Casebook of Eclectic Psychotherapy

Systematic Eclectic Psychotherapy:

Growing into Separation

Larry Beutler

Commentaries by

Windy Dryden & Stephen C. Paul,
Addie Fuhriman, and Gary M. Burlingame

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CHAPTER 3
Systematic Eclectic Psychotherapy: Growing into Separation

BASIC TENETS

From one eclectic viewpoint, all psychotherapies are founded in common processes, and these commonalities are the most reliable and consistently important ingredients for facilitating positive change in patient condition. Another eclectic viewpoint emphasizes the value of theoretical amalgamation, and still another type of eclecticism expresses belief in the value of technical integration as a guide to therapeutic decision making. The systematic eclectic psychotherapy to be illustrated here represents the latter form of eclecticism and is based on the joint assumptions that: (1) every psychotherapy approach has fostered unique and effective technologies and (2) these technologies can be applied effectively independently of the theoretical and philosophical formulations that initially spawned them. Although nontechnical and so-called *common variables* are typically regarded as the most powerful contributors to positive therapeutic influence, the technical eclectic or integrative

psychotherapist maintains that adding the unique contributions from more specific treatments increases the potential for positive therapeutic outcomes. By applying specific technologies derived from a variety of philosophies, within a general approach that emphasizes the importance of a stable and collaborative therapeutic relationship, it is anticipated that therapeutic gains will be enhanced. However, this will most likely be accomplished, from the standpoint of the systematic eclectic therapist, if the technology is applied in a planned fashion which attends to the particular needs presented by the patient.

From the foregoing perspective, three tasks face the therapist who is interested in applying a systematic eclectic approach to treatment (Beutler, 1983, 1986). The first task is to ensure that there is an optimal compatibility of background and beliefs between the patient and the therapist, so that a fruitful and collaborative relationship can evolve. The second task is to bring specific and relevant techniques to bear on the particular problems presented by the patient at hand. The third task is to modify the therapeutic environment and the treatment techniques as the patient changes and as the variables that indicate or contraindicate various procedures come into focus. In the service of these three objectives, five more

specific sets of questions must be addressed as one develops and implements the treatment program. These questions sequentially proceed from the general concern with the suitability of psychotherapy for this patient, to more specific matters having to do with the selection and patterning of particular procedures. To be more specific, the questions addressed in the course of evaluation and treatment are as follows:

1. Is This Patient a Suitable Candidate for Psychotherapy ?

This question evokes an evaluation process that is designed to determine (a) whether the patient's problem is amenable to change through psychological means, (b) whether the patient is motivated to undertake and maintain a relationship of sufficient duration to modify the problem, and (c) whether the patient has access to sufficient social support systems to provide stability and direction during the course of this relationship. Resolution of these issues usually can be found in the patient's report and history. Of specific importance is a prior history of durable relationships with significant others in which some degree of intimacy is experienced and emotional support is received. Beyond this, it is important to ensure that intellectual resources are available

at a level that will allow the patient to experience some continuity between in therapy and extra-therapy experiences. At this point, it is sufficient to know that the patient is able to understand that the psychotherapy relationship is in some ways similar to and designed to impact relationships and behaviors in the outside world.

2. What Should the Focus of Treatment Be?

This question extends the evaluation process to determine whether the patient's problem can best be perceived as a collection of isolated symptoms, each with their own unique genesis, or as a pattern of interrelated behaviors emanating from a common interpersonal and/or intrapsychic struggle with wants, wishes, impulses, and fears. The term *symptom complexity* is used to describe this range of symptom dynamics. If the symptoms presented are seen as isolated habits, developed and maintained by a consistent set of reinforcing contingencies, they are judged to have low complexity, and this form of systematic eclectic psychotherapy asserts that the focus should be on the symptoms themselves, with the goal of symptom removal. On the other hand, various problems and symptoms presented by many patients are an indirect expression of a common set of unresolved

internal conflicts, including an array of unrealistic interpersonal fears whose intensities are inconsistent with the observed environmental probabilities of encountering dangerous events. In the latter cases, it is assumed that the therapy focus should concentrate on the dynamically active struggle and conflicts that give rise to the various complex patterning of symptoms rather than on the isolated symptoms themselves.

An index of symptom complexity is derived from a clinical judgment which evaluates: (1) the extent to which symptoms have generalized to impair the patient's interpersonal functioning (i.e., the number of areas of life impacted), (2) the degree to which current problem and symptom patterns reflect a learning history with similar contingencies as opposed to being a disturbance arising from idiosyncratic generalizations and perceptual distortions of contingencies that never were or are no longer realistically present, and (3) how adequately the patient deals with the resulting distress (i.e., the severity of disturbance). A balance of these three factors is used to make an initial determination of whether the presenting problem represents a simple adjustment to a specific environment (i.e., habit), or whether there is a dynamic conflict represented that

supports and maintains the disturbance (i.e., neurotiform adjustment).

In the event that one determines that the presenting problem is a reflection of a consistent and linear reinforcement history, the focus of treatment becomes the isolated symptoms, and one need only identify and prioritize these at this point in the assessment process. If, on the other hand, the initial assessment suggests that the patient's presenting problems represent a dynamic struggle, represented as a life pattern of similar struggles, the therapist's task must be extended to define the central theme or focus which has characterized the patient's struggle and which is assumed to underlie the presenting problems. This target of treatment, defined as the *core theme,* involves the process of postulating the nature of the motivating struggle.

In developing a postulate of the patient's life theme, the systematic eclectic therapist relies on whatever theoretical or philosophical foundations are most comfortable and with which she or he is most familiar. Psychoanalytic formulations, interpersonal formulations, or formulations derived from object relations and social persuasion are all possible guiding constructs. Because of their simplicity and their probable relevance to the patient-therapist

matching process to be discussed shortly, the formulation of conflicts along the dimension of dependence-independence developed by Millon (1969; Millon & Everly, 1985) has been of considerable help to this author.

Although the truth of the formulation ultimately selected is impossible to assess, it is important that: (1) the therapist believes that it accurately represents the patient, (2) it is sufficiently logical to make sense to the patient, and (3) it is capable of being taught within the probable time frame of the therapy. This postulated formulation becomes the guiding thread of psychotherapy and serves as the glue that holds together a variety of specific interventions. The specific nature of these latter interventions is defined by the answers derived from responding to the remaining central questions addressed by the therapist.

3. How Tolerant Is the Patient of Directive Influence?

Once the decision is made that psychotherapy is a relevant intervention and the focus of this therapy has been defined, the subsequent questions address how the therapist should approach the

patient. Raising a question of patient tolerance for directive interventions is designed to remind the therapist that psychotherapy is an interpersonal influence process. This question will focus the therapist on the fact that his or her viewpoints will be transmitted to the patient and that the manner and force with which this is done can either motivate the patient toward improvement or mobilize resistance against change.

Inherent in the determination of the patient's susceptibility to influence is a need to evaluate *what* is being transmitted. This process involves assessing the amount of compatibility existing between patient and therapist belief systems and backgrounds. Research on attitude change in psychotherapy (Beutler, 1981; Beutler, Crago, & Arizmendi, in press) has quite consistently observed that certain demographic similarities between patient and therapist facilitate the patient's initial commitment to the treatment process, whereas optimal differences of viewpoint around cardinal therapeutic issues (core themes) may mobilize the patient to make changes. However, if viewpoints between therapist and patient are too discrepant, the patient may find the therapist's views to be intolerant and unacceptable (Beutler, 1981). Unless this factor can be offset by other

variables, the development of a collaborative and therapeutic relationship may be impaired. Therefore, the effective eclectic psychotherapist must be aware of the interpersonal and attitudinal compatibility that exists between himself and a prospective patient and make a judgment as to whether or not there is sufficient background similarity to maintain a collaborative relationship and for the patient to find the therapist's viewpoint credible. At the same time, however, the therapist must make a judgment as to whether there is sufficient difference of opinion around those cardinal attitudes and values which maintain the patient's problem to stimulate change.

The second task of the therapist in assessing the approach to take is a determination of *how* the interventions should be delivered. This decision is reflected in variations in how directive the therapist is in conveying alternative viewpoints, in dealing with problems, and in implementing the techniques designed to resolve the patient's problem. Systematic eclectic psychotherapy has borrowed the term *reactance* (Brehm & Brehm, 1981) from social psychology to describe the degree to which the patient might resist interventions that are initiated by the therapist. An assessment of the patient's reactance level, therefore, predicts the degree that directive procedures will be

tolerated when mobilizing the patient toward change. Without belaboring the point, the principle of reactance is based on considerable research both in clinical and in laboratory settings which suggests that the highly reactant patient may resist both the attitudes conveyed by the therapist and any directive procedures that may be used for implementing change. It has been suggested that deterioration in the patient's condition may occur if the therapist's level of directiveness is not geared to the patient's tolerance for directiveness. In contrast to highly reactant patients, those with low levels of reactance seem to be very tolerant and may even present an affinity for directiveness in the therapist's efforts to convey both adaptive attitudes and in implementing technical procedures (Beutler et al., in press).

4. What Specific Interventions Are Likely to Yield the Greatest Gain?

Once interpersonal compatibility and degree of tolerance for directiveness have been determined, the therapist is faced with the task of deriving a menu of interventions that are both suitably situated on the specter of directiveness to be accepted by the patient and appropriately focused on either the conflictual theme or the

independent symptoms that serve as the guiding thread of treatment. In order to make such a determination, the therapist now focuses on defining the patterns of behavior and defense that the patient typically uses to cope with the inner conflicts and/or situational pressures. In the case of habitform conditions, represented as simple or monosymptomatic patterns, this determination represents simply an assessment of whether the patient's presenting symptoms exist because of a relative excess of certain kinds of behavior or an insufficiency of alternative behaviors in their repertoire. This knowledge then determines for the therapist whether the treatment will concentrate on skill development (for behavioral insufficiency), or on curtailment and extinction of those excessive behaviors which are defined as "symptoms."

The situation becomes more complex if the patient has been defined as having a neurotiform or "adjustment" difficulty. In this event, the therapist must determine whether the *principal* way the patient attempts to control anxiety deriving from the thematic conflict is through: (a) overcontrol of both emotions and behaviors, (b) undercontrol of both emotions and behaviors, or (c) a middle point, usually represented by emotional lability in the presence of excessive

inhibition of impulses.

It is postulated that patterns of direct *anxiety avoidance* (undercontrol) are most amenable to interventions that take a behavioral focus. These individuals cope with driving conflicts by externalizing anxiety through acting-out and excessive behaviors, dictating that the interventions concentrate on controlling and stabilizing the behavioral manifestations of the conflict. In contrast, some patients present defensive styles designed for *anxiety containment.* These patients overcontrol and compartmentalize emotions and engage in behavioral and social withdrawal. Such defenses suggest that these individuals have constrained their emotional experiences and have placed corresponding constraints on behaviors that represent these needs. Therapeutic procedures that emphasize the escalation and magnification of arousal as well as the awareness of emotional needs are therefore applicable.

A third group of patients present a mixture of both anxiety-containing defenses (e.g., internalizing, overcontrol, and impulse constriction) and direct-avoidance defenses (e.g., externalizing, undercontrolled and exaggerated feelings). This pattern, referred to as

anxiety magnification, is indexed by the presence of emotional liability and the absence of corresponding behavioral displays. These individuals may express a great deal of affectivity, primarily in the form of anxiety and agitation, but continue to compartmentalize emotions and to constrain impulses, even when acting out certain impulses would be appropriate. Depressiform patterns of cognition are often observed, as are patterns of hypersensitivity. The recommended therapeutic interventions emphasize management of the perceptual patterns and cognitive beliefs which prevent modulation of emotions and which serve to constrain even normal and appropriate behaviors.

By selecting interventions suitable to the patient's defensive style and at the same time suitable to the degree of symptom complexity presented by the patient and still adjusted for greater or lesser directiveness in the intervention process, a menu can be constructed of the most probable interventions for realizing therapeutic gains. To do so requires that the therapist know the demand characteristics of each intervention he or she uses.

In making a task analysis of interventions, it is helpful to

distinguish between *evocative* and *directive* procedures. Evocative procedures are those which are totally under the control of the therapist and require little specific response on the part of the patient. The evocative intervention is designed to facilitate the patient's exploration but does not predetermine the nature, form, or outcome of his response. In contrast, directive interventions are designed to engage the patient in carrying out a particular experiment or task. Although the end point of this task and experiment may be unknown, the process of its execution is under the discretion or recommendation of the therapist. Generally, directives require the exertion of more control on the part of the therapist and compliance on the part of the patient than do evocative interventions. In addition to this general rule, specific interventions within each of the broader categories vary in: (1) the degree of control required on the part of the therapist for implementation (directiveness), (2) the degree to which the interventions are amenable to symptoms or underlying conflicts, and (3) the degree to which the intervention is compatible with the patient's defensive style, varying along the general dimension of internalizing/containing to externalizing/avoiding.

For want of space and time, the reader is referred to other

written sources in which a task analysis of various interventions has been described in some detail (Beutler, 1983, in press). It bears emphasis here, however, that the three categories of defensive style described in the foregoing are roughly equivalent to the three realms of experience to which various interventions are addressed. Interventions can be seen as emphasizing either *behavioral, cognitive,* or *affective* experience. These are broad categories of experience and associated interventions, but they do embody a certain logic and consistency. This is not to say that many interventions cannot be used alternatively to address two or all of these levels of experience. As a general rule of thumb, nevertheless, it is postulated that behavioral interventions are most appropriate for individuals with externalizing defensive styles in which direct avoidance of anxiety is achieved through acting out, projection, and attention seeking. Concomitantly, cognitive change interventions are postulated to be most appropriate for those individuals whose anxiety magnifying/sensitizing defenses are manifest in behavioral constraint and emotional liability or depression. In contrast, the affective interventions, which are typically drawn from experiential and humanistic therapies, are postulated to be most useful among individuals who most severely constrain

emotional experience and withdraw from sensory stimulation. These internalizing, anxiety-containing individuals are judged to be amenable to interventions that heighten affective arousal and draw their attention to emotional experiences and nuances.

Within the foregoing broad intervention categories, specific techniques and procedures can be even more precisely defined in terms of the amount of therapist control and suggestion required for their effective implementation. Among the evocative strategies, for example, reflections require little power or control on the part of the therapist and minimal compliance on the part of the patient. In contrast, dynamic interpretations require that the patient exert focused energy to give up defensively protected awareness's in order effectively to accommodate the insight offered by the therapist. Questions and clarifications fall somewhere between these extremes of required therapist control.

Among directive procedures, task-oriented homework assignments and in-session experiments require a relatively large amount of therapist control and patient compliance. Imagery-based procedures, however, may require less in the way of external

manifestation of patient compliance and are thus less likely to threaten the patient's sense of autonomy. Such procedures as dream analysis, relaxation training, and hypnosis require varying but lesser amounts of therapist control when compared to directives that insist on some behavioral manifestation either within the session or external to the session.

It is a tenet of systematic eclectic psychotherapy that once the various therapeutic procedures are analyzed for their task structure and demand characteristics, one can select a menu of appropriate strategies, adjusting these to: (1) correspond with the ability of the patient to tolerate directive interventions (i.e., reactance level), (2) maintain the selected focus on the patient's cognitive, behavioral, or emotional experiences, and (3) suitably address the complexity of the problem by emphasizing either targeted symptoms or broad-band dynamic conflicts.

Unfortunately, therapists can only select from among the procedures with which they are familiar, and therapists have varying abilities to adjust specific procedures along the dimensions of directiveness and focus. Therefore, it is advisable for therapists to

become very familiar with a wide range of therapeutic procedures and to seek to acquire considerable flexibility in their application so that these procedures can be made to accommodate the patients' defensive style, reactance level, and need for symptomatic or conflictual focus. Moreover, the therapist must know when to shift therapeutic stance and modify the treatment menu.

5. How Should the Interventions Be Changed over the Course of Treatment?

Neither patients nor the problems they present are static qualities. When therapy is effective, it exerts its effect through a dynamic process in which the patient's reactance level, coping skills, and coping effectiveness change as treatment progresses. As an outgrowth of developing a compatible and collaborative therapeutic relationship, the patient's ability to tolerate directiveness within therapy may change even though this change may not rapidly transfer to the extra-therapy environment. Hence, the effective eclectic therapist is constantly engaged in the activity of process diagnoses, evaluating changes in response, defense, and receptiveness over the course both of a single session and as one proceeds through broader phases of treatment. The menu of interventions fruitfully used to

initiate treatment, therefore, must be altered as treatment progresses. The nature of this adjustment reflects a complex interplay between adjusting the directiveness of the intervention, on one hand, and gearing the intervention to match the patient's defensive style, on the other. Throughout, the focal objective remains constant, whether it be symptom removal or core conflict resolution. This latter continuity of focus provides the integrative force of treatment.

Because patient reactance, defensive style, and problem complexity are all subject to idiosyncratic patterns of change, numerous possible scenarios of treatment patterning may emerge. One scenario often observed among patients who exhibit strong internalizing, anxiety-containing defenses may proceed as follows: (1) The initial treatment menu may emphasize emotional awareness and escalation in the beginning phases of treatment; procedures from Gestalt therapy may be used to heighten here-and-now, sensory-emotional experiences. (2) As the patient becomes less emotionally constrained in the middle phases of treatment, cognitive interventions may be utilized both to help the patient develop a new perspective on his behavior and to reinforce his ability to control the impulses that may be activated by new emotional experiences. (3) In the later

phases of treatment, behavioral retraining and assertive skill training may be employed to facilitate the patient’s social roles and interpersonal relationships.

On the other hand, when treating an externalizing, anxiety-avoidant patient, the initial behaviorally tuned interventions may be followed by cognitive interventions as impulses become constrained and agitation increases. These cognitive interventions may be used to reinforce the strength of the behavioral controls that have been implemented. In this case, an emphasis on emotional experience and awareness may be reserved for the late stages of treatment and will be designed to tune the patient to the subtleties of interpersonal communication and intrapersonal needs.

The principles outlined in the foregoing discussion can be only partially illustrated in a single case example. Since the fundamental propositions emphasize patient-to-patient variations in therapist planning and approach, one cannot hope to capture a full picture of these differences in action without a large number of systematically different therapy-patient-therapist matches. Nonetheless, the following case example is offered as a sampling of how the reasoning

behind this form of systematic eclecticism operates in practice.

A CASE EXAMPLE

Patient Selection/Evaluation

The patient to be presented in the remainder of this chapter was the first psychotherapy candidate to contact the author for treatment after a commitment to contribute to this volume had been made. Moreover, she was the only patient seen for this purpose and from whom weekly audio recordings of therapy sessions were made. Although this case cannot be considered entirely representative of patients in the author's caseload, no attempt was made to preselect the patient. Many aspects of the patient and her treatment were typical, at least to the degree that any one treatment process is "typical" of another. Although several features of the patient's history and status will be altered in the following presentation, in the interest of anonymity, the essential features will be preserved.

The patient (R. T.) was originally referred to the writer from out of state. She was relocating close to her mother in order to begin her college career. She is female, 18 years of age, and indicated that her

initial problem was residual anger at her parents and a desire to get rid of her tendency to "think, judge, and question myself.”

The referent for this patient was a psychiatrist who, along with a psychological counselor, had been treating the patient for nearly a year. The patient’s psychiatric and medical history was considerably more extensive than would be indicated by this knowledge alone, however. For example, she presented a long history of a "seizure disorder” and had recently been diagnosed as having narcolepsy. Moreover, the patient’s parents were both alcoholic and had divorced when she was eight years of age. The patient recalled a good deal of turmoil in the family both prior to and following the divorce but had no knowledge of the specific reasons for the marital breakup.

Following her parents’ divorce, the patient initially stayed with her mother, but because of her mother’s disrupted lifestyle, the patient subsequently moved in with her father and stepmother at the age of 13. The patient reported that her stepmother was aggressive and hostile and frequently had "emotionally” abused the patient. Interpersonal problems reached critical levels between the patient and her father because of her reactions to her stepmother, and these

problems were complicated by the presence of a half-brother (aged four) who occupied a favored role with the parents. Her father's continued alcoholism further introduced conflicts between him and his wife, and the intensity of these frequently left the patient feeling isolated from all family members. She was often restricted to her room for long periods of time and prevented from seeing friends. Thus, she remembered few good friendships during early adolescence. In her early years, she recalls her father as being physically abusive. He had a history of periodic depressions (probably representing a bipolar disorder), and these episodes significantly exacerbated his pattern of explosiveness and withdrawal.

The patient reported that her medical problems began at approximately age seven. Originally she experienced "dizzy spells," but later these were accompanied by blackouts, loss of memory, and probable psychomotor seizures. By the time she went to live with her father at age 13, these spells were sufficiently pronounced that they were interfering with other life functions. She had been a competitive swimmer but, because of social fears, depression, and seizures, was forced to give up the pursuit of her parents' dream of Olympic stardom. When she began to experience sleep paralysis and sleep

attacks, she was treated by a neurologist who prescribed several anti-seizure medications with little effect.

By age 16 family difficulties had become sufficiently intense that the patient began experiencing severe bouts of depression with pronounced suicidal ideation. It was at that time that she first was taken to see a psychiatrist. In the initial few months of treatment, he prescribed response trials of from 12 to 15 different types of medication, most of which did not substantially help either her depression or her seizures. She was ultimately diagnosed as having narcolepsy, on the basis of a clinical symptom pattern, and placed on Dexedrine with some benefit. At the time the patient saw the author several months later, she was taking 15 milligrams of Dexedrine twice daily and maintained that this had been a lifesaving force for her because it had partially relieved the intensity of her depressive episodes. Nonetheless, she reported the continuing presence of periodic blackouts, triggered both by intense visual stimuli and by emotionally arousing situations. Moreover, she acknowledged being dependent on the medication.

Prior to the initial appointment, the patient was provided with a

series of psychological assessment devices. These included the MMPI (Dahlstrom, Welsh, & Dahlstrom, 1972) to assess personality organization, with particular emphasis on defensive style and reactance level; the Shipley Institute of Living Scale (Paulson & Lin, 1970) to assess her cognitive functioning and conceptual ability; the SCL-90R (Derogatis, Rickels, & Rock, 1976) to evaluate the pervasiveness of her symptoms; and the FIRO-B (Schutz, 1958), which was used as a brief screening inventory to assess the interpersonal attachments from which a core theme might be constructed.

The patient was oriented in all three spheres, but acknowledged being hypersensitive to any threat of altering her medication or treatment regimen. In that context, she was very distressed at the neurologist who had also seen her on initial referral and who was managing her medications. This attitude remarkably contrasted with her feeling about her prior psychiatrist, whom she idolized. Her negative feeling toward the current neurologist was instigated when he suggested that he would like to withdraw her from medication in order to evaluate her narcolepsy.

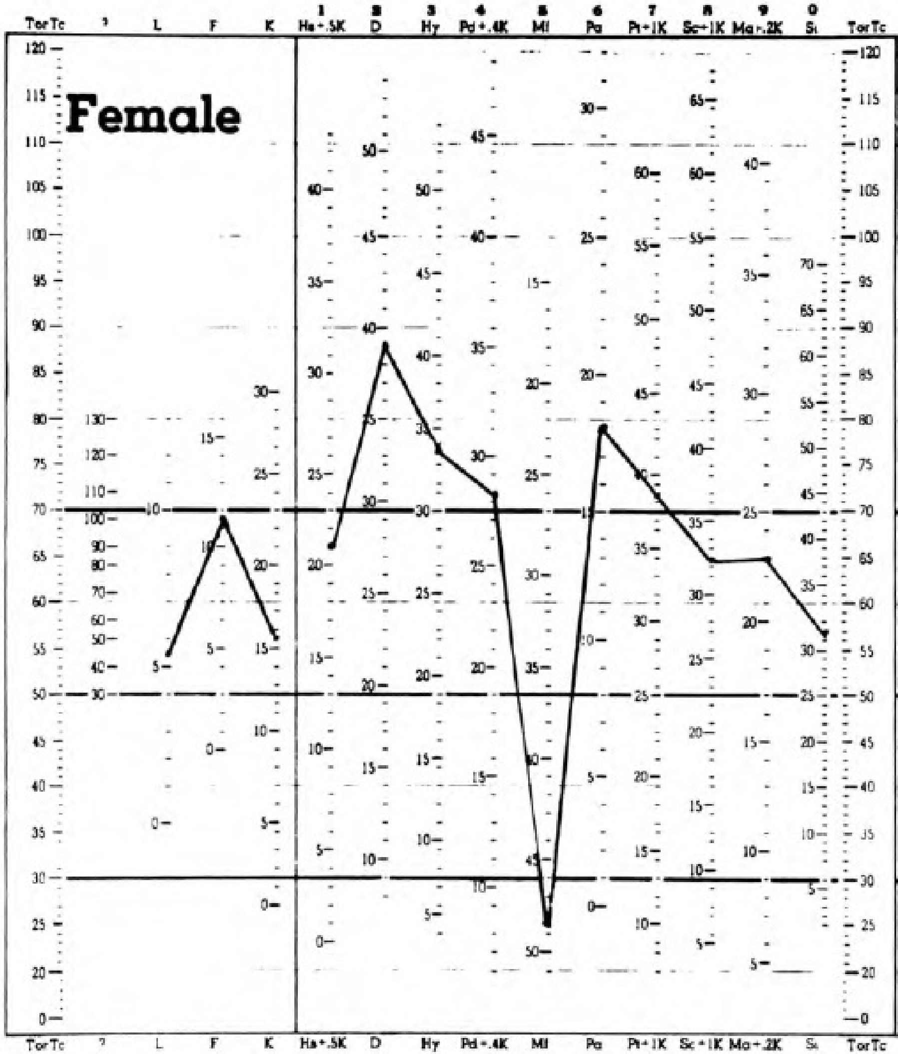
Figure 1 presents the patient's MMPI profile at the time of intake.

As noted, she was extremely suspicious and quite depressed. The extensive reliance on traditional feministic philosophies and attitudes (Mf) contrasted with the assertiveness represented in scales Pd and Pa. This pattern was interpreted as suggesting an individual who was suspicious, particularly of men, who tended to confuse dependency and aggressive feelings, who felt victimized by others, and who presented a high degree of interpersonal reactance to external control.

By the same token, an analysis of the personality profile suggested that the patient presented an anxiety-magnifying coping style. For example, the evidences of depressiform patterns (D) suggested the presence of intropunitive self-consciousness, which was further exemplified in her obsessi form ideations about religion and her sense of guilt (Pt). This point was underlined at the time of the initial interview when the patient reported preoccupation with supernatural forces and religious experiences. She reported that she considered herself to have supernatural powers but felt tremendously guilty at her inability to utilize these to benefit others. She expressed great feelings of guilt about religion and the sense that God either had deserted her or was helpless to assist her. In either case, He had been a disappointment to her and had become an object of her anger. Her

primary social contacts had been with religious groups who maintained literal interpretations of scriptures and placed strong demands on the patient for compliance with certain religious codes and standards. Her failure to comply totally with these invoked considerable anger, guilt, and apprehension.

Figure 1. Pre-therapy MMPI profile (corrected T scores).



Prior to and during the first session, the patient’s status was

evaluated by addressing the five questions outlined in the earlier sections of this chapter.

1. Suitability for Treatment

The patient had a prior history of being able to benefit from a therapeutic relationship, both with a psychiatrist and with a counselor who had worked with her for approximately a year. She also exhibited hope for the pending therapeutic relationship. Moreover, she functioned within the superior range of intelligence and at a high level of cognitive efficiency, as assessed at the time of intake. These strengths suggested the ability to develop insight and to evaluate the significance and generality of in therapy behavior. Although she was overly involved and unable to step back and objectively assess her own behavior, her desire to do so and her cognitive resources suggested that she was a good candidate for individual psychotherapy.

2. Treatment Focus

The patient’s difficulties had been going on for a long period of time, and at the time of initial evaluation she presented moderate to severe psychological disturbance as represented in formal

psychological assessment devices (MMPI, SCL-90R). She had inordinate concerns with punishment, extensive guilt about minor matters, and extensive, self-imposed performance demands. These observations suggested compromised coping abilities and a broad-ranging psychological disturbance. The pattern of social withdrawal and ambivalence pervaded a variety of areas and had interfered with social relationships, religious activities, family relationships, and school. She had previously been a promising class A swimmer, for example, but had withdrawn in the midst of family crises and, for a period of time, had dropped virtually all social relationships. She reported evidence of periodically becoming fixated on one aspect of interpersonal functioning or another (e.g., religion, school, etc.), only to become frustrated with insoluble dilemmas, and had abandoned social activities in the midst of her depressions. This pattern suggested the complexity of the psychological disturbance and argued for a treatment approach focused on conflicts and conflict resolution.

A review of the patient’s history, particularly those aspects suggesting abuse and abandonment, suggested that a primary focal theme in her interpersonal relationships may be in the counterbalancing desires for attachment and nurturance, on one hand,

and distance and individuation, on the other (ambivalence; cf. Beutler, 1983; Millon, 1969). A review of both the patient's MMPI and her FIRO-B suggested intense needs for affection and dependency, counterbalanced by a striving for individuation and separation. In part, this struggle was age appropriate, but appeared to be exacerbated beyond the patient's years in the context of profound family struggles.

With the interpersonal focal theme defined as one of ambivalence, the therapeutic objective was designed to concomitantly assist the patient in selecting an attitudinal and behavioral pattern that would allow gratification of both her desires for nurturance and her desires for individuation. The patient's bipolar approach to this conflict was represented in a cyclical and disruptive fashion rather than in a pattern that modulated these two need systems as befit the situation. Developing the ability to modulate these competing forces was judged to be a critical treatment concern.

3. Approach to the Patient

The patient came from an upper-middle-class background, with

traditional religious beliefs and a strong emphasis on social conformity. Interpersonal compatibility with the therapist was considered to be relatively similar in the dimensions of: religious background, socioeconomic background, and traditional values. In these demographic and background spheres, the patient's and therapist's similar history suggested compatibility (Beutler, 1983; Beutler et. al., in press). However, compatibility also emphasizes the importance of differences of viewpoint, particularly around those critical issues of life reflecting needs for attachment and individuation. Here, the patient exhibited extreme views in both directions. My own views regarding attachment and separation issues are somewhat more moderate but place value on individuation and autonomy. Hence, this informal evaluation of patient-therapist value systems and the patient's developmental needs for individuation suggested a basis for a compatible and productive relationship. This basis was further explored in the first session by assessing and questioning the strength of contact and attachment that took place between the patient and therapist.

A second aspect of the approach to be used was determined by assessing the patient's reactance level. As noted, R. T.'s history

suggested relatively high levels of interpersonal reactance and was supported by initial psychological evaluation which provided evidence that she was resistant to directives and sensitive to losing a sense of choice. These observations suggested that the patient would be most likely to benefit if the treatment interventions selected deemphasized directive control on the part of the therapist.

4. Specific Interventions

A menu of potentially useful interventions was selected initially from an assessment of the patient's defensive style. The MMPI profile presented in Figure 1 suggested that the patient presented a mixture of both internalizing, anxiety-containing (Pt, D) and externalizing, direct-avoidance (Pd, Pa, and Hy) patterns. The elevation in both externalizing and internalizing indices of coping style, coupled with the patient's history and affective presentation, suggested a pattern of anxiety magnification, expressiveness, and intro punitiveness. She had no history of impulsiveness or acting out, but clearly felt her emotions to be tenuous and exaggerated. This emotional under control in the presence of behavioral constriction and inhibition suggested the probable value of procedures that were cognitively focused and

emphasized perceptual change methodologies (Beutler, 1986).

Taking into account the patient's degree of reactance, the need for a theme-focused intervention, and her emotionally sensitized coping style, a menu of therapeutic procedures was outlined. This menu included the following types of interventions:

1. A relatively heavy reliance on low directive evocative interventions: reflection, questions, clarifications, and reframing

2. Lesser but selective reliance on patient-controlled, directed interventions: cognitive practice, role playing, fantasy/imagery, directed dialogue, evidence gathering, self-monitoring, and practice in alternative thinking

All these procedures were selected because an earlier task analysis (Beutler, 1983) suggested that they can be implemented with little therapist directiveness and would provide minimal threat to the patient's need for autonomy and freedom. The procedures also were selected to be applicable to assessing cognitive patterns and establishing cognitive control of emotional experience while still addressing underlying conflictual themes. The themes and schemas of

relevance here were judged to be related to the patient's ambivalent attachment needs in family and interpersonal relationships.

5. Changing Therapeutic Interventions

The initial therapeutic menu was designed to focus on cognitive change and perceptual restructuring. A precise delineation of how the therapeutic procedures would need to change during treatment depends on how the patient responds to the initial interventions, how coping styles and reactance level are modified over the course of treatment, and what changes take place in the patient's defensive style. However, some prediction of the probable patterning of change can be based on clinical experience with the nature of change. In my own experience, for example, I observe that in effective relationships, high reactance levels are modified relatively early. Although, initially, a patient's reduced reaction propensity may not extend beyond the therapeutic environment, the establishment of a collaborative relationship allows a patient to benefit from increasingly directive, in therapy interventions.

Other changes are more difficult to predict at the outset,

however. For example, a patient who approaches the world with a heightened sense of anxiety may, as one explores the expectations and beliefs that underlie this reaction, become increasingly emotionally constricted or occasionally manifest behavioral impulsiveness. The therapist must be prepared, therefore, to implement external, behavioral controls, in the latter event, or move increasingly toward an exploration of emotional issues, in the other.

As treatment progressed, this particular patient moved increasingly toward emotional control and overmodulation. Hence, with time, therapy became increasingly focused on differentiating among R. T.'s various feelings and sensitizing her to the meanings of these subtle nuances which differentiated emotional states. Only in the late stages of therapy did the focus turn to exploring the behavioral skills that she might directly implement in her relationship to other people. Thus, treatment was designed to initially impact cognitive patterns, including insight and understanding of the relationship between cognitions and feelings, and then progressed to an affective orientation and, finally, to a behavioral one. The therapist's stance, on the other hand, moved from very non directed through a period of relative directiveness as the patient's reactance level decreased and

then returned to a stance of relatively low directiveness in late treatment phases.

Interventions

The first session of contact was devoted to evaluations of the patient, problem, and environment and involved gathering information about the patient's background and providing her feedback about the results of the psychological assessment. At her request, her mother joined us in the latter moments of this session. During that time, I explained that the patient appeared to be quite depressed and anxious and that such individuals frequently felt like they were victimized in their relationship with other people. At that point, the patient confirmed this impression, and we made plans to begin an open-ended course of treatment the following week. It bears emphasizing that the distinction between the evaluation sessions and the treatment sessions is a very unclear and undefined one. My own view is that the evaluation session constitutes treatment and that each session includes an evaluation component, which we have called "process diagnosis." Nonetheless, treatment sessions are counted for the purposes of this presentation as those which followed the initial

evaluation session.

The first treatment session (8/23) was not recorded. The patient was presented with the therapist’s desire to make audio tape recordings during this initial session, and although apprehensive, she accepted the invitation after some thought and discussion. Beginning with session 2 the subsequent 27 sessions of treatment were audio-recorded. The following pages will present excerpts from various of these sessions, to illustrate both the patient’s dynamics and the application, and, perhaps, the misapplication, of certain procedures. The second therapy session deserves special attention. It was in this session that we began to explore and clarify the patient’s theme of ambivalent interpersonal relationships and a contract was initiated regarding the risk-taking activities that were deemed to be important if her treatment was to be successful. The patient’s ambivalence was exemplified in her description of her father’s behavior.

Session 2 (8/30)

T: What did you mean when you said that you felt "abused”?

P: Well, like when you showed her [mother] that test and told her that people like that, like feel that they’ve been abused, I

remembered that three people have, what I call, abused me.

T: Can you explain that?

P: Well, the first was my father. I remember that when I was very young, like before he and my mother divorced, that he used to get drunk and slap me. Sometimes he'd hit me right here on the cheek or on my nose. All the time he'd be yelling at me and telling me that if I didn't like it, to run away. I tried to run away but I couldn't. I was afraid of being caught and hit harder.

T: How are you feeling when you describe that?

P: Pm afraid. I was afraid that he would, like, hurt me. It reminds me of one of my mother's boyfriends, after she and dad separated and he got remarried. She became very depressed and began doing really strange things. She started running around with younger men, getting drunk and staying out all night, like that. She had this one friend. D., who scared me a lot. He was drunk a lot and always made me afraid that he would, like, hurt me. One night I woke up and he was by my bed, touching my stomach. I was so afraid, I couldn't call out. I thought that maybe he had kissed me and I was afraid he was going to like touch me other places. When he finally got up and left, I went looking for my mother. I told her that he was really scaring me and touching me, and she only said, "Well he's not been very nice tonight to me either." She didn't, like, pay any attention to what I was trying to tell her and how frightened I was.

T: You had other times of being frightened too?

P: Yes, I was always afraid that mother would, like, die and not come back home when she was out late. She talked about killing herself, and I was always really afraid that something gory had happened to her.

T: Gory?

P: Yes, it wasn't as if she would die a healthy death. It was as if she would be hurt and like be destroyed and be bloody and everything. I remember one time I couldn't find her in the house and found an open window in our apartment on the sixteenth floor. I looked out and couldn't see her but then I saw her on a ledge and she began calling for me to come out and telling me that she could fly. She was drunk but I was scared that she was going to jump. I felt, like, I had lost my father; he was no longer interested in me. I was afraid that without her I wouldn't have anyone. I didn't want to see her die and began crying and pleading for her to come back in. She eventually came back in, but for weeks she laughed at me for being upset. She abused me too, you know, I mean, emotionally.

Later in the session, the patient was challenged with the possibility of taking some risks in her own behalf in order to overcome her fears and change her views of the world.

T: If I understand what you've said, it scares you when you start

feeling better. It seems more comfortable and somehow, as if you're more "sensitive" if you stay kind of depressed.

P: That's right, I even get, like, afraid of being too happy. I think it's wrong to become so happy that you like lose sensitivity to what's happening around you.

T: You mean what's happening around you is depressing and you have to keep hold of that?

P: That's right.

T: Might it be just as dishonest to pay attention to the depressing things and ignore the happy ones?

P: Yeah, but if you get too happy, people will take it away from you —they'll leave you or something like that.

T: And if you stay unhappy?

P: Well, at least then you don't have, like, far to fall.

T: So, if you're unhappy you control what's going on, but if you're happy, other people can take it away from you and have control over you?

P: Yes, something like that.

T: I guess, a big risk for you would, then, be taking the chance that you could be happy and paying attention to all the happy things in your life. Would you be willing to take that kind of a

risk?

P: Well, if you could, like, guarantee that people wouldn’t disappoint me or leave me.

T: If I could make that guarantee, it wouldn’t be a risk. Are you willing to take a *risk* in order to feel better?

P: I’m not sure. I guess I’m getting closer to the idea of doing that.

T: Maybe you’d find out that you could be happy and still be sensitive to the painful parts of life.

P: Yeah, maybe I would, but it sounds awfully scary to me.

The patient quickly developed an involvement in the treatment process. In subsequent sessions she began talking about her new role as student in a university environment and in session 3 described a nightmare she had of hell. The nightmare illustrated a pronounced tendency to think in dichotomous terms of "good” and "bad” and a similar tendency to apply this dichotomous thinking to other people, seeing them as either friends or enemies. Utilizing this nightmare, we began exploring the cognitive therapy concept of how her thoughts might change her feelings. At my suggestion she was able to reconstruct a sense of anxiety and depression and then to remove it by altering her thoughts about the nightmare itself. In session 4, the

concept that R. T.'s depression could be altered by her conscious thoughts and images was developed further.

Session 4 (9/11)

T: Can we start, then, by me asking you a little bit about where your thoughts went after the last session?

P: Um, I don't think I thought so much. I mean I didn't analyze it or anything. I was just pretty happy you know. In the middle of the week I got a depressed feeling, but then I was able to get out of it within an hour, which is really good. I haven't had any more of these little depressions at all. I mean, things weren't too bad. It was pretty good because I kept thinking about the meetings that we had and how you just let me get out of depression. You know you got me to get into it and out of it when I wanted to. The depression came when I was with my mom, and as soon as I got back to the dorm with my roommates and everything I got smack, right out of it, like I totally forgot about it. And then the next day, I couldn't even believe I was mad about anything. T: Mad and depression kind of go together?

P: Yeah, I guess so, yeah! Yeah, like it's really an injustice or something is unfair. Some of the past, sometimes, sneaks up on my mom and she started doing some things that bothered me a little bit. And . . .

T: I don't understand that. Can you remember a little bit of what

went on last time you were with your mom, that might relate to being depressed?

P: Oh yeah, I know what it is, I know exactly what. See, my problem with her was that she likes that guy T., so it just bothered me a lot because she just gave up the mother role a lot. You know, saying she didn't want to be in that role, but yet she wanted me to always respect her; she wanted to have her cake and eat it too, and it really hurt. And then all this time with my father has been so bad, and when I talked to my mom over the last several months, before I came, she was very, very supportive of me. Extra-, extra supportive; more than she'd ever been before. And I thought that she had changed. Right? She wasn't going to do this chasing guys any more. Right? And we didn't talk about the past or any of that and she didn't go to bars or anything. And then, I guess it was just three days ago, she said she went out to this really wild bar here, and I got kind of mad. She told me when I was in a great mood and I just got depressed. I just want a mom that doesn't do that. I'm tired of it. I guess there are two reasons why I'm angry. For one thing I get really jealous because, as much as the tests all say I fear men, it does not apply to this. I mean I like guys and it has always been this constant source of grief that I never get asked out. It just happens. Like, all my friends go out but I never get asked out; it's just the way it is. And it's been like this constant source of agony and grief and tears for me. I mean, it makes me so angry and I don't understand it and I get very depressed.

T: The tears and the anger kind of come together?

P: Oh, yes.

T: Depression and anger get all twisted up.

P: Yeah, anger turns to tears, cause, yeah, yeah!

T: So you get a little jealous of your mother, too?

P: Oh, it's extremely, it's not even a little bit.

T: She makes friends and I don't.

P: Um hmm. Yeah, that's one part of it. I get a little bit jealous of my friends but I get extremely jealous of my mother. Because I don't understand why me, as an 18-year-old, can't get asked out and she, as a 50-year-old, can. And she gets asked out by guys who are 23 and 24, and it makes me really mad because that's almost my territory at this point. I mean, it makes me mad that someone her age is trying to take away the males that are my age. They're like a couple years older than me, you know. I mean this is like, "It's our turn now, give us a chance." And yet she goes around and she's got them . . .

T: Give *"me"* a chance?

P: Yeah, right, give *me* a chance. It's not fair. It's like we're competing for the same aged guys.

T: *My* potential boyfriends.

P: Potential yeah, and it really makes me mad.

T: Help me understand the anger. What goes into it besides her competing for your boyfriends?

P: Okay, well that makes me angry but what also makes me angry is the fact that she doesn't want to play the mother role because as soon as she gets in these relationships, she's not "mother." Second of all, she's competing, like she's my enemy.

T: "She's my enemy." First, she's going with people who I want to go with or who I *could go* with and secondly, she is not taking care of me.

P: She's let me down. Right! They both go hand in hand. Right? I mean I've been let down and she's not . . .

T: It seems to me that those two thoughts would cause very different feelings. One sounds like angry feeling and the other sounds like a feeling of loss.

P: Yes, exactly. Yeah, yeah! And one is much more like feeling like, I don't know. I guess they are both just as powerful, but they are different feelings. The one is jealousy really, and it makes me really mad. It's more explosive than the other and can end sooner, where the thing about her not being "mom" is gnawing there all the time, like a dull pain that doesn't go away.

T: That sounds like depression. It's always kind of there and then

lying on top of that is the sharp pain of your anger or jealousy.

P: Right.

T: Then you *really* feel it.

P: Yeah, I do. I got really mad and then I went back to the dorm and I talked to my friend B. We've had some of the, you know, same things happen in the past and she understands. I mean, she understands where I'm coming from and she was saying that she understood about my mom not really wanting to be a mom. You know, I wanted to be able to sit down and talk to someone, but a lot of other friends started coming in and there was a lot of people congregating around our room and, you know when a lot of other people came in we stopped talking. We just had a good time, we all jumped around. It's like every day . . . oh total, I forget about it and the next morning I wake up and it's, like, gnawing at me more than the fact that my mother is letting me down. I don't know why. I can't figure it out. Maybe one is worse than the other and I don't. . . I can't sort it out. I'd say right now, though, the one, the jealousy, is gnawing at me a lot.

T: If it's all right, let's follow those two things. Let me see if I understand because it seems like there's a chain of events that might be very important for us to focus on. One situation, mother going out with a guy, produces two different thoughts inside of you and hence, produces two different feelings, one angry and one depressed. But, one

way you found to get away from those bad feelings is to distract yourself, get around your friends, and they make you think about other things and they make you pay attention to good things that are happening. Does that fit?

P: Yeah, except that I worry about that part because my friends are starting to go out now and it reminds me of mom and it gets to me, and then I get depressed ’cause I see in the future that I’ll always feel the same way.

T: They start doing things that remind you of your mother. Then you start having the same kind of feelings you’ve had with your mother?

P: Yeah. Yeah. And it’s hard not to get even a little bit jealous of them. I mean, I think it’s that some of it just came from always feeling isolated in some way. Like, intellectually, because I was advanced in school; kids isolated me because I was good or isolated me because I was younger. I felt very isolated and then the whole thing with being isolated from guys. I mean. You know, I mean that’s terribly painful. That’s more painful than anything, almost, or at least to me.

T: Why is it painful?

P: Oh, it just makes me like, I . . . I mean if I can’t have the feeling of being feminine, if that ever goes, that’s just like the end of me. I mean, that’s the end of me. . . .

T: Are you afraid it will go?

P: If I don't get a response from males to say that I am feminine . . . I mean it's hard to survive. . . .

[A little later.]

T: If I run down the chain of events maybe it'll help us understand it. Let's just take the situation of mother going with a guy.

P: Right. Except he's young so that makes a difference too.

T: Okay, a young guy. How much of a difference does it make if he's young or old?

P: Very big.

T: So, she goes with a young guy. The first thought that you're aware of seems to be "she's competing."

P: Um hmm, and winning.

T: Okay. "She's competing and she's beating me." Okay. And the second thought you seem to be aware of is "Pm going to lose my femininity."

P: Um hmm. I don't understand why she has more femininity at the age of 50 than I do at 17. It doesn't fit.

T: Maybe it's not a matter of losing it; you're afraid that you don't have it.

P: Um, yeah. I feel like, that it won't matter if I do or not cause it'll

never be discovered. That's the whole thing of it.

T: And you see her as standing in your way of having it discovered.

P: Yeah, she stands in my way like 80% and my friends stand in my way maybe about 15%.

T: Okay, so about 80%. If pain is marked on a scale of 10 to 100 it gets up to about 80% when your mother goes out with a young guy and you have these thoughts.

P: Oh yeah, oh easy, yeah.

T: With your mother but only around 15 or so . . .

P: With my friends.

T: So it could be with your mother or it could be with friends. The pattern is the same except with your mother the pain is bigger.

P: Right.

T: Okay. And that pain is kind of a combination of the anger and depression.

P: Yeah, yeah, just like that, yeah, so far.

T: [writing] Let me see if this makes sense to you. You've described it really very well. I like to think that if we look at this as the *situation* A and this is C, your *feelings,* your feeling

is not caused by the situation. It is caused by B, what goes on in your mind about this. How you interpret it.

P: Um hmm. Oh yeah, yeah.

T: You saw that a little bit last time; in fact you made a similar comment.

P: You can interpret things differently, oh yeah, yeah. But the thing is, to me it's almost like a basic obvious principle so that I think that if you're given 10 people, about some things you'd get 10 different views, but with this one I'd say maybe eight people view it the same and two different. I mean this thing is like, I'd say most people would feel this way.

T: You believe that most people would feel this badly in this situation.

P: Um, well I think I feel this badly because of the friend thing too, or maybe, I think the fact that all of this occurs simultaneously. I think that she becomes "not mother." I don't feel . . .

T: You begin interpreting her as "not mother."

P: Right. In fact, I guess I feel two things with my mother and a guy. I don't have a boyfriend so I don't feel protected, okay that's one thing, and my mother gets a boyfriend and believes she's protected, but I'm not protected by her as a mother.

T: You want her to secure you and protect you.

P: Right and I’m not protected by a male or anything.

T: So you don’t have anyone.

P: Right, I guess maybe that’s some of it.

T: So part of the feeling of real loss is your sense that you have no one.

P: Um hmm.

T: Okay, that’s where we get the two different feelings it seems to me. We get the "angry” feeling and we get the "loss” feeling.

P: Yeah.

T: They both come down here to this pain.

But, what if your interpretation of that situation is wrong?

P: Well, how could it be wrong cause the pain is, like, immediate. And the pain happens first and then the thoughts for the pain follow.

T: Let me give you a perspective on that, a different way of thinking about it. Sometimes these thoughts or similar thoughts become what we call "automatic.” That is, you’ve learned them over such a long period of time that they come so fast that you’re not even aware of them being there. But if

you change them, your pain wouldn't be there either. P: Um hmm.

T: Now our job, as I would see it, is to look at those thoughts and see if there is another way of interpreting that situation.

Throughout this session, the patient appeared to be responsive to the therapist's intervention, with some struggle beginning to develop around the concept of the ABC's. The possibility of her reactance level getting in the way of her understanding the concepts and applying them in a systematic fashion became apparent. In the hope of exploring, more directly, the degree to which the patient's reactance level would prevent her from participating in directive intervention at this stage in therapy, a "reactance challenge" was initiated at the end of the session. The objective of such a challenge is to see how the patient manages a directed assignment, observing whether she will, in fact, comply (low reactance) or resist (high reactance). Utilizing this information, the therapist can then adjust the directiveness of the interventions, either being less directive to accommodate the patient or employing paradoxical interventions that capitalize on the presence of reactance by prescribing the opposite of that desired. The patient's response to this challenge was observed in session 5.

Session 5 (9/18)

P: I just have to say something. You know that form you gave me you wanted me to do. Right? Okay. Last time, like the next day I went to school and I was thinking of all these little things I was going to write down at the end of the day and I realized that I started focusing on all this mess. You know, what I was really afraid of. The more I focused on it, the worse I felt and the more afraid I got and the more I started getting this massive tension headache you know, and so the next day I didn't do anything with the paper. I left it. I was figuring out that this wasn't a really good thing cause it's not making me happy in my present life. I mean I'm trying to do something that might benefit our meeting a week from now, but right now I wasn't happy with this. So on Thursday I tried to do like you said. I started trying to notice every time I have this thought and it made me so totally paranoid that, like, it ruined things so that what I did was I forgot about it. So I didn't do anything and then I felt a lot better and I wasn't afraid or anything. By focusing on it, it just makes me totally paranoid. I almost have the feeling that it puts fear in me that really wasn't there before. I mean, you know?

T: If I suggest to you to focus on something it makes it into a problem.

P: Uh huh. I think, for certain things. I don't think everything's that way.

This reaction, to become worse instead of better when complying

with a home monitoring assignment, suggested that reactance level and sensitivity to interpersonal influence were still very high. Hence, the need to proceed cautiously and without a great deal of teaching-instructional activity was emphasized. The more typical and traditional cognitive therapy format, therefore, was modified to reduce the amount of formalized instruction.

In the next four sessions, the effort to identify and clarify the patient's theme of interpersonal ambivalence was intensified. Session 6 proceeded from a rather specific concern with achievement in her classes, to the more general theme of perfectionism and compliance.

Session 6 (9/25)

P: I feel as if I get really depressed because I'm coming nowhere near my ability. I know it. I often got that way when I was in swimming too. I got sometimes to where I swam a lot faster than girls I went to swim meets with and who beat me. You know? It happened time after time. It's just that every time I have to go faster or do more I'll think, "God, I can't do it." You know? It's like, why even do it?

T: You'll ultimately fail especially if you work hard at it.

P: Yeah. Exactly. And like the less I work, the better I do; the more

I work, the worse I do.

T: Why do you do so much then?

P: Why?

T: Why spend 70% of your time working on . . .

P: I don't know. That's what I'm trying to figure out. I'm trying to figure out if I should. I mean it's so much easier to fail if you haven't studied and you can say, "Well, if I would study then I would do better." There's always that possibility of improvement. There's nothing worse than when you study and then you don't do well because then it's like a fact. You're *stupid.* Okay? And then at the same time, that can't be true so it's so much easier if you don't study, and you don't do well . . .

T: Then you don't have to call yourself "stupid."

P: Oh sure. I mean, only a stupid person gets a 60 on a Latin test.

T: They don't have any other kind of people getting a 60 in Latin?

P: Well, only those who don't have ability in that subject.

T: Any other kind?

P: No.

T: That's it?

P: Yes.

T: So if you do poorly, you're either stupid or you don't have that ability and that's it?

P: Yes.

T: No room in there for a person who's just anxious?

P: Yeah, but who cares then? I mean, at this point, if I can't take a test, I shouldn't be in college. You know? I mean, I don't want a series of D's or F's. I won't get a job from that.

T: It's interesting to me to kind of follow your thought process when you say that. It sounds almost designed to make you more anxious.

P: I don't feel anxious. I guess I am, but when I'm taking a test. . . I mean, I go in there and I don't feel nervous or anything.

T: You don't?

P: No. I know what it's like to feel nervous. I mean, I can't write anything if I'm nervous.

T: So it doesn't feel like anxiety.

P: No. I mean, it feels kind of like being a little depressed but not anxious.

There followed an exploration of her depression, particularly as it

related to a demanding and accusing internal dialogue. A few moments later, this exploration took a turn when the patient began to explore why she had such a need for high grades.

T: If you don't get an A, you haven't done well?

P: Yes. Right, right, exactly and that's how I grew up. I mean, it's probably my fault that I took it on but I did it anyway. I don't know how to unload it. It's like a pride thing, you know. I mean, if only people in my high school could have seen what my real ability was, you know. I mean, people kept talking about "how smart you are." And, I could swear that, I was smarter than just a lot. I mean, I don't think I was the smartest in school, but I think in some areas I was. I mean, I was in all the top classes always so I knew who was up, you know? And I'd get in a class, like English class, you know, and we had discussions about books, and I would find insight, after insight, after insight, then when I'd get to tests, I'd get aC + on my written work on it. The teacher would say, "God, R., your ideas are A + but your writing, it's terrible."

T: What makes anything less than A failure?

P: Um, I guess I have to tell you where it comes from, then. It's from having never felt good enough at anything. I guess it's like I have a negativism that I've always felt for myself. I'm the worst or I'm the best. And since I've always felt like the worst, then it becomes the best that I strive for. I have to be the best because I've always felt like the worst. There's no

one worse than me. I’ve always been the worst. And so then I become, I *have to* become, the best.

T: You *have to* have something to counterbalance being "worst.”

P: Yes.

T: But, you kind of see yourself as being at one extreme or the other.

P: Yeah.

T: You’re either the worst or the best. What is similar about being the worst or the best that you have to be?

P: What is similar about them?

T: Yeah.

P: They’re both extremes.

T: Does that mean you’re noticeable in both positions?

P: Yeah.

T: Is it important to be noticeable?

P: Maybe that’s it. I don’t know. I’ve never thought about it before. I mean, if I’m the worst, it means the same thing as being the best. Why try to study for tests. Don’t study and actually fail. Then it’s easier to accept being the worst. I mean, there’s

nothing you can do.

T: If you try and fail anyway, you may have to confront the probability that you don’t have what it takes.

P: Yeah.

There followed a discussion of the patient’s need to succeed in all areas of academia and her anticipation that to fail at academia was to fail at life. Her dichotomous thinking was obvious, and some effort was made to explore the possibility that some middle ground might also represent truth. This led to a discussion of how she came to define the world in such extremes. She began with a description of her belief in God and her sense of inferiority which resulted from that belief.

P: I feel that this is why this religion thing is making me so irritated. I get so angry about my whole impression of "who” God is or "what” it is. The last three years, there’s always this image that God is teasing me. He is being mean all the time to me. Like, He kind of sets things up for me and gives me hope and then makes me go and waste my time. I never really succeed. You know, it’s like, I can never get what He promises. He gets me to waste my time on it and then purposely pulls it away so I can’t get it. Like He has a big thing of gold or something, and I run and run and run to get the gold and He pulls it away.

T: God sounds a lot like your father. He makes a lot of demands and then won’t let you have what you want.

P: Hmm, that’s interesting. I never thought about it. That’s true, I’ve never done anything my father gave me to do and heard him say, "God that was really good.”

T: It sounds like you’ve made God into dad’s image.

P: Yeah. Except that like . . . yeah I guess so. I mean, like, yeah, he’s always been like that even like if. . . when I did get my 100 on the math test, it’s like, "It’s about time.”

T: "It’s about time you did what you’re supposed to.” It’s not that you’re bright. Instead it’s, "Why didn’t you do it before?” He kind of teases you like you think God teases you.

P: Yeah.

T: What if God’s not like that at all?

P: Probably you’re right, but He’s so distant and everything and He irritates me anyway. I feel He’s tricking mankind by not being in physical form and putting smut and stuff in the Bible and giving us, like, bad instincts and bad things that we have to always struggle against, you know. I think that’s unfair and He’s not down here to really show Himself or anything. Then on this little tiny bit of energy we have left, we have to try to figure out that He’s really good and then He has all the stuff built into the Bible so that if we have any doubts that He is good, then we’re going to go to hell for it. So it’s really, I

mean . . .

T: No way to win.

P: Oh no, no way. And then you work, like, on your own life and then He takes it away from you. I mean, my feeling is, "Don't give it to me in the first place."

T: Well, again it sounds like that's the same struggle you have with dad, maybe with mom too.

[Later.]

T: How did you learn to be so afraid?

P: I know, it's true. I mean, I know I'm afraid of a lot of things, and my dad, he's afraid really. I was five and six and he would go on at length about the Holocaust. And then when I was seven and eight, I remember him telling me about how the Christians were killed and everything. They said they believed in Christ, then they would get fed to lions and if they said . . . I was getting really scared when I was seven. I remember, I mean, I remember one day. I mean in my mind is, I swear, in my mind it's like it is today. I remember this heavy onset of emotions and I went to daddy about this same thing. I remember saying to my dad, "Well, aren't you scared?" You know, at the age of seven I was even more afraid.

T: By the age of seven, you've already learned that the world is going to get you if you're not really careful.

[Later.]

P: Oh yeah. He was very scary. I mean he used to . . . Oh God, he used to tease the hell out of me, he's just so mean. I don't know, like, he used to do stuff when I was little about . . . I don't know. By the age of three he used to hit me. He'd, you know, he'd bend down real low and hit me in the jaw and it like . . .

T: Did it hurt?

P: Yeah, it hurt. I would like cry.

T: What would he do?

P: He would laugh and he thought it was funny. So then I'd get really upset and I'd try to get away from him because he had a bad knee, and he couldn't run after me. He did this periodically, and then when I was like 14 or 15, it got really bad, you know. And then I couldn't take it anymore. I couldn't take the rejection so I just started laughing along with him like it was alright . . .

T: So you had it faked.

P: Yeah, I faked that it was all right. But that was when I got older. But when I was littler he'd hit me. That was the first; that was a physical fear. I remember . . . I remember I was three years old and we had a little complex we lived in. There was a little thing of flowers, and they were really pretty. I was out one day and I, you know, I loved to be outdoors. I always

feared other kids because I was. . . I was always the youngest child around. It just happened that way. And because of that, I always got hit or beat up on by older kids. I was always left out. Everyone would go over and leave me alone on the swings and they'd all whisper and start laughing and look over and come back at me and start pushing me off the swings. So, physically, I was afraid of the kids. So anyway, I'd be walking out of this complex, this was when I was three, and I'd be really scared that I was going to get hurt by one of the older kids so . . . and then I was looking around and I was feeling really down and I remember thinking, "I ought to give to somebody, I ought to give something." I remember I was sad. And I saw the flowers and I thought, "Oh, aren't they pretty." And thought, "Oh, I'm going to go pick one and give to dad and mom." You know? To make them happy because mom liked flowers. So I picked a flower. I went in and she was on the phone and my dad turned around and looked at me and goes, "What's that?" I said, "It's a flower." He says, "What did you pick that for?" And I said, "Well I was going to give it to Mom." And he said, "Do you know that you just killed that flower?" I was just like, you know, I'm like, "Oh my God." And he goes, "That flower's never going to live again because you've killed it." And I go, "Well is there any way to put it back?" "No, there's not," he said. "It's dead." And so I took the flower into my room and I remember it was my first really painful experience.

T: I can imagine that. What did you learn from that that translates to where you are now in your life?

P: Like, when I deal with someone, communication has been a problem. What I intended doesn't happen right.

T: The good thing that you try to give . . .

P: Turns to bad.

T: It's bad?

P: It's bad. It's evil! Only evil could have done it.

T: You murdered.

P: Yeah. I killed a flower and that was like really tragic for me.

T: Let me push you a little bit further on that. Imagine that you're in the room, as you are now, when that little girl comes in and tries to give the flower. What would you like to say to her or to your father.

P: I would say, "No, you didn't kill it," and "It's all right," and "It's a really pretty flower."

T: You would comfort the little girl.

P: Of course. Yeah.

T: What would you say to your father?

P: I'd say, "Why'd you do that?" or "Don't spread your ugliness to some child who can't protect himself."

T: Say it again.

P: I would say, "Don’t spread your ugliness to someone who can’t protect himself from it.”

T: How does it seem to say that to your father.

P: I can’t do it.

T: Don’t do it, but imagine yourself doing it.

P: I’d be really scared that. . .

T: Of?

P: Of, of him totally falling to pieces and . . .

T: You’d be afraid of destroying him like you did the flower?

P: Yeah, but one was different. The flower was always good. The flower couldn’t be destroyed, but he can.

T: Did you hear what you just said?

P: Yeah.

T: Are you afraid of destroying him?

P: Maybe that’s why he always made me afraid.

T: Maybe you’re right. Maybe what we’re dealing with is that you’re very angry at him. And you’re afraid you have the

power to hurt him.

P: Yeah. Oh yeah.

T: So what you do instead is destroy yourself.

P: Yeah. I let myself get hurt.

T: So you really have some kind of a choice somewhere in your mind. Are you going to let yourself live like a flower, or are you going to let him live? It sounds like you usually choose to let him decide.

P: Sure. Yeah, because the outcome is, if I let him live, and it was a bad choice, I'll be forgiven by God. And if I don't let him live, and that was a bad choice, then God's going to punish me, and I'm selfish having done that.

T: What if the choice isn't that? What if you don't have the power to destroy him?

P: Well, that would make the choice simple at that point.

T: Then what would it be?

P: Then it would be okay to choose me. I mean, if I couldn't destroy him.

T: Let's pretend for a moment that you can't destroy your father; only he can do that.

P: Though it might be different than what you are thinking because I have said some bad things to him before, and I felt that he'd go off and drink and quit his job or mess up. Then even if I'm not directly destroying him, I'm indirectly destroying him because I've triggered him on that. And if I hadn't done what I did, he wouldn't have . . .

T: So you are responsible?

P: Yes.

T: What if you're not? Where's his responsibility?

P: Oh wait. If you say I'm not, then I absolutely can't stand him.

T: Okay . . .

P: Okay. I mean, it's not. . . I don't want to say hate but it's close to it.

T: It's close to hate.

P: I mean, it's just, like to me, it's evil, I mean, *God.* It's just total hate.

T: How is it to think of him as an evil person?

P: Yeah, but it's like sometimes though, I know that he's loved me before. I mean, how can I hate . . . I cannot hate anything that's loved me, at any time. If they've ever loved me at any time I. . .

T: So the way to really get you is to love you once and then beat you. So you can never get back at me if I love you and then I treat you bad forever after?

P: Because there's always the hope that you might love me again.

The reader will note that during the course of this session, some exploration of cognitive pattern is combined with some tentative and preliminary initiation of imagined dialogue between the patient and her father. This denotes the shift in procedure from a strictly cognitive orientation to increasing emphasis on feeling awareness and impulse expression. This shift is initiated as the patient becomes somewhat less externalized in her expression of feelings and more introspective, thus revealing the inhibition of impulses that also characterizes her pattern.

Issues related to the patient's ambivalent restriction of certain feelings began emerging further in subsequent sessions, and these were frequently addressed in the context of her relation to me as her therapist. These connections were then extended to parental relationships, always with an eye to highlighting her conflicting attachment and autonomy needs. In session 7, for example, issues of trust were explored in regard to the treatment relationship itself.

Then, these issues were applied to an imagined dialogue exercise in which the patient attempted to engage her stepmother.

Session 7 (10/2)

P: I used to talk a lot to teachers, during that time, and I felt very equal but I usually feel small and immature, around other people . . . adults mostly.

T: How do you feel with me?

P: I don't know. I don't feel . . . I feel equal for some reason.

T: Because, I was just aware that you were standing up to me a moment ago in telling me "no." Did you feel guilty about that?

P: No.

T: Good!

P: I don't know why.

T: Did you lose respect for me, like you have with other people?

P: No. Mostly I feel, I guess, it's the difference between a healthy relationship and one that isn't healthy. I mean, I feel that if my relationship is good with someone . . . and yet, I trust you not to go back on me or something. I trust you. I'm not afraid. I am not afraid to, like maybe, disagree with you. I'm not

afraid to take advice from you.

T: Why is that?

P: Because I trust you, because you've done lots of things that have worked out for me. Like some teachers, you know?

T: Yes.

P: But people that I feel I have unhealthy relationships with, I'm afraid they'll turn around and really hurt me.

T: But in a way, maybe it *makes* the relationship unhealthy because you don't stand up to them.

P: Well, I have. You see, that's the whole thing. Like there have been times when I've tried to, and they got. . . Like, once my parents, we got into the most hideous, ugly, gruesome four-hour argument. I mean, it was just screaming and it was like them against me.

T: They had to defeat you.

P: Oh God, they were *going* to.

T: So you finally . . . ?

P: I was just there crying and crying and they just did it even after I gave up. I mean, I didn't have the words to say it anymore. They would stay at me. I'd cry and she—my stepmother—would just keep at me. They wouldn't even stop if I was

crying or sick.

T: It sounds like a vicious cycle. If you stand up for yourself, then they attack

you and you finally have to give up.

P: Well, the reason—the thing is, it's always the two of them against the one of me.

T: That would overwhelm you?

P: Always. And if I ever tried to argue with one of them, like my dad you know, I could argue with him, but then his little punishment was not to talk to me for the next week.

T: So you're going to be punished.

P: Oh yes, you know . . .

T: If you win, you lose.

P: Yeah, exactly. And M. [stepmother], her thing with me is that if I started to argue, she would stomp upstairs. She'd . . . we'd be eating dinner or something and she'd throw her neck around and she'd stomp upstairs and slam her door. And then she wouldn't talk to me.

T: So you've lost.

P: Yeah, yeah, I mean . . .

T: You can't fight that.

P: There's no way. No, she'd just, like, leave and then she'd call me. She set so many rules down and things when I was really young and they really set in before I could say that wasn't right. You know? Like this swimming thing. When I came back I was 13 and I hadn't been swimming for a lot of years, you know. I was like seven or eight when I was out here and did really well and then I quit, okay? When I was 11, I came back east and that's how I decided to start swimming again. And mom goes, "You're a housebreaker," and so they decided to take me to the swim club at the YMCA, so they paid some money to have me join the YMCA and then join the team. And my father would see the coach and he told the coach that I might want to do double workouts, you know. More workouts! That's the reason I quit before. And I did really well in practice and my times were really fast, and they were really close to state records and things. And this was just like in the first week's practice. And he got all bent out of shape about that and told me I must come to double practice, saying I would really mess the team up if I didn't. He was, like a really nasty guy. And one night on the phone I was just trying to talk to him and telling him what happened because I wanted him to know my reaction. I couldn't do anything. I mean, he was like . . . He was wrong. My dad was sitting there; I just felt depressed. I felt bad because of the money, you know. You know, dad tried to understand it and M. couldn't, she just got mad and said, "You're just a quitter." She said, "You run away from everything." Maybe that's the first time I had ever really been hurt by M. She called me a

"quitter” and, and what was so painful was . . . like swimming was a really, really emotional thing to me. Because all my energy was tied up in this incredible emotion . . . My own, and, of course, my mother’s. She was always like pushing me, you know. And this was for a long time in my life. The swimming was my territory and they had the nerve to sit there and say, "Oh you quitter.” I mean I always felt sort of guilty about quitting swimming but I always felt it was, I couldn’t have done anymore, it. . .

T: It was another one of those instances where you couldn’t win. If you’d gone, you had to face him, the coach . . .

P: Yeah, and I couldn’t do that and then my . . .

T: And if you stood up to M., she’d beat you down. And if you left, you were quitting.

P: Yeah, I wasn’t expecting her to do that to me though. She’d called me things before. You know, like, "you run away from anything.” I mean, it was always like that. I’d just turned 13 and I can tell you at that time I wasn’t quitting. I think back and I feel so sad at myself and so angry at her.

T: Those two feelings come together, feeling really sorry for yourself and very angry at her.

P: Yes, she is just mean. I don’t feel sorrow for her.

T: I want to give you a sentence.

P: Okay.

T: I want you just to imagine that you say this sentence to her. Just once.

P: Okay.

T: "I have a right to live too.” Try that on. Say it.

P: "I have a right to live too.”

T: How does that feel?

P: Oh, it feels right. It feels . . . it definitely accomplishes a lot of things. But I can imagine her reaction. You know . . . she’ll say, "I don’t know what you are talking about,” and she’ll get up and leave.

T: She’d leave, she’d quit.

P: Oh yes, yes, that’s the thing. She’d always quit, that’s why I was the quitter, you know?

[Later.]

T: My head’s going in two different directions. One is, it really sounds like you were so hurt and wanted to get close so much. And I’m aware of how empty it must make you feel.

P: Yeah.

T: The other side of me tunes in to how, in some ways, you and M. are kind of alike. That is, that she may be very scared too. And very empty.

P: Yeah.

T: What if we tried something. I’d like to be you for a minute, and I’d like you to be M. I would like to try on what I think you might feel sometimes. I don’t know if I’ll be right, and that doesn’t really matter so much as seeing how you feel being M.

P: Okay.

T: "M., you really make me mad at you. You’re always trying to control me.”

P: "I don’t know what you mean.”

T: "I mean, you’re always on me trying to tell me that I’m wrong; I’m bad, I’m a failure; something’s always wrong with me; and I get so tired of you always telling me that something’s wrong with me.”

P: That is, like, hard to do because my tendency is to cry and like agree with you. I mean I can’t get into her personality that easily.

T: Maybe she’d feel that way, too. I don’t know. What was that feeling like as we were just doing it.

P: I couldn’t keep hold of both those characters.

T: Oh.

P: I can’t. I mean I just, I sit there and, like, if I think of you as a child, you are helpless, you know? I mean, like I can’t. . . I can’t do it.

T: Ah. If you feel sorry for me, you’d then agree with me.

P: Yes.

T: Be you for a minute, let me be her.

P: Okay.

T: "You’re a quitter, you never stick with anything. I’m not going to sit here and live in this house with you always quitting and never following through with anything. Talk to me.”

P: She wouldn’t say that, she’d leave. Um . . . well, "What do you mean by quitting?”

T: "Well, you quit the swim team, because they won’t do what you want them to do. You want to run away and go to college and live with your mother because we won’t be the kind of people you want us to be. If the people around you aren’t the kind of people you want them to be, you want to run off and quit.”

P: "Yeah. I mean . . . well, yes I wouldn’t call it quitting but yet. . .”

T: "What would you call it?"

P: "I don't know. I just, I just don't think it's quitting."

T: "Well it certainly looks like quitting. You never stand up for yourself, you never take charge of anything, you never follow through with anything, you don't take care of anything, you always just quit."

P: "Yeah . . ."

T: Ah. You gave up.

P: I can't fight that.

T: What was your experience as we were doing that?

P: It just sounds exactly like her. I mean, she is . . . except she wouldn't have even provided the alternative of staying here, you know. She wouldn't even act it, she'd just say it. And then she'd go, "Yeah, go off with your mother."

T: Yeah, "Get."

P: Yeah.

T: "Go." "Quit."

P: Yeah.

T: "That's what you're going to do anyway, go, quit."

P: I can’t, you see, I can’t argue at all. I can’t. I don’t know, I can’t argue with that at all.

T: Do you want to?

P: Not really. I don’t know.

T: How do you feel, little or big?

P: I feel little but right.

T: Justified completely?

P: Yeah.

T: What would it take for you to feel big *and* right.

P: I can’t imagine the two going together. T: That’s what I hear. "Right” means "small” to you.

P: Yeah. That’s always been that way. If I think I’m really being good, it’s wrong. T: If you feel big you’re wrong.

P: You know why I do that? Because she’s so close to my father and I don’t want to lose him. I think that’s . . . because he *always* sides with her.

T: What you’re really afraid of, is losing your father?

P: Yeah, I mean it’s always a choice he makes, to see her again. I’ll never go back to her, but my father will.

The ambivalence theme seen in this interchange became even clearer in the next sessions as we unraveled her fears of abandonment. They dynamic of ambivalence was particularly observed as she began talking about fears that occurred when she anticipated seeing a medical doctor. This ambivalent attachment to people was most prominent in her anticipation of being asked to give blood during a physical examination.

Session 9 (9/23)

P: I am not scared at all. You know, maybe I feel that you care. I feel that you're familiar with things. It's just that I don't like it when someone comes in and they're doing the stuff. . . It just seems so cold . . . they don't care. They forget it's a human being there and they're just like, "Oh, stick the needle in here." You know, they're hurting you and they don't even care, I mean, you know . . . T: I can understand your concern. That's one that a lot of people share with you, but you seem to have a stronger concern with this "coldness" than many people do. I wonder why that is.

P: Um, I don't know, maybe my past? When my dad hit me sometimes.

T: What would happen in your worst fantasy if they didn't care while taking your blood or whatever?

P: Well, that would be that. . . Um, well I don't even know, um, maybe they'd leave me alone and forget me.

T: Oh?

P: That's what's scary.

T: Has that ever happened to you?

P: No.

T: Have you ever been locked in anywhere and abandoned?

P: I don't know, well, maybe, so to speak . . . T: How?

P: Uh, like when I was with my mom and we lived alone and she'd leave to get out. She'd leave me alone and I'd be so scared . . .

T: You'd feel trapped?

P: Yeah. I feel trapped a lot. She's always saying, "I feel trapped in this house."

She said that today. "I feel trapped in this house." So did I, because I was 11 and I didn't have anywhere to go. I just felt all this pain, emotional pain, no one was there.

T: So it would be like being locked up and abandoned.

P: Yes.

T: That seems to be the emotional quality that comes through in a lot of these things that frighten you.

P: Yeah, that was like pain . . . emotional pain, and then she'd leave me there with the pain.

T: So, like if people don't care, there's a likelihood that they will ignore you and leave.

P: Yeah, yeah.

T: The real thing that seems to be bothering you through a lot of things is you are worried that people are going to abandon you.

P: Yeah, yeah, yeah. But, yeah! That's it.

That *is* it. That's exactly it.

T: It's like you look at everybody through these big magnifying glasses and look for some possibility that they'll leave. P: Yeah. Yeah, I don't know why except 'cause like they abandoned me. That's what my dad really did, and I don't trust my dad.

T: You don't trust anybody?

P: Like my dad would be the last person in the world that I would allow to give me a blood test. I know he would leave. I know he would do it wrong. I know he wouldn't care.

Later in the session this issue of trust was explored further by inquiring about how one moved from one level of trust to another. This was approached by drawing a series of concentric circles and trying to identify how the patient allowed people to move from one circle to the other as they became increasingly close to her.

T: Can I show you how I see you?

P: Sure.

T: It's kind of, like, this is you right inside here [draws].

P: Yeah.

T: And these are various layers here. You let some people get this close to you and some people get this close. Some people are clear up here. Some people may even be up further. But here, you don't let anybody get in here. You may let me get in *here* a little bit, but nobody is in *here* [indicating different circles],

P: Yeah.

T: I wonder how a person gets from one circle, here to the next.

P: Well, I'm the only one who can do it. I have to be in the mood and let them get by.

T: How do you get yourself in the mood?

P: I just feel that way some days.

T: I guess it's awfully lonely inside those circles if you don't let anybody in.

P: Well yeah, yeah, um, I mean, uh huh.

T: It's interesting to me that you've let Dr. L. [previous doctor] and me in. We're kind of people who . . .

P: It's cause you're smart enough to. You're the only two people I know that when I say something can either . . . I don't expect anyone else to understand. Like, my other counselor, when I told him something he'd say, "Wow" . . . like he's surprised. I mean, at least you guys are smarter than me so you understand what I'm saying and no one else knows what I'm saying.

T: When he says "wow" what does he . . .

P: Well, it made me happy because it made him understand, but I mean, like, "Oh boy," but I thought, "He's never going to fix all the things because he's never going to understand all of me if it surprises him so."

T: You lost confidence in what he was saying.

P: Yeah, yeah. I mean, I took the solution of my problems faster than he would. I'd come up with what was wrong with me, before he did. And he's a really good guy. I think he's a little slower than you and Dr. L. and you two are the only ones

who can, um . . . who can keep up with it.

T: So that's an important element. You don't let people in if they seem like they can't keep up with you and can't give you some answers before you come up with them.

P: Yeah, yeah, and like you understand me and it's security to me. I don't like the way that I am but I can't help it either. If someone can't keep up with me, it's like something that's always going to be surprising to them, you know? No one's going to catch it and you don't know what it's about so, even though I don't like it, no one else even sees it. I guess it's like making friends. I don't have any boyfriends because I'm so scared about being abandoned by them that I want to abandon them first, you know? I mean, I'm really scared. It's supposed to make you really happy, but I get really bummed out because everyone is going out and here I am. It's late at night and I'm sitting here reading a book or drawing. It's so depressing to me and I go, "Well, God! Why don't I have a boyfriend? What's the problem here. Why is it only me?"

T: Because you're so afraid of being rejected that. . .

P: Yeah. I'm so afraid that the relationship will just go so sour and then I look around and I say, "Yeah, but other people have relationships that go sour and they make it," and I think that I'm a lot more evil and worse than they are.

T: There you go . . . so you talked yourself right back into keeping them out of your circle.

P: Yeah! But then I’m still really depressed because I don’t fit in.

T: You talked yourself into keeping the guard up and into being depressed.

P: Yeah!

As treatment progressed, the patient began experiencing a heightened sense of her own identity. Her reactance levels lowered remarkably, and over the Christmas holiday she was able to make a successful trip to visit her father and stepmother. During the trip, she was able to disengage from the frightening thoughts that had been associated with her anxiety and depression in the past. In session 17 the patient reflected on these changes and how she was able to "anchor” herself by utilizing more favorable images. The interventions at this stage began to reinforce and support these behavior and cognitive changes.

Session 17 (1/8)

P: Well, let’s see, um. It really was nice. Very enjoyable. I went out there thinking that it would probably be really awful and, like, I was really focusing on trying to keep in touch with myself and not be distracted by other people’s emotions, and so when I ran into my dad he was really cranky and M. would

hardly say "hello” to me, and was really mean and everything. I thought, you know, I thought, "It has no reflection on me.” I just saw two unhappy people. I was able to be really happy and nice this time, right? So I was real happy with myself and then the more I said things to myself like that, the happier I got. It’s kind of a cycle. So really it took to the fourth day before M. started really sticking it to me. It didn’t bother me at all that she was like this, you know.

T: You were able, it sounds like, to reinterpret what had happened. Instead of taking it personally, you started attributing it to them. "It’s their problem not my problem.”

P: Yeah, I could really notice that, and then as vacation went along, you know, and I was really nice to her she got nicer. She was actually nice for two or three days there when I was willing to be nice and stuff. I don’t know, I just suppose that people who appear strong to her or something, she’ll be nice to, but if she senses a weakness in someone, she gets scared and cranky.

T: So your strength helped.

P: Um hmm. It did. I could tell. Because she doesn’t want anyone resting on her. Leaning on her. Also, I got out a lot with friends. It was just really nice to see my friends and also to get out for a while.

T: So all that struggle you went through about whether or not to go, turned out okay?

P: Oh yeah, I was surprised.

T: You're pleased with yourself?

P: Really. Yeah, it really, made me feel pretty good. If I go back again, I feel like I can pick up from where I left now, not where I left off last year when everyone was mad.

As in most therapy experiences, periodic crises arose for this patient, which reinstituted central conflicts that seemed to be resolving. These reverberations during later therapy stages are usually short lived but provide important arenas for reviewing and practicing newly acquired coping skills. For example, session 23 began with the patient reporting that her father had sounded drunk during a recent telephone conversation. This event was clearly upsetting and reinstigated many of her rescue fantasies and anger, which characterized her core theme of interpersonal ambivalence. The following segment illustrates her effort to disengage from the competing desires to protect her father, on one hand, and reject him, on the other.

Session 23 (3/28)

P: My dad didn't call Sunday. He calls every Sunday night and in a

letter I wrote, I said, "I'll call you back Saturday morning or you can call me Sunday morning." But he never called. I didn't think much about it because he's done that before, but he usually will *definitely* call back Monday. By Tuesday he hadn't called, and when I came home Wednesday, my mom said, "You better call your father because something could be wrong that he hasn't called you." So I said, "Wow! Are you sure?" And she said, "Yeah, just call and make sure he's all right." Well I called him and he definitely was drunk on the phone. I could tell it and he was really, really just. . .

T: What was your reaction?

P: Well I don't know what I thought. He was in really bad shape. When the girl answered the phone, I was talking to her, and I could hear him whistling in the background, you know? So when he got on the phone I told him, "You were whistling," and he goes, "No." He always lies when he's drunk; I mean always. I tried to talk to him and he didn't say anything. It was just silence, and I said, "Well, call me next Sunday." He didn't answer; he goes, "huh?" He was really . . . I mean it's just the tone of his voice. I can tell when he's drunk.

T: Does it offend you?

P: Well, it was weird because I got off the phone and I didn't feel much about it. I thought that it was too bad but I didn't feel anything. Then, later on in the evening, something else happened, a little small thing with one of my roommates. It was something she did that kind of ticked me off. She went

back on her word or something that wouldn't normally bother me, but all of a sudden I almost wanted to cry. I was thinking, "Now wait! It's not because of this little thing." And then I realized that it was because of my dad.

T: It bothered you more than you realized?

P: Yeah! I mean it just hit me like, "Oh, isn't this something?" I felt really badly. And then I talked to a few people about it and I've been thinking about things since. It's been weighing me down a little bit.

T: Tell me what your thoughts tell you.

P: Well, how do you mean?

T: What kind of worries do you have?

P: About him? Well, it's not related, but I worry about why he's 'drunk. Something really had happened to him at work, which was really unfortunate. He had formed a little partnership within his company with two other guys. One of them was his boss and they were going to try to earn . . . I mean, they could earn lots of money over several years. About a month ago the company asked for a good amount of money to be given to them and my dad had talked to the partners about what they were going to ask for and what it was going to be used for. But my dad found about two, three weeks ago that they lied to him. Not only did they lie, they got in trouble with the company and they blamed it on my father, which was really rotten because one of them is his

boss and he can’t get back at him. So anyway, it’s been really unfortunate and now people are giving him really bad looks in the office. It’s been so unfair because he’s innocent. He didn’t do anything wrong.

T: They did something they weren’t supposed to do?

P: Yeah. And then they lied to him and blamed him for doing something he didn’t do. And it was unfortunate because he had done all the work for them. So much work that in terms of his own health it was bad for him.

T: You’re worried about his health and about how he’s doing at work and whether his drinking means things are getting to him and he’s depressed?

P: Yeah. It just bothers me that he fails at everything he does. It’s just like nothing works out. And in this kind of situation you almost think, "Why didn’t this thing work out?” And it just didn’t.

T: You have worries about his depression?

P: I don’t know. I mean, it makes me upset.

I just worry that M. will divorce him and he won’t have anybody. I just worry that he’s gonna be a drain on her, and I worry that M. will get a divorce and he won’t have anybody. I will feel obliged to go help him.

T: So the worry is that you might have to step in and take care of

him?

P: Well, I guess I don't have to, but I would choose to. That would make him feel better. It just bothers me because he's so talented and it's all going to waste; I mean, he's incredibly smart.

T: There seem to be two sides to your worry about his drinking. One is that it's a waste for him and the other is that it threatens you.

P: Well, I think they're the same in a way. I mean worrying about him and being scared for me.

T: Worry is like being threatened?

P: Yeah, I guess so. So I don't know how to feel. I mean, I can't help but feel, like, sorry about it.

T: Yeah, I can understand that. Is there some belief that he's not going to be able to get where you would like him to be without you?

P: Well, I just pretty much think of it as "he seems to be happy but he's not." And I don't know how he can feel better because he doesn't go for help. He goes through phases, you know. On the phone the week before, he was real happy and he seemed okay.

T: In the past, how depressed has he gotten?

P: Nothing good. I mean everyone gets down but. . .

T: Does he come back up?

P: I would say that during the year there is about 20 days that he's happy. So if he comes out of his depression it's, like, a month later and then he's down again and it goes on and on and on.

T: So I wonder if it really makes any difference whether he's drinking or not or whether things are bad at work. He's kind of unhappy anyway.

P: If this hadn't fallen through, he wouldn't be so upset.

T: What role do you think he played in all this?

P: In what?

T: In making himself depressed or drinking.

P: Well, I think that when he joined the company, he was anxious about the job and he had a feeling that people were a little dishonest. He needed the money and the income at the time. He knew the deal would fall through, but he just didn't know when. He knew that there would be something going wrong. And it was a little bit risky to do this partnership.

T: He knew it was risky?

P: Yeah, but I don't think that he deserved it, you know, but he *did* know. So his whole world is really going to collapse and then

there's really no place to go.

T: Are you worried about him committing suicide?

P: Yes . . . no, he'll drain other people before he does.

T: In a way, he is a survivor. He survives through a lot of ups and downs.

P: Well, it seems like his whole life has been that.

T: So any guess that he'll survive through this?

P: Yes, if you mean physically breathing, yeah. I mean it; he has incredibly bad luck all the time.

T: I wonder. Maybe if his luck is that bad so much of the time, it may not be luck.

P: What do you mean? The bad luck is intentional . . .

T: The bad luck he kind of. . .

P: Created? Well yeah! I mean, I think. But, of course, in this situation it's hard to say. It's bad luck but, yes, he needed to take the job and he was taking the risk, but I can say that I didn't feel the way that I perceive him to feel. It's okay to think that he made it happen, but I'm not him. I don't know.

T: What part do you think he plays in his unhappiness?

P: It's his fault that he doesn't go to a psychiatrist or talk to somebody because . . . I mean, I was pretty messed up before I came to talk to you. I think I've gotten a little better and it's just. . . It's a macho thing with him, you know? He's not going to be talking to anybody; he's not going to take any medicine for it.

T: He doesn't take care of himself. He contributes to his own downfall? So, how realistic is it to be upset. . . *responsible* for him being depressed?

P: Well, I mean, it's just sad that that's the way he is.

T: I hear two things. One is, of course, it's sad, just like it's sad anytime somebody destroys himself. It's especially sad and hurtful if it's somebody you care about in the way that you care about him. So you're sad and it's kind of a reminder that you *do* care. So there's a nice side of it.

P: Well, yeah.

T: But there's another side. The other side of it is that it kind of scares you that it would then seem like you had to take care of him.

P: I don't know. It depends on how I take it. I mean, I don't know that it's unrealistic that my stepmother might divorce him.

T: That may be. What would that mean for you?

P: Then, he'd be alone. I don't know. I don't know. I'd just have to

treat it like he was alone. What if he drank? He could fall and hurt himself and there wouldn't be anyone there because he has no one then but me.

T: There's some kind of belief in there that you should be there if nobody else is?

P: Yeah. I don't know.

T: Because he's taken such good care of you?

P: No! No, I don't know why.

T: Because you're his *daughter* and that makes it a requirement, so you just have to be there.

P: Yeah, I guess that's it.

T: Do you have a belief in labels . . . "daughter," "father"?

P: Yes. That's so weird.

T: It's understandable. My guess, though, is that it's not very realistic to think you "have to." If he goes under, you could decide whether or not you go and take care of him. It's not that you would "have to." It's the "have to" that may catch you. Somehow there's an obligation you feel because he's your *father.* Maybe one way to think about it is to step back a moment and think of how your relationship would be if he was "L. J.," not "Dad."

P: Well, I wouldn't have anything to do with him.

T: Yeah. So, why should you if you call him "Dad"?

P: Well because he's not L. J.

T: He is to everybody else in the world.

P: Except me because I'm his daughter.

T: What role did you play in that?

P: I don't know.

T: Is that something you believe you chose?

P: No.

T: It's something you had control over?

P: No. But it's the same way that a parent might protect a child if their child got into trouble.

T: But, parents have had control over whether or not they have a child.

P: So they're responsible for it!

T: They decided to have a child. The child didn't decide to have a parent. All of a sudden you reverse roles. You act like because you have the label "daughter," something you didn't

choose to have; you didn't pick your parent; because you happen to have a parent who is alcoholic and has other difficulties, somehow you should always be responsible for him and take care of him when he can take care of himself. I think that's really very noble of you, but I question whether you "have to."

P: I don't know if I would *have to.*

T: Do you know where that sense of obligation comes from?

P: Maybe it's not realistic. I guess that if I couldn't go see him, I would feel badly about it. I feel badly about the reality of the situation.

T: You're a caring person and you'd feel badly about anybody in that spot. But, being a caring person is one thing; being obligated because he carries a label around and you are the only one in the world to use it, as his daughter, that obligates you for life?

P: I don't know. I mean, I guess it's not realistic when you think of it that way.

T: What would you think about him as L. J.?

P: I would be irritated with him, for not getting himself calm again.

T: Why should it be any different when he wears the label "Dad"? The behavior is the same.

P: Well, because as L. J. I wouldn't have any feelings for him and I could make that judgment on him without feeling anything about it. My major feeling would be one of anger or disgust for him.

T: That sounds like you love the label; you don't like the guy. What would your reaction be to the person, L. J., not filtered through a label?

P: Probably irritated. I get miffed because he had nice things going . . . I mean, it's irritating.

T: What would you want to say to him?

P: "Go see a psychiatrist!"

T: If you look at him as L. J. what you want to do is tell him to go get himself taken care of and to take care of himself. If you look at him as "daddy" or "dad," part of you wants to take care of him, whether he gets help himself or not?

P: Yeah.

T: If he is just L. J., where do your responsibilities end? How much do you owe him?

P: I feel sorry for him, but not that sorry. I mean, I can't.

T: Well, if he says, "I'm not going to go get help. I don't need help," and he's just L. J.?

P: Yeah. Well see I can’t forget him, because I talk to him every Sunday.

T: I know you can’t forget him, but how would you deal with it if it was just L. J. that calls?

P: Well, it depends on how much he says to me.

T: What do you think your debt is to him?

P: On a scale of 1 to 10, right?

T: Okay, on a scale of 1 to 10, how big a debt do you have?

P: Three or up.

T: Is that a big debt?

P: No.

T: What is your debt to him if you call him "Father?”

P: You know it’s going to change [laughs]. Um, well, actually as I think now, it’s only about a three or a four. It’s about the same I guess.

T: So, do you need to take care of him?

P: No. I’m starting to see. Yeah, I understand. He’s got to take care of himself.

T: Maybe the best thing you can do for him is to not take care of him.

P: Yeah. I guess he's just by himself or something cause he's always so mean to people who try to help. It's like the meaner you are to him sometimes, the more he's nice to you. It's really weird, people like that.

T: And the opposite works too? The nicer you are to him, the meaner he is to you?

P: Yeah, usually.

T: If you were to go back and take care of him, then, how would you expect him to be?

P: Mean. Like, he'd make fun of me for it.

T: Is that what you want?

P: No.

T: Maybe you could explore what you really owe, versus what you *want* to give. Maybe the "want to" is closer to realistic than the "need to."

P: Yeah, I see.

[Later.]

T: We've seen how you filter your feelings through the label of

"father." Do you do it with your mother too?

P: No, not at all. She hardly has any motherly ways.

T: Do you miss "mother?"

P: Yeah, I guess. Well, I think of her as a "real good friend." ,

T: Yeah, as you talk about it it sounds like you're friends.

P: She's really nice, but it's just that. . . I don't know. It's just, my friends have a different relationship with their mothers. There's always a little bit of a gap between them. It's not bad, but it's just the way it is; there's not a little gap between us. You know?

T: It's like you're the same age?

P: Yes.

T: But you're not her age, she's your age?

P: Right. Only sometimes when I'm depressed, I feel like I'm her age.

T: When you're down you're the same age, but you're her age. When you're up you're the same age, but she's your age?

P: She seems older, though. She does seem older than I am, but not a whole lot. She just never does mother-daughter things. She never could, you know. There's not any labels on this. She

never did act like a mother.

T: It sounds like neither one of your parents acts like your idea of what parents should be but, if I understand right, the idea of "father" has a whole lot clearer meaning to you than the idea of "mother" does.

P: I think it's because my parents are divorced and I lived with my mom and I missed him really, really, really badly when I was little. I mean, I really wanted a father. And he was always very, very nice when I visited him.

T: He seemed bigger than real?

P: Oh yeah. He was everything. And then I went back and he just crumbled my image. And my mom was out here, but of course I was visiting. On the last visit she started to become more protective.

T: He was a real nice thing to think about when he was gone. It sounds like he disappointed you. You're not so disappointed that she doesn't act like a mother?

P: She never was a mother to me because she could be really mean to me. She'd yell and yell at me for not doing things.

T: So. She didn't use to be even like a friend?

P: No.

T: So she's gotten better by being like a friend?

P: Yeah.

T: Your father's gotten worse by being less like a father. What is your sense of that?

P: Of having a "mother?" I don't know. I don't know how to explain it. I love ray mother, but I don't have any respect for her.

T: What would give you respect for someone?

P: I don't know what it is that makes respect.

T: Do you find it in anybody? In your friend's mothers?

P: Yeah, I guess it's a person that actually puts some limits on me that I can't go past. They take a little bit of my life into their hands and a little bit of. . .

T: A little control?

P: Yeah, just a little. Just to help me. I don't know. It's just a sign of protection.

T: A good mother in your mind is protection; she gives structure and she puts limits on you.

P: Yeah, I guess that's what I needed because sometimes I wish I had someone to say, "No.'

T: Because not saying that lets you feel like you weren't being protected? That it didn't matter?

P: I never really thought of how they thought of it. I just thought my reaction to it was . . . I mean, it’s like I wanted someone to put a limit there so I could kind of go, "Oh, what a pain,” but on the other hand, I’d feel protected.

T: It sounds like a limit is like an arm around the shoulder. Somebody saying, "Here I’ll take care of you.”

P: It’s fun, sometimes, having someone take care of me. But, it’s something that I miss; that I didn’t have. It probably isn’t appropriate now that I’m in college, but it’s something that is missing. T: What’s the closest you ever had to that? P: Probably my Aunt A. Definitely. She would be my ideal mother. My mom just hates things that mothers do. I mean, she hates cooking; she hates station wagons; she hates families.

T: All of the things that mothers do?

P: Yeah. She hates house cleaning and all the kids and the groceries, and she’s always complaining about those things. Every time she has to do mother things, she gets irritated.

T: It would be nice if father could be a little less "father” and a little more "L. J.” And it would be nice if your mother could be a little less "C.” and a little more "mother.”

P: Yeah.

Termination

Through the final sessions of therapy, the patient continued to struggle with her unmet need to feel close to other people. She focused most of her frustration on her mother’s unwillingness to stay in a maternal role, but also expressed awareness of her own developmental need for separation. In the final stages of therapy she began experiencing more comfort with the idea of independence and seemed to give up her struggle to create a mother-daughter relationship.

After the twenty-fifth session, therapy tapered off to less frequent visits, and we did not have another session for four weeks. At that time, she reiterated her continuing progress, particularly referencing a trip that she had taken home during spring break. She had a successful encounter with her father and stepmother and was able to "let go” of the criticism they offered of her. At the end of this session we decided to meet again approximately a month later. She canceled that appointment and rescheduled for three weeks later. By mutual agreement, this session was the last regularly scheduled appointment. At this time, her progress was reviewed and plans were made for the future.

Session 27 (7/16)

P: That's funny. It's funny looking back at both my parents, how I felt removed from both of them. I mean I have a lot of love for my mother, but I still don't think I have for my dad. But, I feel a lot more like my own person; a lot more relaxed. You know?

T: This is a good time for you.

P: Yes! In school, too. I don't know what I got on the final, but I was kind of excited about how I was going to do in math, and it was a brand new subject. At first I got an 83 so I was pleased, but on the second test I got a 98; it just blew me away. I haven't had a grade like that since Latin and it just made me so happy because I had so much trouble with math before. I failed so long at it. I think I may get an A in the course. I would be very happy. So, that's something that really made me happy, you know, that math ability coming back, and being with my mom a little bit and then getting a job. It's real interesting.

T: What about your relationship with guys? Has that changed?

P: Well, I feel like I flirt a lot more; I talk or laugh and joke. I enjoy their company an awful lot and I think I used to be kind of scared of them. Now, I actually enjoy being with them; it's a lot of fun. I'm a lot. . . I'm very relaxed around them ever since I got rid of the idea that the guy does not have to look this certain way. Then, you know, I'm attracted to a lot of

guys; it’s probably my age, too, but it’s nice. It’s nice to have that freedom.

T: And the freedom is, getting rid of that idea that there’s only one kind of guy that counts?

P: Yeah, yeah. It’s nice, especially being able to talk to my friend B. Though I think she's a little too forward . . . she goes out all the time; she’s really, really crazy [laughs],

T: You’re dating?

P: No, not yet, but I think I probably will next year. At least right now, I don’t think I have to go out. I just enjoy being with guys; you know, talking to them and joking. They’ll come into the store and they’re nice, you know?

T: That’s nicer than going out and being worried about how you’re coming across; you’re more relaxed.

P: Things are getting better and, just different. I think it’s changing. I’m also thinking of getting a computer degree. There’s this thing called a "computer auditor” and I think it’s something I can . . . want to do. I’d like to see about that. And also, my mom found out about this program where you can go work for an accountant for a semester and move to another city. I think that it would be really neat to go for a semester and be away from mom and dad . . . on my own and working and doing what I’m gonna be doing after I get out of school. So, I’m really very interested in that.

T: I hear a little excitement.

P: Yeah, yeah. I'm excited about it.

T: How can I help you in all of that? Where are we?

P: Uh, I don't know; it's hard to say. I feel happy; I feel very confident about my life at this time. I don't feel that there are any snags coming up that I can't get over. I'm able to get over the things that arise in life right now.

T: You've not come in for some time and that says to me either that you're unhappy at what went on here or that you don't need what's going on here, at least not with the frequency that you did earlier.

P: I enjoy talking to you a lot, but I don't need it. You know, I feel straightened away. I feel that way! It could change and I might come back some day, too. I don't know.

T: Well the door doesn't close. The door stays open. I'd like to hear from you, though, and it sounds like you want to kind of let this go and if you need it, to call back.

P: Yeah. That would be neat. I feel good right now.

Patient Reaction

Approximately one month after the patient's terminating session,

she was seen in the Sleep Disorders Center for evaluation of her narcolepsy and seizure disorder. By that time she had been completely withdrawn from all medications for two months and reported functioning well.

Two nights of polysomnographic monitoring and a series of multiple sleep latency tests confirmed the presence of a seizure disorder. During the course of the sleep studies, the patient experienced two seizures, one of which occurred during a period of wakefulness. A definitive diagnosis of narcolepsy could not be rendered, however. These findings are interesting in two respects. First, the patient's initial assertion early in the therapy process was that she would never be able to go off her medications because she experienced such great fear any time seizures seemed to be imminent. Hence, the fact that she voluntarily withdrew from all medication and desired to stay medication-free in spite of continuing seizures directly attests to her lowered fear levels. Second, seizures had been initially linked to her fear of death and, more dynamically, to her fear of loss. Just prior to the sleep studies, the patient was reporting no more than one seizure aura per week, which contrasted to several of these per day at the time she was initially placed on the medication at the

beginning of treatment. The observation that seizure frequency had reduced substantially even when she was no longer medicated is testament to resolving conflict patterns.

One month after the last psychotherapy appointment, R. T. was contacted and asked to respond to three questions. First, she was asked to describe the aspect of the therapy process and activity that was most helpful to her. In response to this question she provided the following:

> I feel the most helpful part of my therapy was the honesty expressed by Dr. Beutler. I believe that a lot of my problems were a result of poor communication—i.e., people not showing me their real feelings, which caused me to misjudge the relationship. Because Dr. Beutler said what he felt about me, I was able to come out of my shell and express, at times, how I felt about him. Being able to confront a person who I believe to be honest, rid me of the fear I had of doing that with others. And it seemed, that once I was able to conquer my fear on that front, fear of other things in my life disappeared. I was able to confront them too.

Second, the patient was asked to describe those things about the psychotherapy relationship which she did not find to be particularly

helpful. Her response was as follows:

> It is hard for me to say what, if anything, got in the way of my therapy. I feel that every session really helped and I felt that each session cleared up some confusion in my mind. Maybe because I put a lot of effort into learning from Dr. Beutler, I am prejudiced and unable to find fault with his teaching, or my learning.

Finally, the patient was asked to assess her progress, to which she responded:

> I feel that the program was very helpful because I am able to understand how far I've come. Though I realize that it worked because I put forth effort, I know that the program would not have been complete without Dr. Beutler's help. He is a sincere person who, I sense, has a lot of faith in himself and in others. It is this drive to succeed that I would truly like to thank him for teaching me.

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Commentary: Growing into Separation

Windy Dryden

Commenting on a colleague's work with a patient in the format of this Casebook is a risky enterprise. Even though Dr. Beutler has provided extensive verbatim transcripts of his therapy sessions, my task is akin to giving an adequate critique of the Mona Lisa when one is color blind and can only see the painting through a grille, under conditions where one's line of vision is obscured by the heads of other art aficionados. However, let me state that Beutler has amply demonstrated in action some of the major ingredients of his systematic eclectic psychotherapy. He has shown how his therapeutic stance changed over time, what factors influenced some of his therapeutic decisions, and that he is a caring individual whose honesty and competence were appreciated by his patient. His clarifying style of practicing therapy in this case comes over clearly, and he presents a convincing rationale for this style of therapeutic participation.

Let me, however, make a few points that struck me on reading

Beutler's chapter.

1. Beutler's opening succinct account of his approach is a masterful exposition of his brand of eclecticism, possibly the best I have read on his model. However, the complexity of his ideas is not matched by his chosen case. For example, the sophistication of his idea of formulating complex therapeutic menus does not come across in his work with this patient. This may, of course, be a function of the case he has selected to present.

2. I am not exactly clear how Beutler conceptualizes his client's psychological problems. Specifically, he does not present a clear model of emotional disturbance. He relies too much, in my opinion, on the concepts of "core theme" and "conflicts"—terms that do not seem to adequately account for the diversity of emotional reactions that may accompany such themes and conflicts.

3. In several instances, his cognitive interventions are not clearly designed. Thus, in the examples he provides he fails to give a credible account of the ABC theory of disturbance, fails to show his client clearly how "wants" differ from "have to's" and how these different philosophies may have far-reaching differential effects on her emotional responses.

He attributes his client's failure to successfully execute a self-monitoring procedure designed to help her see the impact of her thoughts on her feelings to her high level of reactance, whereas other explanations may be more parsimonious. Thus, clients often have initial difficulty with such assignments because they do not clearly understand the ABC model (there is a case for arguing that this is so for Beutler s patient). Also, many clients have secondary problems of anxiety that accompany such tasks, which do interfere with the successful initial execution of these tasks. In my opinion, Beutler is too quick to confirm his own reactance hypothesis in this case. All this raises the interesting issue concerning how skillful eclectic therapists must be in executing various interventions in order to practice effective eclectic therapy.

4. My own thoughts about the patient are that her major anxiety centers on being abandoned. Gilbert (1984) has argued that such anxieties often underlie many depressive episodes, and the response of Beutler's patient when he hypothesizes its importance in her problems is marked. P: 'Yeah, yeah, yeah. But, yeah! That's it. That is it. That's exactly it.' " And yet Beutler does not seem to keep it as a central focus. Taking this further, Beutler's work occasionally seems unfocused to me, as if he is more ready to follow his client's lead than to keep the work focused on

core themes that he himself hypothesizes to be central.

5. It is unclear what accounted for the client's improvement. Has she overcome her anxiety of being abandoned? In this respect, does she view abandonment as less likely to occur than formerly or can she cope with it better if and when it occurs ? I would like to have seen Beutler help his client (and himself) to understand better the reasons for her improvement.

6. Finally, I was disappointed with the client's own comments about her therapy. They tell us relatively little. Has she idealized Beutler in a similar way as she idealized her former psychiatrist? If so, what are the implications of this for her sustained improvement?

These, then, are some of the points that occurred to me on reading Beutler s chapter. They need, of course, to be put in the context discussed at the beginning of this commentary. As I have argued elsewhere (Dryden, 1986), I like and admire Beutler s work. Most important his conceptual schema does succeed in explicating criteria that help therapists to make important clinical decisions. It is difficult to demonstrate one's approach to eclectic therapy through disembodied

case material, and I am quite prepared to attribute some of my criticisms to the present format rather than to flaws in Beutler's actual clinical work with this patient.

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Commentary: An Explicit, Selective, and Consistent Eclecticism

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Beutler's systematic eclectic psychotherapy definitely warrants the name. His chapter presents a substantially abbreviated and yet tightly comprehensible explanation and example of his thoroughly thought-out model of eclectic therapy. The years of consideration, research, and applied validation that undergird the approach are clearly visible. Beutler's claim that he has designed a systematized approach to the integration of intervention techniques is backed with an uncanny consistency of concept development, operationalization, and actual application which defied our search for discrepancies.

The clear strength of Beutler's model lies in the extraordinary extent to which relevant issues are identified in ways that lead to the selection of specific, suited interventions. As Beutler noted, this is an approach to an integration of techniques from any number of theoretical perspectives which attempts to planfully match the techniques employed to patient need. As such, especially if one adopts his conceptual terms,

the model offers the eclectic therapist at least one clear road map for practice.

The five questions Beutler asked at the beginning of therapy with the prospective client seemed remarkably straightforward and simplistic, given the otherwise tangled web of psychotherapy literature. Those five simple questions veiled a well-conceived complexity, removing much of the impressionistic or nonspecific from the art of psychotherapy. They addressed head on client suitability and client/therapist relationship factors that have been recognized as critical to successful treatment (cf., Bergin & Lambert, 1978; Parloff, Waskow, & Wolfe, 1978). In addition, they directly attended to Gordon Paul's well-worn question (1967, p. Ill), "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" The resulting complex of information about the client's symptom complexity defenses and reactance formed almost an equation that could be computed to guide technique selection.

The illustration of the therapeutic proceedings in the case material shows the consistency promised by the model. Clearly, the assessment gleaned in the pretreatment phase largely determined the course of

therapy that followed. Once the attachment-individuation theme of the symptom picture was drawn from the client's history, that theme was pursued tenaciously throughout subsequent sessions. An appraisal of client history suggested a tendency toward reactance that was tested later in therapy and confirmed. Likewise, the conclusion that the client presented an emotionally under-controlled and behaviorally controlled defense system was arrived at very early from testing data. These combined conditions suggested a minimally directive cognitive approach in light of Beutler's previous analysis of the available intervention approaches. He began with and stuck with cognitive approaches including reflections, questions, interpretations, and reframing throughout the sessions. Later in therapy, he expanded into what he considers mildly directive techniques (fantasy, role play, alternate thinking) just as he had forecasted he might when he deemed the client receptive. He said what he would do and then proceeded to do just what he had said.

The deliberateness of the systematic eclectic psychotherapy model seems to be a two-edged sword. On the one hand, its explicitness and precision can be thought to provide well-reasoned direction for the practitioner. If we are amenable to his specific formulation (e.g.,

reactance, dependence), Beutler has almost done our thinking for us. It is imaginable that the whole system could be converted into an extended decision tree like those presented in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). Such a tool, even in its current form, is a real boon for those therapists, particularly therapists-in-training, looking for a source of order in the midst of chaos. This is particularly attractive for the eclectic practitioner, who has had few clear theoretical guidelines for practice.

On the other hand, if the practitioner had difficulty with the overall structure or any of the basic concepts that Beutler has adopted in formulating his model, its simple straightforwardness of the model could be jeopardized. Basic assumptions that underline the five critical questions in the model may not match the assumptions held by many eclectic therapists. The very existence of a distinction between simple and complex (neurotoform) problems accepted by Beutler has been debated in the literature for years (cf., Ullman & Krasner, 1969). Interpersonal reactance, one of the core dimensions, may or may not be conceptually congruent with a therapist's formulation of critical elements in the patient-therapist relationship. Likewise, the analysis that

each individual therapist would make, if other therapists were energetic enough to do so, of the array of available treatment techniques may differ considerably from what Beutler arrived at due to differences in theoretical interpretations. Beutler acknowledges the possibility and value of other therapists substituting their own concepts and techniques, yet the very process of doing so requires the therapist to construct a parallel formulation with corresponding alternative concepts, questions, and procedures. In a sense, he or she would have to recreate an equally detailed and complex system that would require its own period of conceptualization, research, and application. Despite Beutler s openness to the mixing of new ingredients into his general recipe, what would seem to necessarily result would be an entirely new meal.

A second extension of this idea concerns therapist match with the model. We often talk of matching client and treatment model, but talk much less of matching therapist and model of treatment. Even though Beutler s model is eclectic in nature, it still has certain characteristics that would be present even if internal elements were modified. The strength found in the structured, objectified nature of the model mentioned earlier suits it particularly well to the structured, deliberate therapist or new therapist in search of structure. However, many

therapists, eclectic therapists in particular, tend to be somewhat pragmatic or even iconoclastic (Garfield & Kurtz, 1977). Whether you choose to classify these therapists as nonsystematic, intuitive, or by some other term, they represent a large segment of practitioners. Although many of them simply may be looking for the right structure to integrate the elements of their practice, others actually may prefer to operate in less linear ways. In fact, they might take pride in their unstructured approach to therapy. Such practitioners would no doubt find the Beutler model to be too structured and restrictive. Modifications of elements inside the systematic model would not change the fact that the systematic nature of the model is inherently unacceptable.

To give him due credit, Beutler notes at the beginning of his chapter that his model is meant to be applied to suitable clients within "a stable and collaborative therapeutic relationship.” He spells out the importance of examining the compatibility between client and therapist belief systems and backgrounds to ensure that the discrepancy is not too great, but adequate to promote optimal change. He further pays particular attention to the role of client reactance in the therapy process and includes this element in his decisions about appropriate technique selection. Nevertheless, his major emphasis seems to remain with the

particular technique selection which then constitutes therapy.

Unfortunately, Beutler provided few of his own observations or reflections throughout or at the end of the transcript material. It would have been interesting to compare his comments with those reportedly made by the client at the close of therapy. The client indicated that she felt the most helpful part of her therapy was Dr. Beutler's honesty because he said what he felt about her, allowing her to interact with such an honest person instead of the types she had dealt with in the past. She further commented that her own effort and Dr. Beutler's sincerity and faith in himself and others were important factors. Although she made no reference to specific techniques or procedures, she did mention that she was grateful for Dr. Beutler's teaching, which facilitated her learning. This global assessment was strikingly similar to the results of outcome research findings that suggest the far greater importance of client characteristics, therapist, and client/therapist relationship relative to technique application in therapy (Lambert, 1983; Prochaska & Norcross, 1982; Smith, Glass, & Miller, 1980).

Would Dr. Beutler have interpreted the positive results of the sessions in the same fashion given the nature of his technique-centered

work? It appears that he would have to experience some cognitive dissonance if his own conclusions corresponded with those of his client. Would he ignore the role and importance of the specifically selected techniques and the skillful unfolding of their delivery as she did in his discussion?

There have been those over the years (e.g., Frank, 1982; Wachtel, 1977) who have argued that it is the common elements of therapies that account for their effects and that the specifics of therapy tend to be less significant. Beutler may even agree with that reasoning to some extent. However, content is part of each session, even if that content is simply the background for the actual, less explicit curative process. Beutler has provided a systematic approach to eclectic therapy that acknowledges and incorporates many of the important common components of therapy as well as addressing the issue of technique selection and utilization. His model represents a remarkable and useful piece of work.

It was a very pleasant experience to watch the model unfold in an actual case. At the same time, we got a glimpse of Dr. Beutler's skill and persona as a therapist. We thank him for the generosity that offered both his extraordinary model and the vivid sample of its application. The

Casebook forum displays theory, practice, and reactions, thus providing an unfolding of the complex, creative therapy process. Hopefully, the Casebook will stimulate additional glimpses at the way clinical theory is translated into practice. The synthesis of case study and normative approaches to therapy research provides a much richer depiction of the therapy process which will allow a closer, more adequate scrutiny and, at the same time, stimulate it to flourish.

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