

## **The Case of Ms. Q: A Demonstration of Integrative Psychotherapy Guided by “Core Clinical Hypotheses”**

**BARBARA LICHNER INGRAM**<sup>a,b</sup>

<sup>a</sup> Psychology Department, Pepperdine University, Los Angeles, CA

<sup>b</sup> Correspondence concerning this article should be addressed to Barbara Ingram, Graduate School of Education and Psychology, Pepperdine University, 6100 Center Drive, Los Angeles, CA, 90045.

Email: [bingram@pepperdine.edu](mailto:bingram@pepperdine.edu)

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### **ABSTRACT**

This case study describes the treatment of a married mother—Ms. Q—in her mid-thirties who sought help for making major life decisions that involved her marriage, career, obligations as a parent, and self-development. A model and method for conducting theoretically integrated therapy as described in the author’s book, *Clinical Case Formulations* (Wiley, 2006), is illustrated through case formulation charts and narrative discussion of the choice points in therapy with Ms. Q. The treatment integrated clinical hypotheses from five theoretically differentiated categories: existential/spiritual (issues of choice, responsibility, commitment, meaning and creativity); psychodynamic (conflicting inner parts, immature “self,” and unresolved guilt and abandonment fears from past relationships); cognitive (faulty schemas about responsibility, parenting, and marriage); behavioral/learning (conditioned emotional responses and lack of skills in decision making, emotional regulation, and marital communication); and social/cultural/environmental (family systems factors, issues of culture and gender, and need for appropriate work environment.)

*Key words:* psychotherapy integration; case study; case formulation; marital conflict; divorce; self-actualization; integrative psychotherapy

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## **1. CASE CONTEXT AND METHOD**

In my book, *Clinical Case Formulations* (Ingram, 2006), I elaborate on a method for integrating ideas from a comprehensive list of theoretically differentiated “core clinical hypotheses” to develop treatment plans that are “tailor made” for clients. In this paper I illustrate how my integrative approach to conceptualization and planning is implemented in psychotherapy. This case illustrates the blending of ideas from existential, psychodynamic, behavioral, cognitive and family systems models.

### ***A. Rationale for Selecting This Client***

Prior to this client, I had effectively integrated ideas and treatment methods from cognitive and existential approaches in my work as a staff member and part-time independent contractor for university and community clinics. After taking a course in the work of Heinz Kohut at a psychoanalytic institute, I decided to enroll in a postdoctoral training program to learn

more about this theoretical model. When I started seeing the client, my intention was to put aside my prior methods and techniques, and wholeheartedly embrace the psychoanalytic approach that I was studying. Instead, I discovered that I was constitutionally incapable of not being integrative. Fortunately, I had a supervisor for this client who saw me in his private practice office and who accepted that I was seeking to integrate what I was learning rather than to convert to a new orientation.

Beside the practical consideration that I had detailed notes on every session with this client, I chose this client because my experience working with her was pivotal for me in discovering how I could integrate psychodynamic ideas into my active, engaged, goal-oriented approach to therapy.

Through this case the portability of a "core clinical hypothesis" became clear: it was not inextricably attached to a treatment method but rather could be used as a tool for understanding a client and creating treatment plans to achieve specific goals.

### ***B. Strategies for Enhancing Rigor***

As part of my training experience, I kept detailed written notes for every single session, notes of my meetings with my supervisor, and additional jottings and diagrams to organize the database and develop my conceptualization.

### ***C. Clinical Setting***

For the first 8 months, I saw the client in a training setting where clients were selected for suitability for psychodynamic therapy. Sessions were twice weekly, and the fee was based on a sliding scale. When we terminated at the end of my program, I gave the client information to contact me. She did so, and we resumed therapy in a private practice office, with the same fee.

### ***D. Source of Data***

The only source of clinical data was my personal contacts with the client. I had access to data that confirmed for me that she was a highly talented writer: her writing was selected by a very selective publisher and received favorable critical reviews. I also had information about her husband from a credible, independent source that confirmed the accuracy of her description of his professional accomplishments and his style of interacting.

### ***E. Confidentiality***

I have changed and omitted many facts and details to conceal the identity of the client and assure that her confidentiality is not breached. The changes I made do not compromise the accuracy of the description of the therapy process.

## 2. THE CLIENT

Ms. Q was an extremely attractive, fashionably dressed, dark-haired, slender 36 year old woman of mixed Asian and Hispanic ethnicity. She had been married for 12 years to a very successful economics professor, who was about 10 years her senior. Her 8 year old son was attending a selective private school, and she had not worked outside the home since her marriage. For the past three years she had been enrolled in creative writing courses, and had just had a short story accepted by a prestigious publication.

Ms. Q was self-referred because of uncertainty over whether she wanted to stay married or live independently, and fear that she would succumb to her tendency to "flee" without reflecting on consequences. Her stated goal was to make a decision "that feels solid, not impulsive." She wanted to devote more time and energy to writing, moving from short stories to a novel, and saw "family responsibilities" as an obstacle. She described her husband as a very reserved, intellectual man who "withdraws when he is angry and doesn't communicate about feelings," and complained that he treats her writing with condescension and objects to her aspirations to be more than a wife and mother.

She talked rapidly, in dramatic story-telling fashion, with vivid details. Although I did not know this initially, she had applied for a six-month writing program in another state and was hoping that therapy would allow her to make a guilt-free decision to leave her son and husband to attend.

## 3. GUIDING CONCEPTION

I have always resisted pressure to "choose an orientation" and believe that every client deserves a unique, personalized treatment plan. Rather than facing a new client with a treatment strategy in mind, the therapist should learn about the unique client and develop a case formulation that draws from ideas from the entire range of available models of human functioning and change.

The development of my clinical thinking stems from a clinical placement at a VA hospital in the second year of my Ph.D. program. Distressed by my incompetence in facing new clients, and frustrated with the lackadaisical humanistic approach to supervision of the staff psychologist I was assigned to meet with, I sought help from the director of the psychiatry education program, George Saslow, who had co-authored an influential article on "behavioral diagnosis" (Kanfer and Saslow, 1965). I was thrilled to be invited to participate in the training program provided to the psychiatry residents. I learned about the application of the "problem-oriented method" (POM) to psychiatry (Weed, 1971), which included the "SOAP" acronym that was used for notes in patient charts: "S" and "O" stand for two kinds of data, subjective (what the client says) and objective (what the clinician observes or accesses through charts, tests, and professional reports); "A" stands for assessment, which in this context means conceptualization and formulation; and "P" stands for plan for intervention. This method assures accountability (plans must focus on resolving problems, progress towards goals must be documented) and incorporates both scientific principles (e.g., data separate from theorizing) and practical problem

solving skills. At the same time, I learned about the use of "core clinical hypotheses" in an article by Aaron Lazare (Lazare, 1976): "A core clinical hypothesis" is a single explanatory idea that helps to structure data about a given client in a way that leads to better understanding, decision-making, and treatment choice. Based on these educational experiences, the foundation of my future clinical work was the development of a case formulation for each client that involved clear specification of "problem titles," and the selection of clinical hypotheses that best fit the data.

When I began my career 30 years ago as a faculty member in a clinically-oriented Master's program, I was determined to teach students the skills of creating case formulations. I developed a list of "core clinical hypotheses" and a set of instructions for defining problems, specifying outcome goals, developing a coherent integrative conceptualization for each problem, and selecting interventions that followed logically from the conceptualization. The result of my teaching and constant revision of my training manual was the publication in 2006 of a book explaining my approach to case formulation, with detailed step-by-step instructions for developing formulation skills and writing case formulation reports. In the book I explained each of 28 hypotheses, providing for each of them a set of treatment recommendations, suggestions for integrating other hypotheses, and lists of recommended readings. Table 1 presents the list of hypotheses with definitions and Figure 1 gives an overview of the steps of the formulation process.

In this section, I will highlight the processes, which will be described in detail in the following sections on assessment and formulation, as they apply specifically to the client.

### ***Data-Gathering***

It takes several sessions to gather enough data to begin creating a formulation. In the first session it is important to check to see if there is an emergency issue (e.g., suicidality, symptoms of organicity, an acute stress reaction) and if not, the unfolding of information should occur by allowing the client to tell stories in her own way, while the therapist "tracks," and shows empathic understanding. The visual tools of a timeline and a genogram are helpful for organizing data. The therapist can gather data through experiential activities, homework assignments, and written assessment tools. It is important to distinguish data from theorizing, and to solicit multiple concrete examples when the client uses abstract language. For instance, if the client says "my husband abuses me," the therapist must ask for examples and definitions to get a clear sense of the specific interactions and behaviors that she labels "abuse."

### ***Problem Identification***

Problems are the targets of therapy-- impairments, symptoms, syndromes, difficulties, dysfunctions, and emotional suffering. The book *Change* (Watzlawick, Weakland & Fisch, 1974) made brilliantly clear how important it is to correctly define the problem and to recognize that clients will bring problems that are the results of their faulty attempted solutions. For instance, the frustrated parent of an adolescent takes a normal developmental change (increased independence of the child) and has attempted to "fix it" with increased restrictions and attempts to maintain power. The parent sees the problem as "my inability to control my rebellious

teenager” whereas the therapist needs to identify the problem as “difficulty adjusting to developmental changes, and ineffective methods of responding to normal adolescent behaviors.”

The problem list needs to be complete and comprehensive. The process of problem identification begins with a comprehensive list of problems that were either reported by the client and or recognized by the therapist. Formal problems are defined by combining certain problems into a cluster with a specific title (“lumping”) and by recognizing subproblems within a single item on the list (“splitting.”) As the client develops trust, and as the therapist asks questions to elicit more data, it is common for new problems to be identified, and for the initial problem definition to be supplanted with a more refined one.

Good problem titles meet the following standards:

- Problems are defined so that they are solvable targets of treatment.
- Titles refer to client’s current, “real world” functioning.
- Titles are descriptive, designed for a specific client, and are justified by the data.
- Problem titles do not contain theoretical, explanatory concepts.
- The therapist is not imposing cultural or personal values in problem definitions.
- “Lumping” and “splitting” decisions are justified in that they lead to good treatment planning.

### ***Outcome Goals***

The outcome goal is directly related to the problem title, and describes how things will be in the future when the problem is sufficiently resolved for the client to function without the help of the therapist. “Process goals,” which are the in-therapy achievements that stem from the therapist’s formulation, is part of the plan. The process goals are part of a roadmap for achieving outcome goals, and at the time the outcome goal is written, the therapist is not ready to formulate that roadmap. By keeping process goals and outcome goals separate, the therapist (and supervisors and consultants) can discover diverse routes to the desired end point of therapy.

The evaluation of therapy requires the specification of outcome goals: Without an outcome goal, the term “effectiveness” is meaningless, and there is no way to know when termination is appropriate. Good outcome goals meet the following standards:

- They are consistent with the client’s values.
- They refer to “real world” functioning.
- They do not contain formulation ideas.
- They are realistic and are not “utopian.”
- They do not contain the “how” of the treatment plan (process goals or strategies).

In the initial sessions with a client, the starting place may be setting outcome goals rather than creating problem titles. For instance, the client may state “I need to make a decision,” or “I want to be able to ...” As the plan is implemented, the therapist gathers data about changes in the

client's life to see whether the therapeutic strategy is leading toward the desired outcome. This description should not convey the idea that the outcome goal is rigidly set in the beginning; in the course of therapy, clients can change their minds about what they truly want and events outside of the client's control may lead to modification of outcome goals.

### *Clinical Hypotheses*

As explained previously, I developed a list of 28 core clinical hypotheses to be used as building blocks in designing formulations. This list is presented with definitions in Table 1 and as a blank form for use with clients in the Appendix. (All tables, figures, and the appendix can be found at the end of this paper.)

There are several skills for using hypotheses:

- Listening to the client talk and recognizing the goodness-of-fit of each hypothesis. This means ruling out those that do not match, and retaining those that are consistent with data.
- Using various strategies to gather more data to either confirm the fit of a specific hypothesis, or to rule it out. (In Figure 1 the bidirectional arrow with "data gathering" indicates that hypothesis-generation guides the gathering of data, and data determine the relevance of hypotheses).
- Brainstorming hypotheses, using the chart in the Appendix, as demonstrated in Table 2. Before closing in on one or more preferred hypotheses, it is useful to systematically examine each one.
- Selecting one or more hypotheses for the preliminary formulation.

Formulations can be formally expressed in essay form, or informally captured in bullet-point notes for the private use of the therapist. In training settings, I believe that students benefit most from being required to write a formal assessment discussion, using their highest level of writing skills, because the process of writing forces them to improve their thinking. If they use theoretical jargon, they need to be sure that it enhances rather than detracts from understanding and does not contribute to tautological explanations. As preparation for such a formal presentation, and as a useful tool for experienced formulators, I recommend the use of a three column worksheet, as illustrated in Tables 3-5.

Standards for a good assessment include the following:

- It integrates hypotheses that are consistent with the prior database.
- It does not introduce new data.
- The focus is on the specific problems, rather than being a discussion of the client's personality.
- It does not include all possible hypotheses, just the ones that are useful in developing intervention plans.

### ***Implementing Plans***

The sole purpose of the case formulation process is the development of good plans. The plan addresses the format and treatment modality (e.g., individual, group, couple, family), the setting, the frequency, and the expected duration (e.g., short-term, time-limited, open-ended.)

Standards for a good plan include the following:

- It focuses on resolving the identified problem and achieving outcome goals.
- It follows logically from the assessment discussion and does not introduce new data or hypotheses
- It provides clarity regarding process goals, intermediate objectives, strategies, specific techniques, relationship issues, and sequencing of interventions
- It is tailor-made for the specific client. Such factors as gender, ethnicity, and personal values are considered.
- It is appropriate for the treatment setting, contractual agreements, and financial constraints.
- When there are multiple problems, it addresses issues of priorities, sequencing, and integration of plans.
- It recommends community resources and referrals, if appropriate
- It addresses legal and ethical issues, if relevant.

The overall treatment plan is like an itinerary on a proposed trip. You can make statements about priorities, sequences, and contingencies. However, once the journey begins, you will be faced with frequent decision points: do I continue on the path I started or is this an opportunity to move in a different direction?

### ***Monitor Effectiveness***

As plans are implemented, the therapist gathers data from in-session responses by the client as well as the client's reports of out-of-session progress (or lack thereof). The therapist needs to be flexible and be able to create a variety of plans for a given hypothesis, realizing that the ineffectiveness of a technique does not invalidate the usefulness of the hypothesis. Sometimes new data are presented or there are changes in the client's life situation that will lead the therapist to switch to different hypotheses.



## 4. ASSESSMENT

The processes of assessment leading to a complete formulation include: (a) identifying problems and setting outcome goals; (b) recognizing strengths; (c) organizing the life history, including the recent history leading to the entry into therapy; and (d) brainstorming hypotheses.

### *(a) Identifying Problems and Setting Outcome Goals*

Ms. Q identified her ideas of her problems in the first sessions:

- (1) I am not able to engage in creative pursuits as much as I desire;
- (2) I have a tendency to leave difficult situations in an impulsive way;
- (3) I neglect my own needs and show over-sensitivity to needs of others; and
- (4) I am not sure if leaving my marriage is the best decision.

After gathering data and separating conceptualizations from problem statements, three formal problems were defined. Following my general model, I assigned each problem an official title (written as a phrase rather than a complete sentence) that is free of theoretical jargon, followed by explanatory sentences. For each problem, an outcome goal is specified in a few sentences, as shown below.

**Problem #1: *Tendency to act impulsively instead of making thoughtful decisions.***

Ms. Q described that there were several times between the ages of 17 and her marriage when she chose to "flee" difficult situations instead of using a reflective approach to decision-making. Her main reason for therapy was to avoid this pattern.

**Outcome goal:** The outcome goal for Problem 1 is for Ms. Q to engage in ongoing deciding about her career and family based on emotional self-awareness, rational thinking processes, a sense of personal responsibility for her choices, and consideration of values and morals. This goal includes Ms. Q making a good decision about how to pursue creativity without hurting anyone.

**Problem #2: *Lack of confidence in her ability to succeed in her chosen creative career and frustration over obligations that impede full time dedication.***

The client believes that her marriage is an obstacle to devoting herself to writing, and that she will not be able to succeed unless she completely isolates herself, yet she is very devoted to her son. (This problem includes her view of her husband as an obstacle; other marital issues are addressed in Problem #3)

**Outcome goal:** The outcome goal for Problem 2 is for Ms. Q to develop the ability to pursue creative activities to the fullest extent without sacrificing competing goals and interests, and to engage in effective problem solving when faced with obstacles.



**Problem #3: *Ambivalence about the future of her marriage.***

She reports being frustrated for a long time with her husband's lack of emotional connection. (The view of her husband as an obstacle to her writing is addressed in Problem 2. It was important to keep the two issues separate.)

**Outcome goal:** The outcome goal for Problem 3 is for Ms. Q to make decisions based on an understanding of her needs and feelings, an examination of data about her husband and marriage, and a consideration of the needs of her child.

Throughout the time that I worked with Ms. Q, she experienced depressed moods and episodes of high anxiety. These could have been treated as problem titles, but instead were viewed as natural emotions for someone struggling to make major life decisions.

***(b) Strengths***

Ms. Q's strengths included the following:

- She was highly intelligent, very verbal, quick to learn, and eager to apply new concepts to understanding herself.
- Except in sessions when she was highly emotional and needed to "vent" without interruption, she was genuinely interested in hearing a new perspective.
- She formed a good, collaborative relationship with the therapist and her stories indicated emotional connection in many friendships.
- She had a good sense of humor.
- Her aspirations were realistic: she had the necessary talent and commitment to succeed at her career goal.
- She was a good mother who genuinely cared about the wellbeing of her child.
- She gave feedback about what was helpful in our sessions.
- She understood the importance of experiencing her emotions without trying to numb or medicate them away.

***(c) Organization of History***

The timeline diagram in Figure 2 shows highlights of Ms. Q's history. Her father was born in Malaysia, came to the US with a relative as a teenager, completed his education, and worked as an engineer in an aerospace company. He never talked about his past and she never knew any of his relatives. Her maternal grandparents met and married in a Latin American country and came to the US prior to having children. Ms. Q's mother was the third of five children, and was very close to her extended family until she got married. Her parents disapproved of her marrying an Asian man, despite the fact that he shared her Catholic religion.

When Ms. Q was born her two older brothers were 10 and 12 and her mother, who had wanted a daughter, formed a very close bond to her. For the first six years of her life she was inseparable from her mother, who spent time reading to her, helping her develop a passion for reading. This happy period of her life ended when a brother was born who had multiple disabilities, and her mother shifted her focus to meeting his needs, which Ms. Q experienced as a "huge betrayal."

During her elementary school years she tried to get her mother's approval by doing well in school and being helpful around the house, but her mother never verbalized any affection or praise. She described her mother as emotional, dramatic, controlling and critical, and her father as quiet, undemonstrative, hardworking, and patient. Her father died when she was 14 after a year-long battle with cancer. Her mother dealt with the loss of her husband by focusing more attention on her young son and targeting the client with anger and criticism. During high school, Ms. Q studied sporadically but still got good grades, and began to develop an interest in creative writing. She was very popular but found her classmates too immature, and at 16 started secretly dating a 24 year old musician. Right before her 18<sup>th</sup> birthday, after completing high school, she moved in with him. Her mother and brothers called her a whore and refused to talk to her. She spent two years in this relationship, and then when her boyfriend's alcoholism and verbal abuse became intolerable, she ended it abruptly by leaving a note, packing up, and moving in with a girlfriend. She refused to talk to him, and then, 2 months later, heard that he had died in a car accident while driving in a heavily intoxicated state. She went to therapy at that time, dealing with grief and guilt, but was not able to let go of the belief that he would be alive if she hadn't broken up with him. When asked what she learned from that therapy, she spoke about how she discovered that she was emotionally strong and that she had focused so much on her boyfriend's needs that she hadn't set any personal goals for herself. This therapy helped her decide to enter college.

In her second year of college, she took a job as a research assistant, and began an intense romantic relationship with her future husband. Six months later he asked her to join him on a sabbatical in a different state, so she discontinued school after only 3 semesters. They got married after living together for a year, and she focused on being "a perfect wife." She felt that her husband adored her and they lived a very comfortable lifestyle.

When her son was born after four years of marriage, he became the "center of my life," and she wanted to make him feel loved and secure. When he started school she began to use her free time to take courses in literature and creative writing. She received encouragement from teachers and began to form the ambition to be a writer. She won a short story competition and then another story was published in a prestigious journal. Her husband at first was very patronizing about her goals and didn't take her ambitions seriously; then when her story was published he was embarrassed because he felt that the husband in her work of fiction was based on him, and was not a very flattering portrayal.

She began to experience the desire to "flee" her marriage about six months prior to coming to the counseling center. She identified with Virginia Woolf's idea of a "room of my own," and was frustrated that she couldn't put aside all her family responsibilities and write full time. Now that her son was in third grade, she felt that he no longer needed her – and that now is

the time "to finally put me first." In clarifying her goals, she stated "I want to pursue my own needs and goals, like a man would," and "If I could only do it without hurting anyone, I would definitely leave." Her husband was aware that she was contemplating separation, and alternated between offering loving gestures that she viewed as temporary, or angry tirades in which he demanded that she make a commitment or decide to leave.

#### *(d) Diagnosis*

The following diagnosis reflects my view of this client as a high functioning individual whose intermittent symptoms of anxiety and dysphoria were related to her self-imposed pressure to make major life decisions. She was in therapy for "growth needs" rather than "maintenance needs," using the terms of Maslow.

Axis I	V61.10	Partner Relational Problem
	V62.2	Occupational Problem
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Marital discord Career transition
Axis V	GAF = 67 (on intake) GAF = 90 (at termination)	

#### *(e) Brainstorming hypotheses*

In my conceptual model, a transitional step between assessment and formal case formulation is the brainstorming of hypotheses based on the data gathered by the clinician. In Table 2 I illustrate the use of the chart that can be found in the Appendix: thoughts about the relevance of each hypothesis to the client's problems and goals are presented in the right column.

## **5. FORMULATION AND TREATMENT PLAN**

The following conceptualizations are based on hypotheses that not only fit the data but also were compatible with the client's values, preferences, and interpersonal style.

- The primary focus on the existential/spiritual issue of finding her own path, making choices and accepting responsibility, accepting her commitments as chosen and not imposed, and pursuing the meaning and creativity she found in creative writing (**ES1, ES2, ES3**)
- The need to explore and resolve inner conflict among conflicting "parts" (**P1**)
- The necessity of emotional reliving of past experiences of her ex-boyfriend's death and her mother's rejection of her, both of which are both consciously and unconsciously related to her fear of separating herself, literally and emotionally, from her husband (**P2, P4**)
- The relevance of the concept of the "self" as it relates both to the development of creativity and to the ability to stand alone and pursue her needs, while maintaining connections to others (**P3, SCE1**)

- The influence of core schemas about the fragility of men and her responsibility for their happiness; the faulty belief that marriage and creativity are incompatible; and the faulty conclusion that she was responsible for her boyfriend's death, leading to the faulty belief that if she left her husband, he would die (**C2**)
- Emotional conditioning and defense mechanisms kept her from experiencing painful emotions and revisiting the events in which she formed her faulty beliefs (**BL2, P4**)
- Difficulties asserting independence based in part on her sex role socialization, which was influenced by the Hispanic and Asian cultures of her parents (**SCE2**)
- The need to develop new skills in decision making, management of emotions, and communication with her husband as an equal instead of as a rebellious child (**BL3**)
- The need for a work environment where she can shut out reminders of family responsibilities and focus on her writing (**SCE7**)

### *Formulating Each Problem Separately*

The basic principles for formulating each problem separately are these:

- To assure accountability of therapy, each problem must be addressed.
- The formulation is for the problem, not for the person.
- Each hypothesis is consistent with the data, helps explain the problem, and provides a foundation for a treatment plan.
- Plans focus on achievement of goals.

Tables 3-5 present, for each separate problem, treatment ideas that follow logically from the relevant hypothesis. For this particular case, to illustrate the logic of the overall model, these charts were designed retrospectively, based on notes that were written during various phases of treatment. In usual practice, the formulation of each problem would be done based upon assessment data collected at the beginning of therapy. These formulations might then be modified by new data that emerge in ongoing therapy.

## **6. COURSE OF THERAPY**

I am presenting the details of the course of therapy with as much accuracy as possible, given that I have eliminated information that would identify the client or would cause her discomfort in the extremely unlikely event that she should read this article. Core clinical hypotheses are put in boldface.

Ms. Q was seen for 75 sessions over a period of two years and four months. The initial phase of treatment was in an outpatient clinic as part of postdoctoral training in psychoanalytic therapy, for five months for a total of 28 sessions, with weekly supervision. At the time I was a licensed psychologist with several years of clinical practice, as well as an associate professor in a graduate clinical psychology program, but in the eyes of the client when she first met me, I was a postdoctoral fellow in a training institute, receiving supervision. In this initial phase, I met her in

a cell-like office shared by many therapists, and we scheduled a termination date eight months in the future, at a time when I would leave that setting.

In the second phase of treatment, which consisted of 8 weekly sessions over 3 months, Ms. Q met with me in a private practice suite, where I rented a room that was decorated by another therapist. This office arrangement continued through the last phase of therapy, which lasted 38 sessions over 14 months.

### *Phase I: Sessions 1-28 (March – July)*

#### Relationship Building and Preliminary Formulation

Ms. Q entered therapy with presenting problems, in her words, of being “pressured by family responsibilities,” “fear of not being able to develop her own creativity,” and “need to make a decision about whether to separate from her husband.” I asked her to consider the pros and cons of individual versus couple’s therapy, and she was adamant about wanting individual sessions. Her choice of a psychoanalytic setting was deliberate and based on knowledge of therapeutic alternatives; she wanted insight as well as protection against her tendency to act impulsively, stating that she “has a history of fleeing situations” when she feels pressured to make a decision. Our preliminary goal was “to focus on sorting things through so she can make a decision that feels solid rather than impulsive; to stay and talk, not run away, and to increase her understanding.” We agreed to initially meet two times per week so that we could fit 7 more sessions in before I left for a two-week vacation.

The first 5 sessions were used for history gathering, where I learned about her difficulties separating from her mother in adolescence, her first boyfriend’s death, and the story of her marriage. Her stories focused on her relationships, family and romantic, and there was little sense of her as a separate person exercising volition. She claimed that her husband was “stifling her development” and that he “refused to respect her as a separate person” with creative talent and ambitions.

The relationship between us was warm and “in tune”: We spoke with similar tempo and intonation, and sat with casual postures, both leaning forward with similar facial expressions. She talked at great length, filling in circumstantial details, and I was careful to stay empathically attuned and let her know that I wanted to hear everything she had to tell me. I offered a few interpretive comments about her **inner parts in conflict (P1)** – her “strong side” which doesn’t want to dwell on feelings and the voice of her “fear of craziness” – both of which served to keep her talking rapidly and not wanting to get close to feelings. She confirmed that she believed “the whole thing will topple if she lets feelings [from ex-boyfriend’s death] out, again.” I was silently hypothesizing about her **schemas (C2)** about men’s fragility, and speculated about **unconscious dynamics (P4)** in the possibility of schemas out of her awareness, such as “If I leave him, he will die” and “I don’t deserve happiness and fulfillment because I am responsible for killing my boyfriend.” My earliest intervention was to try to get her to express her needs and feelings, and to explore why it was so hard for her to do this, explaining that it was impossible to make a good choice without considering them (**E2 freedom and responsibility**).

By the 8<sup>th</sup> session, I noticed that she used words that confirmed the good fit of the **internal parts hypothesis (P1)**: the "real me" (a nonverbal part), "good wife" (her social role), "dark side," and "in control strong side." One very scared, childlike inner part -- "I won't be able to handle it, I'm going to have a nervous breakdown" -- needed to be soothed. She also recognized a "rescuer" after she blurted out, "I pick maimed men."

From both the stories she told me and my own experience of our therapeutic relationship, I was attempting to apply the concepts of Heinz Kohut (1980:1991) and evaluate the maturity or **immaturity of her self and conception of others (P3)**. In a concise summary of Kohut's complex theory, Kohut and Wolf (1978) explain that the intermediate stage of relationships between symbiosis and viewing other people as "real" objects, having their own needs, feelings, and separate perspective, is experiencing others as "selfobjects" (a term coined by Kohut), someone who is experienced as an extension of the self, valued for the functions she serves, and needed to shore up self-esteem and soothe painful emotions. A person at an immature (narcissistic) stage of development would be expected to need continual "mirroring" (confirming and admiring responses) and to react negatively to responses by the therapist that were not perfectly attuned and in agreement with her point of view. Such a person would not be able to take the point of view of others, soothe her own emotional distress, or tolerate challenges by the therapist to take a critical view of her own behaviors and choices.

In a key incident in our 8<sup>th</sup> session, Ms. Q demonstrated some of her more mature capacities. When she said "I think the 'true me' wants to leave my marriage," I invited her to check in with other parts, and asked "which part would feel guilty if you left?" She accused me of meaning "you should be happy with what you have." Without any intervention on my part, she quickly recognized that she had distorted my words, mistakenly assuming that I would give her the response she gets from family and friends when she expresses emotional torment about her life. The fact that she recognized her own incipient negative transference disconfirmed the hypothesis that she functioned on the narcissistic level in her relationships. In fact, when she told anecdotes of relationships with friends, she seemed very capable of empathy and able to handle minor ruptures in the relationships in an effective way.

### "Parts" Work

After a two week break in our sessions, we picked up where we left off, continuing to meet twice a week.

She wanted to deal with the pressure from her friends, mother, and brother to stay with her husband. After hearing her complaints about how the opinions of these people were obstacles to her happiness, I suggested "isn't there a part inside of you that feels that way and says that to yourself?" She immediately agreed, and this is when I described the **inner parts hypothesis (P1)** to her and explained the value of doing "parts work," where we could identify each part and let it make its needs known. In the next session she identified her conflict between "the creative, growth-oriented demands of her self" and "the pull of family ties." As I heard her externalizing the second part, referring to "them" as "sucking her in," I reframed it to identify an inner part of her that felt responsible and obligated to put them first. She rejected the idea of changing chairs



to express the different parts, but was willing, from a stationery position, to dramatize the parts with different voices and body postures. As I was listening to these parts, I found support for the **family systems (SCE1) hypothesis**: her attempts toward the differentiation of her self, a concept of Murray Bowen (Bowen, 1994), was both disturbing her family of origin and disrupting the equilibrium established with her husband and son.

### Integrated Cognitive and Emotional Focus

When we heard from her "thinking parts," it was easy to identify **faulty thinking (C2)**. With her all-or-nothing thinking, she wanted to embrace the male role, and accused me of using cultural stereotypes when I assumed that she would have guilt feelings if she left her child. I attempted to challenge all-or-nothing beliefs such as "it is impossible for a woman to develop her creativity and at the same time, be a good wife and mother." I pointed to the evidence that she had just received a very positive response from a publisher for a story she had submitted, and that she had achieved this success without neglecting her obligations to her family. While recognizing the cognitive distortions, I also saw these thoughts through the lens of the **cultural hypothesis, SCE2**. She was expressing gender disparities as well as describing the role that her Latina mother had enacted in her family of origin. In one session she brought in a book about gender differences and we had a conversation about society, socialization, and social change that would be indistinguishable from an academic classroom or a reading group.

In the next few sessions, we focused on her relationship with her husband. She described him as unresponsive to her needs, appreciative only of the functions she served for him, and belittling of her creative ambitions. My goal was to move her from describing her thoughts about him to expressing her feelings about his treatment of her. She began to express anger that had been building for a long time, and I attempted to maintain the focus on feelings. After a period of intense emotions, she admitted that she knew that her anger towards her husband was excessive, and that, as difficult as it was, she had to talk about the death of her ex-boyfriend. For several very emotional sessions I tried to just stay with her and let her describe and relive the period after the death. I had been influenced by Eugene Gendlin and wanted to stay with her moment-to-moment experiencing, and trusted that if she stopped avoiding the painful feelings, she would experience a positive transformation. The premises I was operating on are very similar to those of Leslie Greenberg's Emotion-Focused Therapy (Elliott & Greenberg, 2007; Greenberg & Paivio, 1997), derived from Rogerian, Gestalt, and existential frameworks, but at the time I did not have the benefit of Greenberg's clearly articulated theoretical framework. As I reflect on the process of this stage of therapy, I can see the relevance of the **conditioned emotional response (BL2) hypothesis**: "exposure" to her painful feelings was accompanied by my acceptance, warmth, and understanding, and she gradually reduced her fear of her own feelings.

The emotion of guilt was a focus of a few sessions, and I asked questions that gently challenged her **cognitive map (C2)** – that she was the only support he had (his parents were aware of his problems), that a person's drinking can be caused by another person's decision to break up, and that it was her duty to subjugate her feelings to make him happy. A significant cognitive change occurred that could be classified as a "redecision" (Goulding & Goulding, 1979). Whereas after the death she made the implicit decision that she was responsible and



deserved to suffer guilt, she was now able to believe, "I was not really responsible for his death – my leaving a man does not automatically kill him, and I have the right to make that choice." After these sessions she no longer needed to make her husband the bad guy to justify her leaving him.

In session 18 she reported that she had received a fellowship to attend a prestigious 6 month creative writing program in another state, which would begin in September. She had not previously mentioned applying for this fellowship, and admitted that she had done it as an impulsive gesture when she was in her "I must run away" state, and hadn't talked about it because she hadn't expected a positive response. She felt that she would benefit from not being in the shadow of her husband. To her amazement, her husband supported the plan of her going on her own, leaving him in charge of her son. At this point, she realistically could no longer view him as an obstacle to her creativity, and was motivated to look at her internal barriers.

### Inner-Self Work

For several sessions we focused on her fear of "being trapped" and losing artistic momentum. Using the conceptualization of the "grandiose self" from Kohut's self psychology (**P3**) combined with the methods of inner parts work (**P1**), I helped her to experience her "grandiose, creative self" by inviting her to talk from that part, in the present tense. She experienced the "scary excitement" of her "creative strength." She accepted the interpretation that she looked to external restraints (her husband, Motherhood) to keep this part in check. When the artistic self emerged in the session, or the vulnerable part that wanted its own true needs to be honored, I was "mirroring" in the sense of listening, accepting, putting words to inarticulate feelings and needs. She remembered as a little child that the family would clap for the achievements of the children; it was only in school, when she was teased by her classmates for being praised by the teacher, that she learned not to boast and to feel afraid of her joy in her creations. As her "inner artist" began to feel powerful, she applied the magical thinking of a two-year-old child to her decision-making process. She stated "I know I can have it all," and went on to detail how her husband will change, she will get whatever she wants, and there will be no negative consequences. Then a more rational inner voice asserted itself, reminding her that her husband very rigid in his approach to life, and her fears and qualms emerged again.

A key incident occurred when she confessed in a halting, shaky voice that she had engaged in impulsive behavior which she was very ashamed of, and appeared to be expecting my moral disapproval, or an analytic approach to expose deep psychological defects. In a spontaneous move on my part, I made a psychoeducational intervention, and said, "that sounds like 'acting out' behavior," and I gave a didactic explanation of how people often behave impulsively when it is hard to deal with the emotional internal conflict. She seemed appreciative of this information, and we went back to the prior topic. I was quite embarrassed about what I had done since it was unplanned and seemed too academic and lecture-like in its execution, but from the fact that, in future sessions, she used the word "acting out" and her desire to avoid it, I realized that this **cognitive label (C2)** was very useful, not only because it normalized behavior she was disgusted with, but because it gave her a framework for developing **better skills (BL3)** for coping with intense emotions.

Continuing the cognitive focus, I invited her to explore her beliefs. "What do you fear would happen if you became extremely successful without leaving your family?" "My husband would fall apart," was her immediate answer. She firmly believed that her husband's mental health depended on her downplaying her own talents and abilities, and that if she surpassed him in any respect (not just professionally and creatively) she would have to feel guilty about inflicting great harm. When I repeated back her words to her, she immediately recognized that her feelings of responsibility for her boyfriend's death were fueling her belief. I asked if there was evidence that her husband developed symptoms as she became more successful, based on the **family systems hypothesis, SCE1**. She admitted that he could very well tolerate her success, and laughed as she concluded that he would probably give her more appreciation than her mother had. Here it can be seen that I was implementing cognitive therapy in the style of Aaron Beck, helping her to become a better "personal scientist."

In an important session she recognized an **internal part that opposed the creative part (P1)** – she identified a "need to nest." Speaking from this part, she expressed how much she loved putting around the house, baking, relaxing on the couch in front of the TV, and noted that this part resented the demand to lock herself in a lonely room and engage in the painful process of writing. This awareness helped her understand why she felt she needed to get away to be creative – she found this "homebody" part too easily overpowered the "writer." Significant progress also occurred when we recognized that the part that had been treated as the "creative" voice was actually an alliance between two different parts – the "Creative Artist" and "Glorified Impulsivity." I pointed out that although she had come to therapy to reflect and avoid fleeing, she was expressing her glorification of a lifestyle guided by "pursuit of impulse" and a disdain for one guided by "devotion to duty." The concept of "duty" triggered a discussion of "good wife" and "good mother" in our society, and introduced issues of **gender, cultural history, and her intercultural background (SCE2)**

### Focus on Decision-Making

My termination from the clinic would occur at the middle of July, so we agreed to use our final sessions there to focus on the decision – to go or not to go? She wrote a letter to accept a place in the writing program, and felt that she had until the end of August to make a final decision. She saw that she didn't "have to escape" to pursue writing, but she was presented with a valuable opportunity and wanted to make a good choice. This statement of goal invited a strategy based on the **existential and spiritual hypotheses (ES2 and ES3)**: She had the freedom to make choices, but she also had to accept responsibility and live with the consequences of her choice. She wanted to minimize the negative effects on her son of leaving him for six months, and I repeatedly challenged what I viewed as faulty thinking. For instance, when she said "Being a good mother comes naturally to me, I know there's no danger of my hurting my son," I asked "How do you imagine he will feel at night when you're not there to tuck him in?" In one session she accused me (accurately, I admit) of trying to make her feel guilty, and I responded by explaining the difference between "neurotic guilt" and guilt that stemmed from her own, freely chosen moral values. I believe these interventions ultimately benefited her, but I was aware that my motivation could be classified as countertransference. As a child of 5 (3 years younger than her son) I had been sent to summer camp for two months, and, based on the intensity of my

suffering, I believed that 6 months away from his mother would be equivalent to torture. In the next session, I chose to self-disclose about that experience, in the framework of explaining why I was focusing on her son's feelings. To my surprise (and gratification), my disclosure caused her to recollect how she felt when her brother was born (she was 6), which led to much greater empathy for her son.

In our last session, she had not reached a decision, but I felt that she had an understanding of all the pros and cons of either choice, and was relatively free of self-deceptive rationalizations. She understood that she was welcome to see me in my private practice, and we agreed that we would have a follow-up meeting in the beginning of September.

### *Phase II: Sessions 29-36 (8 weekly sessions, September – November)*

#### New Settings

She arrived at my office, and after conversation about my new surroundings (spacious, sunny, nicely furnished), she announced proudly that she had made a decision to not enter the program. Instead, she had rented a studio apartment in a community an hour away from her home. She would spend weekends with her family, and spend the week away from them, writing. Her husband would be assisted by a housekeeper, who would be there five days a week. This was a *fait accompli*, and, in her mind, a mature compromise. When asked about her goals for continuing in therapy, she said "I want to go deeper into my past and my fears of abandonment and hurting people. I want to face who my husband really is, apart from my projections, and decide if we can be happy together in this marriage." With this statement, she indicated her openness to the hypothesis that **unconscious dynamics (P4)** were affecting her ability to make mature decisions.

This was the first time she had ever lived alone, and she had upsurges of strong feelings – panic, euphoria, desperate loneliness, and excitement. We focused on **inner parts work** – and identified the "Super-competent Caretaker" who holds everything together and the "Desperate Little Girl" who feels she is falling apart. She admitted that our sessions together were dominated by the first personality "I come in here and I sound so confident, then I go out and nothing is clear." She decided to bring in her journal and read from it so I can see the "Basket Case" side of her. We discovered another part, "Inner Peace," who she felt was at the center, and who "doesn't have to respond and rush back and forth like a gypsy to pacify, placate, control and manage." In learning to access this part when she was feeling confused and overwhelmed, she was finding **spiritual resources (ES3)** to manage her emotions.

#### Teaching the Concept "Selfobject"

In these sessions, I applied Kohut's concept of "selfobject" (**P3**) to explain that she was experiencing for the first time her disconnection from people who served the functions of maintaining her inner calm, and was facing the deficiencies in her ability to sooth herself. She announced in a session that she suddenly recognized that she had been emphasizing how men need her and she becomes responsible for them, but the truth was that it is she who needs the man to help her "keep it together." I used this new awareness as an invitation to teach her about

the concept of "selfobject," and described how people often need the relationship with another to help them regulate their feelings, and when that relationship is ruptured, they experience themselves falling apart.

She lit up and began describing how this concept made sense of many things in her relationships. She recognized how her episodes of chaotic emotions occurred when she was deprived of connection to her "selfobject." We discussed how in the first 7 years of their marriage, she was meeting her husband's needs and serving as his selfobject – he would ignore her when he didn't need her and expect her to be available when he wanted her. She saw the connection of the selfobject concept to her perception that her husband had used her as his trophy and ego-booster, rather than being aware of her as a separate person. She also realized how her ex-boyfriend had needed her as a selfobject. Something clicked for her then: it was not her responsibility to serve that role, and if he had lived a little longer he would have found somebody else to fill the same functions. She recognized that it now made sense that she wanted to hold on to her husband because of the security he provided.

In the next two sessions she talked about her experience of losing her special relationship with her mother as a little girl, when her brother was born. She narrated how she had been forced to suppress her true feelings and felt responsible for "keeping my mother glued together." She got emotionally in touch with the "hungry starving child" and had a very tearful session, over "being 35 and never having experienced that someone would actually want to give to me without my having to work for it." In discussing her childhood I used concepts from Alice Miller's *The Drama of the Gifted Child* (Miller, 1981), describing for Ms. Q how she had been exquisitely empathic to her mother's pain because of her natural gifts, and that this was the same sensitivity and awareness that she was now channeling into writing. She had a moment of recognition when she started laughing – "It's my sensitivity to others' pain that causes problems, and I keep blaming them for trapping me."

For several sessions, we focused on her writing and how productive she was, living in her own home/studio. She felt that she had found an **environment (SCE7)** where her true self was expressed, and she described the **spirituality of her creative process (ES3)**. She announced that she wanted to take a break from therapy to put all her energy and creativity into writing. I suggested we meet for two more sessions, and used these to review her progress.

***Phase III: Sessions 37-75 (38 sessions over 14 months,  
from May of year 2 to July of year 3)***

After six months, she called and expressed an urgent need to resume therapy. We decided to meet twice a week.

Contemplating Divorce

Her husband had entered individual therapy in order to work on the faults she had accused him of (e.g., inability to connect with her emotionally). She was angry that he wanted her to commit to their marriage and return to living together, and said that he was threatening to fall apart if she doesn't stay with him. Her mother and brother were taking her husband's side

and she felt "they think I'm doing the wrong thing, and they will never forgive me." Although her stated goal was to "settle the conflict I have over what to do with this marriage," I believed her goal was to strengthen her courage and resolve to leave the marriage without fear or guilt, and she wanted my seal of approval. She was proud of her increase in confidence and self-sufficiency: "When we met he was my strength and stability, I used to be so dependent I thought that if he would die I would be nothing, and now I think I can survive alone." She claimed that her only reasons for staying in the marriage were "not wanting to destroy him," and "not wanting my son to lose a father."

In this phase of therapy, I chose a cognitive focus, and challenged her beliefs about the obstacles to divorce. She realized that her son would not lose a father, and that in fact the more likely scenario would be that her husband would want custody (which was essentially what their current living situation was like.) She needed to remind herself again and again that her fear of destroying her husband was based on the **faulty beliefs (C2)** formed when her ex-boyfriend died. I also wanted her to test the beliefs that her husband could never meet her needs. She agreed to keep a daily journal and write at least a sentence a day to address what she defined as key questions for her decision: "Is he capable of the kind of intimacy I need? Can he ever understand me? Can he ever touch my emotional core?" In session #39 she proposed to revisit the period after the death of her boyfriend, saying "no matter how I try to avoid it, we always seem to go back there." Later in the session she went back to the pain for her childhood. She stated that she didn't see why she should be so afraid of being alone, because "I have always been alone, I have always covered my pain and presented a good show to others."

She began to review events in the marriage that she had brushed aside. For instance, her husband had problems with alcohol and had neglected many responsibilities. She expressed her desire for an unrealistic solution: to keep the marriage, live separately, have total freedom, and share parenting. (This falls into the category of **utopian thinking, C1**). My goal was to listen, ask questions, let her bring out her feelings and thoughts, and to keep the focus on her and her inner conflict, instead of letting her drift off to talk about other people. Her greatest pain seemed to be over her family siding with her husband. She reported that her son asked her about divorce, and that was the first time that word entered our sessions.

### Balancing Different Roles

It was at this point, when she was satisfied with her path as an artist and that no one could take it away, that she brought her parenting concerns into the session. She announced that she was no longer satisfied with the arrangement and was going to live full time with her son again. She explained that she had "needed to strengthen my sense of being an independent self in order to face how much he needs me," and "if I had let myself think about it earlier, it would have totally stopped the process." We examined her definitions of "nurturing" as being "sucked," forced to make sacrifices, and being incapable of functioning as an independent self. One of the metaphors she used was "valves" – she needed to know that she could turn off the mothering valve and get fully into her own (creative) needs and then turn the mothering valve back on, as needed. Similarly, she needed to know that she could turn on and off the "creative artist" valve at will.



When she told her husband she wanted to move back home, instead of embracing this chance to restore their family, he expressed relief that now she could care for their son and he could accept a visiting professor opportunity at a prestigious east coast university. That response shocked her and triggered feelings of rejection. Then she learned from a friend that her husband had started a relationship with a woman who was affiliated with that university, and that he was intending to live with her during his leave of absence. Ms. Q's outpouring of rage was mingled with laughter and relief. Her husband's infidelity made it easy for her to view him as having made the decision for her.

She announced to her husband that she wanted to divorce. She spent several sessions becoming comfortable with her decision and feeling the joy and fear of standing on her own and choosing her own direction. She expressed gratitude for the growth that allowed her to realize how stifled and unhappy she had been. She decided to take her son on a trip to Europe for the two months in summer, and to resume therapy when she came back.

### Standing on Her Own

At the session after her return from vacation, she announced that she had accepted that her husband had changed and described her lethargy and grief over the finality of the split. She was insightful and introspective about her failure to grieve her first ex-boyfriend's death, and accepted responsibility for many of the problems in her marriage. She identified her goal of working out details of child custody and division of property in a calm, businesslike way. During the eight months until her divorce was final, we met at a frequency that was very flexible – sometimes twice a week, sometimes twice a month. We identified the need for better **communication and emotional management skills (BL3)**. Through role playing, she practiced how she could ask him questions to get him to express his thoughts and use "I messages" to express what she wanted. We did some parts work to find a self-soothing part, a voice that would calm her emotional reactions. When she tried to speak from this part, she recognized that she was hearing the "Be quiet" messages she got as a child. This was a significant breakthrough, and we talked about it for several sessions. She realized that she had bundled together "creativity," "freedom," and "out-of-control emotional tantrums," and felt that a message to suppress the latter was an attack on the other two. We discussed alternate ways for her to express a self-soothing message that would not be experienced as an attack, but as a helpful voice that would help her function more effectively. She made the connection to the need to "flee" and the lack of an inner "voice of calm." She also recognized that whenever her husband said "calm down," she became enraged as if she were fighting for survival.

### Final 5 Sessions

As part of the divorce agreement, they sold their house and she received a substantial financial settlement. She decided to move to a coastal town about three hours away, and we set the termination date of therapy at the end of July, two weeks prior to her departure. This made the total course of therapy 23 ½ months, spread over 2 years and 4 months.

In the second to last session she reported going to visit her mother and siblings and being able to stay calm and not respond to behaviors that would have triggered outbursts in the past. She was pleased that they were furious at her husband for his "deceit and betrayal," and were now saying that she should have divorced him years ago. This validation seemed to relieve her of a burden of guilt and regret.

I wanted to use the remaining sessions to review her progress in therapy, invite her to express her feelings about terminating, and help her prepare for the future. I reminded her that the initial goal was to make a decision about her marriage with reflection, instead of impulsively running away. She said that she had gotten exactly what she wanted (living separate from her husband) but that thanks to therapy she hadn't abandoned her child, and felt satisfied that she and her husband will be able to work cooperatively as parents. She found it difficult to express any emotions about ending therapy, claiming she was overwhelmed with the shopping and packing she had to do. I suggested that we focus on her achievements during the course of therapy and what specific gains she was taking with her. She stated that the biggest gain was that she had given up the game of suppressing herself and living for others. She called it her "caretaker addiction" and noted that she no longer felt that if she pursued her creativity that it meant that people would abandon her and that she would end up alone. She said that she had gained a new awareness of having a "solid strong core" and that the "crazy hysterical out of control self" that she used to fear was her core was just one part of her, and that she was no longer afraid that it would take over.

## **7. THERAPY MONITORING AND THE USE OF FEEDBACK INFORMATION**

In general, I view the monitoring process as ongoing. The client's response gives immediate feedback to the appropriateness of an intervention or the quality of the therapist-client bond, and the client's report of out-of-therapy experiences provides data of positive change, deterioration, or maintenance of the status quo.

From the very beginning, I realized from Ms. Q's feedback to me that she would respond better if I refrained from an analytic style and instead became more engaged, sharing my opinions and a few relevant experiences, judiciously. She told me point blank that she did not want to be treated like a "case" but like a "real human being" and complained about the prior therapist who had listened and allowed long periods of silence, without ever offering an opinion. My style with her was also influenced by her use of metaphors and humor, which I happily integrated into our sessions. For instance, she used imagery of "valves" to help her integrate her roles of mother and creative artist, she mimicked the voices of other people when she described conversations, and she dramatized the voices of some of her inner parts in a playful, dramatic way. Consistent with the "common factors" literature, I think that the strength of the relationship was a major therapeutic factor, and I monitored it closely.

I received direct feedback from Ms. Q that the "inner parts" way of viewing inner conflict and my cognitive approach during the first phase of therapy were both effective approaches. She reported that she had had coped successfully by using these new tools when a very close friend



had been unavailable to her. Whereas previously "it would have put me in bed for days with a breakdown," she was instead able to immerse herself in her creative work. She used language from our parts work to explain this improvement: "My needy part was not going to take over just because I didn't get the comfort I wanted."

In another session, she described a "breakthrough" and showed that something I had suggested 5 sessions previously had borne fruit. She was willing to talk about her ex-boyfriend's death and became very tearful. In this session, as I wrote in my notes "she is letting me see the scared, trembling, overwhelmed kid inside, instead of presenting me with the smiling, articulate, poised, and in-control woman." Her belief that "I've already dealt with it" had yielded to "I need to stay with this in order to get unstuck." She said "I know this will make you happy" in a collaborative, cheerful way, indicating that she was not depriving me of that experience, as she would do with her mother. In fact, after this session, she paid some visits to her mother and their relationship was more comfortable and equal, and she was able to test reality and learn that her mother was proud of her and thought she was a good parent. These events gave me feedback regarding her maturation and differentiation from her mother – she no longer was stuck at age 17, when her mother had been an obstacle to her happiness.

In session #22 a bit of unintended psychoeducation had surprising benefit. She confessed to me something she was very ashamed to have done, and I gave her a technical-sounding definition of the term "acting out": "It must be so hard for you to contain the overwhelming feelings that you're letting yourself experience, you used a common mechanism to deal with or avoid them." I was reframing her impulsive behavior from "something bad and shameful" to "a not-so-effective way of avoiding emotions." At the end of therapy, Ms. Q said that this was one of the most helpful moments because it motivated her to learn to tolerate her feelings and not push them away. Similarly, my didactic explanations about the "selfobject" concept were beneficial in giving her an explanation for painful feelings as well as a conceptual framework for the weaknesses in both of her relationships. At the time of my psychoeducational interventions, I had felt embarrassed over switching to the role of teacher and, in fact, had felt guilty about reporting these incidents to my supervisor. I learned from this experience that the quality of an intervention must be judged by how it impacts the client and whether it produces positive change in her life. Furthermore, since the client used the intervention in a way that exceeded my expectations, it underlines the importance of therapists listening carefully to our clients to discover the impact of our words.

I was fortunate that Ms. Q was quite direct in telling me her occasional doubts about the benefits of therapy. For instance, in one session she asked "what's the use of therapy, is this really helping?" I asked her to think about it, and then a couple sessions later asked for her response. She said "It's my time, I get to focus on myself. Otherwise I'm fragmented and confused. I feel confirmed." This feedback confirmed for me that she was experiencing benefits predicted by Kohut's theory, by developing capacities of a more mature self.

On three occasions, she brought in books and read passages related to gender roles and conflicts. I noticed that the content and tone of her chosen excerpts had progressed from strident feminist male-bashing to an appreciation of the struggles of both men and women to develop

their fullest capacities. These changes corresponded with a more internal focus, less blaming of her husband as an "obstacle," and the ability to tolerate her own painful emotions instead of focusing on externals.

## **8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME**

The case formulation is an essential framework for therapy, but rather than being an architectural blueprint it is an ever-evolving itinerary on an unpredictable journey. It is modified through various influences and obstacles: the client's preferences, the therapist's interpersonal style, the real human relationship that develops between the two, and the impingement of real life events and reactions of other people outside the office.

Instead of being short-term/time-limited, or long-term/open-ended, the course of therapy was actually three separate episodes, with breaks in between resulting from vacations, what Cummings and Sayama (1995) might call "intermittent." The client's outcomes at the time of our last contact included satisfaction with her decision to terminate the marriage, pride in having not neglected her responsibilities as a mother, greater personal confidence and maturity, and success in engaging for longer periods of time in creative writing, her chosen career. I believe that therapy contributed substantially to these successes. However, major credit for positive change goes to factors out of our control: her husband found another girlfriend and didn't wait around for her to overcome ambivalence; this led to her mother and sister turning against him and becoming very supportive rather than blaming; and she gained external validation for her writing talents from the acceptance of her stories in magazines and the praise of other writers.

I began working with this client in a psychoanalytic institute that provided instruction and supervision in therapy based on Kohut's self psychology, emphasizing the development of transference. I initially expected a selfobject (narcissistic) transference to unfold, in which I would be viewed by Ms. Q as someone serving functions to shore up her self, rather than as someone who is a separate individual with a separate point of view. Some of the markers of that type of transference is the need for "mirroring" (uncritical acceptance), a rejection of ideas from the therapist that offer a new perspective, and an overreaction of rage to minor "empathic failures." Such is the pressure of training settings with a firm orientation that it would be easy for trainees to ignore the data from the client and make assumptions about the client's dynamics from the preferred theory. Determined to resist that pressure, I attended to the client's reactions to me, and to the development of our relationship, and found that she was open to new ideas, very tolerant of my mistakes, and eager to change her perspective. The pleasure of working with this client stemmed from the fact that she was intelligent, motivated, and, most important, viewed me as a "real" person and valued my contributions. Since that time, I have always emphasized the importance of "developmental diagnosis" for understanding the client, creating the best relationship, and making appropriate treatment decisions.

Kohut's theory not only helped me evaluate her level of maturity in relationships, but also was an invaluable lens for understanding her difficulty separating from her husband as well as how her healthy, creative, "grandiose self" had been squelched and now needed support to

find its power and voice. Thus the therapy process was enriched by my integration of Kohut's concepts, without my embracing his treatment methods. Instead of functioning like an analytic therapist, I engaged in a more equal, collaborative, "real" relationship, often similar to what Kopp (1978) described as a "fellow pilgrim." I also took the expert consultant role when I implemented cognitive strategies, directed experiential inner parts activities, and offered psychoeducation.

I was aware of how my personal values were involved in the process of therapy. When she talked about leaving her 8-year-old son with her husband, I had judgmental thoughts about her being a bad mother, and, trying not to sound judgmental, confronted her on her rationalizations ("my son doesn't need me any more"), and tried to strengthen the part of her that felt guilty. For instance, when she said "Being a good mother comes naturally to me, I know there's no danger of my hurting my son." I said "How do you imagine he feels at night when you're not there to tuck him in?" In my view, in these sessions I was the advocate for her child, although I suspect that my approach would be labeled "countertransference" by others at the institute.

It was an enormously valuable experience for me to write this case report and re-evaluate the course of therapy from my current perspective. At the time, I was trying to learn a psychodynamic orientation and frequently felt embarrassed and annoyed at myself for violating the rules: I spoke too often, I "broke the frame" by giving opinions and validation of the client's strengths, and I destroyed opportunities for transference to develop by being too spontaneous, self-disclosing, and genuine. In hindsight, I see that I created a positive relationship, showed respect for Ms. Q's autonomy and maturity instead of emphasizing pathology, and exhibited flexibility and creativity. This case report illustrates how "core clinical hypotheses" influenced my therapeutic decisions, and how diverse ideas can be integrated coherently when the focus is on resolving problems and achieving desired outcomes.

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**Table 1. Twenty-Eight Core Clinical Hypotheses**

**Biological Hypotheses (B)**

- B1:** The psychological problem has a **BIOLOGICAL CAUSE:** The client needs medical intervention to protect life and prevent deterioration, or needs psychosocial assistance in coping with illness, disability or other biological limitations.
- B2:** There are **MEDICAL INTERVENTIONS** (e.g., medication, surgery, or prosthetics) that should be considered.
- B3:** A holistic understanding of **MIND-BODY CONNECTIONS** leads to treatment for psychological problems that focus on the body and treatment for physical problems that focus on the mind.

**Crisis, Stressful Situations, and Transitions (CS)**

- CS1:** The client's symptoms constitute an **EMERGENCY:** Immediate action is necessary.
- CS2:** The client's symptoms result from identifiable recent **SITUATIONAL STRESSORS**, or from a past traumatic experience.
- CS3:** The client is at a **DEVELOPMENTAL TRANSITION**, dealing with issues related to moving to the next stage of life.
- CS4:** The client has suffered a **LOSS AND** needs help during **BEREAVEMENT** or for loss-related problems.

**Behavioral and Learning Models (BL)**

- BL1:** A behavioral analysis of both problem behaviors and desired behaviors should yield information about **ANTECEDENTS** (triggers) **AND CONSEQUENCES** (reinforcers) that will be helpful in constructing an intervention.
- BL2:** A **CONDITIONED EMOTIONAL RESPONSE** (e.g., anxiety, fear, anger, or depression) is at the root of excessive emotion, avoidant behaviors, or maladaptive mechanisms for avoiding painful emotions.
- BL3:** The problem stems from **SKILL DEFICITS** – the absence of needed skills -- **OR** the **LACK OF COMPETENCE** in applying skills, abilities and knowledge to achieve goals.

### **Cognitive Models (C)**

- C1:** The client is suffering from the ordinary "miseries of everyday life" and has unrealistic **UTOPIAN EXPECTATIONS** of what life should be like.
- C2:** Limiting and outdated elements in the **FAULTY COGNITIVE MAP** (e.g., maladaptive schemas, assumptions, rules, beliefs, and narratives) are causing the problem or preventing solutions.
- C3:** The client demonstrates **FAULTY INFORMATION PROCESSING** (e.g., overgeneralization, all-or-nothing thinking, and mindreading, or is limited by an inflexible cognitive style.
- C4:** The problem is triggered and/or maintained by **DYSFUNCTIONAL SELF-TALK** and internal dialogue.

### **Existential and Spiritual Models (ES)**

- ES1:** The client is struggling with **EXISTENTIAL ISSUES**, including the fundamental philosophical search for the purpose and meaning of life.
- ES2:** The client is **AVOIDING (or needing to utilize)** the **FREEDOM** and autonomy that come with adulthood **AND/or** does not accept **RESPONSIBILITY** for present and past choices.
- ES3:** The core of the problem and/or resources needed for resolving the problem are found in the **SPIRITUAL DIMENSION** of life, which may or may not include religion.

### **Psychodynamic Models (P)**

- P1:** The problem is explained in terms of **INTERNAL PARTS AND SUBPERSONALITIES** that need to be heard, understood, and coordinated.
- P2:** The problem is a **REENACTMENT OF EARLY CHILDHOOD EXPERIENCES**: Feelings and needs from early childhood are being reactivated and patterns from the family of origin are being repeated.
- P3:** Difficulties stem from the client's failure to progress beyond the **IMMATURE SENSE OF SELF AND CONCEPTION OF OTHERS** that is normal for very young children.
- P4:** The symptom or problem is explained in terms of **UNCONSCIOUS DYNAMICS**. Defense mechanisms keep thoughts and emotions out of awareness.

### **Social, Cultural and Environmental Factors (SCE)**

**SCE1:** The problem must be understood in the context of the entire **FAMILY SYSTEM**.

**SCE2:** Knowledge of the **CULTURAL CONTEXT** is necessary to understand the problem and/or to create a treatment plan that shows sensitivity to the norms, rules, and values of the client's cultural group.

**SCE3:** The problem is either caused or maintained by deficiencies in **SOCIAL SUPPORT**.

**SCE4:** Difficulty meeting demands for **SOCIAL ROLE PERFORMANCE** contributes to the client's distress and dysfunction.

**SCE5:** **A SOCIAL PROBLEM** (e.g., poverty, discrimination, or social oppression) **IS A CAUSE** of the problem. Social problems can also exacerbate difficulties stemming from other causes. You must avoid *blaming the victim*.

**SCE6:** The problem is causally related to disadvantages or advantages to the **SOCIAL ROLE OF MENTAL PATIENT**.

**SCE7:** The problem is explained in terms of **ENVIRONMENTAL FACTORS**: Solutions can involve modifying the environment, leaving the environment, obtaining material resources, or accepting what can't be changed.



**Table 2. Twenty-Eight Clinical Hypotheses for Conceptualizing a Case, Illustrated for the Assessment and Treatment Planning for Ms. Q**

Hypotheses	Space for Data, Questions, and Ideas
<b>I. Biological Hypotheses (B)</b>	
<b>B1 Biological Cause</b>	There was no biological (medical) cause for the client's difficulties; many of her strengths (intelligence, artistic talent have genetic roots.
<b>B2 Medical Interventions</b>	Her intense anxiety and dysphoria were directly related to the major life decision she was struggling with, and we agreed that diminishing the emotions with medication would not be helpful.
<b>B3 Mind-Body Connections</b>	Instead of medication, stress-management techniques that focused on breathing and exercise were used. She spoke rapidly and kept a very fast pace of daily activities, avoiding feeling her emotions in her body.
<b>II. Crisis, Stressful Situations, and Transitions (CS)</b>	
<b>CS1 Emergency</b>	The pressure of needing to make a major life decision within a specified time frame set a note of urgency and prevented the leisurely pace of open-ended therapy. The choices she was considering would have an impact on the welfare of her child.
<b>CS2 Situational Stressors</b>	The stressors in her life were self-imposed, although she spoke about them as if they were external. At one stage in therapy, once she had made decisions to change her residence, she was coping with situational stressors.
<b>CS3 Developmental Transition</b>	This hypothesis is relevant on both the individual and family level. Her only child was in school, moving to a more mature developmental level, which reduced the demands on her time for mothering activities. She saw this as a new stage – time for her to pursue her professional goals.
<b>CS4 Loss and Bereavement</b>	There were several prior losses (death of father, death of former boyfriend) that were still powerful influences on her sense of worth and autonomy. As she moved towards the decision to separate from her husband, anxiety over impending loss became prominent.
<b>Behavioral and Learning Models (BL)</b>	
<b>BL1 Antecedents and Consequences</b>	The behavioral model was not explicitly used in therapy, but I was aware of rewarding certain behaviors in therapy, e.g., "taking responsibility instead of externalizing the cause."
<b>BL2 Conditioned Emotional Response</b>	This hypothesis meshes nicely with the psychodynamic ones discussed below: her fears and avoidance had developed from earlier learning experiences and she needed to learn how to tolerate unpleasant feelings without impulsively acting. The therapy process provided a reconditioning experience – warmth and acceptance instead of punishment for expressing "bad" thoughts and feelings.
<b>BL3 Skill Deficits or Lack of Competence</b>	She had poor skills in many areas, such as emotional management skills, communication skills, and problem solving. She also had many areas of competence: verbal skills, creative writing, homemaking, parenting, and friendship.

<b>Cognitive Models (C)</b>	
<b>C1 Utopian Expectations</b>	She frequently described impossible goals – “to leave my husband and have him be happy with my decision,” “to take a vacation from my mother role without it having a negative effect on my child.”
<b>C2 Faulty Cognitive Map</b>	Numerous faulty beliefs were identified: “my marriage prevents me from fulfilling my creativity”; “If I leave a man, I am responsible for his future welfare,” “being true to my self means that I will lose love and be all alone.”
<b>C3 Faulty Information Processing</b>	She engaged in mindreading with her husband, never checking out the validity of her assumptions.
<b>C4 Dysfunctional Self-Talk</b>	There were many examples of ways of thinking that increased her anxiety and anger, and limited her choices, such as (while sitting down to write) “it’s not fair,” “I can’t bear this,” “this is my last chance.”
<b>Existential and Spiritual Models (ES)</b>	
<b>ES1 Existential Issues</b>	This was one of the most important hypotheses in my approach to this client. She was seeking a more meaningful life, and was faced with difficult choices. The concept of existential anxiety was a good match for the intensity and timing of her anxiety – she was afraid to stand on her own and accept the consequences for her choices. The themes of freedom, limitations, and commitments were very relevant to her struggle to design a path for the next phase of her life.
<b>ES2 Avoiding (needing to use) Freedom and Responsibility</b>	This hypothesis integrates seamlessly with the prior one: She wanted freedom without consequences, and wanted to experience herself as forced to move in a certain direction, rather than freely choosing it.
<b>ES3 Spiritual Dimension</b>	The push to develop her creativity seemed to stem from spiritual roots. She was fighting for the welfare of her soul. As she explored more deeply her relationship with her husband, she focused on the lack of connection, using terms and metaphors that come from the spiritual realm. She rejected the religion of her childhood (Catholicism) but her strong sense of guilt and conflict over divorce were no doubt influenced by her upbringing.
<b>Psychodynamic Models (P)</b>	
<b>P1 Internal Parts or Subpersonalities</b>	This was a very useful hypothesis and was easily applied because she clearly recognized that she had inner parts in conflict – to stay or to go, the mother versus the writer – and she found the inner-parts work very productive. Understanding the “cast of characters” in her own drama was compatible with the tasks she was familiar with as a creative writer.
<b>P2 Reenactment of Early Childhood Experiences</b>	The template from early (and later) childhood was that she couldn’t be her true self and maintain her mother’s love and approval.

<p><b>P3 Immature Sense of Self and Conception of Others</b></p>	<p>Kohut's concept of "grandiose self" was important for understanding the creative drive; the fact that it was inadequately "mirrored" in childhood contributed to her need to protect it, and her assumption that it would be attacked and stifled by her husband. As a child in her family she was initially in a very close relationship with her mother, where the normal roles were reversed, and she had to be sensitive to her mother's emotional needs, instead of getting the empathic attunement and calm, loving acceptance for her true self that she needed (Alice Miller's (1981) <i>Drama of the Gifted Child</i> is a good fit with this client's history) Her maturation over the 12 years of her marriage was an important factor in understanding the marital dynamics. Initially, she had been immature and was satisfied with serving her husband's needs, deriving a sense of safety and worth by being his wife. However, at the time of therapy she wanted to assert her own needs and fulfill her own talents. She was having difficulty finding inner sources of self-affirmation, and wanted to separate in the way an adolescent wants to break away. Her empathy for others was variable.</p>
<p><b>P4 Unconscious Dynamics</b></p>	<p>There is plenty of material in the history for speculation: rage at brother (for being born and stealing her mother) and father (for dying and abandoning her) may have contributed to her feelings towards her husband. The guilt over her boyfriend's death was talked about, so it seemed conscious, but its persistence despite her awareness that it was irrational suggests that it persisted in limiting her ability to leave another relationship.</p>
<p><b>VII. Social, Cultural, and Environmental Factors (SCE)</b></p>	
<p><b>SCE1 Family Systems</b></p>	<p>As the client matured and became more independent and assertive, it disrupted the marital equilibrium Her husband wanted to assert pressure to return things to the status quo, and did indeed seem to want to sabotage her career development. Her desired solution of "cut off" was easier than the process of differentiating and standing on her own.</p>
<p><b>SCE2 Cultural Context</b></p>	<p>Her mother's hostile disapproval of the client's lifestyle choices stemmed from Latina/Catholic background. The issue of gender was important to the client: men have an easier time pursuing careers and ignoring the needs of their families and she felt hampered by the traditional female role.</p>
<p><b>SCE3 Social Support</b></p>	<p>She had a good support system in her friends. Her mother and siblings sided with her husband and pressured her to put family ahead of "selfish" goals.</p>
<p><b>SCE4 Social Role Performance</b></p>	<p>The roles of wife/mother/homemaker were the ones she was familiar and successful with. She experienced conflict when she wanted to pursue the role of writer/professional.</p>
<p><b>SCE5 Social Problem is a Cause</b></p>	<p>This hypothesis was not relevant: although she was of both Asian and Latina background and fits into minority categories, she had not directly experienced discrimination, came from a middle class background, and had been expected to complete college.</p>

<b>SCE6 The Social Role of Mental Patient</b>	Not relevant, she had never received a stigmatizing label. Her prior therapy was in response to a situational stressor (death of ex-boyfriend); she was not seeking to evade responsibilities and, in fact, objected to therapeutic methods that made her feel like a "case."
<b>SCE7 Environmental Factors</b>	This was an important consideration in that her ability to concentrate on writing and feel relieved of the pressures of family responsibility was affected by the physical location/setting of her writing.

**Table 3: Formulation Ideas for Problem #1**

<b>Problem #1 Tendency to act impulsively instead of making thoughtful decisions</b>	
<b>Outcome goals:</b> Make a decision to resolve current dilemma as well as develop decision making and emotional management skills for future situations	
<b>HYPOTHESES (and explanations with reference to data)</b>	<b>Treatment Ideas</b>
<p><b>BL3 – Skills deficits and lack of competence</b>                      Client needs emotional management skills so that she can tolerate anxiety and develop awareness of hidden emotions (e.g., fear, anger) that influence her decision and contribute to impulsivity. She also needs to improve problem-solving and decision making skills.</p>	<p>Suggest methods for coping with intense feelings; help her conceptualize two separate decisions, (1) how to best pursue her writing (problem #2) and (2) how to either improve her marriage or seek an amicable separation. (problem #3)                      Discuss multiple alternatives and possible compromises.</p>
<p><b>ES2 -- Freedom and responsibility</b>                      She needs experience in exercising freedom while examining consequences and making choices that are consistent with her values and taking responsibility for her actions. The anxiety that she experiences will be accepted as a natural part of exercising freedom, making a major life decision.</p>	<p>In conversations about her dilemma, confront self-deceptions, challenge her when choices go counter to values, invite imagery of probable consequences.</p>
<p><b>C2 -- Faulty cognitive map</b>                      She is fixed in either-or conceptualization and has faulty beliefs that her husband "stops her" from being successful, and that her son won't miss her.</p>	<p>Challenge her faulty beliefs and ask questions to test her belief that her son won't miss her. Plans for problem #2 will enrich her conceptualization of the issues and help her see more complexity in her motivation.</p>
<p><b>P1 – Internal parts and subpersonalities</b>                      Her "impulsive" or "freedom-seeking" part becomes overly powerful, and she needs to strengthen the rational and self-soothing parts so that she can deal with ambivalence.</p>	<p>Discuss inner parts; experiential activities to let her speak from different parts, serve as role model of a "rational problem solver"</p>

**Table 4: Formulation Ideas for Problem #2**

<p><b>Problem 2 Lack of confidence in her ability to succeed in her chosen creative career, and frustration over obligations that impede full time dedication</b></p> <p><b>Outcome goals:</b> She will feel confident that she can put her best efforts into writing, regardless of her marital status, and without neglecting obligations as a mother, and understand and cope with internal impediments.</p>	
<p><b>HYPOTHESES (and explanations with reference to data)</b></p>	<p><b>Treatment Ideas</b></p>
<p><b>P3 – immature self and conception of others</b> Her artistic drive is an expression of the “grandiose self” which was never adequately mirrored and supported. The emergence of these needs and talents at this time in her life is a healthy movement, yet at the same time, the “archaic” nature of this need fuels the impulsivity; as an adult the healthy grandiosity needs to be integrated with her duties and obligations, and attention to the needs of other family members.</p>	<p>Listening, empathic attunement, refraining from judging, recognizing and circumventing transferences that put me in role of judgmental mother. Interpretation of early childhood origins of her weakened “creative self.”</p>
<p><b>ES3 -- Spiritual</b> There is a powerful spiritual drive behind her desire to create, find meaning, and put her heart and soul and talents into the creative process.</p>	<p>Validation and emotional connection with her spiritual, artist self. Focus on strengths and a healthy drive for maturation and creativity, and abstain from behaviors and words that would “pathologize” her strivings and dilemmas.</p>
<p><b>SCE2 -- Cultural factors</b> There are gender and cultural issues that impeded her confidence in success. She learned that women are supposed to subjugate their own needs and both depend on and take care of men. In her limited contacts with her mother and sister, she is pressured to put his needs ahead of her own “selfish” goals.</p>	<p>Psychoeducation about culture and gender. Use self-disclosure, when relevant, regarding possibility of balancing career and family.</p>
<p><b>C2 -- Faulty cognitive map</b> Many cognitive schemas impede her ability to both confidently pursue her writing and engage in her family responsibilities. A major one is “I can only succeed as a separate and unencumbered single individual,” “My son won’t miss me if I go away,” and “My husband prevents me from succeeding.” She also believes “This would be easy if I were a man.”</p>	<p>Cognitive reframing and challenges to distorted thinking and repeatedly keeping the conflicts and fears inside of her, instead of allowing her to externalize, blame, or seek magical solutions that ignore her other commitments and obligations.</p>
<p><b>SCE1 Family system</b> The degree to which her husband is exerting pressure to maintain the equilibrium of traditional marital roles (he, the brilliant successful scholar/writer, she, the dependent housewife, hostess and social companion) needs to be evaluated.</p>	<p>Get concrete descriptions of words and behaviors. Support her differentiation from the family of origin by dealing with guilt.</p>

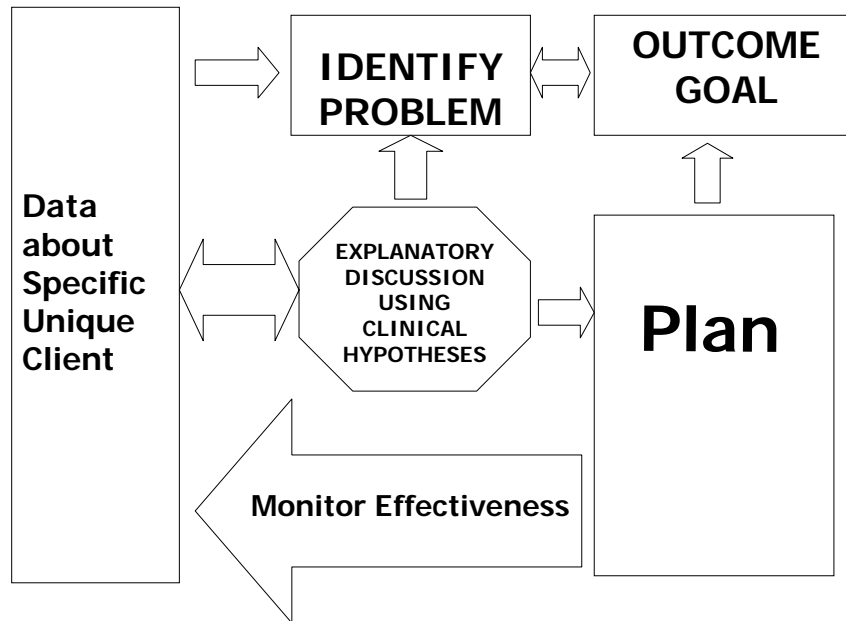
**Table 4: Formulation Ideas for Problem #2 (cont.)**

<p><b>Problem 2 cont.: Lack of confidence in her ability to succeed in her chosen creative career, and frustration over obligations that impede full time dedication</b></p> <p><b>Outcome goals:</b> She will feel confident that she can put her best efforts into writing, regardless of her marital status, and without neglecting obligations as a mother, and understand and cope with internal impediments.</p>	
<p><b>HYPOTHESES (and explanations with reference to data)</b></p>	<p><b>Treatment Ideas</b></p>
<p><b>SCE7 Environmental factors</b> She needs a work environment that meets her needs for boundaries between work and family. To date, she has tried to write in a room adjacent to her husband, in the home with pressures of other obligations.</p>	<p>Problem-solving discussions on how to find an environment and other supports for her writing.</p>



**Table 5: Formulation Ideas for Problem #3**

<b>Problem #3: Ambivalence about future of her marriage</b>	
<b>Outcome goals:</b> She will see her husband realistically and no longer view him as the obstacle her creative writing career. She will make decisions based on needs as an adult, while considering best interests of her child.	
<b>HYPOTHESES (and explanations with reference to data)</b>	<b>Treatment Ideas</b>
<b>C2 -- Faulty cognitive map</b> Her husband is misperceived as an obstacle to the development of her talents. She has many faulty beliefs about men, marriage, and the possibility of combining marriage and career. Her difficulty contemplating breaking up the marriage stems in part from guilt over her boyfriend's death, which she believes she was responsible for.	This issue is addressed in the plans for the prior 2 problems. Use questions and suggestions to help her see her husband as a real person, and examine the real data of their relationship. Gently help her approach the death and express her feelings. Then explore the schemas that developed and help her relieve herself of guilt by understanding that she was not responsible for his addiction or choices.
<b>P4 -- Unconscious dynamics</b> Her unresolved guilt over the death of her boyfriend is a barrier to making the choice to leave her marriage. The thought of leaving flooded her with fears and anxieties, which she had been pushing out of awareness. Early childhood issues of abandonment (when mother rejected her in favor of her brother) were also under the surface.	Therapy will need to focus on the emotional consequences of her boyfriend's death following her breaking up with him, and of her mother's rejection. Emotional expression in therapy will be necessary.
<b>SCE1 -- Family systems</b> At a young age she married an older man who met her needs for parental approval and connection. However, 15 years later, as she matured and became more independent and creative, the equilibrium was disrupted. Her husband wants to maintain the familiar roles and power structure.	Psychoeducation regarding psychological development and family systems. Help her explore her objections to conjoint therapy for marital issues.
<b>BL3 -- Skill deficits</b> The marriage might be improved if she learns to express her needs and limits in an assertive (not passive or aggressive) way, and if they both develop greater competence in solving problems together, and finding solutions that meet both their needs.	Practice different styles of communication and help her test whether husband's response changes. Invite her to take his POV and role play how he thinks and feels.
<b>ES2 -- Freedom and responsibility</b> The decision about staying or leaving the marriage will be easier when she has resolved other problems, and achieved new ways of thinking and behaving.	Help her understand why a better decision about the marriage will result when she has achieved other goals. Support her freedom and remind her of consequences.



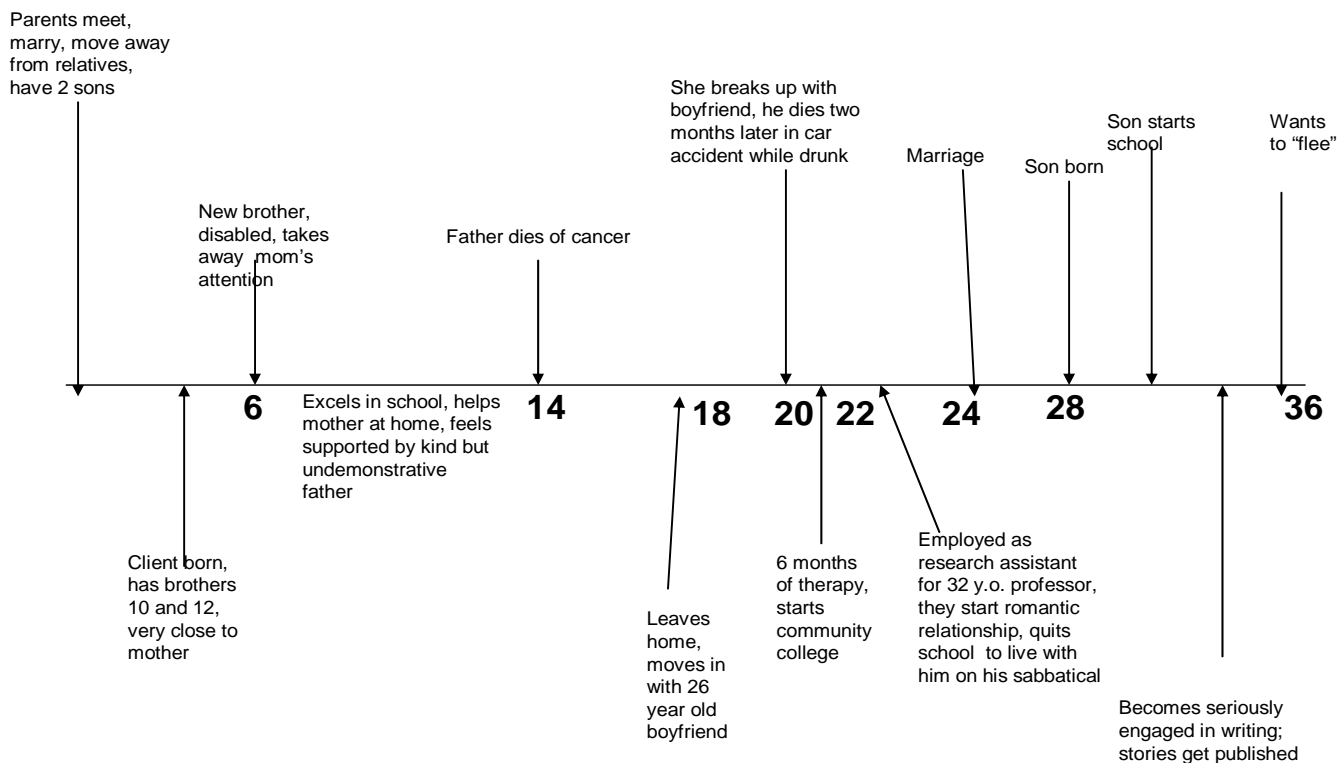
**Figure 1. Overview of Tasks of Case Formulation**

Guided by "Core Clinical Hypotheses"

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**Figure 2. Timeline with Highlights of Life History**

**Appendix: Twenty-Eight Clinical Hypotheses to Use with a Case**

<b>Hypotheses</b>	<b>Space for Data, Questions, and Ideas</b>
<b>I. Biological Hypotheses (B)</b>	
<b>B1 Biological Cause</b>	
<b>B2 Medical Interventions</b>	
<b>B3 Mind-Body Connections</b>	
<b>II. Crisis, Stressful Situations, and Transitions (CS)</b>	
<b>CS1 Emergency</b>	
<b>CS2 Situational Stressors</b>	
<b>CS3 Developmental Transition</b>	
<b>CS4 Loss and Bereavement</b>	
<b>III. Behavioral and Learning Models (BL)</b>	
<b>BL1 Antecedents and Consequences</b>	
<b>BL2 Conditioned Emotional Response</b>	
<b>BL3 Skill Deficits or Lack of Competence</b>	
<b>IV. Cognitive Models (C)</b>	
<b>C1 Utopian Expectations</b>	
<b>C2 Faulty Cognitive Map</b>	
<b>C3 Faulty Information Processing</b>	

Hypotheses	Space for Data, Questions, and Ideas
<b>C4 Dysfunctional Self-Talk</b>	
<b>V. Existential and Spiritual Models (ES)</b>	
<b>ES1 Existential Issues</b>	
<b>ES2 Avoiding (needing to use) Freedom and Responsibility</b>	
<b>ES3 Spiritual Dimension</b>	
<b>VI. Psychodynamic Models (P)</b>	
<b>P1 Internal Parts or Subpersonalities</b>	
<b>P2 Reenactment of Early Childhood Experiences</b>	
<b>P3 Immature Sense of Self and Conception of Others</b>	
<b>P4 Unconscious Dynamics</b>	
<b>VII. Social, Cultural, and Environmental Factors (SCE)</b>	
<b>SCE1 Family Systems</b>	
<b>SCE2 Cultural Context</b>	
<b>SCE3 Social Support</b>	
<b>SCE4 Social Role Performance</b>	

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<b>SCE5 Social Problem is a Cause</b>	
<b>SCE6 The Social Role of Mental Patient</b>	
<b>SCE7 Environmental Factors</b>	