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Commentary on A Life-Saving Therapy: The Theory-Building Case of "Cora"

The Life-Saving Case of "Cora": A Rogerian Perspective

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ABSTRACT

Halvorsen, Benum, Haavind, and McLeod's (2016) *A Life-Saving Therapy: The Theory-Building Case of "Cora"* is rich in ideas and findings. My reflections fall into four categories. First, I comment on the finding that therapist and client reports of change in the case of Cora differ from results on objective measures. I argue that an extensive qualitative examination could better resolve this issue. Second, I raise questions concerning the idea that clients' problems necessarily stem from early childhood abuse. Third, I argue that the authors' finding of the importance of persistence in therapy may better explain how therapy works than a primary focus on significant events or significant moments. Finally, I agree with the authors' finding of client courage, but give an alternative interpretation of that.

Key words: adjudicational method; early childhood causality; persistence; courage; case study; clinical case study

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Overall I am impressed by both the case and the case study of Cora. I have no specific criticisms to offer of it. Therefore, since I have been asked to comment, I have decided to respond in terms of my own thoughts in regard to several issues and findings. I will comment on: (a) the issue of the apparent disagreement between the "objective" measures and the subjective accounts of therapist and client as to whether therapy helped; (b) the issue of early childhood causes of the client's problems; (c) the issue of how therapy works with a focus on the idea of persistence, and (d) the issue of client courage.

A RESEARCH CONSIDERATION: DID CORA CHANGE?

Halvorsen et al. (2016) raise the question of whether therapy was helpful or not for Cora. Did she change? Based on the self-reports of both her and the therapist she did. Both said that it saved her life. Yet on two "objective" measures, the OQ-45 and the IIP, she did not change. Furthermore, after three years of therapy, she is still in therapy. What should we trust—objective measures or the therapist's and client's self-reports?

For a segment of psychological researchers (e.g., see Seligman's [1995, 1996] comments on the *Consumer Reports* study of therapy effectiveness), the qualitative self-report of the client is not to be trusted. There are various reasons why one might not trust Cora's qualitative self-report of positive change in her life. First, this may be a "halo effect": she may be reporting something about symptom improvement just because she had a good experience in therapy. Second, it may be cognitive dissonance: since Cora has invested three years in the therapy, in order to reduce dissonance she needs to believe it has been helpful. Third, Cora might wish to be a "good client" and not to disappoint either her therapist or the researchers. Fourth, therapy clients in particular, and humans in general, are poor at self-knowledge; they do not know themselves well and so Cora's perception of change may be a faulty self-attribution. That is: Cora has had a number of significant emotional experiences with the therapist, and she may be making an assumption that they must have helped her and so she concludes she must have changed. Fifth, there may be a memory bias involved: perhaps Cora does not remember accurately how things were before she started therapy and is mistakenly concluding that things are better now.

It is even more problematic for Cora to conclude that, if she did change, it is due to the therapy. We do not know details of what went on in her outside life over the years she was in therapy. However, perhaps there were life changes that contributed to her getting better. Her conclusion that it was therapy might be an "availability bias": what she is most aware of are the events in therapy and so she concludes they must have been the contributing factor. Or perhaps it is simple maturation: whatever changes have happened simply represent naturally occurring change processes, and, again, she mistakenly attributes that to therapy.

Many of these problems would also hold for the therapist's conclusion that the client had changed. Hence, his concurrence that she has changed is not to be trusted either.

On the other hand, an argument can be made against over-reliance on the objective measures. First, as Halvorsen et al. (2016) argue, the objective rating scales may not be sensitive to the kinds of changes Cora has undergone. Perhaps, for instance, there has been no reduction in symptoms on the OQ-45. Yet perhaps she has gains not measured on that instrument. For instance, Halvorsen et al. suggest there has been a reduction in self-harm, an increase in affect tolerance, and an increase in social activity.

The authors also note:

> Specifically, while Cora and her therapist did not explicitly negotiate the goals in the early sessions, they talked about the importance of getting in touch with Cora's feelings, looking at her defenses as survival strategies, increasing her self-compassion, and establishing points of connection to people around her. Looked at from this perspective, the goal was not primarily about reducing Cora's distress but rather about increased awareness of it, leading eventually—after the three years, e.g., in the inpatient trauma program and in subsequent individual therapy—to a working through of her distressing feelings. (p. 180).

There is a similar discrepancy with regard to findings on the Working Alliance Inventory (WAI) measure. It is clear from the client's comments that she largely attributes the usefulness of therapy to her alliance with the therapist. She does not dwell on his transference interpretations

or whatever other technical interventions he engaged in. For Cora it was his willingness to engage with her and to stay with her that was primarily helpful.

Yet on the WAI alliance measure she rated her therapist lower than is the average for her client sample. Given that Cora both rated him lower, and appeared to show no change on the quantitative measures, we might conclude that these findings are in accord with the findings of other psychotherapy research, namely that the alliance generally correlates with therapeutic change (Horvath, 2013). Here we have a case where a comparatively low alliance is associated with (apparently) no change.

Yet once again we have the problem: the client says she did change and she attributes it primarily to the alliance. Yet the objective measures are not in accord with that.

These findings, I think, bring up the problems with a purely quantitative approach to research on psychotherapy and provide a basis to the argument for adding qualitative information in measuring outcome. As noted by the Halvorsen et al. (2016), Elliott et al. (2009) have also noticed that quantitative and qualitative results do not always coincide. Elliott et al. studied a client with a fear of driving over bridges. Quantitative measures indicated that he had not changed. Yet by his self-report he had, including his reports of numerous successful attempts to drive over bridges. In a presentation in Scotland on this case, Elliott (2008) played a videotape of the client. Listening to the client, I was convinced that the client truly believed he had changed. He gave concrete examples to back that up that were convincing to me. In addition, using Elliott's Hermeneutic Single Case Efficacy Design (HSCED) methodology, in which a whole body of data, both qualitative and quantitative, is presented to "jurors," who evaluate it and make a judgment, three expert jurors from three different theoretical traditions concluded that the client had changed. The experts were all well-known figures in their particular approaches, as well as well-known psychotherapy researchers. They included Louis Castonguay (cognitive-behavioral), Stanley Messer (psychodynamic), and Jeanne Watson (humanistic). Elliott (2008) noted how complex the question of change in psychotherapy can be.

It is worth taking a further look at this issue. We have seen how one can criticize the client's (and therapist's) subjective reports on whether therapy helped or not. Should the "objective" measures be given the nod as to truth in this case? As I have noted, the authors argue that there are changes that may not show up on the objective measures. However, there is another problem. The same problems that exist on the subjective measures exist, to some degree, on the objective measures. After all, they too are self-report. How do we know that when Cora rates herself on one item, say, as a "5" this time, that that is the same "5" as the one at the start of therapy two years before? We do not. Her subjective scale may have changed in the ensuing two years.

This is not a problem when the objective scales are used in group designs, where a group receiving therapy is compared to a control or placebo group. There, if there is error in one client's score, it is assumed to be canceled out by, perhaps, the opposite error in another client's score. The scales, while their reliability and validity, overall, has been established, are also not perfectly reliable. Again, they have been validated using group designs. This means that, on average, they are reliable and valid. It does not guarantee that they are in an individual case.

Thus, in Cora's case, we cannot be sure that scale results are not biased by some of the same factors as in self-reports. In this case we do not know whether, as I have said, the client's subjective scale may have changed and, while she thought she was rating herself as having improved, her actual scores were the same as they had been two years before. Parenthetically, we don't know because we didn't ask her.

I therefore would argue that, particularly in assessing whether a given client has changed, qualitative data may be as or more useful than quantitative. However, by qualitative I do not mean relying solely on client (or therapist) self-report. There are other ways of using qualitative data that can potentially lead to a reliable conclusion. Elliott's above-mentioned Hermeneutic Single Case Efficacy Design (HSCED) is one such example. I wish to also mention our own "Research Jury Method" approach (Bohart, Tallman, Byock, & Mackrill, 2011). I will briefly discuss how we would have approached the question of whether Cora had changed or not in this study.

As with Elliott's HSCED, our logic was to use the metaphor of a jury trial. In a jury trial the jury is given all sorts of data. They are given evidence. As one judge said when I was summoned for jury duty, "Evidence is what you will be presented with; facts are what you decide on." In other words, "evidence" is not fact. Evidence becomes "fact" when a jury makes a decision on it. Fact is determined by human judgment operating on evidence. I have argued (Bohart et al., 2011) that this is the same process which occurs in deciding upon fact in psychology and science in general, no matter whether the data is qualitative or quantitative. In other words, fundamentally, "fact" is a matter of human judgment, operating upon evidence.

With this in mind we argued that, given a sufficiently rich case record, one ought to be able to make decisions about (a) whether a client has changed in therapy or not, and (b) if therapy was a cause, or at least a partial cause, of that change, from the case record, in a manner similar to how a jury decides on fact and on the question of guilt or innocence.

Juries depend upon a convergence of evidence. Frequently no one bit of evidence may be perfect in and of itself. In this respect, science too depends on a convergence of evidence. For instance, Rozin (2001) has pointed out that most of the evidence supporting Darwinian theory is imperfect, imperfect enough that it would not get published in top-notch professional psychological journals. However, the evidence converges to a strong conclusion in favor of the idea of natural selection and evolution.

So: what if "psychological jurors" could look at a sufficiently rich case record, and, in a manner similar to a criminal trial jury, weigh the evidence for and against the propositions that (a) the client has changed, and (b) therapy played a role in that change? Our research explored this proposition. Our method was similar, although not identical, to that of Elliott's HSCED, with the single difference that we decided to try to develop the method in a purely qualitative fashion for demonstration purposes, although in theory, quantitative data, as in HSCED, could be included.

In one article (Bohart, Berry, & Wicks, 2011) we also provided a lengthy list of criteria, derived from some of our initial attempts to do this, which could be used to help make plausible

inferences that the client had changed and that therapy had something to do with it. One set of criteria focused on what clients said. They included more than simply clients saying they changed. They included: Clients giving specific examples, particularly if they were given as spontaneous utterances in the course of therapy. Other evidence based on client self-report included, for instance, clients mentioning areas where they did not change, which would suggest they were making discriminations between areas where they did and did not change, reducing the probability that their report is a function of a halo effect. Other criteria that were included were not primarily a matter of client's saying they had changed. They included reports or other evidence of things getting better, such as getting better grades; successes at work; engaging in new, positive activities; and so on. Still another set of criteria had to do with in-therapy behavior: appearing less anxious or depressed, dressing better, showing more energy, showing better decision-making, clearer thinking, greater ability to handle emotion, and so on. I will not go into the extensive list, but see Bohart, Berry, and Wicks (2011).

In our research we found that we could make plausible and evidence-based inferences as to whether clients had changed or not. In our studies we used several different forms of evidence. In one study (Bohart & Boyd, 1997), we used questionnaires that clients and therapists repeatedly filled out, similar to what the client and therapist did in the case of Cora. In another study we had audiotapes of all the sessions (Bohart & Humphreys, 2000). In a third study we relied upon a lengthy write-up of a case based on audio tapes of sessions, as well as therapist and client journals (Bohart, Tallman, Byock, & Mackrill, 2011).

So could the Research Jury Method be used with the case of Cora? In theory it could. A limitation would be that the case is lengthy: 121 sessions. The authors note that even with only 25 sessions sampled, the amount of data was overwhelming. It is hard to imagine a "jury" of, say, four researchers (because that is what the four researchers in this study were) combing through the transcripts of 121 sessions and painstakingly documenting the evidence for change. Furthermore, because some of the criteria include nonverbal cues, such as tone of voice, the ideal form would be to have researchers looking at videotapes or listening to audiotapes as well as at transcripts.

Still, in theory it could be done, and I would suggest that if it was carried out, systematic evidence for change would have been found. I doubt the client's and therapist's impressions are solely or largely based on a halo effect or cognitive dissonance after 121 sessions. I suspect that an intensive examination of transcripts would find examples of behavioral sequences and spontaneous utterances by the client to support both the authors' conclusions that the client indeed changed and that the therapeutic alliance had something to do with it. As one example of evidence that the client did change, consider what the client says about greater interpersonal connectedness in her last session:

> Yes, that is true, and that was exactly what I told her (Cora's friend). Because she has reminded me about it several times, that I am not as alone as I believed all the time. I do have someone. … And especially regarding my sister, you have helped me to realize that she is there (p. 177).

And what she says in a post-therapy interview:

> I have resumed contact with my sister. ... So bit by bit, we have established a very good contact. And I now realize that I do not need to be alone with it [i.e., the history/traumas] in my head all the time. Even though we have many sad memories, we also have some good ones about her (i.e., their mother) (p.177).

These statements, coming in two separate interviews, suggest, at least to me, that Cora may have experienced a positive change in her openness to social connection. Not only does she note the change on two separate occasions, but in the post-therapy interview she fleshes it out with a bit of detail, such as that, although she and her sister have sad memories about their mother, they have also retrieved some good ones—evidence backing up her statement that they now have a good contact. A skeptic might disagree with me here. But what if we had further examples, and evidence of a positive trajectory over time. Early on in the therapy, perhaps, there is no evidence of talking to friends, and evidence of not talking to the sister. But as the therapy goes, this gradually changes, as evidenced in a variety of utterances in therapy, perhaps accompanied by spontaneous recitals of concrete examples, perhaps even a spontaneous utterance like "I was talking to my sister the other day…." This would provide plausible evidence that what Cora says in the last therapy session and in the post-session represent real change.

The authors seem to be struggling towards this realization in their conclusions at the end. I would suggest that it would be possible to do a more systematic examination of the transcripts in this regard to document evidence for change, if they so chose. If they did this they would be in the situation Elliott et al. (2009) were in: a plausible, evidence-based conclusion that therapy worked from sufficiently rich data in the form of therapy transcripts, in contrast to results on quantitative measures.

So imagine that this is done. Who is right? Whom should we trust? I would argue that we should trust the qualitative data, but more so the conclusion that change is complex. Why would I argue this? Because, as I have mentioned, the quantitative measures are not perfect when used in an individual case. I believe that data intensively gathered from an examination of the transcripts can be treated as at least as reliable as the quantitative measures. And in either case, what is most important is that it is ultimately a matter of human judgment as to whether we go with the qualitative or quantitative data. Ultimately it would be up to a "jury" of experts as to which data appears to be more reliable over time. That is how science operates.

CLINICAL CONSIDERATIONS

The Importance of Early Childhood

The authors appear to come from a psychodynamic perspective. They talk of transference, defense, early childhood, and so on. Since my theoretical and philosophical perspective is person-centered, these are not concepts that I particularly use. Thus, in one sense, I have a theoretical difference with how they interpret what is going on. I will not specifically dwell upon the theoretical differences, although I do wish to make one comment.

The authors start out by giving their guiding conception:

> We define early relational trauma as a negative experience with a caregiver within the first few years of life, that is marked by active and intrusive attack rather than (or as well as) mere neglect. On the basis of extensive clinical literature, we conclude that this type of early experience has been found to result in lifelong difficulties in intimacy and forming attachments, lack of trust, and fearfulness or terror around the possibility of closeness with another person (p. 160).

I would like to take the opportunity of this article to make a comment on something that often nags me when I read such formulations. Certainly this client, from what is presented in the article, has had a traumatic history of being abused as a child. But is it in the "first few years of life?" Psychodynamic theoreticians talk as if the primary damage comes from "the first few years of life," meaning, typically, ages 0-3 or at most, 0-5. Yet most of the examples they typically cite of abusive early experiences are of things that have happened to children in later childhood, or in adolescence. We do not have any specific examples here so I do not know at what age this client suffered "severe emotional, physical, and sexual abuse by her mother and her mother's friends" (p. 159), but I would venture a guess that the incidents that the client reports are from later in childhood than the first 2-3 years of life, particularly as she appears to remember them.

The way psychodynamic theorists get around the problem this poses is to assume that if the parents evidenced abusive practices later on in life they must have engaged in them earlier, and that must have been when the real damage was done. I simply want to note that rarely is there any evidence of this in case histories. As Wachtel (2010) has noted, if you have an abusive mother at age 1, you probably have an abusive mother at age 5 and at age 11. It is just as plausible to argue that it is living in an abusive environment for year after year that causes the damage as it is that somehow it is just the first few years of life. I make a point of this because, as a Rogerian, I am inclined to believe in people's resilience and have a hard time believing that the human being, who has the longest childhood of any species, presumably meaning that it has the longest learning history, is "all done" by age 3, if there is early malparenting, which is what psychodynamic theories imply. I suspect that it is more likely having a repeated history of being abused over time. Furthermore, that fits with the authors' contention that it is persistence that causes change. I suspect it is the persistence of a negative "envelope of events" that causes problems as well.

Having said this, I would not disagree with the authors who say:

> Cora could be regarded as a person struggling to address underlying life deficits, rather than as someone who had benefitted from a secure start in life and then at a later stage of development encountered destabilizing conflicts (p. 160).

Without further data I cannot say for sure, I would only wonder if the time period involved in her not getting a secure start was really only the first three years of life, but rather, and perhaps more importantly, later childhood and even adolescence.

Be that as it may, we do not have evidence from what was presented in this particular case history of when the damage was done, but we do know that as a child Cora was abused, and there appear to be clear residuals of this in her behavior.

Persistence

I wish to comment on two themes the authors found in their qualitative analysis. First, they found a superordinate theme of persistence. They conclude that a consistent, recurrent interaction pattern is in part responsible for change. They argue that it is the persistent, recurrent, rhythmic interaction which helps the client learn to emotionally self-regulate. They talk of this in terms of procedural learning.

Why I think persistence is important is that typically we think of the effective elements in therapy in terms of specific "significant moments" or particular "significant events"—such as insights or emotional breakthroughs, as if it is these momentous moments that create change. I have previously argued that this may not always be what's happening. I have suggested that clients are active agents, who try to make sense out of their therapy environments. They are learning not merely through what therapists think they are providing—specific interventions that make specific changes—but through what clients are deducing or extracting from the overall, ongoing therapy interaction. In one study, Gayle Byock and I (Bohart & Byock, 2005) tried to imagine ourselves into the role of several of Carl Rogers' clients, and to track, response by response, what we thought they might have been experiencing. This was done to explore my hypothesis (e.g., Bohart & Tallman, 1999) that clients are active self-healers and in one sense the "real" therapists in therapy. Based on our "vicarious ethnographic investigation," we concluded that clients may have been changing because of their ability to detect an ongoing pattern of how they were being treated by the therapist, rather than as the result of specific empathic responses, or significant moments.

We noted:

> For two of the clients…it appeared that the most important learning had to do with their extracting meaning from the flux of the relationship. For Jim it was extracting the invariant meaning that he is cared about, which was conveyed through numerous acts of Rogers….This 'constancy of caring' was conveyed even if some of Rogers' responses might themselves have seemed invalidating.…Even for Gloria it may have been the "constancy of caring," even when Rogers missed with many of his empathy responses, which was the most important part of the interaction. Evidence for this can be found from the fact that Gloria suddenly changed topics and talked about how she could never talk to her father as she was talking to Rogers. She was clearly responding to the "invariant" of how Rogers had been with her the whole interview" (Bohart & Byock, 2005, p. 201).

Greenberg (2014), an emotion-focused (EFT) therapist, has commented:

> In EFT, the relationship is seen as being curative in and of itself in that therapists' empathy and acceptance promotes breaking of isolation, validation, strengthening of the self, and self-acceptance. The relation with the therapist also provides a powerful buffer to the client's distress by the co-regulation of affect. A relationship with an attuned, responsive, mirroring therapist is essential in developing interpersonal soothing and emotion regulation. This type of relationship helps clients regulate their overwhelming disorganizing emotions by breaking the sense of isolation and the unbearable aloneness of emotional pain. Over time, the interpersonal regulation of affect becomes internalized into self-soothing and the capacity to regulate inner states (Stern, 1985). When an empathic connection is made with the therapist,

> affect-processing centers in the brain are affected and new possibilities open up for the client . …
>
> > Clients' right hemispheres respond to therapists' micro affective communication as well as to their explicit words, and all these influence clients' processes of dynamic self-organization (p. 351).

The finding in the current study that persistence contributed to change would therefore make sense, in terms of the therapist's offering a consistent envelope of empathic relatedness, which it appears is what this therapist offered. Perhaps it is the persistent, consistent "envelope of events"—the persistent experience of working collaboratively with a caring, empathic therapist—that does the job. Perhaps it is less interventions, transference interpretations, "two chair" techniques, and so on, and more the fact of two people working together over time that leads to the kinds of procedural learning changes the authors talk about, or the internalization Greenberg talks about.

Coincidentally, as I was working on this comment I was teaching an advanced couple-therapy class. In the class we were watching a ten session video on emotionally-focused therapy with Rebecca Jorgenson as the therapist (Jorgenson, undated). Through the first four sessions the couple did not seem to be making noticeable progress. Then, by the time of the fifth session, there had been a noticeable shift. It appeared that the shift happened between the fourth and fifth session.

So what were the "mechanisms of change" in this video? Of course this is not a scientific study: these are my impressions. However, I would not say that the important process of change seemed to have much to do with significant moments. There were several such significant moments in sessions one and three, when the couple appeared to get significant insights. Yet when the couple returned in sessions two and four they appeared to be in the same place, if not in a worse place.

The concept of persistence, as defined in the case of Cora this research study fits with what I observed in the Jorgensen video. The "significant event" was actually the persistent envelope of events provided by the therapist. Repeatedly, over four sessions, what the therapist did was interpret the pattern between the couple to them. She continually reframed their experience in terms of the vulnerable emotions each was experiencing "beneath" their defensive fronts, and she repeatedly sent the message that each made sense in front of the other, and that the pattern was their enemy.

I speculate that what happened between the fourth and fifth session, when a significant change had taken place at home, was that the couple's procedural knowledge had changed, as Halvorson et al. speculate. After "living through" four therapy sessions with a therapist who consistently and persistently demonstrated that each made sense to the other, this carried over at home. The next time an argument came up, each was more motivated to find sense in the other person's behavior, without necessarily consciously deciding to do this. This led the husband to be willing to approach the wife to talk about a sensitive topic (this hadn't happened before), and led the wife to decide, spontaneously, to modify her pattern of criticism of him. Yet it did not

seem the result of any specific event in therapy. Indeed, at the fifth session the wife noted, despite the therapist repeatedly pointing out to them the pattern they were caught in, that she could not remember exactly what was the pattern they are supposedly caught in. And the husband notes that he has no idea why they have changed.

Courage

A second superordinate theme Halvorsen et al. (2016) found was that of courage. I am pleased to see that their case of Cora found evidence of client courage. However, I have a somewhat different take on client courage than the one presented in their case study. Elsewhere, I have argued that clients are more courageous than we give them credit for (Bohart, 2013).

As I have noted, my work has suggested that it is ultimately clients who make therapy work. They are the real therapists (Bohart & Tallman, 1999). Furthermore, clients have impressive potential for resilience and self-righting. To paraphrase Rosenbaum (1996), despite their many problems, most clients manage to keep their lives together, albeit painfully and somewhat inefficiently.

Cora is no exception. I see her as courageous before she comes into therapy. Despite how she feels, she has continued to live life—to struggle. Given the intense feelings and experiences she has endured, this is courageous. In a long-ago article that I cannot find right now, Carl Rogers used a metaphor of clients as plants in a basement struggling to grow towards the light. You can almost see Carl Rogers' plants struggling towards the light in Cora's behavior. You can see this in Cora even before she comes to therapy. In fact, given her high levels of shame and self-loathing, the very fact that she has come to therapy, instead of having already committed suicide, shows courage and a great deal of capacity for tolerating and facing up to pain. For that reason I have a a disagreement with some of the things that both the therapist said, and what the authors say in the article. It is a subtle and somewhat elusive difference, but I will see if I can pin it down.

It seems as if the therapist is seeing Cora in a typical psychodynamic way. Although the therapist encourages her to see her defenses as survival strategies, it seems to me that he has that typical psychodynamic way of looking at them as designed to avoid certain kinds of "forbidden" painful feelings and experiences. The emphasis in therapy accordingly becomes having her "take risks" and "face up" to them (although this term is not used), all the while she is being supported and reinforced for using them this way as survival strategies. I agree with the part of seeing them as survival strategies. However, I do not believe they are primarily done to avoid painful experience per se.

It seems to me that, contrary to avoiding feelings, she has already demonstrated a huge capacity to live and survive while feeling waves of terribly disruptive and painful feelings. It is odd for the authors to say something about her "gradually daring to acknowledge and tolerate painful emotions" (p. 170). It seems to me that she has tolerated and acknowledged painful emotions for most of her life, although she may not have managed them or regulated them well.

I have an objection to the idea that therapy is primarily a matter of clients "facing up" to

painful emotions. Many clients are already experiencing highly painful emotions. What therapy helps them do is learn how to listen to them and stay with them in a way that helps them process them. And the fact that they have not done this before is not because they cannot face up to them and must avoid them, but because no one has ever helped them learn how to do that, nor given them the support and space to do that, nor helped them understand that it might be useful to do that. It is not easy to tolerate and process a painful emotion all by oneself, especially when it is complicated by self-condemnation and self-criticism, as in Cora's case.

Furthermore, why dwell on a painful emotion if one has absolutely no idea how to deal with it? It is avoided not because it is painful—clients often face up to painful emotions—but rather because from the client's point of view there is no profit in dwelling on it, facing it, and fully experiencing it. In other words, clients can feel that there is nothing they can do about painful emotions, they don't know how to process them, and so better to "avoid" them and divert one's attention as best one can to things that one can control. In essence: Do what the serenity prayer says—focus one's attention on what one can control, rather than on what one cannot (one's painful emotions). However, this is different from saying that the client is avoiding difficult emotions because they are painful or because a client isn't taking risks.

Similarly, while I would agree that Cora's shame and self-loathing is an attempt to deal with feeling vulnerable, I would interpret that in a somewhat different way too. It is not that she is trying to avoid *feeling* vulnerable. The feeling of vulnerability is a signal of vulnerability. She is trying to cope proactively with the threat of *being* vulnerable. In other words, she is legitimately trying to protect herself by engaging in what she sees as self-righting activities. And how does she do this? By engaging in intense self-shaming, self-loathing, and self-criticizing. It is her internal critic trying to whip herself into shape. Paradoxically, while destructive, it is a proactive attempt to survive, to try to let herself never forget, never avoid, but to face up. In other words, it is precisely the opposite of avoidance: she is doing to herself what therapists do—accusing herself of avoidance, in an attempt to make herself face up, be courageous, and take chances.

In a similar manner, Halvorsen et al. (2016) note that the therapist "underscored the importance of challenging oneself to promote change" (p. 26). But I would contend that Cora was already doing that. That is precisely what her shame and self-loathing was all about—she was challenging herself to change. And in these ways I would argue she showed courage in ways that were different than the ways articulated in the article.

I find it surprising that we accuse clients of avoiding pain. Most of the clients I saw, while I was doing therapy, like Cora, experienced—and coped with—large amounts of pain. Since the theory is that we avoid pain, that presents a problem for the theory. The typical way out of that is to assume that clients experience pain A as a way of avoiding a bigger pain B. This kind of thinking is evidenced in this case by the following therapist comment to Cora about her self-loathing: "So maybe the self-loathing becomes a way to cope against something that is even more frightening: the thought of being condemned by others" (p. 168).

I would like to suggest an alternative view, one in which makes Cora even more courageous (which is what I think she is). I doubt that her self-loathing is a defense against a fear

of others condemning her. More likely her self-loathing, as I have suggested, is a proactive attempt to cope, to not fool herself. She is trying to be brutally honest with herself and to goad herself to be a better person. She is already doing to herself what the therapist assumes she is afraid of others doing to her—being intensely self-critical. It seems unlikely she is trying to avoid others doing it to her. More likely she is trying to be brutally honest with herself to try to make herself "face up." As Dan Wile (1992) has noted, like other clients it is Cora's self-criticism that is doing her in, not her avoidance. There is plenty of evidence of how self-critical she is throughout the transcript. I, like Dan Wile, would see self-criticism as her problem more so than avoidance.

So it is her life force which is leading her to self-criticize, in hopes of self-righting. Her self-criticism is a courageous attempt to confront herself. She self-criticizes in an attempt to try to find a place for herself on the planet. It is proactive, albeit dysfunctional. I agree with Halvorsen et al. (2016) (and the therapist) that it is a survival strategy for Cora, but we differ in how we interpret that. We both see her as courageous, but we differ in how we see that as well.

Nonetheless, I agree with the thrust of what the therapist did: validate Cora's patterns as survival mechanisms. Undoubtedly these helped Cora reduce her shame around them. Furthermore, she definitely did appreciate the therapist encouraging her to take risks.

In regard to the courage issue, I want to comment on Cora's demand that she be allowed (a) to commit suicide, and (b) to continue to self-harm. I agree that the therapist was courageous in going along with this, and I have no doubt that this contributed to her faith in him, and in his strength, which Cora needed. I am not sure I could have agreed to those conditions. At the same time, from Cora's point of view, I once again see her demands as a sign of her courage. It is quite a risky thing to do, for someone who is feeling so vulnerable, so hurt, and so alone, to demand that she have the right to be herself, to make her own decisions, even to the issue of her own personal physical well-being and safety. It probably comes out of a proactive desire to assert herself, and it shows that she is not completely helpless and defeated. She is defiant. "Dammit, I am not going to be bossed around!" She will take her life in her own hands. One wonders how much the strength behind that demand played a role in the progress she made in therapy.

CONCLUSION

I believe that the case of Cora makes a very valuable contribution to the literature. I think the findings on persistence and courage are particularly important. Furthermore, I believe the kind of methodology used in this study can productively shed more light on the process of what goes on in therapy than do the results of randomized trials. I believe in the case of Cora we have genuinely learned something about the actual process of change.

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