

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

Considering "Cora": A Critical Appreciation

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ABSTRACT

This discussion examines Halvorsen, Benum, Haavind, and McLeod's (2016) case study of "Cora," from a perspective both appreciative and at times critical of certain mixed-study methods it employs. While impressed with the clinical alliance it illustrates between therapist and challenging client, we find the study raises more theoretical questions than it answers in terms of our ability to enumerate the conceptual elements necessary to convey valuable clinical truths. The case study does indeed provide systematic data on the presence of dyadic courage, persistence, and symbolic expressions of trust during treatment from which there is much to be learned. As readers we were left marveling at an account of a therapist's clinical acumen with a client who had faced unbearable childhood trauma, and at the same time wondering how much more we might have learned about how to actually do such work from a comprehensive narrative written in his own voice.

Key words: case-study methodology; practical knowledge; trauma; clinical case study; case study

In this discussion of Drs. Halvorsen, Benum, Haavind, and McLeod's (2016) case study of Cora," we note the valuable questions it raises with regards to identifying and conveying effective elements of the therapeutic process when expert clinicians treat difficult cases, integrating the narrative case study with formal qualitative research in a relatively large sample of cases, and case study methodology in general. We examine the unique authorial voice of the case study, in this instance not that of the treating clinician; and we review some of the difficulties that arise from the authorial voice chosen for readers seeking to understand treatment process and its results. Finding there exist some "missing pieces" to the case conceptualization, we suggest other useful frameworks in which it might be regarded. Finally, in the light of what we do not know, we discuss the valuable and unique lessons derived from Dr. X's interactions with Cora and hers with him.

SITUATING THE CASE OF CORA IN THE LARGER RESEARCH STUDY

The case study of Cora is written within the context of a large-scale study with both quantitative and qualitative research methodology arms, and was not a pre-planned case study. We were struck by the incongruity in the findings between the quantitative and qualitative measures of process and outcome for Cora's therapy. Her symptom score on the quantitative measure was very high at the beginning of a course of psychotherapy with an expert clinician, and equally high at the end of three years and 121 hours of treatment. The process data attempting to measure the working alliance was equally poor and unchanged for the client, while the assessment of the alliance from the therapist's perspective was only moderately improved. Paradoxically, independent qualitative interviews of both therapist and client at the conclusion of the therapy revealed a startling use of the same phrase: "the therapy was life-saving." The therapist and client also identified similar characteristics of their therapeutic encounter—using words that indicated that each saw the other as courageous and persistent in the face of daunting problems in the client's life and the therapeutic relationship. Both acknowledged that it was critical that the client be permitted to explore her suicidality without a punitive response from her therapist. In an attempt to explicate these paradoxical findings, the audio transcripts of a sample of the 121 sessions were subjected to a qualitative thematic analysis to substantiate and explicate the reality of such a seemingly counter-intuitive, paradoxical finding. All the comprehensive quantitative data on the outcome of the case, and most of the process data, had been wildly misleading. How could this be?

To answer this question more fully, and to provide a wider context for the case of Cora, would require an examination of the more general quantitative and qualitative findings. One wonders how many other therapist-client dyads contained evidence of a lack of convergence between quantitative and qualitative findings. Although the qualitative data in the work by Halvorsen and her colleagues has begun to be published by Ekroll and Ronnestad (2016), it appears that the quantitative data has only been presented at conference by Ronnestad et al. (2014).

THE IMPORTANCE OF AUTHORIAL VOICE

In the preponderance of case studies, the author is the therapist who treated the client described. Consequently, the motivation to share the therapy and its result are clearly present in the passion of the prose as well as explicit statements describing the specifics of the impetus to share. While the authors of Cora evidence their wish to convey the details of what they conclude was an interesting case of difficult work, because they believe useful strategies can be inferred, and despite quotations from Cora's therapist, whom we'll call "Dr. X," the therapist remains a shadowy figure. Dr. X is described by himself in answer to post-interview questions, his case selected from a larger study of 50. We can conclude he agreed to participate in the creation of the Cora case study. But we do wonder, would he ever have written up this independently? Did he himself believe his work to be illustrative of principles which, when applied in similar circumstances, might yield similar results?

Likewise, consequent to the structure of this case, the case itself feels strangely ephemeral. For the purposes of this paper, it ends after three years (not certainly a short time) with a placement in a 12 week, inpatient, trauma-informed program, after which we are told that Cora resumed treatment with Dr. X. Due, however, to the fundamentally slow nature of work with trauma victims, and her persisting suicidality, paired with the Dr. X's evident promise they might continue, in some ways the case of Cora feels at only the mid-way point with much working through to be completed (which our curiosity about must remain frustrated). The work with which we are presented is at once profound but preliminary. Although the original grant proposal (Ronnestad, 2009) listed post-therapy and follow-up at one and three years, this information is not made available by the authors in Cora's case study. Dr. X's limited comments are due to unanticipated problems with his health, but their absence is surely felt. We cannot but hope his recovery is complete, and his wealth of clinical knowledge and expertise again being mined for further insight into the work with difficult clients.

There was ample information of certain kinds generated in this case study. In some ways more than is typical. The writers, who have much expertise (99 years of combined practical experience), *likely* based their conclusions upon the vast number of session transcripts they had access to and read but which we only know from short excerpts. Post-session interviews, conducted with both Cora and Dr. X, produced intense, value laden, descriptive phrases such as the previously noted "life-saving." Quantitative measures were administered throughout the therapy at designated intervals. Yet in some significant, persistent way we still do not know Dr. X or Cora. We remain at a remove because the authors are not the practitioner, and a full narrative write-up was not provided. The discussion and analysis of factors contributing to the process of the successful therapy are all formulated by "outsiders." Skilled and experienced to be sure, but "re-viewers," not the primary viewer. Does this secondhand-ness matter? Does voice, first-person versus third-person, matter? We think it does because aspects of this presentation tend to feel imposed upon later reflection rather developmentally intrinsic to the work.

NARRATIVE DATA AND THE EPISTEMOLOGY OF SUSPICION

Let us for a moment digress to consider the knotty question of the need to collect "data" when engaging in psychotherapy research. From the decision to do so we can infer the presence of the increasingly prevalent idea that a full narrative write-up by the therapist, attached to comments by the patient, is somehow fundamentally an inadequate tool by which to convey the truth of a therapeutic endeavor. We see three potential problems with this view. First, as is evident in the case of Cora, when qualitative and quantitative data yield discrepant results, even with scholarly speculation as to the possible reasons, our understanding of what happened between therapist and patient, and within the patient internally, actually becomes clouded and is undermined. Second, we argue that the process of data taking is fundamentally intrusive and perhaps the necessity to participate in rating their recent experiences could even be traumatic to vulnerable clients. Third, the inclusion and interpretative discussion of data results usually results, structurally, in the narrative portion of the case study being shortened to make the final presentation length manageable. The reader is then left with less first-hand narrative truth to independently assess but more authoritatively pre-digested conclusions. It seems to be assumed that the professional readership no longer possess the critical, analytical faculties to draw conclusions from the self-described experiences of the primary clinician. How have we

intellectually arrived at this juncture, where a traditionally presented case study narrative needs independently collected data “proofs” to validate them? We think this results from a fundamental category mistake of confusing the practical knowledge of psychotherapy for scientific knowledge of abstract theoretical principles (cf. Miller, 2004; Miller, 2013). However, expanding on this argument is for another day.

MORAL ENGAGEMENT IN THE THERAPEUTIC RELATIONSHIP: THE RIGHTS OF THE CLIENT AND THE VIRTUES OF THE THERAPIST

Returning to Cora, as we read, our picture and understanding of Dr. X does develop. He had no special training in trauma but had extensive work experience in an outpatient clinic. He was a very seasoned practitioner, 31 years in the field of psychology. He is quoted in post-session interviews, and in this way we are able to hear him directly. Yet much that the reader concludes is inference, for the questions he is asked to respond to—the very structure of the paper—belongs to the authors, not him. We are told that he and Cora both name courage as an important attribute. The transcript is not introduced to support this claim so when we decide he is indeed brave, it is because we unconsciously have put ourselves in his position; we are referred a client who has experienced dreadful, intrusive trauma, who is so severely depressed and isolated that she is suicidal. Not only does she feel hopeless, she evidently requires that her clinician honor her right to commit suicide. This is an unusual caveat for a clinician to find a way to accommodate, psychologically, ethically, and in terms of potential liability. We wonder if we could do this, then we recall Dr. X managed the dangers inherent in having this client, for three years, overcoming Cora’s lifelong inability to trust, and somehow, tolerating her persistent death wish, her pull towards the annihilation of the self. “Yes,” we are able to say, Dr. X exemplifies courage.

The authors include a useful discussion of writings on and working definitions of courage. None of them, however, suggest from where courage comes nor indeed, if it can be taught. In an earlier age, it would have been considered a virtue. But if the authors select this case as one which might “identify strategies through which ... clients may be helped” (p. 159), do we not need to know how we, the reading audience, might acquire this critical quality which so permeated and affected Cora’s treatment?

Persistence is similarly identified by Cora and Dr. X as having been exemplified by each of them, and we do not find this hard to accept. Through weekly doses of proffered anguish punctuated by periods of intensified distress and lack of progress, each member of the dyad came to the appointed office and met with one another for a period of three years, we might say against great odds. This is persistence exemplified. But as with the case of courage, we find ourselves frustrated when the authors are content to identify these exemplary characterological qualities but do not speculate about their origins. Persistence seems related to courage, perhaps they go arm in arm. A more modern word might be commitment. We are curious when we reflect that we are not aware of training classes which purport to teach courage and persistence, yet they are identified as vital to the therapy outcome.

How do a clinician and a client remain mutually committed to a difficult process, session after session? Perhaps the answer lies in conceptualizing these admirable qualities as single threads in a much larger tapestry they wove together on a co-constructed loom. Cora found Dr. X funny, he found her smart. She felt his warmth and he felt, despite her depression, that she was "present." She felt her defenses validated and he felt challenged in a way which brought out the best in him. In other words, on a personal, human level, each felt engagement with the other. In every session they experienced each other's aliveness, intensity, and interest—their humanity perhaps one might say. To look upon another with regard, as both Dr. X and Cora did, and brave the resistance to share and hear the deepest of grief, moves the reader deeply; and we acknowledge admiration for their endeavor, even as we are uncertain of how to emulate it.

For the reader as clinician, one of the most intriguing of the unanswered mysteries about Dr. X remains how he contained his own fears about Cora's perilous hold on life. In his reaction to her request he keep the mother & golden heart picture, which occurred after two years of therapy, he clearly reveals that his first thought was that it signaled an intention to leave this earthly realm, and he firmly tries to have Cora clarify this. This raises the paradoxical issue for a clinician of wanting and needing the client to trust one is benign and has their best interests at heart, while never quite trusting them to remain in the land of the living. We like to imagine a therapy land of mutual trust but sometimes part of truly apprehending another's horror story of a life means acknowledging on a gut level that their "no exit/must exit" reaction isn't necessarily irrational and that consequently, it may not be possible to trust their literal capacity to "remain." Evidently when this happened with especial intensity, Dr. X. would persuade Cora to place herself in an inpatient setting until she stabilized. This case represents an interesting example of the struggles which must needs ensue for Dr. X and Cora when the social contract is compromised, and all bets are off.

THE CLAIM OF A THEORY-BUILDING CASE STUDY

In considering the case of Cora, we need to ask, as the authors indeed urge us to do, "What is this a case of?", and additionally, what kind of a case study is this? Case studies commonly follow a particular narrative arc, begun by a description of the client's presenting problem, often defined by a formal diagnosis, and followed by details of the treatment provided, moving in a linear progression towards its conclusion, most frequently reported as successful. Indeed, Spence (1997) argues that case studies tend to borrow a narrative structure from the heroic novel wherein the heroine or hero overcomes "obstacles on the way to a pre-ordained resolution." The reader expects to be treated to a tale of triumph; psychotherapeutic process vanquishes neuroses. Early on in the Cora case study, we are aware she is suffering intensely and that there would be no miracle cure, although it might indeed be argued it was a noteworthy triumph that she remained alive and participatory for the duration of the three years. The authors contend that Cora and Dr. X's work have valuable lessons for us about the labors of this experienced therapist and this challenging client, and they offer qualitative data to support the claim. This claim might be stronger if there were other cases in the original study that showed this pattern of weak quantitative evidence that is contradicted by strong qualitative data, and it raises again the unclear relationship between the purposes of the original study and the case of Cora. The authors make the claim that this is a theory-building case, which begins with a theory to be explored through a series of cases. It is unclear whether persistence, courage, and client use

of physical objects as symbolic of the client-therapist relationship are part of an articulated theory of psychotherapy. It is possible that they are components of the alliance formation the authors' larger study set out to investigate, but as readers we struggle to locate their origins.

We have discussed how this case lacks the voice of the Dr. X as overarching case conceptualizer, and how that detracts from our understanding of what the treatment consisted of, why certain decisions were made, and what the measurable outcomes were. While grateful neither the authors nor Dr. X himself use psychological jargon, we find ourselves wondering what theoretical ideas the doctor found useful, incorporated, or based his long practice upon. We are told his orientation was "integrative; drawing on narrative, systemic, humanistic and psychodynamic perspectives." These descriptors convey curiously little given the broad range and the diversity of views one encounters in each approach. What psychodynamic ideas inform his work? Does he admire Carl Rogers' concept of "unconditional positive regard"? How did he develop into the clinician we meet in the case of Cora? These frustrations noted, we would like to point out that even when a case study is presented by the treating therapist, with utmost clarity and supported by persuasive quantitative data, it is not, and must not be conceived as, analogous to a recipe. While we desire to learn from each study, human behavior cannot be reduced to "ingredients" which when combined in a particular manner will yield a recognizable and desired outcome. That even when a clinician identifies a "turning point moment" in a therapy, as is sometimes done, psychological treatments are not similar to geometry, there is not the QED moment when the "curative effect" can be proven. Sadly for some, the application of psychological principles and theories does not easily and consistently lend itself to the laws of science. We as clinicians should hesitate to say each client represents a formal experiment, one we are collecting data on. Rather though, while we are endeavoring to help, we are also keenly observing every process and result we can, that we might be able one day to describe it; to share it with our colleagues to see if it resonates and can be of use to them.

In our discussion of Drs. Halvorsen, Benum, Haavind, and McCleod's case study of Cora, we have been trying to determine what they offer us and how we might use it. The answer lies, we think, in examining the possibility that while not formally and intentionally employing specific trauma or psychoanalytic theory (or at least not revealed by the authors and by himself), Dr. X can be viewed as having operated as if he did. He saw and felt in Cora's presentation, as Stolorow writes, that "the essence of trauma lies in the experience of unbearable affect" (Stolorow & Atwood, 1992, p.52). Indeed, Cora evidently and frequently imagined ending the bearing of this burden of affect. Dr. X believed her, and that is why Cora felt he "validated and respected my destructive survival mechanisms" (p. 166), which made her feel understood rather than negated. We do not know the details of Cora's trauma, except that it involved her mother, but Dr. X did, and was able to balance his belief in the need to change against a wish his client not suffer unduly. We see that he must have successfully calibrated showing empathy with being frank, which to him meant he'd rather take "some chances, and repair the damage, than move too gently" (p. 174). This, as clinicians know, is one of our most difficult challenges, one which if navigated clumsily results in a client's withdrawal, sometimes from the entire therapy. Although there were times, it is reported, that Cora was angry and conveyed this by acting out and missing an appointment or by engaging in self-harming behaviors, Dr. X's words and probably facial expressions must have been profoundly and sturdily comforting and stabilizing, for the dyadic enterprise remained intact.

The authors discuss at some length the effect of relational trauma on an individual's capacity to trust and form attachments. They reference a Pearlman and Cortois (2005) hypothesis that cumulative trauma "may require therapy in which it becomes possible to revise inner working models of attachment relationship" (p. 160). Additionally, they speak of the importance of alternative support figures, referencing Saunders et al., (2011). They conclude with a strong statement, "Clearly, a relationship with a psychotherapist represents a potentially curative form of support" (p. 161). This calls to mind Alexander and French's (1946) famous concept/phrase, the "corrective emotional experience." Interestingly, most clinicians generally disavow this as an intentional therapy goal, finding it perhaps too grandiose to claim as an undertaking, but privately acknowledge it to felicitously occur. If Cora's mother ravaged her youthful psyche, creating a deficit in Cora's capacity to permit herself to be dependent, to trust, we do imagine that Dr. X's stalwart, dependable attention provided the opposite, a relationship experience devoid of betrayal.

In passing, in a section titled "Guiding Conception," the authors mention "the development of a capacity for mentalization (Stein & Allen, 2007)" (p. 161). Although they do not pursue this, we find it worth exploring, as it relates to Cora's history, therapeutic process, and development. If we examine what we are told of Cora's childhood, using ideas of Winnicott, we see that the facilitating environment he spoke of as necessary for a typical maturational process was not present. A mother who hurts her child and perhaps abets others who hurt that same child is not the "good enough" mother. This alarming figure of a mother almost certainly did not mirror Cora's internal states for her, nor provide instances of "thinking about" so critical to developing the capacity to mentalize. Garland (1995), who examines the effect of trauma on the development of thought and language, explains the maternal containment function as fostering "The internalization of the mother's own capacity to think about something... which is central to the development of real symbolic thinking" (p.111). It is axiomatic that the therapist, inadvertently or by design, often models a "primary maternal preoccupation," seeing the client so the client may experience being seen, imaginatively contemplating the client that they might learn to contemplate themselves without excess affect. We understand then how in Cora's case, it was not until the 11th session that she was able to make use of her perhaps nascent capacity to symbolize, and introduced the request for Dr. X to keep the mother & golden heart picture for her. It took perhaps two plus years with an increasingly trusted therapist and new adult modeled thinking about trauma for Cora to begin to understand that if objects can represent things, then perhaps the trauma might be represented rather than continually relived in the present moment.

Let us try and contemplate two seemingly opposing wishes in our mind at once; the impulse to succumb to the strong pull towards belief in an imagined, manualized, empirically validated approach to therapy, and the need to acknowledge the intellectual gift given to us in the form of the case study of Cora. We have all found ourselves drawn to the idea of a formula for treatment, a precise metric for insuring progress. We might all enjoy being the dispenser of golden, curative advice. But experience and humility teach and guide us otherwise. The essence of therapy often involves delicate nuanced interactions, both explicit and only hinted at, that over time, facilitate salutary change and sometimes defy quantification. The case of Cora simultaneously does not provide a specific blueprint for therapy with a difficult client, but it does offer a unique, rarely discussed mechanism for clinical development: inspiration. Even as we wish the case study methodology had provided us details sufficient to better understand how Dr.

X actually navigated the dangerous emotionality of Cora's legacy of a painful childhood, we apprehend that he did find his way. And with him, Cora. We realize we have the half-formed thought, "I hope I would do as well." And later, as we meet our own clinical challenges in private, an image of this at once elusive but compelling case may be recalled, quietly urging us to stay the course. The authors then have created an instance of epistolary mentorship, clinical guidance from afar, "par exemple." For would we not all be proud to be a living proof that there are some who will witness and hold another's anguish until it might be better borne? To free the unspeakable and the unthinkable from their prisons is indeed lifesaving.

REFERENCES

- Alexander, F., & French, T.M. (1946). *Psychoanalytic therapy*. New York, NY: Ronald Press.
- Ekroll, V. D., & Ronnestad, M. H. (2016). Processes and changes experienced by clients during and after naturalistic good-outcome therapies conducted by experienced psychotherapists. *Psychotherapy Research*, published online February 2, 2016. <http://dx.doi.org/10.1080/10503307.2015.1119326>
- Garland, C. (Ed.). (1998). *Understanding trauma: A psychoanalytic approach*. London: Karnac.
- Halvorsen, M.S., Benum, K., Haavind, H., & McLeod, J. (2016). A life-saving therapy: The theory-building case of "Cora." *Pragmatic Case Studies in Psychotherapy*, 12(3), Article 1, 158-193. Available: pcsp.libraries.rutgers.edu.
- Lippe, A.L. von der, Oddli, H.W., Halvorsen, M.S. (2014, June). *How do highly experienced therapists succeed with "difficult-to-treat" clients?* Presentation at the annual conference of the Society for Psychotherapy Research, Copenhagen, Denmark.
- Miller, R. B. (2004). *Facing human suffering: psychology and psychotherapy as moral engagement*. Washington, D.C.: American Psychological Association.
- Miller, R. B. (2013). Deny no evil, ignore no evil, reframe no evil: Psychology's moral agenda. In A. C. Bohart, B. S. Held, E. Mendelowitz, & K. J. Schneider (Eds.). *Humanity's dark side: Evil, destructive experience, and psychotherapy* (pp. 213-236). Washington, DC, US: American Psychological Association. [doi:10.1037/13941-011](https://doi.org/10.1037/13941-011)
- Ronnestad, M. H. (2009). An intensive process outcome study of the interpersonal aspects of psychotherapy. Application for the Research Council of Norway, downloaded from: <http://www.sv.uio.no/psi/english/people/aca/helgero/process%20outcome%20study%5B1%5D.pdf>
- Rønnestad, M. H., Gullestad, S., Halvorsen, M. S., Haavind, H., Lippe, A. L.V., Nissen-Lie, H. A., & Reichelt, S. (2014, June). *The outcomes of therapies conducted by highly experienced therapists*. Presentation at the annual conference of the Society for Psychotherapy Research, Copenhagen, Denmark.
- Spence, D. (1997). Case reports and the reality they represent: The many faces of "Nachtraglichkeit." In I. Ward (Ed.). *The presentation of case material in clinical discourse*. London: Karnac.
- Stein, H., & Allen, J.G. (2007). Mentalizing as a framework for integrating therapeutic exposure and relationship repair in the treatment of a patient with complex post-traumatic psychopathology. *Bulletin of the Menninger Clinic*, 71, 273-290. [DOI: 10.1521/bumc.2007.71.4.273](https://doi.org/10.1521/bumc.2007.71.4.273)

Stolorow, R., & Atwood, G. (1992). *Contexts of being: The intersubjective foundations of psychological life*. Hillsdale, NJ: The Analytic press.