Casebook of Eclectic Psychotherapy

Depression and Structural-Phenomenological Eclectic Psychotherapy:

The Case of Gill

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Commentaries by
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e-Book 2015 International Psychotherapy Institute

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Depression and Structural-Phenomenological Eclectic Psychotherapy: The Case of Gill

Stephen Murgatroyd

INTRODUCTION

The classification of depression has been and will continue to be a controversial matter. Kendell (1976) has observed that not only are those not directly involved in the classification debate extremely confused, but it is now also the case that those most intimately involved are increasingly unsure of their ground.

Rumke (1960) has identified 13 forms of depression. However, much more common are classifications involving one (Lewis, 1938), two (Pollitt, 1965), three (Overall et al., 1966), four (Paykel, 1971), or five (Blinder, 1966) depressive etiologies. Almost all of these multiple classifications draw a distinction between type A depressions (endogenous/psychotic) and type B depressions (reactive/neurotic). In this chapter a case study is presented of a

person experiencing a type B depression.

Of these two major depressive types, type B is less well differentiated than type A. Indeed, most of the debate about classification clusters around: (a) the distinction between psychopathological and non-pathological depressions of the neurotic-reactive kind; and (b) the extent to which reactive depressions are conditioned responses to given social situations as opposed to a cognitive-affective state, which is largely independent of social cues (Foulds & Bedford, 1976).

Classical behavioral formulations of depression have sought to address this last issue. All six major "classical" formulations of depression—[(a) reductions in the quality of reinforcement (Lazarus, 1968); (b) reduced frequency of reinforcement (Hersen et. al., 1973); (c) the loss of reinforceable behavior (Ferster, 1973); (d) the loss of reinforcer effectiveness (Costello, 1972); (e) aversive control (Moss and Boren, 1972); and (f) learned helplessness (Seligman, 1975)]—assume that depression is "a consequence of the reinforcement contingencies of which the individual's behavior is a function" (Eastman, 1976). Individuals are seen to be responding in a depressive way to social and personal situations—they pursue what Lazarus (1968) has called an "extinction trial." Until relatively recently, affective and cognitive factors did not overly intrude into these behavioral formulations.

More recently, cognitive-behavioral explanations of depression have emerged which give emphasis to the importance of the phenomenological experience of the person in maintaining the depressive responses to internal and external cues. Of particular importance in this respect is the work of Ellis (1962), Beck (1976), and Meichenbaum (1977). The essence of this position is that depressive actions are maintained by irrational thoughts and inner monologues that cue the individual to experience actions and the social world in a depressive way.

The development of the cognitive-behavioral school of behavioral analysis has a further implication, important for our purposes here. When a person's belief system and irrational thoughts are seen to cue and trigger behavioral responses, then it is necessary to ask questions about the experiential bases of these beliefs and thoughts. Mandler (1975) observes:

Whenever a search of appropriate action systems indicates that because of past experience or the generalized evaluation of personal competence, no actions are available that will achieve desirable ends then helplessness and hopelessness will result. These means and ends need not be associated with the avoidance of aversive events, *they may just as well relate to the unattainability of desirable states* [pp. 211-212, my emphasis].

Mandler implies that we need to have an understanding not only of the

persons' behavior but of the origins of this behavior in experience. To do this, we need a comprehensive theory of motivation and metamotivation.

The theory of psychological reversals, developed by Smith and Apter (1975), refined by Apter (1982) and enhanced by Apter and Smith (1985), provides an appropriate theory of motivation and experience for understanding a great deal of depression. What is more, this same theory provides the rationale for structural phenomenological eclectic psychotherapy (Murgatroyd & Apter, 1984, 1985).

The theory is based on the assumption that an individual's actions have specific motives, but that these motives are not sufficient in themselves to explain either the action or the way in which the person experiences that action. To have such an understanding it is necessary to understand the metamotives a person has for his actions. In this context, metamotives are the motivational states within which the person experiences specific motives for action. To use an analogy from literature, a novel is one form of metamotivational structure within which words are written; the stream-of-consciousness poem is another. Although the actions of writing may appear similar between the person who on one day writes poetry and on another works on a novel, they are in fact "driven" by different values, assumptions, and beliefs. The same action (writing) carries different meanings in these two instances. There are two important features of this example: (a) the same

action can be undertaken for different motivational reasons; and (b) individuals can change their motives for action such that the same action can be undertaken for oppositional and different affect.

This is not the place to elaborate the detail of this theory (but see Apter, 1982; Murgatroyd, 1985a; Murgatroyd & Apter, 1985). What is important to recognize here is that a person can become depressed not only because of a specific reaction to a specific cue (reactive depression) but because of failure to achieve changes in the metamotivational state. For example, Mike is a serious and hard-working executive who finds his work demanding and intellectually strenuous. He experiences work in a *telic metamotivational state* —as something serious, to be planned for, and in which arousal has to be avoided if effectiveness is to be achieved. When he is not working, he likes to be outgoing, arousal seeking, and here-and-now oriented—he seeks out experiences characterized in this way since he is seeking to reverse into the *paratelic metamotivational state.* This reversal between two major metamotivational states (telic to paratelic and, at a later time, back again) constitutes a major feature of Mike's inconsistent metamotivation. Mike is typical of most people—he seeks such motivational inconsistency in order to maintain sanity. When, for whatever reason, he is unable to achieve an appropriate reversal or he reverses inappropriately, or he behaves appropriately for the state in which he finds himself but inappropriately for the social conditions he is experiencing, then some kind of distress occurs.

The extent and nature of this distress depend on the nature and duration of the "barrier" to reversal. In some individuals the resultant affect can be anxiety; in others, depression may occur.

Apter (1982) offers a formulation of depression that takes this model a little further. He identifies four types of depression: (a) *anxiety depression,* in which depressive experiences are layered with anxiety; (b) *apathy depression,* in which the person is unable to produce arousal or activate an affective state other than depression and lethargy; (c) *overexcitement depression,* which occurs rarely in the case of mania when the person feels unable to escape from a state of chronic overexcitement and experiences depression along with this feeling—Apter (1982, esp. p. 251) observes that this form of depression occurs also when a person "is unpleasantly overwhelmed by strong sensations of all kinds which he feels he cannot avoid"; and (d) *boredom depression,* in which the person is unable to attain either the excitement or level of activation he desires.

The first two of these depressive types relate to the telic metamotivational state. They occur because the person is "locked" into a state that is serious, arousal avoiding, and planning orientated and either cannot achieve the satisfactions of this state or is unable to exit from this state into its opposite. Anxiety depression occurs because the person experiences excessive arousal in this state and cannot reduce it or reverse into a paratelic

state to experience this arousal differently; apathy depression, in contrast, occurs because there is so little arousal that the person cannot activate the behavior and affective tones "required" by the telic state. The third and fourth of the depressive states identified here relate to the paratelic metamotivational state—arousal seeking, a here-and-now orientation, and high intensity of experience. Depression occurs in this state when the affective needs of the state are not satisfied or when the appropriate level of arousal and hedonic tone cannot be achieved. Overexcitement depression occurs when the person feels trapped in a sensation-seeking state, and boredom depression occurs when the person is aware of the needs he is seeking to fulfill in the paratelic state but is unable to discern appropriate ways of achieving these needs.

This formulation of depression has many implications for treatment strategies, not all of which can be examined here. Indeed, the intention of this chapter is to focus exclusively on a case of apathy depression experienced by a 28-year-old single person called Gill. The point about the Apter (1982) model is that it emphasizes the need to understand the phenomenology of the person and the structure of that phenomenology (in terms of metamotivation) if the depression is to be treated.

The remainder of this chapter will examine the way in which a person experiences both actions and motives in a depressive frame. In addition, the

procedures used to promote a change within the telic state and reversal to the paratelic state will be described. Throughout the therapy with Gill detailed transcripts from videotapes were made available to both the therapist and Gill, and these will be used at several points to illuminate procedures and document the images and experiences that characterized this work. In the final section some written reactions of Gill to this chapter are provided together with some extracts from letters to indicate the nature of subsequent progress and her own evaluations of therapy.

THE BASIS OF REFERRAL

Gill was referred for psychotherapy through a self-help group that specialized in the depressive and phobic problems in a particular community with which I have had considerable involvement. The referral occurred because of the concern within this group about the severity of Gill's depression. She had had no psychiatric or medical history that was relevant to her current state, according to the referral information I received—which Gill later confirmed. She was then 28 years old, unmarried, and not currently involved in relationships with males. Though in the past she had had many relationships, some lasting over three years, she claimed now to no longer need either the intellectual, emotional, or sexual fulfillment that such relationships had given.

By any standards, Gill was middle class. She was an assistant manager for a group of stores selling clothes and cosmetics. She earned an income that rivaled that of most women in business of her age (app.

£8,000—a considerable income for a woman, or a man, in Britain). She owned a house, which she had inherited from her parents, and a sports car. She was always well dressed and attractive. She had received a college education in business studies up to the age of 21.

Gill was the only daughter of Sam and Mary. Sam had died when Gill was 20 and he was 68 years old. Her mother had died when Gill was 24 and she was 56 years old. Gill said that the discrepancy between her parents' ages had not bothered her, though at the time of referral she was somewhat preoccupied by the fact that both her parents had died of coronary heart disease, which for her meant that she too was at risk. She ruminated on questions about the effect that she had had on her parents' life; in particular, she spent some time reflecting on the fact that her parents "had not expected to have *any* children—then I came along and they wanted another but never managed it." She said that she had never "envied those with brothers or sisters or both" and that she had been "quite happy" as a child.

PRESENTING ISSUES

The following extract indicates the nature of the presenting problem as

seen by Gill in the first session.

> P: I am just going through the motions of being alive and around. Inside I feel empty, lost, and without purpose. I have no energy . . . [silence for 18 seconds] I just can't find anything that. . . [silence for 11 seconds]
>
> T: You say you have no energy and you let your speech drift off into silence. What other forms does this lack of energy take?
>
> P: I forget what I am doing sometimes . . . quite often in fact. . . [silence for nine seconds] I won't make decisions . . . I am relying on others at work to do more and more of the work . . . and even small things (like shopping or going out) become things that I am unable to make decisions about. It's like having a black hole inside me that wants to engulf me and take me over. The only response I can have to this is to feel engulfed and overwhelmed, and yet continue to . . . well . . . just exist.

This presentation of self was offered in a monotone. Though the language appears firm and clear, it was expressed without a feeling of firmness or clarity. The timed pauses actually seemed to be more substantial than the numbers indicate.

In the first session I was able to establish: (a) that Gill was normally a serious person—she liked things to be planned and to be clear, she did not like spontaneity or practical jokes or unforeseen circumstances—she was "at her best" when she "knew just what was going to happen"; (b) she sought out relationships with others that were largely undemanding of her—a good relationship was one in which "both knew where we were going and what it was we wanted from each other—if that was sex, that was fine . . . if it was

intellectual stimulation, that was fine . . . as long as I *know where I am"; (c)* that her expectation of her own development was that she would simply continue to experience the social world as she had always done and that she had "passed the period of changes" (her expression); and (d) that her current depression and inability to engage the social world or to obtain satisfactions from her actions was a sustained and painful experience that was both unique and extreme for her. Though she superficially appeared to be coping with her work, close inspection of her work behavior and performance would, she claimed, reveal that she was currently not working to the benefit of the company and she felt "helpless" to do anything about it. She was sleeping badly and not able to eat properly—she claimed to have lost 18 pounds in weight in seven weeks.

My detailed notes, arranged under the headings suggested by Lazarus (1976), of the presenting issues are given here:

Behavior. Gill is not sleeping or eating well, she is losing body weight rapidly. She speaks in monotone and behaves in routinized ways. She has disengaged from social behavior and has not engaged in relationship building for some time. She presents a coping image to the world but does not behave as if she is coping in her own judgment. She finds holding a sustained personal conversation difficult, though is succinct in her language use.

Affect. Gill presents as if she is devoid of affect. Her monotone shows no anxiety or energy. She talks about her depression as if she was incapable of ever having experienced excitement. Any pleasurable affect in the past has been planned *(telic)* and deliberate—she now does not seem to have the energy or the "will" to engage in such planned activity. She presents her emotions as having been drained into a black hole. The overwhelming impression was of apathy (passionless existence; lack of interest or desire) layered with considerable pain and self-pity.

Sensation. Gill does not present herself as bored—she does not operate from a sensation-seeking or frustration mode—she is clearly apathy depressed in terms of her extreme telic orientation. She is not trying to do anything that will raise her arousal; she seems to be seeking to maintain her arousal at the lowest possible level *(arousal avoidance is extreme)* while expecting that this will lead to affective satisfaction. It is as if satiation of this state has occurred but that the reversal that normally follows satiation has failed to materialize. This leaves her with a sense of depression both about the state and about the experience of satiation.

Imagery. Gill uses two images in her self-presentations about her depression: (a) feeling as if she is being engulfed and overwhelmed by a black hole, which she finds immensely depressing, and (b) feeling trapped under the weight of her own depression. Occasionally, she refers to her state as "the

drained coconut" or as "the sapling tree that cannot leaf." Clearly, the most powerful image is that of the black hole. (A subsequent analysis of the transcript of this first session shows that she used this image 26 times in 58 minutes to describe her depressed state.)

Cognitions. Gill had difficulty in identifying her own self-talk and cognitions. One was clearly evident: "There is nothing I can do about the way I feel, it's just how it is supposed to be." I explored with her the idea that "she had passed the period of changes," which seemed to constitute another belief. She said that she felt no different now than when she was 18 (apart from the depression) and that she certainly did not feel that she wanted to change. When pressed to express this as a single belief statement, she simply said, "Change is what happens when you're younger; when you get to my age you are how you are." This seems to me like another version of the irrational belief that unhappiness is a function of events outside the control of individuals.

Interpersonal. Gill has poor interpersonal skills, according to her behavior during this session. She has had relationships in the past (some of which have lasted up to three years), but these have to be planned and purposive. She cannot have casual relationships (she says) and needs to have a clear agreement about the parameters of a relationship before she feels comfortable.

Drugs. Gill is not seeing a doctor at this time and only takes an occasional pill (paracetamol or Anacin) when she has a headache.

Toward the end of this first session I asked Gill to complete the *Telic Dominance Scale* (Murgatroyd, Rushton, Apter, & Ray, 1978) and the Leeds Depression Inventory (Snaith, Bridge, & Hamilton, 1976). These revealed that Gill was extremely telic (a score of 13 on serious-mindedness, 11 on both planning orientation and arousal avoidance—highest score possible on any subscale = 14) and chronically depressed. We contracted for eight sessions of one and a half hours. A clear part of this contract was that Gill would complete homework assignments. At the end of the first session I asked her to keep a visual diary of her experience between appointments (which were weekly). This diary would involve her trying to capture her experience in drawings and words so that she could discuss these with me. I also asked her to bring photographs of herself that represented the way in which she thought of herself before she became depressed. I felt that these requests would provide me with more insight into Gill's phenomenological field while creating some arousal in Gill. Creating arousal was important for therapeutic progress—a part of her depression related to the experience of extreme low arousal. Gill now writes that "these requests challenged me: It was as if I was being asked to go into the black hole and confront it. . . . I found this very disturbing, but somehow managed to complete the tasks that I had been assigned."

In discussing this case with a colleague as part of my own supervision arrangements we explored the difference between apathy depression and boredom depression. What was clear about Gill was that she was a very serious and planning-oriented person and that her depression was very well described by the item on the Leeds Scale concerned with apathy ("I have lost interest in things") rather than the item concerned with boredom ("I am restless and can't keep still"). She made several statements about not having the "energy" to "invest" in her plans for the future or the patience to start new activities or relationships. She seemed both depressed and apathetic about her depression. She was a clear case of apathy depression. What made this clearer was the description of boredom depression provided by Apter (1982, esp. p. 251) as having its origins in the paratelic state. Gill did not seem to have residual arousal that she was able to activate so as to become more spontaneous, action oriented, and sensation seeking (these being the qualitative features of the paratelic state)—she was not bored.

This hypothesis about Gill's presenting problem guided my thoughts about initial treatment goals. The first task was to encourage her to understand her depression in motivational terms. The second task was to encourage her to identify her motivational experiences and their structure. The final task was to facilitate a change in the way in which she experienced her own motivation and actions. Almost all of these would require Gill to experience higher levels of arousal than was the case at this first session. I

intended that her arousal levels should provide a major focus for the process of therapy. I also decided that at the next session I would seek to explain the motivational theory in which I was working and to relate this theory to her depression.

SESSIONS 2 TO 4

I have grouped the second, third, and fourth sessions together since they form a natural developmental segment of the work with this client. This segment can be characterized by the phrase "exploration and exaggeration" for reasons that will soon become clear.

Gill presented at the second session in a more distressed and depressed state than at the first. She said that the homework assignment I had set had caused her "a lot of pain" and that if therapy was going to make her more and more depressed, she was not sure that she wanted to continue. She said that she had become angry by the fact that I was "making her" go into the black hole and that I was "making her" depressed. She also said that she had undertaken the homework tasks with considerable reluctance and had only been able to complete them by using the "insomnia" time that was available to her—"it was one way of trying to get me distracted enough to sleep." She created an extension to one of her images—the homework had "been like an insecticide sprayed on me as a leafless sapling."

I used these statements to congratulate Gill on a clear identification of her symptoms and to encourage her to reveal more of the inner workings of her experience, since this was a central part of the process by which her depression could be affected. In addition to giving her symptoms a positive connotation (see Minuchin & Fishman, 1981, esp. pp. 33-34), I also reinforced her use of her "insomnia time," arguing that it was a constructive use of time she would otherwise have wasted and that, even though it made her angry, this was more constructive a use of her time than being depressed. This last comment is a variant on Haley's ordeal therapy method in which time "wasted" in negative emotional experiences has to be compensated for by the completion of behavioral tasks (Haley, 1974).

Providing two positive connotations for statements that Gill anticipated would be received negatively seemed to promote some arousal in her. She looked startled and confused. She had expected me to be angry as she had been. Here is some dialogue from this session, which illuminates the impact of positive connotation and reinforcement:

> P: You mean to say that you are *pleased* that I was *angry*?!
>
> T: No, I am pleased about two things—your ability to be clear and precise in understanding just what is happening to you and the fact that you were something other than depressed. I am also pleased now to hear that your voice is reflecting your feelings and that you are completing sentences that describe precisely the way you are feeling.

P: This is something else! [Sits upright in chair, moves forward, and begins to gesticulate by pointing a finger] I do not like being angry and I do not like being depressed I just want to be me—we'd better understand this before we go much further.

T: Gill, am I right in seeing that you are aroused right now? Am I right in seeing you aroused and feeling that this is making you anxious?

P [hesitantly]: Yes, yes you are . . . I suppose I am feeling aroused . . . and upset.

T: Gill, please help me. I want you to focus on arousal and what happens to you when you experience arousal. I want you to describe what is happening to you now that this arousal is around. Do it quickly, Gill, before this arousal goes away. Tell me, what's this arousal like?

P: Well [sits more forward on the chair—on the edge] . . . I feel my heart beat a little faster and I can feel the blood pulsing in my neck [puts left hand to her neck] . . . I also feel my thoughts beginning to move a little quicker, as if I could get out of control if I don't watch it. . . I feel I have to do something, say something or do something so that I stay in control. . . .

T: Gill, I want you to notice something. When I asked you what happens when you experience arousal, you described your feeling that you needed to control that arousal so that you could control your experience. This is another good insight into your experience, Gill, and I am grateful for your clarity. It shows me that your feeling of depression is about over controlling your experience of arousal.

P [flash of anger appears to produce this statement]: What's this? Instant diagnosis!

T: Thank you for sharing your anger with me, Gill. It shows that you can get aroused quickly and that you can, show that arousal to others. Is that what happened right then . . . you got angry?

P: [moves back into chair and looks directly into my eyes for the first time during these first 20 minutes of the session; pause for nine seconds; voice is quiet

and hesitant]: Yes, yes that's right, [pause for 12 seconds] I am sorry that I was angry with you.

T: I am happy that you can be angry with me, Gill. I am also happy that you were angry . . . it shows me that you do become aroused and that you experience arousal in a particular kind of way.

P: Yes, but it always makes me upset. . . .

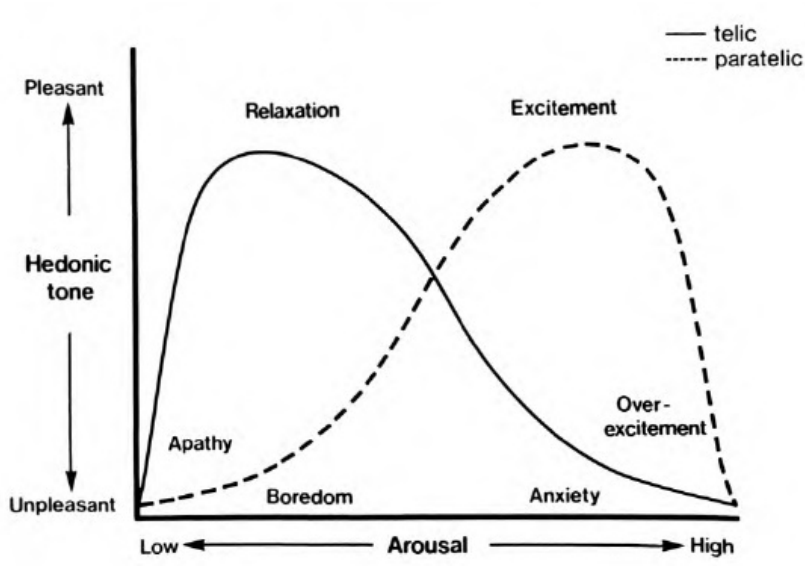
This interchange was a critical lead into two features that dominated the first session: (a) the fact that her arousal was experienced as something unpleasant indicated that arousal was being experienced in the telic state and was therefore being suppressed; and (b) we had established the focus on here-and-now issues for therapy rather than past or future issues.

The remainder of this session was spent explaining the nature of reversal theory, with the emphasis being placed on the way in which arousal is experienced differently in the telic and paratelic meta-motivational states (arousal is felt as unpleasant in the telic state and as pleasant in the paratelic state). I asked Gill to work through the meaning for her of the curve shown in Figure 1. She clearly identified herself as at the extreme end of the telic curve —beyond relaxation and in a state of apathy. She related her drawings and photographs of herself to this figure and was able to further confirm that she was to be located in apathy at this time and on the telic curve "when I'm not this bad." She claimed to recognize few, if any, paratelic experiences.

In exploring this diagram and its meaning for her—a basic way of enabling us to share a language about arousal and its link with experience—I emphasized some of the features of the telic state that are of particular importance in understanding the nature of depression. These are summarized in the list given here which I worked through with Gill:

Means-Ends. In the telic state you attempt to complete tasks, to meet essential and imposed goals that you see as unavoidable; you are acting to achieve ends and are not that interested in the processes by which these ends are achieved provided that the process is not over-arousing; you are reactive rather than initiating.

Figure 1



Time. In the telic state you prefer planned and purposive activity; you like to know where you are going; you therefore constantly look to the future and see yourself more in future time than the present, here-and-now time; your life always points beyond where it is to where you see yourself; you prefer events to have high significance in terms of this plan, though you recognize that your plan will modify itself in the light of experience.

Intensity. In the telic state you prefer low arousal—high arousal is experienced as anxiety, which is often expressed as frustration, anger, or agitation; you are generally realistic, not risk taking, and you seek out situations in which the things you experience will have a low emotional

intensity rather than a high intensity; you work hard to create "safe" environments.

Gill claimed that these observations described her experience of the social world well, and she was able to connect to many features of the description. She further connected her photographs to these items.

She showed herself dressed conventionally, doing conventional things, and minimizing the interest in photographs that could have had interesting features. She also discussed the quality of her relationships with men as being about safety and planned relationships. At the end of the second session I asked Gill to make a note in a notebook I had provided her of all the feelings that she experienced between this session and the next appointment. I asked her to be diligent and encouraged her to be explicit. I reminded her of her skills in self-observation (further positive reinforcement of her symptoms) and asked her to attend to the features of the telic state we had just explored; means-ends, the experience of time, and the intensity of her experience.

The third session built on this foundation and used her "feelings diary" to connect her experience with the model represented in Figure 1. Of particular importance to this period of continued explanation was her realization that the experience of arousal in telic terms was only one way of experiencing motivation and emotion and there were alternatives. The

following is an extract from her feelings diary:

> *Tuesday.* Annoyed at how late the postman is becoming and at the fact that no one has written to me anyway. Felt numb for most of the morning. Felt a pain in the base of my back—put it down to stress after the therapy session. Felt sad about being so depressed and then felt depressed about being so depressed.
>
> *Wednesday.* Felt tired and exhausted as soon as I awoke. Felt weak and limp and a little better. By 7:30 a m I wanted to scream with the pain of being so depressed. Then I slowly began to feel angry: thought about this in terms of what we'd talked about—angry is aroused, isn't it, and that's what's wrong, I am not aroused enough! (Does this mean I am getting better?)
>
> *Thursday.* Couldn't get out of bed today and felt miserable. Thought a lot about this paratelic idea and tried hard to remember when I had let myself go. I recalled an incident when
>
> I was eight and was running wild in a field and got beaten for it and a sex thing with a girl and a boy from school when I was eight and felt guilty . . . but nothing else. By noon I was too tired even to be depressed. By 4:00 p.m. I was fitful and somber. Slept. Felt tired when I awoke. Felt bitter about another wasted day. Felt bitter about having to keep this diary. Felt bitter about everything.

The diary read as a kind of intellectual diary—feelings had become intellectualized and her emotions relegated to a set of standard statements that had literary merit. Her apathy was apparent as well as her bitterness. I felt that the diary indicated the operation of a second pair of metamotivational states outlined in reversal theory—the negativism and conformity pair (see Apter [1982], esp. pp. 220-223). In particular, there is a

high degree of "self-negativism" displayed in the diary material (and in the earlier drawings). Apter (1982) defines self-negativism in the following way:

> If the self-polarizes into the "I" and "me," then it is possible for the "I" to see the "me" as external to it in some way, and to see its requirements as coming "from outside." Therefore under these conditions the "I" can, when the negativistic state is operative, act negatively against the "me." This will be referred to as self-negativism (p. 220).

There are a number of ways in which self-negativism can arise, but the most appropriate in this case is to regard it as a form of retroflection (Peris, Hefferline, & Goodman, 1973). Gill has substituted herself for her environment and acts against herself rather than those things in her environment which she would really like to react against. This observation adds a new element to my hypothesis—Gill is highly telic, satiated in this metamotivational state, and depressed because she cannot achieve a reversal to the paratelic state or achieve the satisfactions of the telic state, and now it is clear that she is also self-negativistic.

Once again I congratulated her on the clarity of her own understanding of her symptoms and on the diligence with which she had completed her homework task. I said that in this third session I wanted her to enable me to see and feel the kinds of experiences she had written about and that I wanted to use some drama work to achieve this. I explained that the way in which I wanted her to behave was risky for her—she would get aroused—but that

this was all part of the therapy. The essential task was for her to portray, in as detailed and as elaborate a way as possible, the emotions she had recorded in her diary. I further observed that this way of working is derived from the work of Keith Johnstone (1981) and will involve her in having to improvise; I pointed out that this would not be too difficult since I wanted her to improvise being herself as described in her diary. At first she did not take me seriously. She asked, "Is this for real?" and I observed that her diary was for real, but this was to be an enactment of her feelings. After some considerable persuasion, she agreed to "try this stuff' but did so with the feeling that it would not work.

I began by asking her to act out the scene in her diary in which she describes waking and feeling angry (see the Wednesday entry). To make matters easier for her I said that I would play at being a servant—I intended to use this role to engage in some paradoxical interventions. Each time she offered a scene I (as the servant) complained that it was not depressed and exhausted enough—she did not really look like she was about to scream or that she was in pain—and I asked her to work harder and harder at being depressed. After five or six tries at this scene the following encounter (with us both out of our role play) occurred:

> P: Shit! It's me that knows what it's like to be me. I am the one that gets fucking depressed not you . . . so will you just stop badgering me and stop making me so fucking angry! God, it's awful and I'm paying for this . . . charade!

T: You keep saying you're depressed, but you never show the depth of your depression.

P: What more do I have to do, for Christ's sake [shouting] . . . cut my fucking wrist! Slit my throat! Would that make you happy? God, everyone always has plans for me and I never get to be myself.

T: And what would being yourself mean, Gill?

P: Oh . . . not having to take responsibility all the time . . . being, well, being the me I was never allowed to be as a child.

Through the use of a dramatized paradoxical intervention (Riebel, 1984; Coleman Nelson, 1962) in this third session I was able to achieve: (a) a display of negativism toward me, which highlighted this feature for both patient and therapists; (b) a high level of arousal in Gill, which she experienced initially as anger and subsequently as exhilarating (as she herself reports below); and (c) a new statement of her experience of the social world, which seemed *for her* to encapsulate her depression. This session was to prove critical in her therapy, as we shall see. What was also critical was the attempts I made to ensure that she left this session in a state other than one of anxiety and anger. I did this by using a quick relaxation method (Murgatroyd, 1985b) and by talking her down and building an agenda for our next meeting. This session ran for two and a quarter hours.

I did set Gill a homework assignment. It was to write a letter to me that should arrive the day before our next scheduled meeting. This is the letter she

wrote:

> Dear Stephen,
>
> I have thought a lot about the last session. You really got me angry! So angry that I didn't have time to be depressed!! For the first time in five months I felt as if I had grown some foliage. I hope you will not be angry with me when we meet tomorrow—it all just poured out of me. I felt so angry at being directed and forced to be something that I don't want that I just had to scream at you. (Do you know that I have never used those words before with another person present?)
>
> After I left the session, when you'd taught that quick relaxation method, I was still quite high. I felt like I could be me for a while. Since then I have become more depressed. I think that what is happening is that I am feeling that it is okay to be me when I am pushed to be by you, but that I can't keep it up when I am out here. This is something I would really like to talk about when we meet.
>
> One other thing, I would like to explore just where this thing about everyone else having plans for me comes from. I have not thought that way since I was around 14 or 8 and I am not sure what it means for me now.
>
> Anyway, don't be angry with me.
> Gill

My objectives for the fourth session were discussed with my colleague and supervisor following the receipt of this letter. Both of us felt that the fourth session would shape the direction of the therapy that followed. I felt strongly that the essential task was to continue to generate arousal which Gill could experience in a variety of different ways, the point being that the experience of arousal as anger, excitement, or frustration might induce either

a shift in the telic state such that Gill would become more adept at handling the social world or a reversal into the paratelic state, which would certainly lead to a lifting of the depression. My colleague, however, felt that the issue of control ("everyone has plans for me and I never get to be myself') was so central to her experience of the social world and her self-evaluation that I should focus exclusively on this feature in the fourth session. I decided to combine both perspectives and to use some challenging and confronting techniques to do so.

When Gill arrived for the fourth session she looked a little more alert than usual. I noticed that her voice had far more modulation than had been the case during her normal conversation on previous sessions. I began by thanking her for her letter and explained that, far from being angry, the last session had produced some important material for us to work on. She agreed, noting that she had identified an issue in her letter to me which she felt was important and about which she had been thinking carefully. I said that I had observed that, but that I wanted her to engage in some more work first. I said that I had listed on a piece of paper six features of Gill which I would like her to look at. These were: (1) Gill the worker—efficient and enthusiastic; (2) Gill the daughter— alone and unsure; (3) Gill the planned relator; (4) Gill who has never said "fuck" with someone else present; (5) Gill the frustrated; and (6) Gill who can only be angry or depressed. I asked her to throw dice and talk for five minutes about whichever feature of Gill the dice indicated. I made clear

that after five minutes I would ask her to throw the dice again and repeat the process. My aim in using this technique (developed from Luke Rinehart's *The Dice Man* [1972]) was to provide a frustrating opportunity for Gill to talk about different features of herself so that we could explore the meaning of her social world and her motivation while at the same time increasing her arousal. I assumed that the uncertainty inherent in the procedure would be arousing as well as the fact that some of the content would generate arousal in its own right. Gill was persuaded to comply. The dice was thrown and landed on 3. Here is a transcript of the next few minutes:

> P: Hmm . . . well, when I was small mother used to always brief me on how to behave when we went anywhere. If I went to someone's house then I was expected to behave in a certain way and was always rewarded when I did so. If I didn't do what she expected then I was punished—not physically . . . perhaps I wouldn't have things I wanted or perhaps mother would become ill or something like that, but I knew when I had to behave. After father died it became more and more important to her that she knew just what I was up to. I used to plan my day and tell her about my plans and then she would check on my progress. When I went to college I was still living at home—mother used to plan my work and my time and my money and I just learned how to do it from her.
>
> T: So your mother shaped your behavior, Gill. Tell me about your relationships with others.
>
> P: Well, I found that on my first date this boy was, well what we call "keen" . . . he kept feeling my breasts when we were dancing and making suggestions. I could feel myself getting worked up and I didn't know what to do . . . I was all confused and I hate that. . . I told you, I like to know just where I am . . .. So I decided that my relationships with men and with my friends (some of whom would drop their pants for anyone!) should be careful and planned. . .

. You'll not believe this, but I once wrote out a list of how to be with a boy . . . you know, date 1 holding hands and kissing with mouth shut; date 2 holding hands and kissing with mouth open; date 3 kissing with mouth open and letting him touch my breasts outside my clothes . . . and I actually kept to that schedule . . . it looks funny looking back at it. . . .

T: . . . but it is the kind of plan your mother would have expected?

P: Yes, well . . . no . . . I mean, she wouldn't have expected me to . . . well, you know . . . Anyway, since then I have been careful about the way I relate to others, and . . .

T [interrupts]: It's time to throw the dice again, Gill.

Gill was clearly frustrated by having to curtail her exposition, but complied. The dice this time took her to item 5. Before she began to speak I reminded her that she only had five minutes. She got angry:

P: Now look, I have waited a week to tell you about this and you tell me we only have five minutes! What in hell's name is going on here?

T: I am listening, Gill, you have four and a half minutes.

P: Typical! Typical! All my life I have had to plan to get what I want and well over half the time I get frustrated by other people. Now it's you! You sit there pontificating and telling me to do this and to do that and then I get pushed around. Well, I am not having it with you or anyone else, I am just through with it I begins to cry] . . . I can't go on any longer.

T: You still have time to tell me something about it, Gill.

P: I haven't got time! I haven't! It would take over this whole session to tell you about my frustration, about the way I have screwed up my career and about the way my mother manipulated me and about how I feel trapped. . . . I haven't got time and now it's too late. It's too late here and it's too late for

anything, I am trapped.

T: . . . and whenever you feel trapped like this, you get angry and then you start to get depressed, is that right, Gill?

P: Oh, we're back to the instant diagnosis again are we!

T: I asked a question, Gill. . .

P: I heard you, for Christ's sake, I heard you! Well . . . [calming down] I suppose so. . . I suppose you're right. . . [wiping her eyes and beginning to take control of herself] . . . if I am not angry then I am depressed . . . and recently, well until I started seeing you, I have just been depressed . . . it was as if I couldn't even be bothered to get angry anymore . . . that's how depressed I was.

T: Time to throw the dice again, Gill.

P [looking defiant and on the edge of tears]: I'm sorry, I can't go on with this . . . it's too much . . .

T: What you are saying is that you won't go on with this, is that right, Gill? It's not that you can't go on with this, it's that you don't want to, isn't it, Gill?

P: I don't want to go on with this . . . no.

T: Are you clear about what it is that you *do* want, Gill?

P [sobbing]: . . . No . . . I don't know where to start. . . .

T: Are you missing your mother's guidance, Gill?

[At this point Gill cries for about two minutes continuously.]

This interchange provided a further element for my hypothesis about Gill. The hypothesis can be thought of as having the following components: (a)

Gill is a highly telic person who plans ahead and seeks to avoid arousal; (b) Gill has planned ahead and sought to avoid arousal for so long that she is satiated within this meta-motivational state *(telic)* but appears unable either to shift within this state or to achieve a reversal into another state; (c) this failure to achieve a reversal or a shift is the source of her depression, which in turn is producing a degree of self-negativism; (d) the self-negativism is in itself arousing, and this leads her to experience anger as the learned alternative to depression—increasing the number of anger incidents in therapy appears to be revealing more about the underlying dynamics of Gill's life; (e) the self-negativism and the depression are both related to her current frustration to perceive future goals and her consequent feeling of entrapment; and (f) in the past, her failure to perceive new goals and tasks has been something which others gave attention to, but now she has no one to provide new goals or purposes for her and this too adds to her feelings of depression. The consequence of this interpretation for Gill is that she will continue to alternate between depression and self-negativism or anger while she persists in her feeling of pointlessness. The consequences for therapy are that it is time to choose between seeking out new goals that make sense to Gill and restore the satisfactions of her telic orientation or seeking to promote some reversals between the telic and paratelic states. Given that our contract was for a brief therapeutic intervention (only eight sessions), I felt that the first of these therapeutic options was the most appropriate for Gill. It is also

the option most likely to be attainable.

I ended the fourth session of her therapy by sharing my hypothesis about her depression and negativism and by drawing her attention once again to the importance of goals in her life. I observed the role her mother had played historically in the development of goals and how the need for goals had so permeated her life that she had lost the ability to relax in the telic state or to see goals in the context of change and development occurring throughout adult life. I pointed out that her essential reason for depression was that she had achieved the goals she had set herself and was now empty of goals. She needed more if she was to continue to develop as a person. What is more, she needed to feel that she "owned" these goals—that they were genuinely from within her—and that they were not imposed from outside. To recognize and own some new goals would enable her to feel satisfaction in itself, even before she began to work on achieving the goals.

Throughout my exposition of this interpretation, Gill remained motionless but very attentive. At the end of the exposition she said simply, *"The black hole has a white star and the leaves are growing."* The hypothesis appeared to be accurate. I asked her to consider what goals were important for her and to give thought not to *how* she could achieve them (or to the problems associated with them) but to just *what* the goals might be. She agreed to come to session 5 with some goals.

So far the therapy with Gill had used explanation, interpretation, and paradoxical intervention using drama and a dice-based confronting strategy. All these therapeutic tools were intended to increase arousal, to create a need for Gill to experience that arousal and interpret it for herself, and to facilitate the release of negative and positive emotions. Another way of saying this is that a variety of methods were employed to test a hypothesis that in itself was derived from the theory of psychological reversals. The next stage of therapy would require the use of other strategies.

SESSIONS 5 TO 8

I had decided that the goal of therapy was to restore active coping in the telic metamotivational state—achieving reversal was a goal for a therapeutic contract with Gill other than the one under which I was now working. This meant that I needed to facilitate: (a) the identification of goals and tasks and the ownership of the significance of these; (b) the restoration of relaxation; and (c) the removal of self-negativistic responses to arousal. All these therapeutic tasks derive from my understanding of reversal theory. I shared these observations during a routine supervision session. My colleague agreed that these tasks were appropriate for Gill given the way in which the therapy had developed. He suggested that some form of relaxation training may be appropriate, since he felt strongly that Gill needed to be taught that relaxation was a realistic alternative to depression once goals had begun to be worked

on and she felt that arousal was low.

Gill arrived at the fifth session 15 minutes early. She looked much more confident than she had been on the previous two occasions and her conversational tone was normal and her voice modulated appropriately during conversation. Gone was the outward portrayal of apathy and depression. Before I could begin the session, Gill took command:

> P: Right now, before we start, Stephen, I have something to say. On the last two occasions we have met you have pushed me into a corner and I have become angry and been very upset. So angry that I swore at you and that I have cried. Since I saw you last I have decided that I am old enough to be able to deal with the kind of anger that you generated, and I want you to know that I am not going to even start playing any of your games this week. Is that clear?
>
> T [smiling, and humorously]: Perfectly, ma'am.
>
> P: What I am going to do is to talk to you about what I have decided to do . . .

Gill then outlined three goals she had decided were appropriate for her. The first was to sell the house her mother had left her—"too many memories and too much pain . . . in any case, I need the money and do not need a four-bedroom house . . . also, I think a two-bedroom apartment is much more manageable. . . ." She had already placed the property in the hands of a real estate company. The second goal was to work toward opening her own business—"After all, I have virtually run the one I work for and I am qualified in business. . . . I am sure that I can manage. . . ." Her final goal was by far the

most ambitious, at least to me—"The next thing is that I am going to stop being so miserable about myself. . . . I've wallowed in self-pity and pain for too long." She looked pleased with herself. The session progressed as follows:

T: Do you mind if I speak now?

P: Of course not, I haven't shocked you?

T: Why should you shock me. . . . No, I am pleased that you have taken my advice to identify goals so seriously, though I do hope that you haven't moved too quickly in seeking to implement them. Remember, I asked you to look at *what* the goals might be not *how* you might achieve them. But no, what strikes me, Gill, is this . . . where has all this energy come from? When you first came here it was like looking at and talking to a China doll whose batteries were flat! Now I feel that I am receiving messages from a ghetto blaster!

P [laughs]: . . . I don't know where this energy is coming from, I only hope it can last [looks serious]. It will last, won't it?

T: That is up to you and the way in which events unfold. . . . None of what you have mentioned sounds easy and all will be challenging. . . .

It is obvious from these extracts that the tone and focus of this session are markedly different from those of sessions 1 to 4. What is more, at no time in this session did Gill show any signs of anger, apathy, depression, or fear. Instead, the session was characterized by calmness, occasional amusement, and a kind of certainty that had not been evident before.

Toward the end of the session I suggested that some activity intended to

release energy and, at the same time, to promote relaxation would be beneficial. I indicated that I felt that Gill had a reserve of energy which remained underutilized and that a particular form of dynamic meditation (Rajneesh, 1983; Murgatroyd, 1985b) would be a valuable skill to develop. I gave some instruction and provided her with a tape especially made for the meditation, which involves shaking, dancing, swirling, and total relaxation. I asked her to engage in this activity each evening for the remainder of the therapy and to regard this as a task that I attached importance to on her behalf. She agreed to undertake the meditation, but not on these terms. She said, "I do have energy and I will try your suggestion . . . if I like it I will continue, if I don't I will return your tape in due course." I began to suspect that she had been to an assertiveness training course since I saw her last!

In many ways, this was a remarkable session. It marked an abrupt change in Gill, which can only be accounted for by events outside the therapy. One of these, I learned later, was her decision to finally get rid of her mother's belongings and clothes (except for photographs and jewelry), which had remained in the house since her death. Another was the decision of her company to reduce the number of stores in the area—Gill felt that one of these was a viable business concern that she could make profitable if the overheads were reduced. These two events were significant for Gill. She later wrote about them:

> . . . What the therapy did at this stage was make me more sensitive to events outside me. I felt that the therapy challenged me and led me to want to find a challenge. Both the decision to break my ties (which were still very physical—clothes and furniture) to my mother and the decision to become a business entrepreneur were the result of looking for a challenge. I am not sure, looking back, whether the therapy I had had (which hurt like hell for the first few sessions) made me want to prove something to Stephen . . . but I certainly wanted to prove something to myself.

This letter (written to a friend, and shown to me by Gill for the purpose of completing this case study) makes clear that she had made her mind up to work with some goals and tasks that she felt she owned. By session 5, then, a major task of the therapy had been achieved.

The sixth session was spent discussing her reaction to the meditation technique I had asked her to try. She said that she at first found it strange. The technique is physically very demanding. It begins with the person shaking for 15 minutes, followed by 15 minutes of dancing, then 15 minutes of relaxation, and then 15 minutes of swaying and gently rocking. The audiotape I had provided is a tape of music specially recorded for this purpose. Gill had completed this meditation each day for seven days. She said that "it gave me so much energy and I felt so calm that I have enjoyed the sensation of relaxation more than anything else I have experienced in the last five or six months." She said that the use of an hour a day for the purpose of deliberately trying to relax while at the same time using a lot of energy had had a kind of purging effect. We explored the meaning of "purging" for her—she made clear

that it involved, at least at this stage in her life, "getting rid of all the feelings of being destructive to herself," which I saw as a statement about actively seeking to rid herself of her self-negativism. I used this observation to explore with her the idea of retroflection and the objects in the social world which she really felt negativism toward. It became clear that the objects were largely her own lack of spontaneity and her feeling of a lack of direction in her employment and in her social life. The session ended by me asking whether she needed further sessions. We agreed that she should come in the next week and that the eighth session would be a month after the seventh—a follow-up session.

The seventh session was a detailed exploration of her emotional experience of being active again. She made clear that the plans and tasks she had set herself had a high level of ownership for her and that she was "restored." I asked her how she dealt with frustrations and uncertainty and with the need to be more spontaneous, now that she was running her own business (she had bought her store). This is her reply and the exchange that followed:

> P: I have given this some thought. I think I am more willing to take risks, somehow. One reason is that I really feel, perhaps for the first time, that I am doing things which I planned and I decided upon. Almost everything else I have achieved was under the direction of my mother. I hadn't realized just how significant that was for me, until I decided that it was time I made my own mind up. Now that I have sold the house, sold her things, started on my own as far as work is concerned and started to relax for the first time in my life

(at least it feels like that), I am much more able to take each day as it comes. So, I think I am slowly being able to live an easier life, though it is hectic.

T: Gill, can I ask you something. Did you attend your mother's funeral?

P [looks mournful and a little hurt at this question]: No . . . no . . . I didn't. . . . I made all the arrangements and made sure that all the practical things had been taken care of. . . but on the morning itself I . . . I . . . just collapsed and couldn't face it. . . that was four years ago . . . I have felt guilty about it since . . ..

T: But now you feel that you have attended to the burial as well. Is that what the sale of her clothes and possessions was about, Gill?

P: Yes, yes, I think so. I had wanted to feel as if I was no longer dependent on her. You see, I had achieved all the ambitions she had for me . . . I had got what she wanted . . . but somehow this left me feeling empty. Now, well, what I feel now is that I have my own plans. . . . I mean, I am grateful for the guidance and help and love my mother gave me . . . don't get me wrong . . . but now I feel, well, I am on my own . . . and I should enjoy it.

T: You are no longer willing to feel guilty about having plans of your own?

P: That's it. I smiles I You know me very well, don't you, Stephen?

As is often the case with depression of this type, unresolved issues were at the core of the depression. In this case, the loss-grieving process (see Murgatroyd & Woolfe, 1982; Parkes, 1972) had not been completed, and grief and locus of control issues had remained unresolved for Gill. I used this observation to begin the discussion with Gill about the impact of the termination of therapy. She said that, though I had provided a trigger for her to snap out of her depression, she felt that she had achieved a great deal on

her own and was feeling capable of overcoming any difficulty about termination. In any case, she said, we were seeing each other in a month's time and this would provide a basis for her rehearsing life without therapy-

A month later Gill arrived promptly for her final session. She said that she could only stay for an hour (the session was planned to be an hour and a half), but that she thought this would be adequate. She explained that she had been extremely active since I last saw her. She had moved house, her business was beginning to work in a way that she found acceptable, and she had started to go out with a female friend—Jenny—whom she had met through the community group that had referred her to me. They met each Friday and went to a yoga class and then on for a drink. She said that she had enjoyed Jenny's friendship and had not felt that it needed to be something that was controlled and planned. One of the things that she had learned in therapy, she said, was that even careful plans about what would happen can come to nothing if the other person does not fully share the plan or the need to plan. She referred particularly to session 4 in this discussion.

I asked her to review her therapy. She said that the most critical experience was being forced to realize that the only alternative to depression that she could produce was anger. She particularly identified with the feelings of negativism, which she felt she was strongly directing toward herself. She realized that this must be some kind of displaced anger or hostility. It was

only later that she realized that this anger was directed at her mother. The other thing that she felt was important to her was having some features of her personality recognized in the beginning (session 2). For her, knowing that the work we completed was grounded in something she herself could understand ("it wasn't all mumbo-jumbo and black magic") meant that she was willing to trust me when I asked her to do some drama work or the dice work.

After an hour of this discussion and evaluation, the session ended, and my contact with Gill was over—at least so I thought.

Three months later Gill wrote to me—a kind of thank you and evaluation letter. Here is the text:

> Dear Stephen,
>
> It is some time since my last session. It occurs to me that I did not really thank you. When I came to you I was very depressed and so exhausted that I felt near to the point at which life would seem pointless—you made me feel that there was an explanation for how I felt and that I could overcome the depression.
>
> You challenged me in a number of ways. I understand now that you were trying to get me back on the telic curve (I hope that's the right term); at the time, though, I thought you were cruel and hard on me. I kept hearing my mother say that "nice" people are always kind and considerate and that your behavior meant that you were not a nice person. So, I thought bad thoughts about you. But then I started to think about the way I had always been controlled by mother and about the way in which I felt that, even though she was dead, she still controlled me.

> The one thing I have given a lot of thought to since we met (we've been very busy at work) is why I did not go to her funeral. It seems to me that I was afraid of seeing her being cremated and knowing that, from that moment, I was on my own. I think a lot of the anger I had was about knowing that I was free from her influence and yet not knowing what to do with my freedom. You helped me find this issue, so I have to thank you for that.
>
> One more thing. I do really want to thank you for the meditation. I still do it each day (unless something else has happened). It gives me such a tranquil feeling and it's so reliable that, well, I think you should tell all of your clients to do it!
>
> So, thank you, Stephen. If you ever need any cosmetics let me know.
>
> Gill

This was my last significant contact with Gill. Though there appear to be many unresolved issues in her life that she may one day wish to discuss, Gill is certainly not currently depressed.

CONCLUDING COMMENTS

This case study indicates the way in which a body of theory about the person and about the structural impact of therapy (Murgatroyd & Apter, 1984,1985) can be used to provide a rationale for eclectic therapy. In my work with Gill I used a variety of techniques from paradoxical intention to meditation as devices for changing the way in which Gill experienced arousal. In terms of her depression, changing both the level of her arousal experience

and the way in which these experiences were interpreted by her was critical to the change in her phenomenal field. These interventions were derived from my understanding of her presenting problem in terms of the theory of reversals and in terms of my understanding of the likely impact of these therapeutic interventions on both her arousal and motivational systems. Reversal theory thus guided my hypothesis about Gill and my assumptions about the impact of therapy on Gill.

Other cases using reversal theory have been published (Blackmore & Murgatroyd, 1980; Murgatroyd, 1981; Murgatroyd & Apter, 1984, 1985) which illuminate the way in which the theory of psychological reversals offers a framework for eclectic practice. The case reported here illuminates some limited features of the eclectic model—the other reported case illuminate different facets of this approach. It is hoped that the case of Gill illuminates the nature of structural phenomenological eclectic practice.

REFERENCES

Apter, M. J. (1982). *The experience of motivation—The theory of psychological reversals*. London: Academic Press.

Apter, M. J., & Smith, K. C. P. (1985). Experiencing personal relationships. In M. J. Apter, D. Fontana, & S. Murgatroyd (Eds.), *Reversal theory—Applications and developments.* Cardiff: University College Cardiff Press.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Blackmore, M., & Murgatroyd, S. (1980). Anne—The disruptive infant. In S. Murgatroyd (Ed), *Helping the troubled child—Interprofessional case studies.* London: Harper and Row.

Blinder, M. G. (1966). The pragmatic classification of depression. *American Journal of Psychiatry*. 123. 259-269.

Coleman Nelson, M. (1962). Effects of paradigmatic techniques on the psychic economy of borderline patients. *Psychiatry*, 25 (2), 119-134.

Costello, C. G. (1972). Depression—Loss of reinforcement or loss of reinforcer effectiveness? *Behavior Therapy*, 3. 240-247.

Eastman, C. (1976). Behavioral formulations of depression. *Psychology Review*, 83, 277-291.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* New York: Lyle Stuart.

Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, 28, 857-870.

Foulds, G. A., & Bedford, A. (1976). Classification of depressive illness—A re-evaluation. *Psychological Medicine*, 6, 15-19.

Haley, J. (1974). *Ordeal therapy.* San Francisco: Jossey-Bass.

Hersen, M., Eisler, R. M., Alford, G. S., & Agras, W. S. (1973). Effects of token economy on neurotic depression—An experimental analysis. *Behavior Therapy*, 4, 392-397.

Johnstone, K. (1981). *Impro—Improvisation and the theatre.* London: Macmillan.

Kendell, R. E. (1976). The classification of depressions—A review of contemporary confusion. *British Journal of Psychiatry*, 129, 15-28.

Lazarus, A. A. (1968). Learning theory and the treatment of depression. *Behavior Research and Therapy*, 6, 87-89.

Lazarus, A. A. (1976). *Multi-modal behavior therapy.* New York: Springer.

Lewis, A. J. (1938). States of depression—Their clinical and aetiological differentiation. *British Medical Journal*. 2, 875-878.

Mandler, G. (1975). *Mind and emotion.* New York: Wiley.

Meichenbaum, D. (1977). *Cognitive behavior modification—An integrative approach*. New York: Plenum Press.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques.* Cambridge, MA: Harvard University Press.

Moss, G. R., & Boren, J. H. (1972). Depression as a model for behavioral analysis. *Comprehensive Psychiatry*, 13, 581-590.

Murgatroyd, S. (1981). Reversal theory—A new perspective on crisis counseling. *British Journal of Guidance and Counselling*, 9, 180-193.

Murgatroyd, S. (1985a). Introduction to reversal theory. In M. J. Apter, D. Fontana, & S. Murgatroyd (Eds.), *Reversal theory—Applications and developments.* Cardiff: University of College Cardiff Press.

Murgatroyd, S. (1985b). *Counselling and helping.* London: British Psychological Society and Methuen Books.

Murgatroyd, S., & Apter, M. J. (1984). Eclectic psychotherapy—A structural phenomenological approach. In W. Dryden (Ed.), *Individual therapy in Britain.* London: Harper and Row.

Murgatroyd, S., & Apter, M. J. (1985). A structural phenomenological approach to eclectic psychotherapy. In J. C. Norcross (Ed), *The handbook of eclectic psychotherapy.* New York: Brunner/Mazel.

Murgatroyd, S., & Woolfe, R. (1982). *Coping with crisis—Understanding and helping people in need.* London: Harper and Row.

Murgatroyd, S., Rushton, C., Apter, M. J., & Ray, C. (1978). The development of the telic dominance

scale. *Journal of Personality Assessment*, 42, 519-528.

Overall, J. E., Hollister, L. E., Johnson, M., & Rennington, V. (1966). Nosology of depression and differential responses to drugs. *Journal of the American Medical Association*, 195, 946-950.

Parkes, C. (1972). Bereavement—Studies of grief in adult life. London: Tavistock.

Paykel, E. S. (1971). The classification of depressed patients—A cluster analysis derived grouping. *British Journal of Psychiatry*, 118, 275-288.

Perls, F., Hefferline, R. F., & Goodman, P. (1973). *Gestalt therapy—Excitement and growth in the human personality.* Harmondsworth: Penguin. (Originally published in 1951 in the U.S.)

Pollitt, J. (1965). Suggestions for a physiological classification of depression. *British Journal of Psychiatry*, 111, 489-495.

Rajneesh, B. S. (1983). *The orange book—The meditation techniques of Bhagwan Shree Rajneesh*. Rajneeshpuram, Oregon: Rajneesh Foundation.

Riebel, L. (1984). Paradoxical intention strategies—A review of rationales. *Psychotherapy*, 21, 260-272.

Rinehart, L. (1972). *The dice man: A novel.* London: Granada.

Rumke, H. C. (1960). *Psychiatrie* (Vol. 2). Amsterdam: Scheltema en Holkeman.

Seligman, H. E. P. (1975). *Helplessness.* San Francisco: Freeman.

Smith, K. C. P., & Apter, M. J. (1975). *A theory of psychological reversals.* Chippenham, England: Picton Publishing.

Snaith, R. P., Bridge, G. W. K., & Hamilton, M. (1976). The Leeds Scale for the self-assessment of anxiety and depression. *British Journal of Psychiatry*, 128, 156-165.

Commentary: Why Not More Phenomenology and Less Structure?

Joseph Hart

The task of commenting on this chapter is not an easy one because I found much to admire, several features of the approach I did not like, and much to question. To put all of these impressions and thoughts together in a few pages will be difficult—perhaps the best way to do it is the direct way.

WHAT I LIKED

The therapist managed to blend a variety of techniques in truly ingenious ways. His use of a "feeling diary," role-playing, photographs of the client and her relatives, homework assignments, paradoxical interpretations, meditation instructions, and the teaching of the theory to the client were all combined into an effective and innovative professional approach. I thought that his use of the dice technique to teach role flexibility and enhance feeling expressiveness beyond the client's usual boundaries was especially impressive. (I had read the novel The Dice Man several years ago but Murgatroyd's is the first therapeutic

application that I have heard about.) I believe it is extremely important that therapists draw widely from the arts and the culture at large in our search for techniques and ideas and not confine ourselves to whatever is currently normative and accepted within professional circles.

The author described sessions 2 through 4 as focused on "exploration and exaggeration." His willingness to encourage emotional expressiveness that took the client outside her typical meanings and feelings was impressive. All too often clients spend weeks and months talking about themselves from emotional ruts simply because therapists pay more attention to the content of their talk than the style. Murgatroyd showed a real deftness in directing Gill to attend to the ways in which she expressed herself as well as what she said. By attending to the theatrical side of the communications, the therapist was able to challenge, directly, the long-established, restrictive meanings that Gill had attached to being angry, depressed, and aroused.

WHAT I DISLIKED

Most of my problems with this chapter were with the theory that seemed to be guiding the therapist; in other words, I was concerned not with what he did (which in most instances I found desirable) but with his explanations. Part of my difficulty with the author's explanations is undoubtedly due to my own unfamiliarity with structural phenomenological psychotherapy. My own

training and reading have included the study of phenomenological and existential theorists such as Rollo May, Medard Boss, and Eugene Gendlin, but I find their emphases to be quite different from those of Murgatroyd and his colleagues. For one thing, the emphasis is often on attending to the phenomena as they are and noticing changes that emerge. In contrast, Murgatroyd typically imposes meanings and changes on the client's experiences, basing these impositions (or interventions) on structural theory. One hopes that the theory is awfully good and complete—if it is not, there are real dangers of prescriptive phenomenology, i.e., teaching the client to have the experiences and meanings that fit the theory. By and large, that is what Albert Ellis does in his rational-emotive therapy. Although a certain amount of prescriptive phenomenology is required in any kind of therapy, it is well to be cautious; the therapist should certainly, in my view, be more of a follower than a leader when exploring the client's inner world.

My second caveat relates to the author's failure to do anything with the symbols presented by his client. He does report them but does not say anything about how they were discussed. The central symbol Gill used to describe herself in the first session was "having a black hole inside me that wants to engulf me and take me over." She interpreted later sessions of the therapy as forcing her to confront the black hole. Finally, she reported a new image of the black hole, with a white star and growing leaves. This symbolism deserves more attention. Within many therapeutic approaches Gill would have been encouraged to relate

to the symbol, through dialogues and drawings or paintings. Because this kind of phenomenological work does not seem to fit within Murgatroyd's telic theory and methodology, the wider meanings of the symbolism remain unexamined for Gill. This seems to me to be a real loss in the client's therapeutic experience because she has lost not only the opportunity to know herself more deeply through understanding her special symbols but also the opportunity to learn a process of symbolic working through that she could have used creatively in the future.

FURTHER QUESTIONS

I have been stimulated by Mr. Murgatroyd's chapter and will certainly read several of the references he cites about the work he and his colleagues have done. When I read those works, I will be extremely curious to see how they relate to phenomenological, teleological, and existential theorists who have very much influenced my own thinking.

First, I am curious to know how the telic conceptualizations of Apter and Murgatroyd relate to those of Joseph Rychlak. For decades now, Rychlak has been arguing, against the mainstream, for the necessity of telic theorizing in psychology. How would Apter and Murgatroyd relate structural phenomenology to Rychlak's rigorous humanism ? (see Rychlak, 1968 and 1977.)

Next, I would like to know how structural phenomenology relates to

Gendlin's experiential psychotherapy. Specifically, how would structural phenomenologists make use of Gendlin's technique of focusing? Focusing is a method that teaches clients how to pay attention to what they are experiencing and to communicate the changes that occur in their experiences. For Gendlin a certain level of focusing skill is considered prerequisite to phenomenological therapy. (Consult Gendlin, 1962, 1979, 1981.)

Finally, I would like to evaluate how structural phenomenology relates to various classical positions within psychology and psychotherapy. What does structural phenomenology have to say about theories of the unconscious and the subconscious such as those of Freud, Jung, James, and Janet? How does structural phenomenology relate to the ideas of religious phenomenology found in Buber? How does structural phenomenology relate to humanistic psychology as found in the works of Rogers and Maslow?

I suppose all these questions relate to one general question: what is the scope of structural phenomenology? That is a question that is too large to be evaluated within the scope of a commentary, or even a chapter.

REFERENCES

Gendlin, E. (1962). *Experiencing and the creation of meaning*. New York: Free Press.

Gendlin, E. (1979). Experiential psychotherapy. In R.J. Corsini (Ed.), *Current Psychotherapies* (2nd ed.). Itasca, IL: F. E. Peacock.

Gendlin, E. (1981). *Focusing.* New York: Bantam.

Rychlak, J. (1968). *A philosophy of science for personality theory*. Boston: Houghton Mifflin.

Rychlak, J. (1977). *The psychology of rigorous humanism*. New York: Wiley.

Commentary: Is There Truth in Psychotherapeutic Packaging?

Robert N. Sollod

Murgatroyd's "reversal theory" approach to psychotherapy, as illustrated in the case of Gill, provoked an odd array of thoughts and feelings. First, I was thrown off by the ostensible underpinnings of the theory, which purported to be not only structural but also phenomenological as well as eclectic. A great admirer of the ideas of Levi-Strauss, Piaget, Heidegger, Husserl, and Binswanger, not to mention a variety of leaders in developing eclectic psychotherapeutic integrations, I was at first prepared for an intellectual tour de force, in which the essential structure of human experience would be first elucidated and then therapeutically transformed. I was also pleased to see that this new theory did not purport, at least in its packaging, to be scientific—as have so many other psychotherapeutic theories that were anything but scientific (Sollod, 1982).

What Murgatroyd has presented in this case illustration, however, seems to me to be less phenomenological in method and spirit than what he desires it to be. It is, rather, an approach that reduces human experience to a relatively

dichotomous labeling system, although using newly invented terms. In my view, Murgatroyd's therapeutic method is no more or less phenomenological than that of a psychopharmacologically-oriented psychiatrist who asks patients how they feel and concludes whether they are depressed based, in large part, on their self-reports. The term structural apparently refers to the use of the newly invented labels "telic" and "paratelic," which constitute, according to the theory, a very large part of human experience. Much of the psychotherapeutic process consists of teaching the patient to label his experiences using these terms. Telic and paratelic states are also referred to as "metamotivational perhaps the title could have included this term: e.g., "An Eclectic, Phenomenological, Structural, Metamotivational Theory."

There are some therapeutically relevant hypotheses and insights indicated in Murgatroyd's case and in his theory (Murgatroyd & Apter, 1985), which I will present below—in plain English:

1. *Normal people are sometimes serious and sometimes playful.*
2. *It is not good to be serious or goal-oriented all the time. ("All work and no play makes Gill a sick girl!")*
3. *It is not good to play all the time either.*
4. *It is best to be calm and relaxed when engaged in goal-oriented behavior and to be more excited when playful.*

5. *The therapist should help a person to be serious and playful at the right times, to be calm when goal-oriented and more playful when excited.*

6. *Whatever the therapist can do to facilitate these goals is encouraged (eclecticism?).*

7. *A good way to tell whether clients have been playful or serious is to ask them (phenomenology?).*

This psychotherapeutic approach does seem, as indicated by Murgatroyd and Apter (1985), to have some useful applications. It is not clear what is added by calling it a structural, phenomenological theory, when it has more to do with labeling of play and work states and assessing high and low arousal. I prefer to call Murgatroyd and Apter's approach "work and play psychotherapy."

The case history does illustrate an important use for theory—that it gives the therapist something to believe in, something to be interested in, as well as something to do. Such sincere therapist belief and optimism have been demonstrated to be an important placebo in outcome research. In addition, the client is given a relatively nonthreatening structure within which she can recount major events in her life, express feelings, and initiate new behaviors. No doubt the packaging of Murgatroyd's approach will attract the attention and encourage the involvement of other therapists and investigators for whom the terms "structural," "phenomenological," and "eclectic" are appealing. What

more can one ask of a theory?

The case history indicates not so much the effectiveness of Murgatroyd's approach but rather the importance of therapist encouragement, a caring relationship, and the efficacy of catharsis. Gill's case also illustrates conventional Freudian dynamics in mourning and depression. Gill's depression appears to result from an intra-punitive reaction to the loss of her mother. In the course of therapy, she grieves, gets in touch with her angry feelings, and becomes mobilized in dealing with her own life. Discussion of such psychodynamics is a notable lacuna in an otherwise wide-ranging eclecticism. If anything, the case supports Wachtel's (1977) integrative psychodynamic approach, in which action and insight reinforce one another.

The case of Gill illustrates a major fallacy in the development of new psychotherapeutic approaches—the classic post hoc, ergo propter hoc fallacy. The psychotherapeutic version is "If a therapist informed with a given psychotherapeutic approach works closely with a patient and the patient improves, then the theory is demonstrated [invalidly, we hasten to remind the reader] to be true."

There are valid psychotherapeutic roles for some of the concepts of reversal theory and related psychotherapeutic techniques. It is hoped that a more modest and appropriate theoretical superstructure can be developed for

this theory. In addition, carefully conducted outcome research, in which various ingredients of therapeutic impact are explored, is clearly a necessity. The intriguing concepts of reversal theory, as presented in the case of Gill, do not appear to be comprehensive enough to constitute a new psychotherapeutic school. It is quite possible, however, that some of the ideas and methods presented in this case will be found to be effective. They might be used selectively with certain clients or integrated into other, more comprehensive psychotherapeutic approaches.

REFERENCES

Murgatroyd, S., & Apter, M. J. (1985). A structural phenomenological approach to eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of Eclectic Psychotherapy*. New York: Brunner/Mazel.

Sollod, R. (1982). Non-scientific sources of psychotherapeutic approaches. In P. Sharkey (Ed.), *Philosophy, religion and psychotherapy*. Washington, DC: University Press of America.

Wachtel, P. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York: Basic Books.