression was improving. He reflected that he still had problems connecting with himself in relation to past issues that reinforced his current repertoire of avoidances. Tim disclosed his feelings of shame and guilt regarding a past experience with an ex-work colleague. He never told anyone at this before and it was a significant moment of trust and intimacy in the therapeutic relationship.

The therapist responded openly and in a caring non-judgmental way by acknowledging how hard it must have been to keep it to himself. She facilitated a caring space of compassion and intimacy, and Tim began to cry. She validated that shedding tears was an important moment of healing.

Following this intense conversation the therapist suggested that Tim try relating to his girlfriend differently (Rule 5) over the week, to let his heart guide him, and to embrace the fear of the unknown knowing that he is doing something that is important to him.

Tim described the feeling that a weight was lifted off his shoulders. He told the therapist that his relationship with his mother was one of over-protection. She used to tell him that he would not be able to get a girlfriend which was a self-fulfilling prophecy until his first kiss at age 21. The therapist evoked further interpersonal intensity by asking typical questions including "Where have you gone just now?"

In the next session the therapist and Tim looked at his loss inventory (Tsai et al., 2009, Appendix I) given the previous week for homework. The purpose of the task was to acknowledge the losses, hurts, disappointments, endings, and betrayals that Tim had endured.

Tim provided feedback about the feelings he had blocked in relation to his difficulty growing up in a state "that his body had let him down." This was a pivotal moment of connection where the therapist and client sat for 10 minutes and created a space in silence for Tim to express his feelings. The therapist initiated a therapeutic hug and encouraged the client to continue taking courageous risks over the week.

At session 20, Tim had demonstrated huge progress both in session by tackling his CRB1s and outside of session by connecting more openly to those important to him. While Tim was getting up to leave the session he engaged in a significant CRB2 by telling the therapist he felt really connected. This was welcomed and reinforced by the therapist by sharing the sense of privilege she felt in witnessing and being part of such an important journey of meaningful change.

Due the progress at the stage it was agreed to spread out sessions to every two weeks, then a month, and then three months in order for Tim to generalise progress further. Tim made these decisions with therapist encouragement to trust his judgment about the appropriate length of time in between sessions.

Over the next few sessions Tim completed his personal mission statement (see Tsai et al., 2009, Chapter 9), which guides clients to live by their convictions and passions in life. Tsai et al. (2009) propose that a mission statement can take many forms including poetry that reflects an individual's goals or a list of values, and can be reviewed and changed over time. They suggest that it is important for therapists to write their own mission statements in order to understand how inspiring the task is before giving it to clients. In this case, the therapist engaged in self disclosure (T2) and read out her personal mission as an example for Tim. Tim responded by using emotionally connected language with the therapist and set himself the task of taking risks with people important to him.

At the next session a month later, Tim presented as confident and had a notable presence including being more present, sitting more comfortably on the chair, leaving moments of silence between agenda items, maintaining appropriate eye contact, and forgetting his notebook (a CRB2 since this allowed him to be more present). He reported that he had been taking many risks, and that after years of deliberation he had proposed to his girlfriend. He previously spent many hours obsessionally ruminating about how to propose perfectly. His proposal was clear evidence that he had developed an ability to embrace his vulnerability and take action in the face of fear.

In his next session three months later Tim continued to sustain progress and demonstrated his resources by dealing with a health scare of a family member, and further commitment to owning joint property with his girlfriend. Tim appeared to have a clear understanding of his areas of avoidances and areas of vulnerability in striving for perfection. They decided he was ready to end therapy.

At the beginning of the final session, it is typical that the end of therapy letters are exchanged in person (see Tsai et al., 2009, Appendix K). In this case, however, the therapist forgot to include the end of therapy letter as a previous homework task. It was agreed that the therapist and Tim would exchange their end of therapy letters by e-mail a week after the final session at Tim's request. The therapist naturally reinforced this CRB2 and explained that it was her mistake not to include it in the previous session. They agreed to start with verbal feedback and both expressed their sadness at ending therapy as they had greatly valued their therapeutic journey together. Tim shared that his fiancee was pregnant and he went on to express fears of passing his vulnerability of striving for perfection onto his child. The therapist revisited all the learning that had taken place. She and Tim shared their perspectives, appreciations and learning from working together.

At the end of the session, a one year follow-up session was arranged. The therapist initiated and embraced the client in a therapeutic hug and delayed letting go for a few extra moments as she felt the client was detaching from the experience, and paying attention to this sense of connection in saying goodbye would be a CRB2 for the client. Interestingly, right after this the client took a risk and asked for a final hug which he embraced fully. As agreed, they exchanged their end of therapy letters by e-mail a week later.

Excerpts of End of Therapy Letters (Therapist to Client).

I smile as I recall the brave, courageous you who looked your fear in the eye and continued to take the meaningful risks in your daily life. I feel honoured and privileged to have had the opportunity to connect with you. Your mission statement will be your map and most importantly if you open your heart to yourself and trust yourself you will achieve great things. (Client to Therapist) One thing that I did not mention is how grateful I am of our interactions and the help you have given me. I truly feel sad to think of this being the "end" of therapy as I feel I've shared and grown so much with you. But this end point is in itself I guess yet another risk to take! Your support, kindness and empathy have made an amazing impact on my life and happiness.

Table 1. Questionnaire Outcomes

Measure	Pre	Mid	Post	Max Score
PHQ-9	24	16	1	27
GAD-7	20	12	1	21
WSAS	30	12	1	40

RESULTS

Data were collected at 3 points--pre, mid, and post therapy. Questionnaires included were: 1) PHQ-9, Patient Health Questionnaire Validity of Depression Severity Questionnaire (Kroenke et al. 2001); 2) GAD-7, Generalised Anxiety Disorder Assessment (Kroenke et al. 2006); 3) WSAS, The Work and Social Adjustment Scale: A simple accurate measure of impairment in functioning (Mundt et al. 2001); 4) CORE-OM; The Clinical Outcomes in Routine Evaluation Outcome Measure (Barkham et al. 2001); 5) FIAT-Q, The Functional Idiographic Assessment Template System Interpersonal domains: for use with interpersonally-based interventions (Callaghan 2006). As shown in Table 1, Tim showed dramatic improvements on the first three measures from pre to post treatment and as shown in Table 2. There were no significant changes in the FIAT-Q.

DISCUSSION

In view of the results obtained, it can be said that FAP was successful in the treatment of depression as suggested by Kohlenberg & Tsai (1994). Tim made a significant recovery that was maintained during the process of spreading sessions out from session 20-30. This included sessions every 2 weeks, 4 weeks up until the 3 month session prior to ending. During the session gaps Tim continued to embrace moments that are connected to his values. This was tested when he took meaningful steps of commitment in his life and dealt with his Dad's health scare. Positive life changes were naturally happening for him at work where he was offered a new job and planning on starting a family. Although Tim showed slight improvement in Class D (Disclosure and Interpersonal Closeness) on the FIAT-Q, more progress may have been made if the therapist had targeted these behaviors more directly in session. In addition, this case study would have been improved if it had been written up after the 1

Table 2. Core Outcome Measure

CORE	Pre	Mid	Post	Clinical Range
Well Being	3.25	1.50	0.00	1.37
Problems	2.58	2.25	0.08	1.44
Functioning	2.17	1.33	0.08	1.29
Risk	0.00	0.00	0.00	0.49
Distress	2.06	1.44	0.06	1.19
Total (Inc. Distress)	2.41	1.69	0.07	1.36

year post therapy follow-up had taken place and included values and happiness related outcome measures.

FAP creates a behavioural structure to work on interpersonal difficulties within the therapeutic relationship (B. Kohlenberg, 2000). While the approach can be evocative and direct in targeting avoidances, it is also charged with an authentic therapeutic love. The essence of FAP is about creating close and loving relationships. Such therapeutic tools may also be a valuable process consideration across various therapeutic orientations.

The "third wave tradition" of CBT acknowledges the growing evidence base on interweaving various components of other approaches to gain clinical flexibility and best possible recovery outcome. These contextually based approaches include ACT, Compassion Focused Therapy, DBT, and FAP (Hayes et al. 2011; Kanter, Tsai & Kohlenberg, 2010). It could be argued that the importance of the therapeutic relationship is nothing new and that early literature noted this (Skinner, 1953). Whilst the use of in-vivo interventions by CBT therapists can vary, a recent study found that cognitive therapists using FAP enhanced cognitive therapy (FECT) demonstrated a high use of in-vivo work in comparison to cognitive therapy treatment as usual (Kanter, Schildcrout & Kohlenberg, 2005).

The author proposes that interweaving the FAP rules into CBT practice could greatly enhance many areas including: a) establishing trust earlier in the relationship, b) providing an interpersonal structure to manage any therapy related behaviours or difficulties in-vivo, c) facilitating a meaningful experience of therapy, d) reducing therapy drop-out rates, and e) reducing length of time in therapy, making treatment much more cost effective overall.

There is definitely a place for further research in this area as we seek clinical developments. It is important that as researchers, scientists, philosophers and practitioners we endeavour to be courageous and continue developing and expanding the most effective therapeutic outcome for our clients.

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