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The Trouble with the Short-Term Therapist-Client Relationship and What Can Be Done About It

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Abstract

When problems from the client's daily life show up in the therapist-client relationship, crucial learning opportunities may become available. Occurrence of the client's problems during the therapy hour turns the relationship into a psychological space where they can be worked on in-vivo. But sometimes the client's daily life problems are specific to long-term relationships, and treatment arrangements may not support their occurrence in the short run. A particular client may deal well with short-term, task-focused collaborations but gradually spoil relationships in the long run, impairing potentially nurturing bonds with family and friends and long-term collaborations at work. Does this mean this client's problems are beyond the reach of in-vivo curative work in a short-term therapist-client relationship? Two case studies are presented to argue that clinically relevant behavior can be detected earlier in treatment when it does not yet have detrimental effects on the relationship. This may make treatment more intense and effective at an earlier stage, even for problems that typically affect long-term relationships. Implications for the theory and practice of functional analytic psychotherapy are discussed.

Keywords

Functional Analytic Psychotherapy; therapist-client relationship; long-term relationship

Kohlenberg and Tsai's (1987) conceptualization of the therapist-client relationship and its curative potential is the starting point of the present article. Their analysis points out that what happens between therapist and client during the treatment hour is chock-full of samples of client behavior that is directly related to exactly those problems the client seeks treatment for. By the same token, the relationship offers privileged opportunities to work on these problems in-vivo as they are happening. Different from traditional conceptualizations, Kohlenberg and Tsai's analysis of the relationship makes functional similarity between the client's daily life and in-session transactions a critical requirement for working with client behavior in this sense.

A first type of Clinically Relevant Behavior (abbreviated as CRB1) covers in-session client behavior that is functionally similar to behavior that causes and maintains the client's problems in his or her daily life. A second type (CRB2) covers in-session occurrences of what would constitute improvements in the client's daily life. Functional Analytic Psychotherapy, as worked out by Kohlenberg and Tsai (1987) provides rules that help the therapist focus on CRBs (out-to-in process); evoke them, when needed; respond to them in ways that strengthen CRB2s; increase the awareness of the potential effects therapist behavior has in relation to CRBs; and finally provide functional interpretations and facilitate generalization of in-session improvements to daily life relationships out-of-session (in-to-out process). For fuller descriptions we refer to Tsai, Kohlenberg, Kanter and Walz (2009) and to Weeks, Kanter, Bonow, Lands and Busch (2012).

What will be of interest for us here is that three conditions need to be fulfilled for the relationship to produce good in-vivo learning opportunities. Ideally, the client's clinically relevant behavior needs to be evoked by the person or the behavior of the therapist. This means that the relationship must have characteristics that promote or at least allow the occurrence of the typical problem behavior with enough intensity that it can be worked on. Second, the relationship must be an appropriate context for improvement to occur. That is, the changes that would help the client overcome his or her daily life problems must also be possible in the therapist-client relationship. And last, the same classes of reinforcement the client will obtain by this improvement in the outside world must first be available in the relationship. In other words, the benefits the client may obtain in his or her daily life as a result of the new behavior must already be naturally accessible by means of the emerging improvement in the context of the relationship.

However, consider the following puzzle. Your client is an outcast in her family. She has no social network or her long-term friendships are highly dysfunctional. Her professional life is pure hell. She tells you about what others have done to her. The interpersonal nature of the problem is undeniable. But in-session, everything between you and her feels fine. Why doesn't the turbulence of her other relationships show up with you? One possible reason is that the clinically relevant behavior may not conspicuously affect any short-term relationship. The relevant patterns may involve behavior that is meaningful or adaptive in a new relationship, but becomes abrasive in the long term.

Alternatively, standard treatment arrangements, with sessions happening in a set environment (e.g. the typical outpatient office setting), and involving a specific task, may not encourage the emergence of the behavior. The problem behavior may be the client's way of responding to unfair challenges or to being pushed

around by others. These behaviors are not part of a therapist's conventional repertoire. Or, as in the cases described later, the problem behavior is the client's response to the other's open expression of disappointment in the client, or the other's clumsy, jumbled initiatives. Therapy is often precisely structured so that these stimuli will not occur in-session. And when they occur, the benign context may set the therapist's behavior apart from the same behavior emitted by others in the client's adverse daily life relationships. As an example, a client may respond with openness and interest to criticism uttered by a therapist at the start of treatment, because the context qualifies this criticism as a form of professional help. The same criticism uttered by the client's husband or in another longstanding relationship may evoke client problem behavior, due to a history in which criticism in close relationships acquired aversive properties.

Critical incidents (such as an unpleasant misunderstanding or an error the therapist commits) may inadvertently change the context of the relationship and put the therapist in a better position to evoke the client's problem behavior. In other cases, the change only occurs over time. As an example, when the problem behavior is related to break-ups with a loved one, the problem may not occur in-session when the relationship with the therapist is experienced as exceptionally safe and secure until termination actually draws near. But, although unforeseeable incidents often play an important role in the treatment process, the authors believe that the therapist need not depend solely on accidents or on the mere passing of time in order to evoke problematic behavior.

In what follows, we present two cases in which a problem pattern only became evident in the relationship after months of therapy. We then discuss how the relationship may be allowed to play a curative role even in these circumstances, which at first glance seem to limit its use as a treatment tool.

FIRST CASE: LONG STANDING PANIC DISORDER

Jack was a Caucasian male in his early thirties, living with his parents while he worked on an ambitious business project. His psychiatrist referred him to LV with a diagnosis of panic disorder without agoraphobia. Jack did not like being referred to a psychologist, and it caused a brutal break-up with his psychiatrist. Surprisingly, only a few weeks later, turning up at LV's office, he was off medication, but firmly convinced of the rationale for cognitive behavior therapy the same psychiatrist had given him. Treatment was initiated only a few days later, with weekly sessions.

Jack's anxiety disorder was nested in an interpersonal pattern which included intolerance of others' shortcomings and rejection of others' initiatives. Anxiety was already a problem during his adolescence, and the first panic attacks had occurred soon after he graduated from university. He abandoned situations that he found stressful, including a well paying job, and educational and romantic engagements. During the six months before referral, the panic attacks had slowly increased in frequency despite his compliance with an antidepressant drug treatment.

Besides the standard rationale for cognitive behavior therapy which Jack already knew, he was also given the rationale for functional analytic psychotherapy, which was that his problems would also be expected to occur in the relationship with the therapist and would be worked on in-vivo. At the beginning of treatment, Jack was still in a romantic relationship, frequently experiencing intense anger at his girlfriend and her family, whom he considered fools. He withdrew from interaction whenever his girlfriend tried to work their problems out and seemingly sabotaged all her initiatives to improve their relationship. In-session, he granted that she made serious efforts to change in response to his criticisms, but he felt that this underlined how shallow she was.

Jack got frequently upset at what he perceived as his associates' and his employees' lack of efficiency. He ruminated for hours each day on this issue. Many sessions started with an anecdote about an uncooperative or inept co-worker, municipal official or commercial representative who brought him to the brink of despair. At times he also complained about excessive turnover in his team which forced him to hire less qualified staff or to bring in workers from distant locations, which caused logistical problems.

Later in treatment, Jack reported a profound resentment towards his mother and attributed this to her inefficient attitude to life and her poor support for his activities. Throughout the years, she tried in a variety of ways to bridge the chasm between them in order to establish emotional contact. He reported she had discussed her feelings with him, engaged his father to mediate between them, changed aspects of her behavior that irritated him and tried to bribe him with financial support for his projects. He effectively resisted her efforts, feeling the solution to their problem lay in keeping sufficient distance.

The client responded well to a traditional cognitive behavioral protocol for panic disorder (Barlow & Cerny 1988). No panic attacks occurred after the first treatment session and in a few weeks he learned to manage anxiety in a series of professional situations. Soon, it seemed much of his daily distress was related to unreasonable concerns about his professional competence. Despite being a newcomer in his field, he demanded results comparable to those of well-established competitors. When challenged, he easily saw that his harsh conclusions were unfounded and his anxiety subsided quickly.

In the sixth session, Jack got impatient with behavioral homework exercises that concentrated on his dealing with professional situations and asked the therapist to concentrate on his underlying beliefs. Considering that panic and situational avoidance seemed to have been taken care of, and that the cognitive therapy rationale made sense to the client, more time from the next session onward was spent on refining the cognitive case formulation (Beck, 1995). However, when practicing at home, Jack found the effects of cognitive restructuring short-lived. Unreasonable worries soon returned after each exercise. He also asked the therapist to take a more directive attitude and to focus on problems one by one.

In the eleventh session, the therapist proposed switching to a problem-solving focus (Haley, 1976), and on concentrating work on the most troublesome moments of the day. The diary Jack had been asked to keep since the start of treatment substantiated a buildup of stress in the evening which interfered with sleep. In the early morning, there was a new peak that only subsided when he had solved the first few problems of the day.

Work was done on changing Jack's late evening and early morning routines. The diaries showed progress both in the way he dealt with these periods of the day – e.g. dedicating his evenings to hobbies he had abandoned and in having breakfast in a variety of interesting places – and in lowering stress levels. Even so, Jack disclosed his doubts about continuing in therapy, dropped out of a professional training, and terminated the relationship with his girlfriend.

By then, with anxiety and situational stress much lower, the therapist had wanted to start work on Jack's irrational anger and his difficulties in dealing with his dependence on his business partner, his team, or his mother. But interpersonal problems were hard to discuss with the client. Jack came up with examples of problem situations, but did not seem to see how his hostile behavior influenced people around him and was only willing to discuss the others' inadequate responses. When, in the 17th session, Jack ended up rejecting the entire rationale of problem-solving therapy, the therapist tried to take another approach to the problem and discussed whether ideas drawn from interventions in Milrod, Bush, Cooper and Shapiro's (1997) psychodynamic protocol would be relevant to his problems. However, Jack became less cooperative and criticized the therapist for asking too much about the past.

This prompted the therapist to change gears again, accept Jack's focus on the future, and in the 19th session proposed a rationale for acceptance and commitment therapy (e.g. Eifert, McKey & Forsyth, 2006). At first, the philosophy and treatment activities interested the client. Soon, the importance he accorded to his concerns about his incompetence and others' shortcomings started to dwindle. Jack made drastic professional decisions prioritizing his most valued goals. These changes took away much of the chronic problems he had experienced at the job and increased his satisfaction with the work he was doing. In the same period, his leisure activities expanded and became more varied. Improvements notwithstanding his critical comments at the end of sessions gradually became harsher. He insisted that his improvements were not the result of therapy and complained that treatment lacked coherence, drifting from one rationale to the other.

Only in the 23th session the therapist saw the similarity between the pattern that had unfolded between them and what happened in Jack's daily life relationships. The following vignette marks the point at which the client for the first time links the interaction with the therapist to the way his girlfriend had tried to connect to him. Both had made a series of efforts to provide what the client wanted from them. He would reject these efforts with growing frustration. And this would prompt a series of new offers on a trial-and-error basis, which would convince Jack the other person in the relationship had nothing coherent to offer.

Therapist: I feel we've been going around in circles for about half an hour and I feel you're as unhappy as I am about this.

Jack: This whole treatment is going around in circles. I don't see how this can help me. [This is a CRB1 for Jack, and in the exchange that follows, he insists in this behavior. The therapist tries to avoid reinforcing it, while he prompts for an alternative response from Jack, which only comes after some patient insistence].

Therapist: I think you've changed a lot. You're not living the way you used to. You allow yourself to enjoy the things you like. Anxiety has dropped tremendously.

Jack: I told you, the way I see it, it's the medication that did it.

Therapist: You stopped taking your medication before we started therapy.

Jack: Yes, the man [his psychiatrist] did not have a clue. That doesn't mean my medication could not have a delayed effect […]. He did not invent or manufacture that drug. If it works, it isn't because of him.

Therapist: We're back in our circle. It puzzles me how you got rid of your anxiety, reorganized your entire life, discovered worthwhile goals you had never thought of and nobody helped you with any of that.

Jack: Don't get me wrong. I like to come here. I walk out of here with new ideas. But that isn't why I came here in the first place. It doesn't help me with my anxiety.

Therapist: Do you still have panic attacks and feel anxious at night and in the mornings?

Jack: No. I told you. A belated effect of the drugs I had been taking.

Therapist: When did the panic attacks stop?

Jack: When we were doing that exposure homework and all those exercises at the start.

Therapist: And when did the worrying at night and that unbearable fear in the mornings clear up?

Jack: That was when we were working on it.

Therapist: And when did you reorganize your week?

Jack: You know what? I just understood what you were trying to tell me when you said my girlfriend was trying to get through to me by suggesting something else for me to do [together with her] every single day.

Six months into treatment, the case conceptualization was reworked along the lines of Kanter, Weeks, Bonow, Landes, Callaghan & Folette (2009). This conceptualization organizes information on relevant history, daily life problems, variables maintaining the problems, assets and strengths, in-session problem behaviors and target behaviors, out-of-session goals, planned interventions, therapist problem behaviors and therapist target behaviors. Based on anecdotic evidence, therapist and client agreed that, from his early youth on, Jack had learned to respond with anger and avoidance when a relationship did not attend to his needs. His parents unwittingly reinforced this, often taking his taciturn response as a signal to make guesses about his needs and attempting to satisfy them. In the new case conceptualization, the main daily life problem became Jack's lack of reciprocity in long-term relationships.

He did not make his needs clear to others, nor did he respond to their statements of their needs. Some of his social and professional relationships maintained these problems. As an example, his collaborators and business contacts who depended on him on a long-term basis often responded to his hostility with a will-

ingness to change and to come to an agreement about the issues he criticized them about. This entailed various benefits for Jack, which reinforced his taciturn and hostile behavior. He gradually became more critical of their initiatives, eventually prompting more guesswork by them as to what he wanted and more fragmented efforts to provide what they guessed he needed.

His competence, his honesty in treating with associates and business partners, and his sense of social equity in treating with his company's workforce were important personal strengths that earned him the sympathy of many who knew him, in spite of his unpleasant attitudes. Once work on reciprocal skills started, these strengths also remained personal assets that helped him to improve social interactions and build healthier relationships.

Jack's leaving the therapist in the dark as to what exactly he wanted, while prompting successive changes of course through his escalating criticisms on the therapist's efforts was the most salient in-session problem behavior. This was directly related with subtler CRB1s which had been present early on in treatment, but had not been identified as such. They included Jack ignoring the effects he had on the therapist's feelings and his general lack of reciprocating when the therapist shared his concerns and his willingness to adapt to the client's needs. The new in-session target improvements were for Jack to tell the therapist about the needs behind his criticisms; to identify the effects his assertions were having on the therapist's feelings; to ask for feedback about how well they were helping the therapist to work more effectively; to actively support the therapist's efforts to help Jack; and to repay the therapist's initiatives with suggestions and actions of his own. The new daily life goal was for Jack to participate in the game of give and take which characterizes healthy relationships. This included he would learn to assert his needs clearly and support initiatives of others to attend to better relate to him.

Interventions that focused the above target improvements were planned, comparing Jack's behavior out of session to that in-session. For that purpose, sessions 24 and 25 were dedicated to discussing anecdotes in which Jack's mother and ex-girlfriend had expressed their feelings of hurt in a vulnerable way and explained what they needed from him. Now the client was willing to investigate how his behavior influenced people around him, it was possible for LV to point out the similarities between how Jack had interacted in these anecdotes and in the relationship with the therapist. By discussing the therapist's needs in the relationship and agreeing on ways the client could help the therapist to help him, Jack could contact the benefits of reciprocity skills in the therapist-client relationship. Further discussion of in-session improvements with what happened in Jack's daily life environments helped expand reciprocity to other relationships.

LV needed to pay heed to various therapist in-session problems. He had become jumpy about the escalating criticisms and developed a tendency to come up with ready solutions for Jack's problems. The therapist needed to contain this tendency and instead construct answers together with Jack. He also needed to pay attention not to abandon interventions whenever Jack rejected them out of hand, but instead use such moments as in-vivo-learning-opportunities for reciprocity skills. Therapist in-session target behaviors were: to collaborate in an open way with the client and to respond patiently to criticisms, without redrawing the criticized intervention.

SECOND CASE: DEPENDENT PERSONALITY DISORDER

Mike is a Caucasian male in his late twenties who works in a state owned company. He met the DSM IV criteria for dependent personality disorder. Mike had difficulty in expressing opinions and emotions and in admitting that anyone cared about him. He was exaggeratedly worried about the possibility of a break-up with his girlfriend and bent over backwards to prevent any quarrel. Mike complained that people found him lazy and incompetent.

Throughout his youth, his parents made too many decisions for him. As a result, he did not feel he owned his successes. So a task well done didn't give him a feeling of pride or confidence. His brother excelled at many activities and was handsome and popular. In order to gain his parent's support, he tried to stick to whatever rule of behavior they seemed to approve of. Mike often felt hurt seeing that his parents were closer to his brother than to him. When he showed that this state of affairs upset him, his parents would become warm and compliant towards him. Mike's dependent behavior was apparently reinforced by receiving attention and support.

As an adult, Mike continued excessively to follow rules established by others, trying to avoid disagreements or negative judgments. His problem behavior continued to be reinforced intermittently. Positive reinforcement was provided by his parents (on whom he also continued to depend for financial support), his girlfriend and the health professionals he sought out. Also, people knowing him for only a short time at first reacted to his demands for closeness in a caring way. For example, he would insistently make telephone calls to people he recently got to know. The other would often find this considerate at first, but soon the same behavior would become bothersome. But negative reinforcement in the form of others' withdrawing their demands seemed to play a more important role. This contingency was very salient in professional contexts. As a result, Mike generally felt indifferent to the tasks and the team he worked with.

At his last three jobs he was frequently absent or late and used vague health problems as justification. His employers, who at first generally showed themselves as understanding, later met this behavior with disappointment and then with mounting hostility. This made Mike feel misunderstood and sad. He tried to change the situation by flattering and groveling, praising others' qualities, contrasting them with his own weaknesses and denying his own accomplishments.

Mike was referred to the second author (JMS) by his girlfriend, who was dissatisfied with his ongoing psychodynamic treatment. During intake, it turned out that Mike had found the psychodynamic therapist emotionally unavailable. However, it was his girlfriend who had decided to change therapists. JMS suggested Mike should discuss his complaints about the therapeutic relationship with his therapist because they might be related to his daily life problems. But Mike refused and stated his decision to drop out of psychodynamic treatment and follow

his girlfriend's lead. He requested two sessions a week and JMS accepted this proposal.

At the start of treatment, his depressed mood, helplessness, recurrent bouts of crying and irritability were the focus, as well as his concern that his girlfriend would leave him at any moment. These problems were worked on by means of behavioral experiments and tasks that were agreed upon to be put to practice out of session. In-session, the goal was to develop positive behavioral qualities that would benefit Mike's interpersonal behavior out of session.

Mike soon started calling JMS an excellent professional and explained how much she was helping him. Whenever she traveled out of town or returned from a vacation, he claimed to have needed her desperately. However, as the treatment began requiring more effort on Mike's part, he became progressively less committed. As an example, Mike agreed to express his feelings sincerely to his girlfriend, but ended up emitting canned standard responses. At the same time, he flattered JMS more and more during sessions and began calling in between sessions. He started arriving late for sessions, putting off payment and repeatedly reported his inability to do therapy homework.

At first, JMS answered most of his calls. These increased in frequency to several times a week. When he was late for appointments, she waited for him and provided a complete session. He started arriving late for every session. The sessions started to annoy the therapist. Mike's praise, while enjoyable in the beginning, started evoking anger in her. She felt discouraged by his lack of involvement, specifically his arriving late, not showing up, not following through on homework assignments and not paying. From the point of view of functional analytic psychotherapy (e.g. Kohlenberg & Tsai, 1987) JMS was not sufficiently self disclosing at this phase and unadvertently reinforced CRB1s.

JMS repeatedly renegotiated agreements on punctuality and commitment to homework assignments. However, these were not kept. In keep with functional analytic psychotherapy lore, JMS shared her interpretations of Mike's behavior, and compared them with what happened in his daily life interactions. She pointed out how his increasingly demanding and flattering behavior seemed to be a way of escaping from his new responsibilities in therapy as well as a dysfunctional strategy to guarantee the therapist's continued care. She also showed the parallels with the behavior that got him into trouble in other relationships.

The vignette below illustrates a key moment in session 133 that changed the relationship. The therapist became aware that, in order to make the relationship a curative experience, she would need to stop reinforcing the dysfunctional behaviors and that she should candidly share her feelings about his lack of responsibility in therapy and about his hiding his needs behind flattery and demands.

Mike: *[at the beginning of the session] What happened? I called you several times this week and you didn't answer. I came to the last session. I arrived at 6:50 [the session was scheduled to start at 6:00 pm] and the secretary told me you had already gone. [This is a CRB1: The client deals with a challenge in the relationship by means of the behavior that causes problems in his daily life settings – in this case, Mike was being demanding instead of cooperative].*

Therapist: *What are you feeling at this very moment? [JMS evokes a CRB, a fundamental clinical strategy in functional analytic psychotherapy].*

Mike: *I'm confused. [Another CRB1]*

Therapist: *I'm asking you about your feelings, not about thoughts.*

Mike: *I'm angry. You should answer my calls, even if only to tell me you're not available at the moment. And I think you should have waited for me till seven. [This looks like a CRB2: Mike asserts what he wants, instead of inducing pity, or claiming to be inept].*

Therapist: *What do you think is happening with us?*

Mike: *I don't know. [Here we are back to a CRB1].*

Therapist: *Well, I feel like giving you some proof of my love. How do you feel about that? [JMS prompts for a different kind of response from Mike].*

Mike: *…*

Therapist: *Maybe I now feel something similar to what Dr. Smith [Mike's last employer] felt. You try to escape from your obligations by saying that you are weak and incapable but often that is not true.*

Mike: *You can ask Dr. Elliot [Mike's psychiatrist] and you will see I really need care. [More CRB1].*

Therapist: *I am mad at you because you arrive late and expect me to wait for you. That makes me feel slighted as a professional. Do you realize that this is the same pattern of behavior that caused problems in your last jobs? [Here JMS discloses the impact the CRB1 has on her and shares her interpretation of Mike's problem behavior. She will insist on this strategy during the following interactions].*

Mike: *You mean … I make others mad at me?*

Therapist: *I mean you seem to try to make others give you proof of their love. People can forgive one or two blunders, but when it becomes a pattern, they start feeling cheated.*

Mike: *Do you want me to look for another therapist? [Back to CRB1]*

Therapist: *No Mike, I do not want you to do that… You can do it if you want to. But even in a new treatment, a special moment will come when you will discuss exactly the issue we are talking about now. And it may take a long time [before the pattern becomes clear in your relationship with your next therapist].*

Mike: *I see.*

Therapist: *What would you like to change in our relationship? [JMS prompts for new behavior].*

Mike: *Well, I will be on time next session. [CRB2].*

Therapist: *Great … And if you want to talk to someone and feel cared for outside the session ... What do you think? [This is an early prompt, preparing for generalization to daily life*

situations].

Mike: *I can call David.*

Therapist: *Yes.*

Mike: *But sometimes I need to tell you that I will be late or that I can't come to a session.*

Therapist: *Then you can send me a text message or call my secretary.*

Mike: *I apologize. [Once again, back to CRB1].*

Therapist: *What are you doing now?*

Mike: *I am asking you to forgive me.*

Therapist: *That is still a way of avoiding commitment. There is nothing [to be forgiven]. We are here to learn from our behavior and try to do something different. How can you discuss this stuff with me without putting yourself down? [JMS goes back to prompting CRB2].*

Mike: *Well, I can commit to arriving on time and not call you needlessly.*

Therapist: *I am sure you can.*

A new case conceptualization was elaborated, emphasizing as daily life goals more commitment to tasks and less demand for pity and for proofs of love and understanding from others. Also, Mike would assert his opinions and feelings, where appropriate, to his girlfriend and in other relationships, instead of hiding behind flattery. The therapist-client relationship seemed to be offering enough in-vivo learning opportunities to promote these goals. Expected in-session improvements included commitment to the principle that progress in treatment would depend on Mike's efforts. This meant accepting his fair share of responsibility in the process instead of attributing success to the therapist's competence. He would also be expected to own his feelings and opinions, particularly when they were different from the therapist's.

JMS' intervention described in the vignette evoked an array of already established dysfunctional behaviors (complaining, putting himself down) and new adaptive behaviors (assuming a commitment, suggesting possible solutions for his needs). Only now, the therapist was able to contingently respond to the clinically relevant behavior, reinforcing in-vivo improvement. Later, the new behavior also worked in Mike's daily life to obtain others' support and attention. He reported professional successes and took firm decisions. A touching moment for the therapist was when he reported that his girlfriend admitted she loved and admired him. Before the turning point described in the vignette above, Mike made himself loved by pitiful, instead of admirable, behavior.

DISCUSSION

The authors suggest that it took such a long time for the problem pattern to make its appearance in the therapist-client relationship in the cases of Jack and Mike, because of the idiosyncratic behavioral functions that were at play in the early phases of treatment. The stimulus functions of the person of the therapist and the functions the client behavior had in relation to typical therapist behavior did not support the appearance of the pattern. As will be elucidated in the following paragraphs, two changes were needed before the pattern could damage the relationship in the ways it did in the clients' daily life. These changes regarded the function of the therapist as a person and that of the client's behavior in the relationship.

From a behavior-analytic point of view, the main purpose of behavior is to transform the environment. This often means that one person's behaviors are strategies to influence others' behavior. Repetition of the same interpersonal act over time can change the function of that particular act in the context of a relationship. For example, when Jack complained the first few times that the treatment focus was not right, that was a welcome cue for the therapist to see the problem from a new angle and make therapeutic work more profitable. Indeed, it helped to identify and work on different issues related to the anxiety disorder. When Mike was late just a few times, this did not hinder treatment. When he started calling the therapist, this seemed an appropriate way of learning to handle difficult moments and for the therapist to offer support. However, over time, these same behaviors evoked negative feelings and avoidance behavior from the therapists.

The kind of behavior one person evokes in another changes during (and because of) interactions. We say that one person functions as an antecedent stimulus in influencing the probability that a certain behavior will be emitted by the other in the relationship. The stimulus functions of the therapist as a person also change during (and because of) in-session interactions. In daily life, Jack responded with intense distress and rejection of others he found inconsistent and unhelpful. This made the others feel helpless and try out a jumbled variety of strategies to get through to Jack. This way, they unwittingly prompted more anger from him. And this process went on until the relationship broke down. For Jack's problem behavior to show up in-session, the therapist first needed to acquire the role of a bungling, incoherent other. This happened after the therapist kept adjusting the course of therapy in response to each of Jack's criticisms, rendering his efforts disjointed as a whole, as had been the case with Jack's mother, his girlfriend, and his co-workers before the therapist. Although progress was made in nearly every phase, the frequent changes imbued the therapist with the stimulus function that evoked Jack's hostile behavior in long-term relationships.

The changes in the function of the client's behavior and in the stimulus function of the person of the therapist can also be traced in the case of Mike. In the beginning, the client interacted with JMS in order to avoid disappointing his girlfriend, who had referred him. His attitudes were deferential and collaborative. Only when the therapist was already an important person in her own right in Mike´s life and benefits of therapy were becoming evident did Mike activate his dysfunctional strategies to avoid losing JMS's care. At first these behaviors evoked caring responses from the therapist. But as Mike got better, the same strategies acquired aversive functions. JMS started getting upset about the behavior that had previously evoked loving responses in her. The more progress Mike made outside the session, the more the therapist tried to get rid of the client's dysfunctional behavior in the relationship. By trying to negotiate compliance, she was acting exactly as others in long-term relationships had

done, insisting on Mike's responsibilities. Mike's established way of dealing with such demands in daily life was to put the quality of the relationship to the test. He typically sought to evoke sympathy. And through more irresponsible behavior and avoidance he tried to make the other withdraw the demands placed on him. In the same vein, he also tried to obtain proof of JMS's love.

In both cases, the client's problematic interpersonal pattern unfolded in the therapist-client relationship after months of treatment. It was only from this point on that in-vivo learning opportunities were explored in a systematic way. As we will discuss under the next heading, clinically relevant behavior could have been identified and worked on in the therapist-client relationship at an earlier stage. What follows is a set of recommendations for early use in the relationship in cases where the client's daily life problems specifically affect long-term relationships.

■ RECOMMENDATIONS

Key to dealing with the challenge discussed in this article is the development of a good case formulation. The following items need special attention. First, set up hypotheses about client behavior that may be a precursor of the client's daily life problem pattern. Scan the available data about early stages of the client's daily life relationships that later went awry and verify if such precursor behavior was involved in the installation of the pattern. Second, do not mistake the problem pattern for the treatment target, but rather work on the client behavior that contributes to it. The pattern is a result of behavior that occurs long before the pattern becomes identifiable in the relationship. Third, identify client deficits that may contribute to the emergence and consolidation of the dysfunctional daily life pattern and include them in the case formulation. And finally, the therapist's feelings may be used to help detect precursor behavior when the pattern has not yet unfolded in the therapist-client relationship. We will now discuss these items one by one.

(1) Ask yourself what kinds of behavior may set the stage for the problem pattern you perceive in the client's daily life. Verify the evidence (including anecdotal information) and check if any of these hypothetical behaviors occurred early in relationships that became dysfunctional at a later stage. Include these early behaviors in your case formulation and mark them as clinically relevant behavior to be expected in-session so that you are prepared to respond to them before the destructive pattern sets in.

In both cases discussed above, precursors of the problem pattern could easily have been targeted for in-vivo interventions. It could have been detected that Jack actively turned the others in long term relationships into the clumsy figures that would then make him desperate. He gradually maneuvered other people into inconsistent attitudes by frequently demanding unilateral changes from them. This maneuvering behavior began occurring during the first month of therapy, when Jack was all too easily dissatisfied with the treatment and prompted the therapist to make the first in a series of treatment planning reversals. Mike started out with the request for two sessions a week, which was a precursor to building a dependent relationship that would permit him to be loved for his helplessness and to avoid responsibilities. He also soon started working on evoking positive emotional responses in JMS.

Since the precursor behavior was not identified soon enough, Jack's therapist unwittingly reinforced his demands for change by trying to adjust to each new criticism and failed to prompt for reciprocal efforts from the client. Jack reinforced the therapist's compliant behavior with renewed interest until the therapist's endless overhauling of the treatment strategy made him seem like a bungler. Mike's requests for privilege and attention were also reinforced by his therapist. For his part, Mike reinforced the therapist's caring responses by expressing admiration and gratitude and demonstrating how effectively she was helping him.

(2) Be aware that the target for change is the client's behavior, not the final pattern of dysfunctional relating that can be observed in the client's long-term relationships. From this it follows that the therapist need not wait to allow him or herself to be pulled into the game. If the pattern in itself were the target for change, the pattern would first have to be allowed to unfold in-session before the therapist could influence it in-vivo. However, the therapist can respond to precursor behavior at a much earlier stage in the development of the therapist-client relationship.

Sometimes standard therapist behavior may hinder the identification of early problem behavior in-session. Therapists are typically expected to tolerate lack of initiative, to construe undue criticism as a clumsy but possibly fair affirmation of client needs and to support reassurance-seeking. One question the functional analytical psychotherapist must ask in elaborating the case conceptualization is: "If I were interacting with my client out of session, how would I respond?" Imagining oneself in the role of the other may make the effect of less conspicuous client behavior more evident. A second question would be: "How would I respond to this behavior if I had to deal with it on a day-to-day basis in a long term relationship with my client?" Such questions may highlight some subtle but important aspects of the others' responses in the client's daily life. And this may improve the functional analysis of the interaction in the client's daily life. A good functional analysis can shorten the delay before in-vivo learning opportunities are identified as such and the clinician can use contingent responding in-session as an effective means of therapeutic change.

(3) Look for behavioral deficits in the context of the client's daily life problems and find out how to evoke the missing behavior in-session. Jack had difficulty understanding the reasons behind other people's reactions to his behavior. He responded to the reactions with rejection. He also did not reciprocate interpersonal behavior. Such deficits can be worked on in the relationship. The effect Jack's early requests for change had on the relationship could have been discussed rather than taken at face value. Finally, the therapist should have prompted Jack from the first month on to reciprocate the therapist's efforts to adapt to Jack's needs. Perhaps Mike would have accepted getting just one session a week, which would have created more in-vivo learning opportunities early in treatment. Both therapists could have cued their client to try to identify how he affected the therapist's behavior.

(4) The therapist should also be quite frank about negative feelings that may seem embarrassing and too petty to disclose.

JMS could have disclosed the effect Mike's flattery had on her at the very beginning of the treatment. If she had discussed her feelings, the veiling of the dysfunctional relationship that was going on would have come to the fore earlier on. From the first month, Jack's therapist felt that Jack was challenging his competence. This feeling was only disclosed when the therapist had already been pulled into the pattern through a series of disorderly efforts and Jack had good reasons to be uncooperative and dissatisfied. Early disclosure of these feelings, when the client's behavior still seems appropriate, may seem awkward. However, it may be helpful in alerting both client and therapist to what may be going on.

In closing, the authors would like to emphasize that it is not their intention to plead for hasty or impetuous interventions. Before disclosing his or her feelings or sharing interpretations of what is happening in the relationship, the therapist needs to reflect on what effect this disclosure is likely to have on the client at any particular stage of treatment. The strategies recommended in this article do not eliminate the need for thoughtful consideration of the timeliness of the interventions. On the contrary: the authors suggest ways to understand more subtle problem behavior earlier on in therapy and to better appreciate the density of clinically relevant behavior in the therapist-client relationship. Careful revision of the case conceptualization is essential to avoid mistakes. In this sense, the recommendations may help therapists take fuller advantage of the curative potentials of the relationship.

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