Casebook of Eclectic Psychotherapy

Systematic Technical Eclecticism:

Two Depressive Episodes Treated with Very Brief Psychotherapy

Bernard D. Beitman

Commentaries by
Marvin Goldfried & James Prochaska

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About the Contributors

Bernard D. Beitman, M.D., is Associate Professor of Psychiatry and Director of Area Studies in Psychotherapy at the University of Missouri School of Medicine. He is coeditor of *Combining Psychotherapy and Drug Therapy in Clinical Practice,* and author of *The Structure of Individual Psychotherapy.*

Marvin R. Goldfried, Ph.D., is Professor of Psychology and Psychiatry at the State University of New York at Stony Brook and maintains a limited practice of psychotherapy in New York City. He is coauthor of *Clinical Behavior Therapy* and editor of *Converging Themes in Psychotherapy: Trends in Psychodynamic, Humanistic, and Behavioral Practice.*

James O. Prochaska, Ph.D., is Professor of Psychology and Director of the Self-Change Laboratory at the University of Rhode Island. He also serves as a consultant to numerous institutions and maintains a part-time independent practice in psychotherapy. He is author of *Systems of Psychotherapy: A Transtheoretical Analysis* and coauthor of *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy.*

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INTRODUCTORY COMMENTS

Systematic Eclecticism and Integration

The movement toward bringing together the conflicting schools of psychotherapy has currently advanced to a point at which two different terms are being used to characterize it. Some call themselves integrationists by which they imply an attempt to meld the warring factions into a cooperative and harmonious whole. Others call themselves systematic eclectics, implying that they are offering a scheme by which diverse approaches may come to bear in the decision-making processes facing each practicing psychotherapist. The apparent conflict in these terms seems to derive from their different intents. Integration is a political and ideological term intended to reduce conflict by recognizing commonality of purpose among diverse groups. It is a call equally well applied to warring religious and to warring political-economic factions throughout the world. There is much to be gained by recognizing common pursuits and interests as well as common means cloaked in differently colored rhetoric.

Systematic eclecticism, on the other hand, implies a more practical approach. It is concerned with the means by which valued results can be reached. Systematic eclectics offer schemes and models by which the contributions from the various schools may be organized for a more rational, more effective psychotherapy.

The intent of both integrationists and systematic eclectics may be very similar. Integrationists pave the way by knocking down ideological barriers with attacks on ideological rigidity, and systematic eclectics provide the alternative means. Ultimately, the result will not be an integration or a systematic eclecticism but rather a clear, usable definition of the psychotherapeutic enterprise.

The Stages of Individual Psychotherapy

I have attempted to fulfill the purpose of integration through the stages of psychotherapy. This basic notion provides the outline of a scheme for systematic eclecticism. It is, hopefully, a way to describe psychotherapy that subsumes the schools (Beitman, 1986). Stages provide contexts by which to judge objectives and methods by which these objectives can be reached. The stages may be defined by their objectives: engagement, pattern search, change, and termination.

The objectives of the engagement stage include the building of trust, the

formation of a self-observer alliance, and the raising of hope that the therapist is competent to be of assistance. Each of the many schools offers a set of techniques by which these goals may be reached, but there is little evidence that therapists should be restricted to one set. Empathic reception is commonly used across therapies, but trial interpretations are confined to psychoanalytic approaches and relaxation training to behavioral approaches. For some clients either one or both may be useful for accomplishing the goals of the engagement stage.

The objective of the pattern search is elucidation and specification of psychological patterns that, if changed, would bring desired relief and promote enduring change. The content of the pattern search is most variable because the major differences among the schools of therapy lie with their theories of psychopathology and theories of personality development. Some say look to childhood; some say look to underlying attitudes; others say monitor environmental contingencies; still others want to observe patterns of affective expression. Many approaches overlap in their interest in those enduring aspects of human behavior enveloped by the term personality or character style. Therapists tend to be interested in how their patients interact with significant others, including the therapists themselves.

The methods by which information is sought in the pattern search are far more limited. Besides standardized questionnaires, therapists use various

forms of listening and questioning to understand how their patients are functioning and what needs to be changed. Therapists may listen to patients as if they are speakers of metaphors, as if their daily speech was a kind of dream production in which utterances are multilayered communications about others and also about the therapist. Patients may also be understood as research assistants, as fellow detectives, trying to comprehend their external reality. They are reporters whose descriptions are taken at face value under the therapist's assumption that significant gaps must be filled. Finally, therapists may listen to their clients as if they are fellow travelers on the road of life—people searching to be experienced, to be understood, to be felt, people wanting to reach and be touched by the existence of another. From this perspective, listening provides access to the inner world of the other, which, for a few minutes, might lead to a community of mood.

In addition to many forms of questions, therapists use homework assignments to gather information. Dream diaries bring the daily unconscious into the therapist's office. Diaries of automatic thoughts bring daily thinking more sharply into view (Beck et al., 1979). Behavioral diaries give rapid, somewhat objective, views of target behaviors. Role playing, hypnosis, interviews with significant others, and direct observation in the environment each carries a different potential for yielding useful information. The therapist's task during the pattern search is to find the most effective means to bring about specification of the patterns to be changed.

The third stage, which is change, appears to have three substages: responsibility awareness, the initiation of change, and the practice (working through) of change. Each of these stages is not necessarily traversed for every patient. Milton Erickson (1976), for example, delighted in not having his patients know what they had been doing to keep themselves dysfunctional, nor did he seem to require that his patients practice their newly initiated changes. Many therapists, however, seem to lead their patients through this sequence. Some techniques seem to be useful for the general sequence (placebo response, desire to please the therapist); some are useful for each of the substages of change (interpretations, exhortation); and some are particularly useful for only one substage. For example, demonstration of repeated patterns is an excellent technique for raising responsibility awareness for psychological dysfunction. In the office, practice is useful for initiating change outside of the office, and behavioral homework is useful during the practice substage.

Techniques appear to offer the means by which therapists can convey their messages to patients about better values and better coping. Although some therapists might hope they are practicing value-free psychotherapy, successful psychotherapy seems to be marked by the convergence of therapist and patient beliefs (Strong, 1978; Beutler, 1983).

Termination is perhaps the most predictable stage since it involves the

universal experience of separation for which there are a limited number of forms. The pair can mutually agree; one can initiate it; or it may be forced by circumstances outside the control of each of them. Grief and the desire to avoid the loss are common responses from both participants.

After therapy is ended, the question of maintenance of change and its continuation is raised. In this area, psychotherapy research has ventured very little, but it will become increasingly more important as the practice of psychotherapy receives increasingly more scrutiny by third-party payers.

Each stage seems also to have characteristic interpersonal and process distortions. Resistance or blocks to therapeutic movement appears universal in psychotherapy whether it is psychodynamic or behavioral or humanistic. Unfortunately, labels are ideologically laden and are difficult to apply universally. I use the terms resistance, transference, and countertransference, but others may choose different terms for similar phenomena. For example, some family therapists may ask supervisees, "How does your family of origin influence your responses to this patient?” rather than use the term countertransference.

Therapist Personal Beliefs

Therapists’ tendency to choose responses based on idiosyncratic experiences and values is an understudied element of the psychotherapeutic

experience. This description of psychotherapy is no exception. Although the foregoing outline is fairly generic, it is biased toward time and toward process. My background as a therapist is a liberal arts education in a variety of psychotherapy approaches with little formal training in any one of them. I read George Kelly (1955) when I was in college and have remained deeply impressed with the variety of ways there are to look at any given phenomenon. I was deeply touched by Freud and his followers during my medical training, both very positively and very negatively. I had one series of psychoanalytic seminars and one six-month period of psychoanalytically oriented psychotherapy. I became convinced that what I had seen and heard about psychoanalysis was insufficient for an effective practice of psychotherapy. Football and baseball showed me the value of behavioral practice. The pain of the life around me, mystical and religious studies introduced me to existential concerns. I have therefore been open to many different contributions to psychotherapeutic change.

Some therapists come to the integrationist movement from a psychoanalytic base; others are behavioral systematic eclectics. Still others are their own types of therapists trying to find the best blend of theory and technique. We need to respect these differences while at the same time drawing an outline of the boundaries of what psychotherapy is and what it is not. I believe that there is much poor therapy going on in the United States and other Western countries under the name of professional services. A

certain variance must also be respected and understood to point the way to future developments and to allow for individual differences among therapists. But some basic, expectable elements should characterize most effective psychotherapeutic relationships. In presenting the transcripts from the case of Mrs. D. G., I hope to show the reader how my personal approach blends with the general definition of psychotherapy described here.

MRS. D. G.

D. G. first came for psychotherapy in November 1982 at age 51 following the suggestion of her oncologist. He believed that she was depressed and in need of psychiatric treatment. She had her second mastectomy in July 1982; the first was in 1974. In 1972, she had a hysterectomy. Mrs. G. was divorced in 1973 after discovering that her husband was having an affair. She had three children from that marriage who at the time of the initial interview were age 25 (male), age 22 (female), and age 18 (male). The youngest was living at home. She had been married to Mr. G. for four years. He too had been divorced once. She was short and moderately overweight. During the first interview she was very talkative. She demonstrated her depression with occasional bursts of sadness and crying during the interview. Her excessive talkativeness also seemed to be a cover for the depression.

TREATMENT OVERVIEW

I saw Mrs. G. twice during November 1982. The first session lasted more than 45 minutes (and was not tape-recorded in its entirety since I did not turn the tape over when it ran out). The second session lasted about 15 minutes since we both felt that she was no longer in need of treatment. I saw her four times in December 1984, each for approximately 50 minutes. Her husband was present during the entire second session and for half of the third and fourth sessions. We terminated because she was much improved but also because we were both leaving Seattle in January 1985. She sent me follow-up letters in 1984 and 1985.

Her Beck Depression Inventory Scores for each of her sessions were as follows:

11/5/82—27

11/10/82—Not done but within normal range

11/16/84—40

12/5/84—45

12/12/84—23

12/19/84—13

I saw her as part of a small outpatient practice (between 6 and 12 patient visits per week).

I selected this case because at the time I was asked to contribute to this *Casebook*, I had only this tape available. I had presented it as part of a seminar on cognitive therapy led by Steve Hollon, Ph.D. After

I decided to use it, the patient returned for a second round of psychotherapy.

I have interspersed the dialogue with comments reflecting my own thinking and details of the interview lending themselves to succinct expression. These additions are enclosed in brackets.

PART 1

11/5/82

T: Did you have any trouble finding it?

P: No, I just went to the Information Desk, and she told me exactly how to get here.

T: Dr. A. referred you. I wonder, did he give you any idea about what I did?

[I want to know her conception of me.]

P: He said, I think he said that you specialized in counseling cancer patients. I mean that is one field that you are active in. Is that right?

[I believed she felt my reputation was positive.]

T: That's right. I wonder if you have any expectations about what counseling is like?

[I want to get her explanatory model for therapy.]

P: Oh, yeah. I've never been. Matter of fact it really bothers me that I feel that I have to come. That bothers me, because I can't seem to cope with my problems.

T: It bothers you to . . .

P: To say that I have to come to see, to get help. That bothers me.

T: What is it that you say to yourself?

[I introduce a key cognitive therapy question.]

P: Why can't I take care of myself? I mean, why can't I bring myself out of this, these feelings that I have, and why do I have to be so emotional now? I never used to be.

[She takes easily to examining her own thoughts.]

T: So when you say to yourself, "Why can't I do this myself?" what kind of feelings do you have?

[I introduce the connection between thoughts and feelings.]

P: I get very upset with myself. Because I feel inadequate to cope with my problems.

T: And when you feel inadequate to cope with your problems, it makes you upset? And how does your upset come out?

P: Oh, I get angry. I'm very short tempered now and I have a son that's home all the time now, he's unemployed. He's really a good kid, he's very thoughtful of his mother. But, I find that I'm always snapping at him, and I don't mean to.

T: You don't mean to, but you're always snapping at him.

P: I'll just get my breakfast things cleaned up, my kitchen cleaned up, then he comes in and starts having some breakfast and this irritates me. Because I'm not used to having anybody at home in the daytime except myself. He's been home for about a year and a half, maybe not even that. But I enjoy being home. I don't like somebody else around disrupting my routine.

T: Okay, when you see him come into the kitchen, to get his breakfast after you've cleaned it up, what thoughts go on in your mind?

P: I generally will walk out and I'll say, "Clean up your mess, I've already cleaned up the kitchen." He'll take them from the counter and put them in the sink.

T: That's what you say to him, but there's more going on in your mind.

P: Oh, I think I probably just wish that he wasn't there because he's not happy being home either. He'd rather be out working.

T: So, when you see him come into the kitchen, there are a number of thoughts that come into your mind. Like, maybe, you're not always aware of them, but "I wish he weren't here," "I wish he were working," "I wish I were alone."

P: Uh huh. I like to choose the times I want to be with people, and basically I've always been able to handle being alone very easily, especially when I was working. To me every night I came home to an empty house was a real treat. Because I enjoyed that.

T: So when you see him come in, you say to yourself, "I don't like having someone else intruding on my time, my privacy. I don't like this." So you get mad at him for, even though you shouldn't, for intruding on your privacy.

P: Yeah, I'll snap at him for little things, and my daughter doesn't live at home anymore, but she stops by, oh, about three or four times a week and has lunch on her lunch hour, because she just works down the hill from me. And, even though I enjoy her, we've always gotten along, but he no sooner gets through with his breakfast and then she pops in, and I don't mean I wait on her, but she just helps herself. But for about two hours there, or longer, I've got all these bodies in my kitchen. When I'm used to being in the kitchen by myself. It just... I don't say anything too much. I just get irritable.

T: Do you know why you don't say anything very much?

P: Well, I don't know, I wasn't really aware that they were the ones that were actually doing this to me. I would just feel irritable. But I didn't want to hurt their feelings, they hadn't done anything wrong.

[She appears to recognize that talking can bring understanding.]

We discussed her guilt for not working. I was once again able to point out a possible connection between her thoughts and uncomfortable feelings. I

then tried to summarize our discussion to that point.

> T: What I've tried to show you in this first 5 or 10 minutes here, is something about the kind of questions that I'll ask you, the kind of ways that counseling might help you. Trying to define and unearth the thoughts that you may not be quite aware of in your mind, but still influence the way you behave and the way you feel and the thoughts about your children coming into the kitchen and invading your privacy. Kind of you knew that, but it made it a little clearer to you that you don't want them there because you don't want your privacy invaded.

By this point we were well engaged: I had a positive reputation; she was motivated to participate; she responded well to the cognitive model of therapy I had quickly introduced. She seemed to gain a partial insight concerning the cause of a recurring irritable feeling. I asked her to tell me the history of her current cancer difficulties. She had a second mastectomy in July 1981. The bone scan suggested metastasis to her ribs and skull. Her husband called for the results.

> P: I remember my husband called one day and asked the results. Now there's always been this confusion. My husband thinks maybe he heard wrong, but he called me and said, everything's okay. I just talked to Dr. A., and the tests are all negative. I kept saying, "You're kidding, you're kidding." I mean, I couldn't believe that. I didn't feel that good either, and I couldn't figure out how can I feel this way and yet everything's okay. Well, then about three days later, I had to come to see Dr. A. When we came in, we found out that the last slice they took, evidently on this lesion, was positive. So, we didn't find out until we walked in the office that the first diagnosis was right. So I did have metastatic breast cancer, and I just sat there and I looked at my husband and he looked at me and I'm thinking, "You knew all the time."[1] You know, just these horrible thoughts went through my mind. But we were just both in such a state of shock that I didn't get emotionally upset or cry or

like that because I couldn't believe ... I was just shocked. I had one x-ray in December (1981) and it showed exactly the same as the one I'd had in August 1981, which was still good because it hadn't spread any more. And then when I had one in June [1982], six months later, if I hadn't seen those x-rays with my own eyes, I wouldn't believe. Like the radiologist said, "You can't tell which is the healthy body. I mean, if you looked at these x rays, you would think it was the body of a healthy person because there is not a mark on them." And, I mean, I was in shock. Really, I just couldn't believe it.

I proceeded to specify her symptoms of depression. She had been overeating, felt as if she could never be full, and had gained 17 pounds in 10 weeks. She felt as she often had during her period—very tense and irritable. She was often unable to get to sleep and not uncommonly woke up to urinate but could not go back to sleep. She was taking a diuretic and an anticancer medication (tamoxifen). Later in the hour she described extreme fatigue and lack of enjoyment in activities that usually pleased her. How many of these symptoms could be attributed to occult cancer, to her chemotherapy, and to her depression may be difficult to say. Nevertheless, I felt she should be considered to have a moderate major affective episode. She then indicated to me her resiliency and initiative by describing how she went to Alaska with her husband during one of his trips and, rather than sit around the motel all day, got herself a volunteer job. They thought she was great.

T: Why don't you tell me about your depression.

P: Well, like I said, I don't really know what makes me this way, but I do know that I got more depressed when my husband called the other night and said that he won't be home now until Tuesday, when I expected him home tonight. I was upset, and I get depressed every time they send him out of town for any

period of time because my thoughts are that life is so short, you know, and I think I feel it more now that I know that my years are numbered[2] and I feel that we should be spending more time together. Because we haven't been married that long.

[She then described her first husband's affair, their divorce, his mistreatment of the children, and mentioned his remarriage.]

T: Do they have children?

P: No. His wife had a hysterectomy about eight years ago. She's quite a bit younger than I am, she's about 13 years younger than me. But I suppose I should probably tell you that after the divorce—we were divorced in March and I wasn't dating—I didn't know anybody. I'd been home with my three kids all these years and so I didn't know anybody. Then I finally went out with a friend to some of these singles dances and she introduced me to this fellow. I used to take the kids with me too. He had a place out on the water, so we used to go out there sometimes for dinner, for a barbecue or something. They would row around in the boat and it was really just a calm relationship. There was really nothing to the relationship. He was just a nice man. That's all I remember him being. Well, anyhow, it was one night that we went out, he came and picked me up and, we were going to a barbecue back at his house. We had 80 people there and he wanted me to help him, so I said fine. So, anyhow, I came and by the time I got home it was about 3:00 A.M., and we just pulled inside the driveway and this car comes in from up the street and here is my ex-husband, jumping out of the car, with the engine running and the doors open, and he pulls the door open and starts beating this guy, and I had to holler at him to stop. Stop! The next thing I know, I hear this popping sound, and I thought what is that and then I see all this blood pouring from this guy. Well, he killed him. Right in the front seat of the car, in my driveway. And my oldest son was standing on the porch. And then I just got hysterical and jumped out of the car because my son kept saying, "Mom, get in the house." So, I tried, I ran around and just as I got to the side of my car, my ex-husband said, "Look," and I stopped dead in my tracks, and he said, "I'm going to shoot myself." And he did fire a shot, but he just grazed himself. Then he evidently walked away, because the police spent all night trying to find him. They had to take me and the kids out of the

house because they were afraid he would come back to get me and [sigh] that's something I've had to put in the back of my mind. That was in August of '71 and then by December, when he was still in the King County Jail, he got married to this gal. And they've been married ever since.

[I was astounded.]

T: And where is he still, now?

P: He's living over in a condo by ----.

T: How'd he get out?

P: Oh, he was out in less than two years. Good behavior. Well, he, he never really was a bad man, and he never ever hit me or anything like that. He evidently had a complete breakdown or something. He couldn't cope with the fact that he was losing his kids. He was really obsessed with his kids.

T: And so he got out because it was called a psychiatric problem?

P: Well, he went into work release. He was released because he had been taking psychiatric treatment at [local prison], and I got a letter that I still have at home from, I can't remember now whether it was the person who was treating him or whether it was the parole officer, telling me what they were considering doing. They were considering letting him out on a work-release program, and he wanted to know my feelings. Well, when I got that letter, I was horrified. Because I thought, "Oh, my God." That's the only time I had felt safe was when he was locked up. 'Cause I just thought, well what's to stop him from coming back and getting me next time. So I wrote the letter back, and I have a copy of that at home too, that I told them exactly my fears. And the fact that he was so obsessed with the kids all the time, that if I was dating another man, at the time, I would be afraid of what he might do to that one. The kids were still living at home. And, I just let them know my fears, but next thing I know, within about four or five months, he was released. But they said that he would start paying child support again, 'cause I was going on two years or so without any child support and trying to raise the kids with $400 a month gross.

T: So, you've been able not to be so afraid of this, today?

P: I'm not afraid of him at all anymore. I found that when I was dating, and I was single for almost eight years, there were quite a few men that as soon as they would hear of this incident, I'd never see them again. So, obviously it scared a lot of them. But my husband [Mr. G.] said, "He doesn't scare me."

T: What sort of treatment are you expecting from talking to a psychiatrist?

She tried Valium from a friend and liked it. She had asked the pharmacist for something for her nerves. Medications had helped her cancer. I thought she would be a strong placebo responder. She also found out that her insurance did not cover outpatient psychiatric treatment. This fact added to her motivation to change.

She fills out Beck Depression Inventory Scale and I summarize:

T: As you suspect, it indicates that you're very depressed.[3] There's two ways that I work with people who are depressed. One is medications. And medications might be of some assistance to you. Valium works on part of what people are depressed about, namely their anxiety. It does not usually help with peoples' depression. Anxiety and depression are two different things. Another way to work with people who are depressed is to begin to examine the thoughts they have that seem to make them depressed or irritable or anxious. When we first started talking today, we were talking about thoughts that made you upset, like you can't vacuum because then you'll wake up your son, but then you think, "I'm angry at him for being there and restricting what I want to do," and that makes you feel tense. Changing these thoughts, which, as you can see, can be changed. You don't have to think those thoughts and, therefore, you don't have to have those feelings. So what we could do, if you wanted to, is work on the thoughts you have, examine the thoughts that are in there. We call them automatic thoughts because they come on automatically and you don't think about them. We

would think about them. I would point out to you, "Is this really true?" Just because you were taught not to vacuum, do you still have to behave that way? I ask you not to take your thought like something that's totally true but is open to question, and I would help you question some of your thoughts so that you could get a more realistic automatic thought in there and, as you can see, if you change some of your thoughts, you would feel better. [The tape ran out here. I reconstruct my last attempt to bring it all together: I suggested that with her husband's failure to return when expected, she was once again experiencing sudden abrupt changes. She had been returning from an outing when her man friend was killed by her ex-husband. Then he was released from jail. Years later she was expecting to die of metastatic cancer and she was suddenly declared in remission. Now she also had to adjust to dramatic switches of expectations again.] [I gave her the antidepressant Trazodone, prescribing 50 milligrams at bedtime for the next five nights until our next appointment. This is a low dose of a medication known to have minimal side effects. I intended it to be an "active placebo" by which I meant that it had antidepressant properties but not in this dose range. It also could be called homeopathic treatment.]

11/10/82

I did not tape-record this session since the cognitive therapy seminar for which I had prepared the first session required only one tape. Mrs. G. reported that immediately after taking the first dose of the medication she felt better and had slept well each of the following nights. On the fourth day, she stopped the medication, having taken it then for three nights. During the interview she was markedly calmer and more accepting of the fact that she had to adapt to her husband's repeated delays. She realized that she wanted more time with him, but sometimes it wasn't possible. She believed she did not need more psychotherapy. We terminated.

Discussion of One-Session Psychotherapy

A small body of literature confirms the efficacy of very brief and one-session psychotherapies. Rockwell and Pinkerton (1982) found three general sources of information confirming this notion: single case reports, reevaluation of early-treatment dropouts, and the Kaiser-Permanente studies.

Ever since Freud treated Katharina in a single session on an Austrian mountain top, therapists have reported single-case cures. Psychoanalysts, behaviorists, hypnotists, and others have proclaimed their own effectiveness through single-case examples. Others have reviewed early-treatment dropouts only to find that many of these patients originally thought to be treatment failures had actually terminated following satisfaction with a session or two. Malan et al. (1975) reported the results of a careful study of all patients seen at the Tavistock Clinic in London who had not seen a psychiatrist more than twice in their entire lives. Of 45 patients fitting this criterion, 23 (51%) were judged to be symptomatically improved upon follow-up. Malan et al. also included criteria for "dynamic" improvement for which 11 fit. Follow-up ranged from two to seven years. Using medical utilization as an outcome measure, Follette and Cummings (1976) found that one-interview patients as well as brief-therapy patients (two to eight sessions) had subsequent significant declines in medical outpatient visits and hospitalizations.

Rockwell and Pinkerton also described three general types of cases for which single sessions might be applicable. Some patients may need only the opportunity to review and receive approval for psychological work already done or require affirmation for a psychological decision already made. Other single-session responders may need only assurance of normality. Since the standards for normality are hardly clear, therapists may fear error and extend sessions with patients about whom they are uncertain. The most challenging group are those who appear capable of significant change in a short period of time. Such people are likely to respond to almost any approach. The challenge is to find quickly and comfortably a focus for change and promote it.

According to Rockwell and Pinkerton's analysis, a number of factors appear necessary in order for a single-interview change to take place. The patient must rapidly accept the therapist's authority, and the therapist must be able to help the client quickly to see him/herself differently. The therapist must be confident in his/her ability to conduct a proper therapy in general, must be willing to attempt therapy in the first session, and must be able positively and decisively to let the patient go. This latter element may be particularly difficult because of the uncertainties about what was left undone and whether or not the changes set in motion would proceed successfully without further therapist intervention (p. 38).

Mrs. D. G. was rapidly engaged because her trusted oncologist had

recommended me and because she wanted to stop being depressed as rapidly as possible. She readily caught on to the style of therapy I was introducing since examining her own thoughts was something she appeared to have done frequently. She seemed to grasp the idea that talking about her thoughts might be useful. She also seemed to know what needed to be changed, rather than simply being in despair without having any idea about which direction to move.

As suggested by Prochaska and DiClemente (1984), the stage of change in which the patient presents is probably a powerful predictor of outcome. She did not like having to ask for help and seemed to believe that she should be able to help herself on her own. Not included in the transcript because the tape ran out was her belief that psychotherapy cost four times my actual fee, another powerful motivator for short-term help.

The factors that predisposed her to change, she brought with her to the therapeutic encounter. They demonstrate how much of the outcome is determined by factors outside the therapist's influence. Causes of change itself were multiple. She readily accepted the necessity for her to take responsibility for the problem. One could argue that she knew she would have to accept the uncertainty of her husband's returns. My comparison with previous unexpected events to which she had to adjust represented an attempt on my part to foster those previously effective coping mechanisms. I

hoped to elicit those old emotions, place the current unexpected events in the same context, and thereby elicit similar tolerance. Aside from this specific technical maneuver, other more general factors were at work. The introduction of a medication could have stimulated her belief in the power of pharmacotherapy, which had already provided her with a "miracle cure" of metastatic cancer. She had not taken enough medication for a sufficient period of time to attribute the relief of her depression to active medication effects. The placebo response is a powerful healing force, which is hardly understood. My own view is that patients may be able to stimulate the production of desirable biochemical activity under favorable circumstances called placebo conditions.

One also cannot ignore the possibility that the depression may have remitted anyway. One can never tell in the individual case whether or not the apparent relief of symptoms was part of the natural course of the disorder. Since she had gone for four months with an increasingly severe depression, I judge that something about her encounter with me was ameliorative.

Follow-Up Letter—August 17, 1984

After accepting the invitation to contribute to the Casebook, I sent Mrs. G. a copy of the transcript of the November 5, 1982 meeting, requesting her views of what helped her to change. She was unable to specify the causes of

her change.

> Dear Dr. Beitman:
>
> After reading the transcript of our meeting in 1982 I have come up with the following observations:
>
> I found that I had very little reaction at all after reading the complete transcript except for Item 1.
>
> 1. I remember at the time resenting the fact that you asked me, "Are you expecting me to give you something [medication] today?" Although it was probably true, I was hoping, and at the time I felt that that was all I would need to get over the depression.
>
> I think also that I expected to leave your office knowing exactly why I was so depressed and what to do to eliminate the problem. However, it is possible that had I had more sessions with you, this would never have been discussed. To answer your question, it is very difficult for me to tell that the one session I had did help me or whether the medication did the trick.
>
> I'm sorry I can't be of more help with your survey but hope what little I have said will be of some help.
>
> Sincerely,
> Mrs. D. G.

Mrs. G.'s follow-up letter was interesting in that she was unable to ascribe her change to anything specific except possibly the medication. She therefore learned nothing specific from the single session about herself that she was able to articulate. As therapists, we often hope that patients will gain something constructive from the experience that they may apply in other

circumstances. She herself appeared to be primarily responsible for this change. Somehow, I performed the ritual through which she could allow herself to make the changes she wished to make.

PART 2

The patient called me in November 1984 saying she wanted an appointment because she felt very depressed. I was glad to hear from her, in part, because I had been criticized by some of the editorial consultants for the Casebook because my case was too short. Now I had the opportunity to illustrate the clinical reality that patients sometimes relapse and choose to return to therapy with the original therapist. Shortly after writing the follow-up letter to me, she had experienced a recurrence of cancer.

11/26/84

[BDI = 40—Done before talking part of interview.]

> T: It seems that you're more depressed than you were the last time I saw you.

She had no energy and lacked interest in everything. It started after her vacation in September 1984. She rambled on in a jumbled, excited way. She reported that it all hit her after returning from vacation. During the summer she and her husband had decided to move to Alaska. The cancer had spread to her hip socket, where she had five separate lesions, and also to her vertebral column, where she had three separate lesions. Because these vertebral lesions caused her so much pain, Dr. A. prescribed 10 days of radiation

therapy. She had known of the recurrence before her vacation but decided to go anyway. This time she received radiation in addition to medications. She interpreted this to mean her condition was worse. She suffered some painful radiation burns, but her husband went on a hunting trip anyway. They had decided to move to Alaska, and she worried whether her husband would give her the support she needed. She stated that she believed that once they got there, everything would be all right.

T: Are you sure of that?

P: Well, see, I don't know, I'm scared; but I don't have a choice. I either go with him or I stay here by myself. I would say every weekend for the last four or five weeks we've had a running battle and then he doesn't speak to me for three days.

[I want details of their arguments.]

T: What do you fight about?

P: About going to Alaska.

T: What's the general way the arguments go?

P: Well, it just seems that every one of these has been on a weekend. He'll be working downstairs in the basement and I'm sitting upstairs by myself again with nothing to do because I don't knit anymore. I start to get this horrible creeping feeling and then I start thinking: "I have, we have a beautiful house and I love it, I just love that house. And . . ."

She describes how her husband has "given up" on his three children because he gave them everything and then they walked away from him when

he needed them. He has no contact with them. I wonder to myself whether she fears he will cut her off. He will not acknowledge the existence of one of her daughters because she did something to anger him.

> T: Back to the weekend fights though, he's downstairs . . .

> P: He's downstairs. I said, I've gotta talk. He says, okay, just talk, what do you want to talk about? I said, I'm scared to go to Alaska. He says, well, what are you scared of?

She talked about her fear of leaving her three children and then described how her husband had gotten angry at her daughter, Chris, because she had left a mess in the house she rented. The patient and her husband, H., had to clean it up around Easter, 1984. H. had complained to his friend Rick that no matter how much you do for children they always want more. Then each time Rick and H. got together, they both complained about that "lazy Chris." Since Rick and his wife had gone on the September vacation with the patient and her husband, she felt her vacation was ruined by their snide remarks about Chris. Chris apologized to H. just before Thanksgiving.

> P: I told H. after vacation, I said, I am never gonna get together with our friends again if you guys do not stop bugging me about Chris. And so, I even made a point of saying to him a couple of days before Thanksgiving, I said, "I want to make something perfectly clear and that is that there will not be any comments made about Chris to ruin our Thanksgiving." "Oh, I think that can be arranged," he said. So, anyhow, that is what has been depressing me and it ruined my vacation. . . .

I had a lot of trouble following this story of Chris, H., and Rick during the sessions even while going over the typed scripts. I moved to the details of the decision to go to Alaska.

T: Okay, well, let's leave that aside for a little bit and talk about some of the other things that are bothering you. Because these may all come together. When did your husband say you were going to move to Alaska?

P: We found out in June, when we were up there. The boss came up and took us out for dinner.

T: And told you then?

P: Uh-huh. But the thing is, ah, that it was pretty well discussed before I even knew; I mean it was a definite goal before I was even told.

T: All right. So that was just a formality, the boss took you out. . .

[I did not believe this entirely.]

P: Yeah, right.

T: Okay.

P: And I knew, I knew it was preplanned.

T: So, you were told in June?

P: Uh-huh.

T: Again, you were given a situation that you couldn't do anything about.

[I pick up again on the theme of helplessness.]

P: Right.

T: And that’s hard for you. It was a little bit the way H. and Rick were interacting was a situation you couldn’t do anything about. . . .

P: Uh-huh.

T: Otherwise they kept doing it.

P: Right.

T: The sense of helplessness you had starting at least with Easter and then with being told about the Alaska move and then you get a recurrence of the cancer.

P: Uh-huh.

T: And that you can’t do anything about either and this radiation on top of it.

P: Uh-huh.

T: And then your son leaving the house . . .

P: Uh-huh.

T: You know it’s a good thing for him to go, ah, but you’re losing your baby, you’re on your own again.

P: Uh-huh.

T: At least four things happened over the last six months or so, that are beyond your control, or relatively beyond your control, and that’s been very frustrating for you.

P: Uh-huh.

T: And that's contributed to your depression.

P: Yeah, and you know, I really think that I would like to go. Well, we've bought a house, I've gotta go.

T: And you really think you would like to go, and that's what's so crazy about this.

We discuss her medical care plans. Her husband has been very active in helping with the arrangements for follow-up in Alaska. But he rarely takes her for treatment himself and that hurts her. She describes him as more affectionate in Alaska and then describes their Alaska friends in more detail.

P: I guess like I said to my husband: actually they're all your friends that we socialize with. They're all men that he has met through work and they all have their own airplanes, including my husband; he just got his pilot's license this summer up in Alaska and we bought an airplane. And these guys just sit around, and Tuesday night is boys night and they sit around and they all talk airplanes and I just sit there and knit; and I'm quite happy.[4]

[She then describes his kindness during a very uncomfortable Alaska trip.]

T: You wanted to tell me that he can be understanding, particularly up there.

P: Up there. See, I mean everything is yes dear, no dear. He would do anything for me up there. And then the Monday after we came back, a dozen red roses comes to the door. And it said, I love you very much and hope this makes up for the bad weekend, because everything went wrong, the flight and everything. This is how he tells me he loves me.

We discuss her ambivalence about going, the depth of her depression, and a friend who said, "What's the matter, D., do you feel you're going up to Alaska to die?" She agreed. She felt as if she was not fighting the cancer as she

had before. She felt that she had no future. I sensed anger at her husband.

T: You sound like you're very angry with him. You're very angry with him. And it's almost as if you're going to just stop fighting the cancer and die because you're so mad at him because you don't want to die in Alaska.

[A way to pull ambivalence and depression together.]

P: Yeah.

T: You're just gonna die right here.

P: Uh-huh.

T: Period.

P: And, I, we both went to a counselor last week at the University together [at the outpatient oncology department]. We met with her for about an hour and a half. She just listens to you, and she turned to me and she said, "Well, it sounds to me that you don't have too many choices." I mean, my choices are I either go up there or I stay here, get myself a little apartment, and stay down here by myself and, of course, I wouldn't have anybody coming home for dinner at night. So, I'd be day and night by myself because I don't work and that is depressing, because I know I couldn't take much of that. So my only choice is . . .

[This is the central current conflict.]

T: To go.

P: Yeah.

T: But you hate the idea of going.

P: Yeah. Now that I've gotten myself in this hole—I call it a hole because I can't seem to get myself up and this is not me. I've always been bubbly and go, go,

go.

T: You thought you were dying after you got cancer the last time. And then you told everybody you were dying. You all got used to it and then suddenly you were in remission again. And you had this very sudden horrible thing happen to you when your husband shot that guy you were dating. That was another death that was out of your control and horrible for you and your family. Just horrible.

P: Uh-huh.

T: Another hopeless circumstance for you to have to fight against.

P: Uh-huh.

T: And now you're being pushed into yet another situation where you have only one thing you can do. Actually you have two things. You can die. You have cancer. No one will ever know that you just let go. If you even tell them, they won't believe you. They'll say the cancer got to you. And you'll do that because you want to die in Seattle.

[I expand on this side of her ambivalence.]

P: Uh-huh.

T: You want to die at home. And you'll do it partly because you're so furious at your husband for abandoning you as he has. Even though the evidence is that he might not do it while you're up in Alaska.

P: Uh-huh.

T: You're still so furious at him now.

P: Yeah. Because, I guess the reason I'm so furious at him is because, he doesn't have to go. I mean, ah . . .

T: He doesn't have to go to Alaska?

P: I mean; he didn't have to agree to go; I mean, everything's cut and dried and the house is bought and . . .

T: And he didn't discuss it with you?

P: Not really. I mean, it was discussed with me when the decision . . .

T: Had been made.

P: Yeah. And I mean, I know it was all discussed before.

[Return to the theme of helplessness.]

T: So here was one thing in your life; the life of a woman who has had her husband shoot somebody; kill somebody; who has had cancer come back once after having had it before; things that seem like they were very much out of her control. Here was a situation where you could have had some control. Even if you would both have decided to go to Alaska. At least you would have been part of the decision. But he did it behind your back and that's hard enough for most people anyway. For you it's even harder because you have cancer, which is beyond your control and you would like to have some control in your life; some experience of that; and he took this away from you too.

P: Yeah. This is what I said to him. I said, I never ever get to make any decisions. They're always made for me, and, it's like I said, financially it's a big promotion, financially for him; plus a lot of extra benefits.

T: No matter what you tell me, he did not involve you in this decision. Now let me ask you about a decision I want you to be involved with. The last time I saw you I gave you some medication.

[I model a collaborative decision.]

P: Yes.

T: Now, are you looking for medication today?

P: Well, I . . . yes, to be perfectly honest. I don’t know what it was that you prescribed but it was only one week’s supply. And then when I came in the next week, I was driving in and I thought, "What am I going in there for? I don’t need any help, I’m fine.” But I was never in the shape I’m in now. I mean, I never was this low. And, it scares me, I mean, it’s just frightening because I feel like I’m slowly dying.

T: You are.

P: And I’ve got to get out of it or I will die.

T: That’s right.

[She describes in great detail how her husband refuses her the smallest kindness because he doesn’t want to "pamper” her.]

T: Is it possible that your husband could come in next week; to see me?

[I want to see his side of this story.]

P: I don’t see why not.

T: I would like you to ask him to come in. Try this. It is the same medication. I want you to take one tonight and one tomorrow night. And then if you feel all right, go up to two on Wednesday night and then two on Thursday night and then Friday night take three a night.

I gave her a higher dose than the last time. I was hedging toward the standard dose range. But therapeutic doses for this medication are usually twice this amount. I judged it to be a more active placebo than the last one.

P: Oh, now, that'll all be on the bottle will it?

T: Yes. Yes.

P: Okay, just in case I forget.

T: By the time I see you, I want you to be taking three.

[By the next appointment she had forgotten this instruction.]

P: Now is this the same?

T: Same stuff. Yeah.

She expresses surprise that her husband came for counseling but doubts he will take the advice of giving her a little TLC. We discuss dying again. I attempt to reframe her experience by calling her leaving Seattle a partial death.

T: You are really dying in regard to Seattle. Just like I am, I'm leaving Seattle too, permanently, so I understand that. [Therapist self-revelation to imply termination.]

And that's painful enough, but you've also got a bad disease, and you've got a husband who doesn't acknowledge it. And you're angry at him and you're gonna kinda kill yourself.

P: Just to get even.

[She seems to accept this notion.]

T: Just to get even.

P: It makes sense. Because I know, I'm just angry all the time. I don't like being this way.

T: You are angry; partly at him, but separate out what's him from what's Seattle. You're angry about having to leave Seattle and you're angry about having cancer.

P: Yeah. I mean . . .

T: And having it come back again after beating it.

P: And having a husband who doesn't acknowledge it. Like the time when it came back I went through days and days of tests and x-rays and bone scans. He told me this one time, I'm not gonna pamper you. Dr. A. said that your problem is probably arthritis. I said, he doesn't know for sure. And he says, "Well, I'm not gonna pamper you." So, I thought, "Okay," then it really started hurting and I just went ahead and made my appointment with Dr. A. and I never even told him I was going in because I was mad.

T: You're still mad. This is our next appointment. December 5. It's a week from Wednesday.

12/5/84

Both husband and wife are present.

T: What is your understanding of the reason that I asked your wife to ask you to come?

H: Why, I think she wants me to hear both sides, I guess, and understand her problems. I don't think I have a problem.

T: Well, you have a problem.

H: Well, yeah, I mean personally, a problem.

T: Well, I think it affects you personally. I'm not saying I'm pointing at you, within you exactly, but . . .

H: Oh, I realize that, I understand that.

T: And, in part, the problem your wife has is the problem she perceives you have with her. Usually in cases like this it's both people contributing something, and maybe that's true here and maybe it isn't. And that's one of the things to see. [Turning to patient.] I see that you are not feeling any better since I saw you last time. [BDI = 45.]

She has remained very depressed, feeling as if she had the flu. I was anxious because she had not responded dramatically as she had in Part 1. How much was due to her cancer or its treatment?

T: How do you understand your wife's depression? How do you understand the reasons for it?

Husband describes the possibility that she may be dying but counters that fear with the argument that she has not yet been declared terminal. He also states that the move is probably hard on her and that she fears a lack of support in Alaska. He counters that with the argument that people in Alaska are just like the people here. This statement strikes me as coming in part from the world view formed by his being a repairman—the interchangeable parts notion. But I am also impressed with his understanding of her concerns.

H: Well, I think she feels that if she goes up there and leaves all the support that she gets here that she'd give up. . . .

T: Well, the idea of her giving up is around.

H: That's right, it's been around and I've heard it, and I understand that part of it. But I don't think that she would. I just don't believe that she could give up that way because I've tested her. I can get her mad and she's ready to fight and she's gonna go, go, go.

T: What can you get her mad about?

H: Oh, I can make her mad over several things. And then I can see the inner part of her, that's her fighting.

P: Probably the easiest way he can get me mad is by not speaking to me.

H: But then she's ready to fight.

P: And I'll fight back.

H: And that fight's there. I mean, I think that the fighting is still in her, it's just that she's . . .

P: That's my anger.

T: Do you talk to him about your anger?

P: I just told him what you said, that I was angry.

T: Did you tell him what you are angry about?

P: No, that I was angry, that I was angry.

T: Well, here's the place to start talking about anger, and some of it is at you.

H: I'm sure that's right. And I probably have some for her, but I, I don't express my feelings, I keep them to myself. If I get angry at her I don't express it to her.

T: You still probably show it to her.

P: He shows it to me by not speaking, you know, I just get angry and I yell and holler and . . .

H: Well, I'm a believer this way. When you say something in anger, you don't mean it, but it still hurts and you can't ever retract that statement. And I don't like to hurt people that I really care about, I don't like saying something that will hurt them.

T: Well, you hurt her by not saying things too.

H: Maybe as . . .

P: And see, that hurts me more . . .

H: To me, no, I don't hurt her as much as saying something.

T: Okay, now this is where you (talking to H.) don't have a problem, but both of you have a problem.

H: Yeah.

T: Now, whose standards are you living up to? Your own, or what really hurts your wife?

H: Well, either way, I'm gonna hurt her.

T: Yeah, which way are you gonna hurt her least?

H: Well, that's her. I don't know. My opinion is if I say something that's gonna hurt her, it's gonna hurt.

T: But if you don't say anything?

H: It's still gonna hurt her.

T: Well, can't she pick her poison?

[I try to force him to see for whom he is making this decision.]

H: Well, that’s true.

P: I don’t think he would say anything to hurt me. If he said anything, he would just say, look, get off my back. If he just said something like that and then let it go. Sometimes he’ll go for days without speaking and that gets me upset.

H: Well, that’s not true. That’s not true, because I know my temper.

T: And you really do get mad.

P: I’ve never seen his temper.

H: I can get mad, and I don’t let myself get mad.

T: Have you hit anyone before?

H: Yes, one time.

T: And who was that?

H: That was my first wife.

T: Did you know about that?

P: No. I’ve never seen him angry.

H: I’m not an arguer. I will not argue. I’ve never argued.

[He is very categorical.]

T: How badly did you hurt your first wife?

H: Oh, I just smacked her in the mouth.

T: But that really bothered you?

H: Yes, it did.

T: You didn't like losing your control like that?

[I transit to the control issue.]

H: No, I don't lose my control.

T: Well, control is the other important subject for us to talk about because that's what Mrs. G. and I were talking about the last time too, control. Now, could you tell him about control, rather than me telling him about it; how you feel like you're losing it? And how he's been taking it away from you.

P: Oh, about not having any choices?

T: Yeah, tell him, not me.

Trying to encourage discussion. In fact they had discussed her sense of having no choices, especially about her not being involved in the decision to go to Alaska. But she would not confront him with the specifics without my encouragement. At first I thought she did not remember our discussion the previous week.

P: That's how I felt the night we went out to dinner, that it was kind of all decided then anyhow.

T: And when we talked last week, you didn't like that. It was another instance of not being included in important decisions.

P: Uh-huh.

T: He had done it by himself.

H: Well, I object to that a little bit, because it had been discussed. In my viewpoint of this thing, I have not excluded her in everything. I keep her informed. I don't think I held anything back.

P: Well, the first that I remember actually hearing about it being for real was the night he [Dave] took us out for dinner and you'd already taken care of all the business part.

H: That was the first time I had heard; basically other than the night that George said something. But, the night that you and I went out with Dave was the first time that he ever said, H., I want you to be the man. That was the first time that I was told personally by Dave, other than two years ago.

P: Well, I had the feeling from the way Dave was talking that he's planned this for quite some time. And I felt like I was . . .

H: Maybe Dave had, but not me.

P: I'm talking about the way Dave talked and it sounded like he had already been talking to you about it.

T: Well, do you believe what he just said?

P: Uh-huh. I believe him.

T: How does it make you feel to hear his side of the story?

P: Oh, I mean, it makes me feel better, yeah.

T: How does it make you feel better?

P: I always thought that somebody was pulling a fast one on me. That they always knew but didn't say anything.

H: No, no, it wasn't.

P: And that's what I felt, yeah. That it was done for my entertainment.

T: Here is a difference of opinion that has harbored a kind of resentment in her for many months.

H: Well, I can understand that situation, but it wasn't a situation that was opened up, bingo, right at that time. It had been discussed a couple of years before of saying, hey, we're gonna put a service department and we want you . . .

T: It was a little bit in the air, but for both of you it was a surprise. More for your wife than for you. You had a little more sniffings about it.

I then moved the discussion to her concern for his support. He states that he gives her all the support she needs *when she needs it*. He lists the many phone calls he has made, the driving and other plans he has carried out. But he does not mention phone calls to Dr. A., for example, because he figured "she could handle it." If she couldn't handle it, he would be there.

P: But he didn't support my depression because he didn't understand what I had to be depressed about. And I couldn't actually tell exactly why I was depressed. I didn't really know. I didn't want to move, I didn't want to do anything.

He changes the discussion to saying he is moving for her. If he was on his own, he could live on very little money. But she wants to talk about her depression and how he does not understand it. I am impressed with his innate psychological astuteness when he sides with her resistance to going by saying he would rather not go either. But it is their last chance at financial

security.

H: But I'm not 20 years old. How many more years of physical productive work in my line of business do I have left? So, what I've got to do is look for both of our sides and analyze the situation. You see, I've got five more years I can produce and we can come out actually with money we can do what we want to. And we don't have to travel, we don't have to do things.

T: And you agree with that?

P: Uh-huh.

T: He doesn't want to move either, but he feels it's a good opportunity and it may be the last opportunity.

His self-sacrificing position neutralizes her calls for support during her depression. She starts to look to the recurrence of cancer, the pain of treatment as the causes. I shift her to her cognitions. We move to a discussion of her possibly dying in Alaska. He counters with the belief that he is more likely to die than she is. This position is not open to my argument.

H: But that's what I'm trying to portray in her mind of a positive thinking situation. And that's the reason I made the statement, I will not pamper you, because if I pamper you, I'll make an invalid out of you.

T: This woman, you're gonna make an invalid out of?

H: Not if we make her do her own thing, keep her strong.

T: She's pretty independent anyway.

H: I know that. But if we would. The kids and I talked about it. We said, we're gonna

treat her just like we always have. We're not changing.

T: What do you want him to do a little differently in regard to your cancer, your physical situation?

P: Well, what it really boiled down to before when we went to the counselor, is just a little more TLC. When I don't get it, I get the impression that he doesn't care. And, ah . . .

T: Tell him.

P: I get the impression that you don't care.

H: But, we've discussed this one time. I'm not an emotional person. And she knows this. We've been married six years and I'm never an emotional person. I don't make; I'm not a person who shows . . .

T: Let me ask you this. I don't know all that much about air conditioners, so I'm going into your area of expertise. Let's see how this works. You've got an air conditioner, it looks like a standard model. You know how it's supposed to operate, but it's not working. You go in there and you find that there's something in there that's not the way you thought it would be. Has that ever happened to you?

[I try to appeal to his explanatory model.]

H: Yeah, quite often.

T: Okay. So you're not gonna try to fix it the way you had in your mind in the first place. You're gonna adjust to what you find.

H: Well, that's true.

T: Well, that's what I . . .

H: You're right, that's true.

T: You got an idea about how to handle your wife.

H: Uh-huh.

T: It ain't workin'. So, you've got some good ideas, just like you have with an air conditioner, but she's different from the concept you have about the way it's supposed to be.

H: It's worked up until this. Or at least she's given me the impression that it has.

T: I think it has. It looked to me like it is a good marriage too. It still looks like a good marriage to me. But there are some adjustments necessary now, because the air conditioner has changed a little bit and your wife is asking for a little more sense that you are worried about her, that you are concerned about her. And I will say it in a very specific way. Your idea about positive ways of looking at five years up there and then retiring and let's get through it, we can beat this cancer, is very important. And it's a great attitude to have. But let's have another one too. That isn't 100% certain. It's a good idea to have a positive attitude, but now, she also has some other realistic possibilities in her mind. Five years, she told me, looks like forever. And it's possible, we can't say it's impossible, it's possible, that what she's doing is leaving Seattle behind and going to Alaska and dying. It's possible.

H: That's true.

T: Well, she wants that accepted also.

H: I've accepted that.

T: Has he?

P: Well, when we've ever talked, I mean, I've talked about it. . .

H: I've accepted it.

P: Well, yeah.

T: Has he, do you feel he's accepted that?

P: No, I just have said I feel like I'm going to go up to Alaska and die. And that's when he said, Well, he says the problem with you is that you're afraid to die and I'm not. And I said, Well, yes, I'm not afraid to admit that I am afraid to die.

[He will not hear her as she wishes to be heard.]

T: The fundamental question you are facing as a couple is that this move to you means the good life in five years and maybe not a bad life for the next five years either, but after five years easy street, good retirement. This is what it means to you.

H: Yeah, right. Well, not just for me.

T: To her, she would like it to mean that, but you have a sick wife. To her now, she's not functioning as she'd like to. She wants to function the way you want her to because she likes to function that way. But you have now a sick wife. We don't know how much of it is depression itself, we don't know how much is due to the illness itself. It's very hard to determine that. But she's going up there sick, feeling like she's not gonna come back to Seattle; feeling like she's gonna die.

[I don't feel I am getting far with him.]

T: I'm gonna have to stop for a minute. Are you still taking this medication?

P: Well, I only went six days like you said, even though I had some left over.

T: When did you stop taking them?

P: Saturday. [Our session was on a Wednesday.]

T: Oh, oh, all right. Why did you stop?

[I am frustrated.]

P: Because it said one . . .

T: But then you were supposed to continue at that dose level.

P: Oh, well, I didn't know and I decided, I thought well, why would he prescribe . . .

T: Then you were supposed to continue at that level; get up to three a day and then stay there.

P: Oh, okay, I, I stopped on Saturday.

T: Did you feel any effect from them?

P: The only thing that I can say that I've noticed is that I haven't been crying. But then I haven't brought the subject of Alaska up and neither have you, so we haven't even discussed it at home. And that's the only time I would cry was when that was the discussion.

T: Well, let's try this stuff again. Take three at night, keep taking it. You're supposed to get there and keep taking it.

I felt uneasy with the sense that her depression seemed so dense that nothing could change it. I tried to encourage more positive responses by her husband and tried to underline his substantial commitment to her general wellbeing. He emphasized how he had tried to make the move easier on her. They discussed how he had told her many of the details of the move including the selling of the house but that she had forgotten. She began to consider the possibility that rather than being left out, she instead had not been paying attention. Perhaps, I thought, her depression had contributed not only to her

lack of concentration but also to her failure to see H.'s positive contributions. Then he added a contribution right out of Beck et al. (1979). I appreciated the suggestion since I was feeling demoralized too. I did not like the idea of writing up a failed case for this Casebook.

> H: I think that by her staying home, not getting out and doing things, it adds to the depression.

He remarks that she never listens to him, but if a friend tells her, she'll do it. I take the hint and ask her to fill out a daily activities schedule. I invite him to return next week with the likelihood that I will see her first, then both together. The session had gone 10 minutes overtime because I was looking for some ray of hope.

Thereafter, *I* felt depressed, helpless. I felt that she was going to Alaska to die. I felt that the stress of the move might exacerbate her weakness. I was worried that it would kill her. I was also being traumatized by my own leaving of Seattle. I would be leaving the same time as she was to leave. I thought that her memory problem appeared excessive. I would need to do a mental status on her. Does she have metastasis to the brain?

Later that day, I called Dr. A. I argued that she was likely to have an organic basis for her depression either with metastasis to brain or due to chemotherapy. I repeated my belief that she was going to Alaska to die. He

doubted the organic basis of her presenting problems.

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BDI = 23, approximately the same as the first time she saw me. I felt relieved and believed that she would probably recover as quickly this time as she had two years ago. She felt that she was "out of the hole” and attributed it to the medication. She could look at the move to Alaska in a better light now. She had begun to think of all the things she had to do where before she could care less. She decided to push herself a little bit but did not acknowledge that her husband had suggested it. Two days after our last session, she had gone to a large shopping center for three or four hours and then cooked dinner. She has been that active ever since. I found it difficult to attribute this change solely to the medication since she had been on it only two days after having stopped it for four days. Her memory remained a problem for her. She had forgotten to fill out the daily activities schedule. I asked her for feedback from the last session to see what, if anything, from it had helped her.

T: Do you remember anything about our session last week? Anything that seemed useful to you, that stood out to you, or seemed not useful to you?

P: Yes, the one thing that stood out to me, that I never found out before was the reason my husband doesn’t speak to me when he’s angry. I often thought that he had done something at one time that he was sorry for and so now he refuses to fight back. He’s never raised his voice; he just doesn’t get angry. It’s nothing unusual for him to go two and three days without speaking to me; and of course, that doesn’t exactly help me. Just gets me deeper and

deeper into depression. After talking to him last week he seemed to be a little bit more attentive and so I think it was good for him to come in. Like I said, I thought there was something in his past. We've been married for six years and he comes from Texas so I don't know anything about his past, other than what his mother has told me. He was always very closemouthed about it and so I often wondered why he never got mad. It wasn't normal not to show anger.

T: Now that you have some idea about why he doesn't, what does that mean to you?

P: It makes me feel a lot better because he has learned to control his anger so that he doesn't strike out at me. But at the same time he's chosen to do it by not speaking. I think that bothers me more. I would rather him say, Look D., get off my back and leave me alone, if something is bothering him. Then maybe a half hour or hour or so later, start talking just like nothing had happened. But he doesn't say anything. He just clams right up. A lot of times I would never know what I even said.

She describes her concerns about his "clamming up" and relates an incident during which he had become angry at her but did not tell her until she pushed it out of him. She worried about going to Alaska because most of the people there were his friends. She mentioned that in the past week her son had moved out, leaving them alone. Perhaps this freedom to be alone in the house had helped their relationship, she thought. In fact, perhaps that was the reason they got along better in Alaska. She believed that he was a little more mellow around the house and that perhaps talking to me had helped even though I had said some of the same things she had said to him.

P: I think husbands have a tendency to turn a deaf ear to the wives just like kids to their mothers.

She then told many details of instances in which he had invited other people to stay with them without first discussing it with her. These incidents contributed to her feeling that she had little control over her life.

P: I said to him, we're not going to be a motel for your company. I mean, last night, the secretary from the Alaska office was down. We had dinner with her last night. She called us from her motel to thank us for taking her to dinner and then she wanted to talk to H. for a couple of minutes. He gets on the phone and they're coming back. She and her husband are coming back through Anchorage Friday to go down to Florida for Christmas and so H. says, "Well, gee, why don't you come and stay with us?" And I just sort of looked up from my newspaper and he said, "Oh, just a minute, is that all right?" And, so, see with her I don't mind, but. . .

T: You still want him to ask.

P: Just ask me.

T: And he should ask before he says anything to anybody.

P: He caught himself.

T: He caught himself.

[Was this an indication of a positive change?!

P: He just says, Oh, is that all right.

T: Okay. So, he is responsive to you. He does listen to what you want from him.

I may be excessively optimistic. I then find myself becoming bored as she describes her Christmas plans. I summarize the apparent interpersonal

change between her and her husband and then predict that based on her previous recovery from depression at a BDI around 25 that she is likely to be much improved next week. I also suggest that next week is likely to be our last session. I then bring up the subject of medications.

P: Oh, yeah, yeah.

T: And we'll see how you are again next week. Now, you're taking three of those pills at night.

P: Ever since Wednesday, I was here last Wednesday.

T: What do they feel like to you?

P: I don't feel like I'm even taking anything. And even when I took them two years ago, I thought strange how I feel so good now, but I never even felt like I had taken anything.

T: Yeah.

P: I get no, no . . .

T: Side effects.

P: Side effects. There's no; I don't feel like; they don't relax me and put me to sleep.

T: They don't do anything.

P: They don't do anything.

T: It's like you hardly know you're taking them.

P: I might as well be taking, what do you call them, those placebos.

T: Placebos.

I laugh silently to myself since I was attempting to elicit a placebo response. I then invite her husband in. He thinks she is improving, that she is more responsive, more willing to be involved, more able to joke a little. She seemed to him to be coming out of a fog and seeing the whole picture more clearly. I encourage her to tell him how she thinks he has changed.

P: You have been more attentive. I think we both seem to be more relaxed and I don't know whether part of it is our session here last week or having the house to ourselves for a change. [Her son had just moved out.]

H: Well, I don't think that I've changed any, I think she's just seeing that the things that I was doing I'm still doing, and she's just more aware of it.

P: That could be, that could be.

T: That could be, but I think you [Mrs. G.] have some points there too. Argue with him a little bit, because you think he's changed a little bit too. I think you're both right.

P: Oh.

T: What's he doing that's maybe a little bit more attentive?

P: Gosh, I don't know.

H: I don't think I've done anything different. I'm still the same, and I still react the same. I think that she notices. I think she was brought aware of the things that...

T: You're doing.

H: Doing, and she wasn't aware of them before.

T: Aware of them before. So that's where you think I was of some assistance?

H: Yeah. And I think I was doing it, but she wasn't observing it.

P: It's just that I can't think of anything different.

T: Yes you can. What about "Is that okay?"

P: Oh, we were discussing about inviting people to come and stay with us.

H: Oh.

P: And I said that we had had discussions about this last summer. And I said, remember I told you.

H: Yeah, I remember.

P: And I said that, remember that I told you if I moved to Alaska I didn't want us to be a hotel/motel for your company. Then last night when Kathy called and you said to her, "Why don't you come and stay with us?" Then you turned real quick and said, "Is that okay?"

H: Oh, I . . .

P: Yeah, but I'm just. . .

T: You never thought about that?

H: I probably wouldn't have before, no.

T: You wouldn't have before?

H: No, I probably would have said come on up.

T: Come on up. And not asked her?

H: Right.

P: But there are very few people that we know well enough to invite that I would say "no" to. But there are a few that I just don't feel like spending my days and my nights for weeks on end with them. I don't have anything in common with them. It drives me crazy.

T: Well, you've made that clear. I think H. has gotten that message.

[Again, as suggested by her follow-up letter, I may have been too optimistic.]

I encourage them to discuss their arguments. She admits that when she gets angry at him she sometimes becomes silent too. She again threatens to leave Alaska if they have more long silences. He offers no guarantees. She wants to simply discuss things with him, not just argue. But she cannot get him to engage in simple discussions. I then confront her with her inability to bring sensitive subjects up to him. She seems frightened of him.

H: I know she's more free with somebody else. I've observed that for seven years. But, you know, it doesn't bother me to the point of letting it bother me. That's fine. I figure if she can talk to somebody else. I don't, it doesn't bother me to the point that I'm gonna dwell on it.

She cannot get him to talk with her. She complains that he always has his eyes on the TV set and only half listens while watching. He counters that if a question comes up he can respond to it. He does give her fuller attention during commercials. Then he complains that she won't pay attention to him

while she's knitting. She says she will after she has finished a row. I state that I think of these as lesser problems and bring the session to a close.

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BDI = 13, within the normal range. She reports feeling much better and begins to talk about her mother-in-law who was now staying with her for Christmas. She feels guilty because her mother-in-law does housework she feels she herself should be doing. D. also believes she should get up early in the morning when the mother-in-law gets up to keep her company. I note that the mother-in-law wants to do housework and likes getting up early by herself.

P: Well, she lives alone and she seems to be quite happy.

T: Maybe she likes to help. Maybe she feels guilty for living in your house without paying you back.

[I offer an alternative view.]

P: I think she probably does feel guilty, because when I took her downstairs she said, "Well, we'll get down here next week and we'll get this basement fixed."

T: So, maybe you're doing her a favor by letting her clean the house so she doesn't have to feel so guilty.

P: You're probably right. I didn't look at it; I was thinking about me, how I feel. I wasn't really thinking about how she feels.

I suggest that this is the kind of thinking that may lead her to being depressed. She goes on to describe how fat she feels and that although her chemotherapy may be contributing, she is very bothered by it. She is now very active, always on the go and hopes that she may burn up some calories in this way. She wanted to continue taking the antidepressant but at two pills per day rather than three and only for a few more days. I asked her once again what she believed had helped her reduce her depression.

P: Well, I think it might be the medication, but at the same time, I can't tell any difference when I take it. I mean, it's not like taking a Valium or something that relaxes you so you feel better. But I don't feel anything when I take these pills. But I figure it must be the pills that's doing it. Because although I think coming in here and talking does help. Just like this last conversation about my mother-in-law feeling guilty. You brought up the fact that maybe she feels guilty because she doesn't do anything and I didn't look at it like that.

T: And the last time it may have helped to see that H. really was trying to inform you about things.

P: Yes, and so you see, he really is very closemouthed about everything. He's Mr. Tough Guy. He doesn't let anything get to him, he says.

T: He doesn't let anything get to him and show it.

P: That's right. And, he's pretty thick-skinned.

T: Actually he looks thick-skinned, but he's a very sensitive and caring person. That was clear to me. Your presentation of him and the guy weren't exactly the same. One of the reasons that I asked him to come in is to check out what you were saying about him to see how true it was. And a little bit of it was true. We didn't ask him about going hunting when you had that sore on your

side. I'm sure that happened. But a lot of the other things. He wasn't quite as malicious as he appeared. Now sometimes when people are depressed, they think negatively of people. But you were beginning to think negatively of him because he didn't really tell you things, because he was closemouthed and you like to be informed. His lack of telling you things at least helped to make your depression deeper. We don't know where it started exactly, but you're looking a lot better and I suspect the same thing will happen as did last time, that you'll come out of it and be fine.

[Did I try too hard to put H. in a good light?]

I invite H. in once again. After some preliminary discussion in which he states that he believes she has improved, I ask her about her memory problem. She describes being forgetful but perhaps not as frequently. Then she remembers an incident between them in which her memory was once again challenged.

P: There was something that just happened this week that you told me that I totally forgot.

T: That's one of the problems. You may tell her and she doesn't remember.

P: Yes. There were other times that when we were driving somewhere the other night, I said, "I know you didn't tell me that." Then he says, "Well, maybe I didn't, but you know I thought I did." So there are times like that where I think that makes me feel better, makes me feel like I'm not going crazy. But you know, it happens time after time. I thought, "What's the matter with me, I can't remember anything anymore." Then I get upset with myself because can't remember things.

[I am encouraged that he is not so dogmatic and perhaps a little more flexible.]

T: Chances are you'll remember better. When people are depressed, they don't

remember things as well.

H: I try to tell her everything, at least I call home and . . .

T: You've got to be perfect though.

P: [Laughs.]

H: Well, I never hide nothin' from her.

T: Your anger you hide from her don't you?

[I challenge another of his absolute statements.]

H: Well, I do that now; that's probably . . .

P: And I've still never seen him angry.

H: And I don't know if I could change that or not.

[I then begin my closing summary. I try to declare positive feelings between them. |

T: Okay, we know that now. Just to know that there are certain limitations on each other's expectations of each other, that he may not tell you everything, and anger may be part of it. You may tell her a lot of like important information, but she may not think she knows everything. And you two may not have the kind of conversation that each of you want to have. You [H.] could turn the TV set off a little more often and maybe you won't. And maybe this will be another tension that you'll have between you that you'll both try to resolve. But for the most part, I'm glad you came in because I got to see you for you instead of what D. was saying. There's a lot of nice feeling between the two of you and that doesn't happen to a lot of marriages.

[I feel like a minister reaffirming their marriage.]

P: The thing is that when I first came in I was so depressed that I couldn't see the

bright side of anything, and I always saw the bad side of everything.

T: Especially him.

P: Yeah.

H: I'm sorry.

[An unnecessary apology.]

T: It's not your fault. It wasn't your fault. [Why did I say this?]

P: Yeah, yeah. Remember you said to me once, you're getting so negative lately. Everything is so negative with you. Well, that's probably when I was starting into depression, and I could not see anything positive in anything.

T: That's right. D.'s had two of these depressions now. They come around for what seems to be good reasons, but still you've had them and you've had them at the same time of year.

P: Right.

T: After you come back after the big summer trip and come home again.

P: Both of them have been in November.

T: You start going down further in November. I saw her almost exactly two years ago. So you have to start watching out for those Alaska winters.

P: Right, that's another thing. I thought if I'm depressed like that here in my home with all my support and friends around, am I going to be twice as depressed up there?

T: You were quite depressed down here. The first time you weren't as depressed as this time. It took you longer to get over it.

P: Well, I know, I could tell it.

[I try to encourage prevention or quicker seeking of help.]

T: But you know that there are a number of psychiatrists up there in case you need to see one. And you can get on it a little faster maybe. When she starts getting overly negative and more withdrawn and more critical of you. You can take it as some part of it is real. There are some things you should question about yourself. Also, she is starting to get depressed again. We've tried medication and we've tried talking. And we don't know which one works, maybe they both do.

P: A combination.

T: Maybe a combination works, I don't know. But you're better now. I'll be sending you a letter. . . .

[They give me an address correction and we part on a nice note anticipating letter communication within six months.

Follow-up Letter—June 4, 1985

Dear Dr. Beitman:

In reply to your letter, I am doing okay, can't say great, but I am slowly adjusting to life in Alaska. Our late and long winter didn't help either, as we were still having snow into May. My children, ages 22 and 25, came up for a visit around Mother's Day, which I really enjoyed, but I did find that after they left I did get depressed. I especially missed my daughter, as we are almost like sisters. I found it was nice to have someone I could confide in. Up here, so far, I don't know anyone that well yet. I had two real bad bouts with the flu, each one lasting about a week. One of these weeks my husband was in Denver, and again I found myself getting really depressed with the long days by myself.

I was taking Desyrel, not Trazodone [Trazodone is the generic name], and

still am taking it. I find that it helps me to get to sleep, although I have reduced the dosage from three tablets to two, as I was having difficulty waking up in the morning.

My husband is still trying to get me to go out in the daytime, but I do find that there are some things I would rather do with him, like picking out some plants for our yard. I just would rather go with him than by myself.

Just today I returned from the doctor's where I am still having pain with the cancer. I am scheduled for another bone scan next week. This will be the fourth scan since arriving here in February. If the results show that the disease is progressing, then I will have to start taking chemotherapy.

As far as activities are concerned, I have signed up to volunteer at Hospital here every Thursday. Part of my problem is that I don't like to do anything where I have to get up early to do it. I don't know whether I am getting lazy or what, but I don't plan anything at all until around 11:00 a.m., and I usually feel guilty, but sleeping in is something I've always enjoyed doing.

Another thing that is depressing me right now is financial. The idea of moving to Alaska was to better ourselves financially. We purchased an airplane one year ago and now that we are up here and my husband is involved with all these young men that are pilots and have their own planes, he is now looking around for a bigger plane, which could run around $40,000, and he wants to put floats on it, which would be at least another $10,000. Seeing as I am the one that writes all the checks I have a hard time convincing my husband that we are going way out of our league. I feel that decisions like this should be discussed together, but the only way I hear about these things is when I overhear him talking to "the guys."

I might say that as of this writing I am giving serious thought to packing up my dog and returning to Seattle, but doubt that I could survive alone with the state of my health and not being employable. Again I feel trapped.

I hope this will give you something to work with in writing the chapter in your book.

Sincerely,
D. G.

DISCUSSION

Although Mrs. D. G. left therapy in remission from her depression, the apparently good mood did not maintain itself after her move to Alaska. Unfortunately, she did not complete another Beck Depression Inventory, but the tone of her letter suggests an increase in unhappiness. What are some of the factors that may have operated to increase her unhappiness and possibly her depression?

She did not state that her metastatic cancer had gotten out of control. She points specifically to her husband's continued failure to consult her on important issues. Rather than sitting happily while her husband discussed things with the "boys," she overheard plans that bothered her. Was he going to squander the money they had come there to save on an airplane so he could feel part of the crowd? Was he going to withhold the information from her as he had apparently withheld the decision about moving, as he may have about the first recurrence of her cancer, as he did about inviting people to stay with them? Was his real reason to come to Alaska not to save money for their retirement? If not, what else did he have in mind? Since she had great difficulty engaging him in discussions about anything, her only resource was to threaten leaving him or perhaps to get depressed. I wondered if the

antidepressant may have been preventing her from becoming seriously depressed again although she was taking a relatively low dose.

The expectation of long-term improvement in personal adjustment following the completion of psychotherapy remains a tacit and generally untested assumption (Steffen & Karoly, 1980). Except for the obvious evidence to the contrary from many returning patients, psychotherapists appear to believe that once a positive change has been initiated, it will endure. Evidence from psychotherapy research on change maintenance is fragmentary. Researchers have enough difficulty trying to agree on adequate measures of change from the beginning to the end of therapy. Except for the study of addictive behaviors, measurable, adequate definition of relapse appears elusive and compounds the already difficult problem of adequate post-treatment criteria. For example, a patient's return for therapy may be used as a marker for relapse, but it also may indicate a readiness for further changes. Other follow-up problems include (1) sample attrition, (2) use of different measure and/or criteria and/or raters at follow-up from those used at treatment termination, and (3) the confounding effects of the events and experiences following termination (Klein & Rabkin, 1984).

The limited evidence from behavioral therapy suggests a consistent trend toward reduction of treatment aftereffect as the length of follow-up increases (Mash & Terdal, 1980). Smith et al. (1980) and Andrews and Harvey

(1981) also conclude that the effects of psychotherapy are not permanent and appear to decrease at a regular rate.

Although these conclusions are based on very limited sample sizes, they are indeed sobering. What are the critical variables influencing the durability of change and what can therapists do to increase the likelihood of change maintenance? To answer these questions, psychotherapists must conceptualize their clients devoid of therapeutic input by picturing them in their environments subject to outside influences buffered only by what they have learned about themselves through previous experience and through therapy.

The major maintenance variables include many of the forces that create problems in the first place. Biological variables may override any psychological ones especially in syndromes like Alzheimer's disease and manic-depressive illness. Time and development bring the necessity to keep changing since the only constant is change. Simply because a person has mastered one set of developmental difficulties does not necessarily imply that the next hurdle will also be passed. How effective is the imparted psychotherapeutic learning? Is it problem specific or is it a learning how to learn? How unstable and disruptive is the person's lifestyle? Are there psychotherapeutic relatives and friends who will assist in the growing and adaptational processes? These variables appear to be crucial determinants in

the process of not only maintaining psychotherapeutic change but also building on it (Beitman, 1986 in press).

In the case of Mrs. D. G., her husband appeared to make changes in what seemed to be a desirable direction but, according to her letter, had simply resumed his standard behaviors. Perhaps further couple's therapy may have made some inroads into their patterns and prevented her current unhappiness. Perhaps the medication was preventing a deeper sense of despair. Perhaps the placebo response had worn thin.

This case illustrates the value of follow-up data and the need for psychotherapists to be vigilant about the sustained effects of their efforts.

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Notes

1 Only in reviewing these typed scripts did I recognize that this theme recurred in our later sessions in December 1984. One of her major beliefs at that time was that her husband withheld

important information from her concerning decisions important to both of them.

2 I thought this would be an important theme to develop.

3 I had yet to learn the Beck Depression Inventory Scale. In fact, it indicates moderate depression.

4 Airplanes are an important subject in her follow-up letter.

Commentary: Producing a Temporary Change in the System

Marvin R. Goldfried

Upon receiving the clinical material sent to me for my comments, I had fully anticipated reading about a course of psychotherapy that reflected each of the four therapy stages described by Beitman, namely, engagement, pattern search, change, and termination. I was fortunate enough to read an early draft of Beitman s (1986, in press) book The Structure of Individual Psychotherapy *and had hoped to see how this conceptualization was put into clinical practice. Although initially disappointed in not having these expectations fulfilled, I nonetheless found the submitted case to be of interest on other grounds, not the least of which is that the four stages of therapy are all combined within just a few sessions.*

A useful way of conceptualizing the psychotherapeutic change process is that it involves the therapist assisting clients/patients in focusing their attention on aspects of their functioning that they heretofore may have been unaware of. As suggested by Raimy (1975), all therapies are alike in that they help individuals to change certain misconceptions they may have about themselves and others. A good deal of this work takes place during the pattern search phase of the intervention, in that patients/clients are encouraged to

adopt a different perspective on themselves and their world. In a sense, it entails having them learn a new causal model by which to better comprehend the problematic aspects of their functioning. Although this is an ongoing process during the course of therapy, there are a number of places in the therapy transcript presented by Beitman where this is nicely illustrated.

The individual therapy sessions conducted with Mrs. G. were based primarily on a cognitive therapy model. Consequently, one of the therapeutic objectives was to help the patient/client focus her attention on possible links between her thoughts and feelings. These connections are reflected in such therapist utterances as: "So when you say to yourself, 'Why can't I do this myself,' what kind of feelings do you have?" and "But you hate the idea of going [to Alaska]." Thoughts are also tied to actions (e.g., "That's what you say to him, but there's more going on in your mind"), and thought-emotion-action links are also made (e.g., "[In this session I have been[trying to define and unearth the thoughts that you may not be quite aware of in your mind, but still influence the way you behave and the way you feel ...").

But the search for patterns goes beyond just the linking of thoughts and emotions to other aspects of the client's/patient's functioning. For example, there is a focus on the specifics of situations (e.g., "So you were told in June?"), connections between situations and thoughts (e.g., "Okay, when you see him coming to the kitchen to get his breakfast after you've cleaned up, what

thoughts go on in your mind?"); situations and emotions (e.g., "[Let's] talk about some of the other things that are bothering you"); situations and actions (e.g., "You were given a situation that you couldn't do anything about"); and patterns that entail links between situations, thoughts, and emotions (e.g., "So when you see him come in, you say to yourself: 7 don't like having someone else intruding on my time, my privacy. I don't like this.' So you get mad at him, even though you shouldn't, for intruding on your privacy").

In addition to various other connections made by Beitman in the available transcripts (e.g., links between intentions and thoughts, intentions and actions, emotions and actions), he also focuses on various patterns in the client's/patient's life. These involve either a pattern of situations that is pointed out (e.g., "At least four things happened over the past six months or so") or patterns of thought (e.g., "You know it's a good thing for him [her son] to go, ah, but you're losing your baby, you're on your own again").

The connections that the therapist urges the patient/client to focus on are primarily intrapersonal *in nature. In session 3, however, when Mrs. G. returns after a two-year interval, Beitman points out an interpersonal pattern that seems to be relevant to her feeling of not having control over her life. Specifically, he juxtaposes the situation where her former husband shot the man with whom she had gone out, and her current husband having unilaterally made the decision to move to Alaska. I would certainly concur with the*

importance of helping the client/patient become more clearly aware of this particular pattern in her life, especially as it seems to be a relevant determinant —along with the recurrence of cancer—of her depressive episodes. Additional pattern searches may have been called for, as well, although the severely time-limited nature of the intervention may have precluded this from occurring. Ideally, I would have liked to have explored the possibility that some of these situations—at least those involving her relationships with men—may, in fact, have been the consequence of certain actions or inactions on her part. Is there anything about her behavior that causes her to be mistreated by men ? Does it have anything to do with the type of man that she selects to begin with? Thus, in addition to helping the client/patient learn to cope more effectively with situations that afford her minimal control over events (e.g., how to handle a dangerous ex-spouse, what to do when her husband has decided to relocate), the knowledge of her role in bringing about such situations may help her to take steps to ultimately prevent them from occurring.

It is evident that during the time the intervention was taking place, significant clinical improvement occurred, even though it was not maintained over time. The question is, why did it occur and why did it not last? In addition to the various reasons offered by Beitman for this improvement, it is also possible that the therapist instigated a temporary therapeutic change in the behavior of Mrs. G.'s spouse. By involving Mrs. G.'s husband in the sessions, Beitman provided her with something she lacked—a more caring and

concerned husband. Unfortunately, this involved only a temporary change in the marital system. Had the marital intervention lasted more than just three brief sessions, and had the husband not ended up in his own social system that encouraged large financial expenditures, it is possible that clinical improvement might have been maintained over time.

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Commentary: Making More Use of Our Models

James O. Prochaska

There is increasing consensual and empirical validation for the assumption that stages of change are a critical dimension for understanding psychotherapy (Dryden, 1984; Egan, 1982; McConnaughy, Prochaska, & Velicer, 1983). Bernard Beitman has been one of the leaders in articulating a stage model for systematic eclecticism. In the present chapter he provides an overview of the sophisticated stage model he has been developing. Beitman also presents a challenging case of brief psychotherapy for recurring episodes of depression.

What is striking, however, is that Beitman makes all too little use of his model for understanding or intervening with his depressed patient. He does a nice job of combining cognitive, interpersonal, and biochemical interventions within a very brief therapeutic relationship. But his interventions were not as systematic and perhaps not as effective as they might have been had he made more use of his model.

Recognizing that being a Monday morning quarterback is much easier than being on the firing line, I shall nevertheless take the liberty of applying a systematic model of therapy to the case at hand. Since I obviously know my own model better than Beitman's, I will apply a transtheoretical approach to see

what differences a model might make.

As with Beitman s approach, our model relies heavily on the stages of change dimension (Prochaska & DiClemente, 1984, 1986). Empirically, we have identified four stages of change: precontemplation, contemplation, action, and maintenance (McConnaughy, Prochaska, & Velicer, 1983). In the present case, Mr. G. appears to be a good example of a client in the precontemplation stage. First of all, clients in the precontemplation stage do not usually enter therapy freely. Often they are brought or sent to therapy by a spouse, parent, employer, teacher, or attorney. As with Mr. G., people in the precontemplation stage tend to deny any need to change their own behaviors. They may seek help to change others but not themselves. Mr. G. said, for example, "The kids and I talked about it. We said, we're gonna treat her just like we always have. We're not changing." Or in talking about his communication with his wife, Mr. G. said, "I know she's more free with somebody else. I've observed that for seven years. But, you know, it doesn't bother me to the point of letting it bother me. That's fine. I figure if she can talk to somebody else. I don't, it doesn't bother me to the point that I'm gonna dwell on it." His denial defends him against any need to contemplate making changes in his relationship with his wife.

Mrs. G., on the other hand, appeared to be in the contemplation stage at the beginning of therapy. She was having difficulty taking action on her own, in part because of her depression, and in part because it was not clear just what

needed to be changed. As Beitman points out, "The objective of the pattern search [what we call contemplation] is the elucidation and specification of psychological patterns that, if changed, would bring desired relief and promote enduring change. The content of the pattern search is most variable because the major differences among the schools of therapy lie with their theories of psychopathology and theories of personality development."

What is the content that Mrs. G. should change? Her cognitions, environmental contingencies, interpersonal conflicts, extended family system, personality, and biochemistry could all be candidates for change. In the transtheoretical model, we use the dimension of levels of change to organize the content of psychotherapy. Psychological content is organized across five levels that are ordered from most conscious and contemporary to least conscious and most historical. These five levels are symptom/situational, maladaptive cognitions, interpersonal conflicts, family I system conflicts, and intrapersonal conflicts.

Again, what is the content that we should help Mrs. G. to change? In the transtheoretical approach we have three basic strategies for intervening across diverse levels of change. The first is the shifting-levels strategy, which begins at the highest level that clinical assessments can justify. If we can begin at the symptom and situational level, we expect changes to occur most quickly at this more conscious and contemporary level of problems. Determinants of problems

at deeper levels are further removed from consciousness, go further back in time, and are likely to be more resistant to change.

If we are relying on very brief therapy, as was Beitman, then we may do well to use a shifting-levels strategy. Therapy would begin at the symptom and situational level with the hope that clients can efficiently and effectively progress through the stages of change. If therapy is not effective enough at this level, then we would shift to the level of maladaptive cognitions and progress or shift accordingly. Beitman did not specify his strategy, but he appeared to use a less systematic form of this approach, as he shifted from cognitive therapy for depressing cognitions, chemotherapy or placebo therapy for depressive symptoms, and conjoint sessions to address interpersonal conflicts. From a transtheoretical perspective, shifting across three levels in one or two sessions can be expecting too much from clients and therapists. Interventions at each level are likely to be too diluted and clients can become confused about what therapy is intended to accomplish.

From a transtheoretical approach, we would prefer to apply a key-level strategy. If the available evidence, both clinical and empirical, points to a key level of causality for a particular problem and if the client can be effectively engaged at that level, the therapist would work primarily at this key level. Retrospectively, at least, the key level for Mrs. B. appears to be the level of interpersonal conflicts. She seems to feel helpless to change her interpersonal

patterns with her husband. Of course, as long as he is in the precontemplation stage, she is helpless. Mr. G. is likely to resist even contemplating changes let alone taking action to change his patterns of relating to his wife.

Even when improvement occurred between therapy sessions, Mr. G. denied having made any changes: "I don't think I've done anything different. I'm still the same, and I still react the same. I think that she notices, I think she was brought aware of the things that. . . [I'm doing]." His wife needs to change, not him. A wife who is already having too many changes imposed on her—cancer, Alaska, corporate visitors, and expensive airplanes—has to make all the changes. As we have indicated elsewhere <Prochaska & DiClemente, 1984), one of the common precipitants of depression is imposed change.

If a therapist is trying to facilitate lasting interpersonal changes with spouses who are in two different stages, the therapist cannot expect to rely on very brief therapy. We have presented cases of substantial and lasting changes in couples with very brief therapy, but only when both partners were ready for action and both could work together at the same level of change (Prochaska & DiClemente, 1984). It is impressive that Beitman was able to facilitate significant reductions in depression in just a couple of sessions; it is not surprising that the changes were not maintained. In a review of the therapy literature on depression like Mrs. G.'s, Coyne, Kahn, and Gotlib (in press) found that the cases that did not relapse were those in which substantial and lasting

changes were made in marital relationships.

Making more use of our model in the case of Mr. and Mrs. G., we would focus most of therapy on trying to facilitate changes at the key level of interpersonal relationships. We would slow down therapy somewhat in order to give Mr. G. a chance to catch up with Mrs. G. on the stages of change. We would have to help him become aware of his resistance to change before we could expect him to participate in interpersonal therapy. Without such help, Mr. G. would at best function as the therapist's assistant, as he attempts to find further ways of changing his wife. With therapy of longer duration, Mr. and Mrs. G. could be helped to take interpersonal actions that could maintain substantial improvements in the mood that depresses their marriage.

These comments are not intended to be critical of Beitman s work. They are intended to highlight the fact that in the area of systematic eclecticism, theory is rapidly outpacing practice. In my own clinical work it is taking years for my eclectic practice to become as systematic as my eclectic model. Why are changes in practice much more difficult to make than changes in theory? One possibility may be that changes in theory can be limited to changes at the contemplation stage. Relying on processes like consciousness raising and self-reevaluation can lead to changes in how we think and feel about therapy. Changing how we practice therapy, however, requires taking action and maintaining such action lest we slip back into old habit patterns. Taking such

concerted action is difficult work that requires considerable time and energy.

Judging from my own experience, however, such effort can pay off. As my practice has become more consistent with a systematic eclectic model of change, my effectiveness as a therapist has taken a quantum leap. I have been successfully terminating most cases within 10 to 20 sessions. Even my long-term cases that seemed more resistant to change have been able to finish effectively. I have gone back to work with some cases with whom I had previously failed and have had much more of an impact as a therapist. In the meantime, referrals have markedly increased. One of the challenging, yet gratifying, types of referrals involves more difficult cases from other therapists. After 15 years of a relatively successful practice, it is exciting to be experiencing considerably greater effectiveness as a therapist.

It is impossible, of course, to determine just what increased effectiveness may be due to. It could be increased enthusiasm; it could be that my clients are working harder; or it could be a temporary streak of good luck. It will take controlled outcome studies to rule out biased judgments on the part of the therapist and to rule in what really makes a difference. My clinical judgment is that relying much more on a systematic model of eclectic therapy can make a profound difference in enhancing effectiveness as a therapist. So just as I am encouraging Beitman to make more use of his excellent model, so, too, would I encourage other therapists to make more use of the excellent models that are

being developed for a more systematic approach to eclectic therapy.

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