CASEBOOK OF ECLECTIC PSYCHOTHERAPY

DIFFERENTIAL THERAPEUTICS:

A Case Illustration

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Commentaries by
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Differential Therapeutics: A Case Illustration

INTRODUCTION

Differential therapeutics is the science and often the art of selecting the most effective treatment or array of treatments for patients with unique combinations of assets and psychological difficulties. This decision-making process is concentrated during the initial assessment of the patient. In addition, as treatment progresses, clinicians must gauge the progress of treatment and assess the need for therapeutic changes. The body of knowledge useful to a clinician involved in this process comes from psychotherapy process and outcome studies, studies of psycho-pharmacological effectiveness, and (since the research base is not totally extensive or exhaustive) the accumulation of clinical wisdom.

There are many ways to structure the growing body of available information for clinical decision making (e.g., Beutler, and our own involves the organization of data around five axes of treatment planning: treatment setting (inpatient, day hospital, outpatient), format (individual, family, group), duration and frequency (brief therapy, long-term therapy, total number of sessions), strategies and techniques, and appropriate use of medication

(Frances, Clarkin, & Perry, 1984). This system is extensive enough to provide guidelines for treatment of patients along the entire spectrum of severity. This system is not focused exclusively on the axis of treatment technique as some other systems, as decisions on the other axes must be made, and treatment technique alone seems to result in little differential effectiveness. This system is eclectic in its selection of interventions across therapeutic schools of thought (e.g., psychodynamic, behavioral, systems, etc.), modes of intervention (psychosocial and pharmacological), and different treatment environments to arrive at a treatment plan tailored to the uniqueness of the individual patient. The intent of this system is to provide the clinician with operating guidelines, formulated in terms of indications, contraindications, and patient enabling factors, for interventions on the different axes of treatment planning.

In this chapter, we will illustrate the process of differential treatment planning by discussing an actual case assessed and treated by one of the authors (PBR). Because of the need for detailed transcripts of the treatment, and also the need for a patient stable and cooperative enough to provide follow-up and reactions to the treatment, we selected an outpatient with considerable assets and a somewhat focal problem suitable for time-limited intervention. Thus, this particular case is better suited for following the intricacies of the therapy process than for following the complications in differential treatment planning. For the application of differential

therapeutics across diagnostic categories, see Perry, Frances, and Clarkin (1985).

INITIAL ASSESSMENT: A DECISION TREE

The patient is a 21-year-old, female college senior who presented at an outpatient clinic complaining of "family tensions" which were beginning to disturb her sleep and preoccupy all her waking thoughts. She had eloped six months before with her boyfriend of some four years' duration, but had never told anyone, including her parents. Her husband thought that her parents knew, but because he was out of state in military training, he did not know anything was amiss.

The patient's parents, especially her father, had actively opposed her relationship with this young man when it became clear that it was sexual. The young couple became openly engaged a year ago, prior to their living together during the summer. When informed of their cohabitation, the father went into a tirade. Ostensibly fearing another such attack, the patient eloped three months later.

The patient is doing well in her courses, has several close friends, and is employed on campus, a job in which she uses her considerable poise and social skills. With the end of college approaching, and her husband due to return to the area at any moment, the patient was eager, if not desperate, for

help. The admission DSM-III diagnosis was as follows: Axis I, Adjustment Disorder with Depressed Mood; Axis II, No Personality Diagnosis, but some dependent Personality Features; Axis IV, Moderate Stress due to the recent elopement; Axis V, 2, Very Good. This patient has functioned above average in both school and work, and her interpersonal relations are mature, if at times too dependent.

Treatment Setting

The patient has a stable living situation and does not present with a major Axis I disorder so there is little doubt that outpatient treatment is indicated.

Format

With this particular patient and focal problem, one could make an argument for each of the major treatment formats— individual, family, or group. A heterogeneous group of patients with various interpersonal problems could help by providing feedback to this patient on her specific situation. However, group format could not *focus* exclusively on her specific issues and would take longer to give her some directed assistance.

Because of her particular chief complaint—a crucial secret between her and her parents—one might recommend family/marital format with patient

and parents; patient, husband, and parents; or patient and husband. The family/marital format could be used exclusively or in conjunction with individual sessions for the patient. This combination of individual and family/marital formats would allow for more intimate exploration in individual sessions, and then the actual disclosure and subsequent working through of the conflict in the presence of the people involved. However, this particular patient was not ready for such a meeting, describing her parents as opposed to any kind of psychological counseling. If the parents would, indeed, be adversarial, then this treatment format must be excluded on the grounds of expediency and efficacy. In addition, this patient refused to let her parents know she herself was seeking help. The patient could not be seen with her husband as he was residing some distance away.

Medication

Although the patient presents in an acute upset with both anxiety and depression, these symptoms are not severe enough to warrant medication.

Duration and Frequency

In cases where the severity of pathology is moderate to mild and premorbid functioning is good, planned brief as opposed to long-term or open-ended intervention should be immediately considered. This represents

a conservative attitude toward intervention, namely, that one starts with the treatment with fewer risks and less ambitious goals. If that fails, one can intervene more aggressively with a treatment that is more invasive and ambitious.

This patient meets simultaneously the indications and suitability requirements for several brief therapy models. There is a clearly defined focus with a precipitating event, the patient's goals are limited, she seems able to separate from treatment, and her usual level of functioning is adequate. She does not manifest some of the major contraindications for brief therapy such as chronic and pervasive Axis I conditions, a lack of motivation, etc. (Clarkin & Frances, 1982). And finally, as the patient was leaving the area when she graduated, the treatment was, of necessity, time-limited.

Thus, the patient was scheduled for two sessions a week for seven weeks. She was seen for 10 of the 14 scheduled appointments, in addition to one follow-up session, in the outpatient department of a large psychiatric facility.

Strategies and Techniques

The field of psychotherapy has devoted a great deal, if not an inordinate, amount of time and effort in debating the relative merits of different treatment strategies and techniques. This attention continues despite the

evidence that most variance in outcome is accounted for by patient and therapist characteristics and very little by strategies and techniques (e.g., Orlinsky & Howard, 1978; Smith, Glass, & Miller, 1980).

Focal psychodynamic techniques (Malan, 1976; Davanloo, 1978; Luborsky, 1984) were chosen for this particular patient because of the delimited problem area involving interpersonal conflict (Clarkin & Frances, 1982; Perry, Frances, Klar, & Clarkin, 1983). In addition, focal dynamic therapy calls for rather stringent patient enabling factors which this young woman meets, such as a capacity to focus on central issues, a capacity for self-object differentiation and reality testing, a tolerance for anxiety frustration and ambiguity, a capacity for introspection, an ability to form emotionally meaningful and reciprocal relationships, and intelligence and an ability to abstract.

Alternative techniques that were considered included interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) and assorted behavioral techniques. As results of the Sloane et al. (1975) study suggest, it is quite possible that specific behavioral approaches would have done equally well with this case. However, she seemed more inner directed (Beutler, 1983) and needed more autonomy to generate her own plan, a level of freedom that would be fostered with dynamic techniques.

For the most powerful effect in brief psychodynamically-oriented therapy, the patient's presenting problem, transference responses, and infantile neurosis should overlap (Clarkin & Frances, 1982). Whether one uses conceptualizations such as Luborsky's "core conflictual relationship" (Luborsky, 1984) or Malan's "current" and "nuclear" conflict (Malan, 1976), the distinguishing feature of this therapy is the interpretation of unconscious wishes, fears, and defenses within the arenas of the transference relationship, the current conflict, and the infantile neurosis to bring about conflict resolution.

It should be emphasized that although focal psychodynamic techniques were chosen for this case, we also placed heavy reliance on the "nonspecific" techniques that are common to all the schools of psychotherapy. These nonspecific factors may potentiate almost equal outcome across the schools of therapy in patients such as this one who have relatively good adjustment and seem motivated and primed for therapy (Gomes-Schwartz, 1978; Strupp, 1980). These common strategies and techniques include the hope engendered in the patient by seeing an expert, the generation of treatment goals with the expectation of some change, the structure of specific times for the therapy meetings, and the provision of a therapeutic atmosphere and alliance which includes warmth, empathy, and nonjudgmental respect from a therapist.

The patient, whose treatment we are following, is a quietly and unconsciously angry young woman attempting to bypass the adolescent passage and its consequent depressions by marriage. Overriding in her choice of marital partner was the perpetuation of her childhood with in-laws who were quite ready to reciprocate. Disappointed with and resentful of her own parents' aloof treatment (which by her account was not a recent development), she was sullenly aloof in return and had angrily eloped in revenge. She was managing to stay just a step ahead of a depression comprised of guilt over what she had done and, more important, the emptiness and apathy that is part of loosening the parental ties in preparation for seeking new investments. This important developmental step had been stalemated with potentially serious consequences for her character and identity development. The mediating goals of this dynamic treatment were to focus on and make explicit the patient's conflict and ambivalence in separating from her own parents, inappropriate over-involvement with her mother-in-law, and intense ambivalence about moving on to a reciprocal and peer relationship with a marital partner. A behavioral mediating goal would ideally be some honest communication with parents and husband about her ambivalence. The final goals of the brief treatment would not be total resolution of these issues as they are significant developmental ones that take more time. A more realistic final goal is some diminution of the intense anxiety about her conflicts, some more honest and open communication with

her husband about their relationship, and a diminution of the over-involvement with her in-laws.

There is general agreement (e.g., Beutler, 1983; Orlinsky & Howard, 1978) that the patient-therapist match is extremely important although the research literature is not totally conclusive about the important variables in this match. In this case a young adult, white, middle-class female patient with a college education and above-average intelligence was matched with a white, female psychologist. There was every indication during the initial evaluation phase that the patient and therapist would share certain key values and beliefs: a need to introspect and understand one's feelings and emotions, and a high priority on interpersonal closeness, loyalty, and family relatedness. It seemed therapeutically propitious that this young person having difficulties making a transition from her family of origin to a married state be treated by a somewhat older person who had successfully completed those milestones. The fact that both patient and therapist were female was not considered extremely important for this brief therapy.

Course of Treatment

As Goldfried (1980) has indicated, there are probably basic therapeutic change principles or strategies that cut across all therapies regardless of the school of thought. We will focus the presentation of this case around a small

number of central strategies: (1) structuring the treatment, (2) focusing the treatment, (3) dealing with the relationship between therapist and patient, and (4) terminating treatment.

Structuring the treatment. There were two principal components in structuring this treatment: first, the delineation of the patient's responsibility and expected role behaviors in the treatment mirrored by expected behavior on the part of the therapist, and second, setting the time limits to the treatment.

At the beginning of session 2, the therapist enunciates the expected behaviors of the patient.

> T: The last time we met, I asked you a lot of questions and you answered them and at this point I think it would make more sense if we shifted the burden of that and you would be more responsible for telling me all the thoughts that you've had and when we're here to tell me anything that comes into your mind. Anything you think of while you're here: thoughts, feelings, even bodily sensations that occur while you're here so that I'll be able to respond to what you're coming here for. For you to, you know, start telling me as much as you can about why you're here and what's been on your mind and even just if a stray thought crosses your mind, I'd want to know that.

This is a standard structuring statement in a dynamically oriented therapy to which every patient responds idiosyncratically. In this case, there is a special irony to the structuring, as the patient is asked to relate everything that comes to her mind to an older female therapist figure, while

the chief complaint is that she cannot tell everything to her mother. The patient's response to the structuring is often predictive of the shape and intensity of future resistances in the therapy.

> P: Okay. I was thinking a lot about what you said at the end last time about keeping secrets from you or anything like that and I want to do this so that there is someone that I don't *have* to keep secrets from. I mean it's kind of pointless if I don't tell you things. I mean, that's the whole problem, I'm not telling anyone things and that's why the whole thing is just getting to be kind of a burden and making me very anxious sort of. . . I felt like last time and then I told you a lot of things but then there are also things that I'm sure I left out. I mean the whole history of my boyfriend and I, well, my husband, my relationship and things that have happened in the past with my parents. . .

After the therapist has begun to delineate the expected behavior of the patient, the patient begins to question what she wants from the treatment and more directly what she expects from the therapist.

> P: Well maybe I didn't come here to ask for help in telling my parents. I mean maybe I came here just kind of to ask for help in how I'm going to deal with telling my parents, but not necessarily. . .
>
> T: Telling them?
>
> P: Well, not necessarily telling them while I'm here. I mean nothing . . . I don't think that anything here is gonna help me when I tell them except for preparing me to deal with whatever is gonna happen. I don't think it's gonna make it any easier for me to tell them. . . . How do you think being here is gonna help me if I were to tell them now?
>
> T: Well, presumably you came here for help with *that,* I mean that is what you said and so I would expect that that would be something we would be working on together unless I was mistaken. And I think that you know you've told me

about the ways in which you don't want to face what you have to face and that you've been putting off doing something about it in ways that are rationalized in various kinds of ways. "Well, if I wait until after graduation, then I won't have to worry about school." But meanwhile you're very preoccupied with this. So that I think it's a fiction that it's gonna be easier for you after graduation. Things are not easy for you now. And you know it.

P: Huh, uh. [sighs] Well, how . . . I mean how am I gonna do this now?

T: And you're asking me?

P: Yeah. I mean if I knew then I would do it.

The therapist makes explicit what the patient is asking for and the therapist chooses to counter not with advice or role playing of possible ways to tell the parents but by putting the responsibility on the patient who is struggling for autonomy.

T: One of them is that you'd like me to tell you how to do it.

P: Well, I'm not, I don't think that you really can tell me how to do it.

T: I agree.

A few minutes later in the same session the therapist makes a second and key structuring move by letting the patient know that she expects the treatment not to be a mere discussion of the problem but a period of positive action. This interpretive work is aimed at the patient's denial of the hostile and vengeful aspects of her elopement and of the continued secret. To undercut her by now rather exaggerated delaying tactics, the therapist

requested she tell her parents during the time of the brief treatment.

T: And whether you feel differently now, or in three weeks I would assume, I think we'd both agree then that you're not gonna feel much different in three weeks about telling them.

P: No.

T: You may know a little bit more about why it was you needed to keep it a secret more than you know now, but at some point it's got to be done and waiting doesn't seem to me to be helpful to you. It's just a wish to put off facing it. And if you were to tell them while you were still seeing me, then I would be here. Otherwise, we have a kind of academic treatment. You know what I mean. Sort of, we'll just talk about a lot but nothing happens.

P: Huh, huh. So, I mean what you're saying is that you really think I should tell them and then we should just deal with whatever happens afterward. Which could be one of [laughs] various things. T: Like what?

P: Well, I mean I don't know exactly how, I know it's gonna be a very big deal, I know it's gonna be a very big scene, I don't know if my father is gonna get violent. I don't know . . . I mean, I don't know.

Once the structure of the therapy is communicated to the patient, in terms of what is expected of the patient and what the patient can and cannot expect from the therapist, the patient's reactions to the structure of the treatment become manifest and the therapist interprets that reaction.

P: No, I mean I'll eventually tell, naturally I'll eventually tell them, but I'm saying I don't know what's gonna make me tell them now. I mean what you're telling me is that I have to tell them, right? But I already know that.

T: So I'm not telling you anything you didn't already know.

P: Right.

T: But you're reacting to it as if I'm forcing you. And then you say, "Well, maybe I just won't tell them at all."

P: No, not at *all.*

T: Or maybe I won't tell them.

P: I'm saying maybe I won't tell them now.

Focusing the treatment. The therapist then points out how the struggle between patient and therapist over the structure of the treatment mirrors the patient's struggle with her parents currently, a struggle that is the focus of the patient's problem.

T: You know one thing I noticed when we were having that interchange about when you would be telling your parents, and if you would, that as I pressed you to consider telling them while we were still together you seemed to get firmer about not telling them.

P: Well, because I'm afraid.

T: I had a different take on it.

P: What is that?

T: Which was, it felt to me as if you didn't like being told what to do.

P: I never like being told what to do.

[laughs]

T: Just like your parents told you not to be involved with your husband.

P: Huh, um.

Predictably and optimistically, the resistances just pointed out became more exaggerated over the next several sessions permitting greater ease of interpretation. The patient canceled two sessions in a row (4 and 5) and requested to change the time of a third (7).

P: Well, I have to go to this thing so. . .

T: You would cancel out?

P: Yeah, I would have to.

T: And that would be three cancellations. P: I know.

T: Cause we didn't meet on a week from today. . ..

P: Yeah.

T: Or on last Tuesday.

P: Let's see if they could do it Monday [reschedule the audio-visual room).

T: Uh hum.

P: I hope so.

T: I think the chances are going to be slim. P: Really?

T: Yeah, but I don't know for certain.

P: All right, we'll see. How do you want me to start?

T: We've already started.

P: Oh, we had already started, but I mean, you know. . . .

T: I think this is part of it, that one of the things that's going on right now is, um, we started to meet, um, and you became, I put some pressure on you to start to deal with this, you became depressed. And then you canceled two meetings and we're meeting now, and there's a third cancellation coming up. P: Well, the third cancellation has nothing to do with me being sick. [One cancellation was due to patient illness.] So, you know, I don't know what to tell you about that. I did become depressed, that's true. I am depressed. I suppose, um, I know I'm, I don't know how to get out of the depression. I don't know how to relieve various pressures. I don't, I mean, I feel kind of lost and isolated and, um, depressed. I guess part of it is that I've always considered myself fun, strong, and knew how to deal with whatever it is that I needed to deal with and go on with what I have to do. But it's getting, it's just getting to be a lot. I think I've always put certain amounts of pressure on myself but I'm starting to feel, like, nervous about a lot of things which I didn't, which didn't, you know, use to make me nervous. And sometimes I feel nervous about coming here and, um. . .

T: When did you feel nervous about coming here?

P: Well, I always feel nervous about coming here.

T: But more than usual?

P: Yeah.

T: When?

P: Well, before I come.

T: You said "I started to feel nervous about coming here," making it sound like

there was some change.

P: No, I always feel somewhat nervous about coming here. I mean, I didn't feel nervous when I'm coming for, like, evaluations and stuff like that. Being here, I feel kind of nervous. And, um, I don't think I should feel that way about coming here. I guess I'm not sure.

T: Why not?

P: Why shouldn't I?

T: Yeah.

P: Well, I think that I should kind of have a different outlook that this is something that is, that I felt that I was doing for myself to kind of help me out or relieve some of the nervousness or relieve some of the tension. But. . . .

T: Well, but you weren't feeling nervous before. And you had every reason to feel nervous and upset and depressed. And you weren't feeling that. And so we've been working on your not avoiding now what you have been avoiding for a very long time. And it's not going to feel good. Although you are doing what you can now to avoid here.

P: [sighs] Well, I guess I'm also not really sure, I mean, I guess it makes me think about why I react the way I do to certain things and why I, I kind of take on a lot of things. And why I avoid a lot of things. And I'm not, I'm not really sure why that happens. I mean, I guess I should feel nervous coming here, apprehensive, or whatever. But it also makes me feel more nervous and apprehensive while not here. Which isn't really a good thing and I guess that I thought that coming here would be a good thing.

T: You did hope, it sounds like you did hope that somehow, magically, you wouldn't have to feel anything about the situation you're in.

Another aspect for focusing the treatment is the order in which

interpretations are made and in which themes are taken up. This young woman had made a slip of the tongue in the second session, saying, "I'm married and I don't want to," adding to the therapist's impression that such a wish was a powerful motivating factor in her elopement and continued secret marriage. She could believe she wasn't married, and in all important objective ways, she wasn't. But the therapist let the slip go by without a remark, deciding that to take it up that early in the treatment would be premature. Only after she could admit her hostility and vengefulness, and begin to experience some of the sadness and apathy associated with losing fantasied parents and their surrogates (her in-laws), could she consciously contemplate the relationship with her husband.

P: I find myself doing things, I find myself not, kind of changing, when you get married you change, I think the ways in which you do certain things. And a lot of your dependencies on parents or whoever and I find myself not changing those things. I'm not saying, you know, I'm married, I can't, I don't. The only thing that I don't do because I'm married is go out with other men. I mean that's the only thing, and that's fine because I didn't do that that much in the past either.

T: So it really hasn't meant anything different for you.

P: I guess I just kind of felt that it couldn't really mean anything different until we were together. 'Cause I'm not exactly sure how I'm supposed to be different. I live with people, I'm surrounded by people all day, every day, who are not married, so, but who are in the same, who are just like me in every other way. So, I'm just kind of, I just, I really did keep my same life-style.

T: And that's the idea.

P: The idea. . . .

T: You weren't ready for whatever reasons to accept the idea that you're a married woman so by keeping it a secret, you could keep on going as if you weren't married and keep everything the same. And buy time that way.

P: So if that's true, then the conflict is really not with my parents, and my parents' approval or disapproval of the marriage. It's with myself and accepting the fact and everything else that goes along with it that I'm married.

T: Did you know that already?

P: Not well enough to say [laughs]. And I guess I would start to think about what I shouldn't be doing as someone who's married. And I couldn't even begin, I don't know what those things are. I feel like, in a way, I feel like I was trying to get in, like the last months that I could have been someone's daughter, and. . .

T: Uh hum. And it didn't work the way you had hoped.

P: Uh, huh. And I guess also, because it didn't work the way I had hoped, I decided to be my mother and father-in-law's daughter, because that worked, really easily.

By the sixth session her ambivalence about her dependency on her in-laws has come under scrutiny.

P: I mean they [her in-laws] treat me like I'm a married woman by acknowledging the fact that I'm married, but they really treat me like another one of their children, not like an adult friend. And I've also been looking at, you know, but yet I depend on that treatment.

T: That you may in fact like it.

P: I don't think that—that's not a good thing. You know, I mean, you know, in a lot

of ways, you know of instances, they put me not in the same category, but sometimes they treat me in the same way like they would treat their daughter, but their daughter is 14. And, you know. . .

T: That doesn't fit so easily with you anymore?

P: Well, it did, it did. It makes it. . .

T: You probably enjoyed it for a long time.

P: Yeah, I've enjoyed it for a really long time, but it's not what should be happening. You know, I was looking at the fact that for Easter, um, my husband's father has always given me some kind of stuffed animal, and you know, he did it again this year, and like, the same kind of thing that he gave to his daughter, and it means a lot to me, but I don't think that it should, you know, that it should make me that happy, that it should make me that excited. I don't, you know, I shouldn't be expecting Easter presents any more, or especially of that sort.

T: You sound today a little bit more like you'd like to grow up. You know, it doesn't, it's like a suit of clothes that doesn't fit any more.

P: Well, I think that it's really important that I do, you know, I look at all the things that I get angry or frustrated with my parents for not doing, you know, that his parents do do. Like when I went to . . .

T: Neither one and you're not happy with either?

P: Right. When, you know, the morning of the funeral, I, um, I was really hungry. And I hadn't slept at home, but one of the ladies, one of my grandmother's friends that was there, you know, said to my mother, "Why didn't you feed your daughter this morning? Why didn't you give her breakfast?" She said, "My daughter is going to be 22 years old this week, you know, she wants breakfast, let her get breakfast" [laughs]. But where, as I was thinking, you know, if I were to be at my husband's house, I would walk downstairs and breakfast would be on the table. And I wouldn't have, you know, I don't have to think about those little things. And they ask me things like, "When are you

going to do your homework? Have you done your schoolwork?" Why should they be asking me that? You know, these are all things that I should be able to take care of without having people tell me. And I've made such a big. . . I always bring my clothes home to wash them, you know, and I always did it myself, and one time this year I asked my mother to do them, to do it 'cause I had a lot of other things to do, and I never really ask her, and she really did, this sounds so ridiculous, but she really did a terrible job, and she didn't take care of my clothes like she used to. And then a couple of weeks ago, I had . . . I brought them all to my husband's grandmother's house 'cause I wanted to spend the time there, and they only have a washer, so I couldn't really dry them, so my mother-in-law took them all home and did them, and, you know, folded them, and I didn't have to do anything, but these should be all, you know, all these little things I should be perfectly, you know, I should just feel, I should never feel that I want to ask anyone else to do these kinds of things for me, you know, I shouldn't, I get so frustrated when I go home that my mother isn't making meals anymore.

T: And you feel ashamed about that?

P: Yeah, it's kind of, it's ridiculous that I expect these things of her. . . .

T: But you do.

The therapist underscores her nascent changes, all the more convincing for the wistful confessional tone in admitting to the old pleasures. At the same time, as she nourishes these new beginnings, the therapist is attentive for more opportunities to continue the focused line of interpretation. Soon the opportunity arises.

P: Like half the time I take on responsibilities that are supposed to be adult responsibilities, like, you know, dealing with his grandmother and taking care of her. . . .

T: And the other half?

P: It's not consistent. And I think that it really needs to be consistent.

[More unrealistic thinking.]

T: But it will be consistent in time. It's just you have to go through a transition right now, and it sounds like what you're doing. It's going to be a bit uneven, more than a little bit uneven. It's going to be uncomfortably uneven for a long time.

The patient continues, showing a greater acuity now in her reality testing as a result of the line of interpretations, and she adds an important piece of historical information, the psychological meaning of which is just beginning to dawn on her.

P: [sighs] And I was also looking at, um, like the relationships between my mother and father, and the relationship between like my mother-and father-in-law, and when my mother-and father-in-law don't have a very stable marriage, and part of that is because, you know, throughout their whole marriage, my father-in-law treated my mother-in-law like a child. She was really dependent on him for everything. And then, when he couldn't, you know, didn't really fulfill that need anymore, and she was expected to do a lot of things on her own, she became really bitter and resentful. And the incredible depression that she's going through over the loss of her mother is because she really has to become, she never became independent of her at all. Like in any aspect. Whereas my mother didn't even live with her mother till she was 17 and was completely independent of her.

T: Your mother didn't live with her mother until she was 17? Who did she live with?

P: Um, her father, her father's mother, and her aunt. Her parents were divorced when she was three years old. So, when she came to go to school in New York, she lived with her mother.

T: So you've got two different models of married women now to look at, too. And you're not sure which one you want to be.

P: Well, I want, I know that I want to be independent of everyone [laughs], but, um, it's really hard, and, I guess, you know, part of coming here has made me realize how dependent I am on everyone.

Relationship between therapist and patient. The patient's magical and childish expectations of the therapeutic relationship are now becoming more overt and open for her inspection. While they work on these aspects of the relationship between therapist and patient, using the structure of the treatment to highlight her idiosyncratic wishes and fantasies, the focus of the secrets between patient and mother became sharper.

T: Listening today, I could reconstruct how you were thinking last fall. "If you, my parents, are going to act this way when I try to discuss something with you, there's no point in discussing it, so I'm going to elope without your knowing it and never tell you, and not tell you." Um . . . as a way of both protecting yourself from getting hit again and also as revenge for their having hit you before.

P: Huh, uh. Yeah, I guess so. And I think, I think there are a lot of things that I just decide not to tell them because I don't feel that I could discuss it with them. . . . I learned in the year, I was really sick and, um, doctors had first thought that I had a tubal pregnancy and I had to go see a lot of different doctors before they figured out that I had a cyst and, um, and in the beginning I was really scared and it was right after my husband had left and people were saying, "Now why don't you tell your mother?" And I just, I never told her. I just didn't want to tell her. In fact, I've never discussed anything, um, that had to do with gynecology or, or, me with her. And I guess I also resent her for not asking me . . . I resent her for not asking me about things like birth control and where she knows that I must see a doctor or where I see a doctor, or anything like that. She did know one time when I went to her

gynecologist once, last year, and I told her that I wanted to go. I wanted to go before I went to California and he gave me a prescription for the Pill and I told her that and she just kind of made herself feel comfortable with it by saying that it was really for cramps.

The psychotherapist then proceeds to do what the patient has always wanted (and not wanted) the mother to do, to ask about sexual matters.

T: What are you using for birth control now?

P: Well, I got off the Pill and my husband left so I guess I'll have to go back to using a diaphragm when I see him again. Because the Pill wasn't good for me.

T: Do you have a diaphragm?

P: Yeah. Which also I know that she knows about because it was, I didn't take it with me to California over the summer, I left it in the drawer in my room and when I came back it was thrown in my closet. . .

The psychotherapist makes a "prophylactic" interpretation designed to prevent any further acting out in a situation rife with acting out. Although it is predictably denied by the patient, the patient will, nonetheless, be less likely to act on this impulse.

T: The two of you are at a standoff, and there's a vengeful component to your, at this point, being married and keeping it a secret. The part of it that motivated it is to get back at her for not acknowledging that you are a sexual person. You might even be tempted to get pregnant to. . .

P: I seriously doubt that. . . I don't think that. I have no desire to be pregnant now. I really don't.

By this point the patient was visibly depressed, and again, unlike the patient's mother, the therapist commented on it.

T: You look different today. You look depressed today. Are you feeling kind of low?

P: Well, one of the main reasons I look different today has been because I guess I didn't get a lot of sleep last night. I got up this morning and went swimming and, yeah, I guess I'm also a little bit depressed.

T: What's the content of your depression? Are you aware of it at all?

P: Well, I'm just depressed about facing this whole situation. And maybe I was also a little depressed coming here and knowing that I was going to have to really face it again. So you know [sighs] . . . I'll probably go home one day this week . . . 'cause usually when I go home I don't stay around them very long, you know, I do what I have to do and I take the car to go to do what I need to do . . . so, Sunday I stayed home all day, which I hadn't done in a long time. I guess maybe inside I expected something miraculous to happen [laughs] but, um, it didn't.

T: It never does.

P: No, it doesn't. But I guess sometimes I expect them to just maybe come to me and say, "What is the matter?" You know, "What's going on?" You can look at me and say, "You look depressed." They can certainly look at me and say that I look depressed or think that I look depressed. I certainly don't walk around the house smiling and happy.

T: You don't?

P: No, and I suppose that at certain points, maybe I even, um, consciously don't do that. So that maybe they'll say, "What's wrong?" but they never do [laughs].

Increasingly and repetitively, this patient's sullen, passively hostile, and

avoidant attitude toward her parents is taken up alongside her passive and magical wishes for the treatment. As a result of this, the patient becomes more direct about and responsible for her anger. In the fifth meeting, she was able to say the following:

P: Uh hm. I am really angry with them.

T: Yeah, you are. I think you alternate between being very angry about it and very depressed about it. You know, feeling hurt and rejected. And I think it was from that that you made the decision to marry your husband when you did and how you did—keeping it a secret was a way of getting back at them. You felt that they were keeping secrets from you. That they had really excluded you, and so you were going to exclude them to get back to them. And I also think that you're trying to cope with a big transition in your life from being someone else's daughter to being someone else's wife. And that you somehow, as you said to me at the beginning of the hour, you said, "I just don't want to feel this way. I don't want to feel this." That you had hoped that you could get through this without feeling any of it. Without feeling depressed, without feeling angry.

P: But I think a big part of it is that I really [sighs] I really want them to be part of it, and I also think that I really, I need them more than I ever thought that I did. I, I really need the help now. And I've needed their help for a long time but I really need it now . . . every time, they hurt me I would always come out of it deciding, well, you know, if they're going to do this then I don't need them. But I really do. Yeah, before I went to California I remember telling you that, um, you know, she said "to go and do what I had to do" and that she would be there for me when I came back and she wasn't. And that really probably has hurt the most out of all of it. And I thought that in the beginning of the year I did, you know, I did make an effort, I asked her to come up to school and took her out to dinner. And we talked, we had a serious talk, and I thought that that would maybe be like the first gesture in a long line of, I mean my mother does not live that far away from me and she sees me and it's not that much for her to get in the car and come up and go out to dinner with me or just come over to my house once in a while. And I thought, I

really thought that she would take this opportunity to do that but instead I feel like she's just kind of tending to what my father needs.

T: Had she ever done that before, though? Just get in the car and come up and see you?

P: No.

T: So you were expecting something more from her now, and back then, you know, last fall. You were expecting more from her than she'd ever given you.

By focusing on her increased and unrealistic expectations of her mother and the ambiguous and ambivalent move into marriage, the patient can begin to experience affects she has been suppressing and repressing. Just a few moments later:

P: I should be prepared for that to happen, instead of, um, wanting to have kind of a closer relationship. Well, also, I mean, a part of it is, I felt that we never really had that very close relationship. And I, part of the reason that I wanted to come back was maybe to try to have that kind of relationship. But, it's not, it wasn't going to happen [sighs].

T: What was that sigh?

P: Well, that doesn't. . . you begin realizing that doesn't stop me from wanting it to happen.

T: And feeling hurt. I had the impression you're feeling quite sad now.

P: Uh hum. I mean, I also, I think that I need [sighs] . . . I needed to have that kind of relationship for a while. And I didn't, and I wasn't finding it in my mother and in a lot of ways I found it in my mother-in-law which has led to a kind of dependence on my part and on her part but concentrating on my part, um, that maybe isn't necessarily a good thing, either.

Terminating Treatment

As the end of treatment approached, a number of hazards, common in brief psychotherapy, became apparent. Chief among them is the patient's attempt to leave in despair, recapitulating in an almost perverse fashion the old behaviors that brought them to treatment. The progress and momentum of the earlier part of treatment are called to a halt, and attention must be paid again to the relationship with the therapist with special attention to the meanings of the imminent separation. To counter the centrifugal pull to undo all the work accomplished so far, therapist and patient alike must review the achievements realistically. Not surprisingly, the harbinger of the termination phase was a broken appointment. All previously missed sessions had been cancelled. Her husband's grandmother had died and the funeral was scheduled during the appointment. At the next meeting, the patient was distant and unable to account for her not calling the therapist. Her husband had flown in for the funeral and stayed with her over the next week. Resistances were intensified. She had devoted herself to her in-laws with a vengeance, using the funeral as the rationalization. With three more sessions left, she had not told her parents about her husband and appeared to be repetitiously engaged in the same behaviors that brought her to treatment. She complained to the therapist:

> P: I just wait, and wait, and wait, and sometimes they get done, and sometimes they don't, depending on, I guess, the importance of the situation. And then, at

the same time, I also always take on a tremendous amount of, you know, extra activities, extra responsibilities, and I end up rushing to get them all done, so, it's not always at the most opportune time, so. . .

She is telling the therapist that she will end treatment the same way she came in, procrastinating and feeling fragmented. The ending is near, but she is not fully aware of her reaction. The therapist used this opportunity to reorient and focus the patient on her initial complaint and did not get interested in the broader characterological issues.

T: Well, that may be, from your description, sounds like it's a broader issue than what you brought here. That it's an issue that has to do with your character in some ways, but I have a feeling, at this point, it may be, you may be using it to try to diffuse our focus on just the specifics of your delay in beginning to rearrange your relationship with your parents.

P: And to accept the fact that I'm married.

Now that her husband had joined her, one hindrance to the evolution of her ambivalence was momentarily remedied. Her husband was keenly aware of her unfinished business:

P: My husband keeps saying to me now at the basis of every argument is the fact that he feels that I'm not, that he's not like my first priority and that I think I told you that he thinks his parents are but that's not really what it is. [Long pause.] It's scary to say it but I guess after my parents, you know, after I've finished everything I need to with my parents, that's when I'm going to be able to really look at my relationship, I guess.

T: What was scary about saying that?

P: But if that's the point, that I'm going to be able to look at it then there's still a possibility that it's—that I'm not going to want it. I guess it's also kind of a question of do I need or do I want a husband or as far as like fulfilling my part of being a wife or do I need a mother, and, you know, then fulfilling my part as being a child. My husband made a comment to me that he thinks his mother and I have what could be considered a marriage, that kind of relationship [laughs]. I mean T thought that was really ridiculous, but he, that's not it at all; it's that we have what could be considered a mother-daughter relationship.

She and her husband had talked about ending the marriage. The patient reported this in a cursory fashion initially, as if admitting to failure, not aware of how long overdue such a talk was.

P: Um, he said, well, maybe we just, you know, aren't the right people for each other and, you know, maybe you need something different, maybe I need something different. And I wasn't happy with that and then afterward he said that that wasn't really what he wanted, he wanted for things to work between us but he wanted, you know, needed to be able to understand more of what he needed and, you know, he said that he compared it to when I was in California and that he was working really hard and he was working a lot of hours but he always took out time for me but then again he didn't have anything else there, you know. My classes end, I'm like . . . when day ends my school work is hardly over. So I have, I'm thinking about other things. But, you know, he felt that I was thinking about his family too much. So, but we, I mean, that's how the thing about marriage ending came up but then he said that isn't what he wanted. So we kind of dropped that idea but it was just sort of startling to have it even come up. You know, that we shouldn't be together.

T: I don't know how startling it is. You certainly have begun to wonder yourself with me how much you wanted to be married.

P: Yeah, but I did, I have, you know, I definitely wondered about that but I think that wondering if I want to be married or not is like sort of the same things

wondering if I want to break away from being, um, a child, or you know, having that security.

At the last session, the patient's affect was stoically depressed. Together, therapist and patient go over what has been accomplished. Of her marriage she says:

P: I think I realized that I wasn't really as ready for it as I thought that I was. But, all in all, it exists and it's not something I want to end so I just have to live up to my part of it. And my parents being included in it isn't really, you know, that's not really where the problem lies whether they're part of it or not. It's completely my own thing, my own doing and they shouldn't really be making it any better or any worse for me. You know, it's kind of looking for them to be able to make it easier for me. And that's not really their, it's not their job.

T: Yeah, well, they're not able to do that. P: Right. So it's also not fair for me to have those kinds of expectations of them, I guess.

T: You can wish to, but when it's as clear as it is that they cannot be more helpful to you now, then it's a problem if you can't recognize that and do what you have to do.

P: Right.

T: And that was the position you were in when you came. And I think you've changed in that regard.

The psychotherapist picked up on her stoic affect.

T: This all sounds right but I'm wondering about a certain flatness in the way you talk about it or I don't know whether you're mildly depressed today?

P: Well, I kind of feel like shit anyway so I'm sure that doesn't help, it doesn't help

at all so—yesterday I stayed in bed all day, which is something I haven't done in a really long time and I really didn't feel well I a cold]. And I think it's also kind of everything coming, you know, the last couple of weeks just kind of came down on me I guess. The weather and all that doesn't help. But I also know that, now I can take care of my responsibilities and I can do what I have to do, just sort of let everyone else do what they have to do also.

T: Part of the things that are coming down on you is our ending.

P: Yeah, that's part of it. School's ending. Lots of things are ending. My husband is back, you know, doing what he has to do, so I have to pick up my end. That's it. I Pause] I don't think there's a lot more to say. I Long pause) I think I've said just about everything there is to say about it.

T: What's the mood you have about all of this?

P: About all, everything that's happened? Um, I could let it be really depressing if I chose to but, um, so, in a sense maybe, you know, maybe I am trying to ignore it but, you know, that's just kind of the only way I feel like I can get things done. I also don't feel like it's that severe a depression 'cause, you know, whatever I would be depressed about I more or less know how I have to handle, so. It's not like a hopeless depression.

She ended seeing her mother-in-law with a clearer eye, aware of the gaps in her relationship with her mother. She saw how it had happened. She ended with apprehension for her future with her husband. She ended sadder but possibly wiser.

FOLLOW-UP INTERVIEW

For the patient's reaction to the treatment, she was invited for a follow-up interview with the therapist four months after termination. The patient

continued to live apart from her husband, with her paternal grandmother or with her parents a couple of nights a week. She was working, saving money, and planning to move to the West Coast in two months when she and her husband would be provided housing by the military. She had not told her parents of her marriage, but she had told her paternal grandmother, hoping, perhaps, that she would tell for her. She had spoken to the therapist two months earlier asking for the name of a psychiatrist for her mother-in-law. She specified a psychiatrist because she felt her mother-in-law might need medication. This represented a consolidation of her new attitude toward her mother-in-law and a clear behavioral change.

> P: . . . I don't have the power to make everything better for them. I don't have the power to change them. I can't let their problems consume my life and my thoughts because that can only be done by them. . . . And I have to keep in mind a distinction between her relationship with her children and her relationship with me. I can't go around seeing her as a mother figure. The whole thing about blood is thicker than water. Well [laughs], it's really true. I have to keep in mind whose mother she really is.

She saw her mother-in-law much less frequently than before, even though she lived even closer to her after graduation.

Symptomatically, the patient was no longer depressed or in crisis. On follow-up, her mood was bright and she had no complaints of disturbed sleep or appetite. She was working as a receptionist for the mail order department of a nationally known department store. She looked poised, and as if she was

enjoying her first job.

During this meeting the therapist read several key transactions and asked her to say what she was thinking at the time and what she thought about it now. The first interchange used was from the second session.

> T: You may know a little bit more about why it was you needed to keep it a secret more than what you know now, but at some point it's got to be done and waiting doesn't seem to me to be helpful to you. It's just a wish to put off facing it. And if you were to tell them while you were still seeing me then I would be here. Otherwise, we have a kind of academic treatment. You know what I mean. Sort of we'll just talk a lot but nothing happens.

Four months later, the patient replies:

> P: I think maybe at the time I was telling you that because I knew that's, that's really what, it was only the second time we met, and, um, I don't think that I ever really thought while we were meeting that I was going to go home and tell my parents. I mean, I think that I thought *about* it, but I don't think that I ever really, inside, felt that that's what I was going to do.
>
> T: And you never told me that. That you knew in your heart of hearts you would never tell them while you were seeing me. Why do you think you never told me?
>
> P: Why didn't I ever tell them?
>
> T: No, told me.
>
> P: Well, because, number one, maybe, somewhere I hoped that I would. I hoped that something would happen in our sessions that would make it possible, easier, whatever. I had no idea what that would be, and also I thought that maybe we wouldn't be able to have treatments if I said that I wasn't going to

do it. So, I mean, I guess I felt like that was really the point why I was there, or that you thought that's why I was there.

T: And that I would kick you out.

P: And also, well, yeah. And also, we also were doing, I mean this wasn't like normal treatment, I mean, you were doing it for a reason, and you were. . . .

T: What do you mean?

The patient repeated with the therapist the same expectation—passively hostile deception, fear of expulsion, and hope for the magical solution in relation to the therapist's injunction as she had with her parents. She adds, to drive the point home:

P: You were doing it. . . I also had in mind that you were doing it for educational purposes. So, and that if I guess, maybe, if I were to tell my parents while we were in treatment, then that would have gone along very nicely with what you were doing. So maybe if you believed that that was, that I was going to do that, then we would be able to keep having treatment.

While the therapist's injunction is a "non-neutral" intervention and controversial in its usefulness, several things could be said about it. Certainly, the patient would bring to bear on this injunction all salient aspects of her personality; namely, she would react within the confines of her transference to the therapist. This is to be expected. The treatment was not successful in bringing to light and working through all these aspects in the therapeutic relationship. And there is reason to believe that in the limited time available one could not have accomplished it, although ideally if one uses such a

parameter, one should be prepared to take up and analyze in the therapeutic relationship her reaction. However, in this particular case, the injunction served another purpose, which the therapist had intended. It is best expressed by the patient during her follow-up interview.

> P: I think that what really came out of our sessions for me is, was, *not* that I absolutely had to tell my parents that I was married but *why* I wasn't telling them. But a lot of it had to do with my maybe not being able to make the transition to really independent living and maybe my being so ambiguous about my husband and things like that. And also looking at my dependence on his family.
>
> T: Was it helpful for me to have insisted that you tell them?
>
> P: Well, it made me look at the whole idea of telling them in a way I hadn't before. It was also kind of frightening. No, it wasn't even frightening. I'm not sure, not sure of the word to use to describe it. It made me very, um, kind of uneasy, but it also made me look at the situation differently.

She confirms our impression that the early structure of the treatment served as an "anxiety-provoking" device to move and focus the treatment.

The next quote was the slip of the tongue, "I think sometimes about what things would be like if I didn't get married," from the fifth session.

> P: Well, then, when I said it, I really did think it was a slip or a grammatical error, however you want to put it. But I remember that very, very clearly. Probably it was the first time that I really thought about the whole idea of not wanting to be married. That was *another* part of why I didn't tell my parents. That's, I really didn't want it to be true. Then I began to think about how many other instances there were that I was acting like I was not married. I remember telling you the only way I felt like I was married was either when I was

> around his family, or when I was approached by other men. Now, that's really not that different. I don't feel—I mean—I feel tied. I don't feel married. I feel, um, like I don't have the freedom to direct my own life in courses I would choose to take after I graduate because there are certain things that I have to do. That's basically it.

But she goes on to say she did not know, when she came for treatment, that she was ambivalent about her husband. The work of treatment was making her conscious of that. On follow-up, she was still aware of it and still seeking compromise positions. She was married, living on the other side of the country from her husband, and planning to live with him in several months. She led the life of a single woman but was married, without a husband.

On follow-up, she had accomplished some of the mediating goals of the treatment. She had accomplished more honest and open communication with her husband that included awareness of her ambivalence. She had greatly diminished her over-involvement with her in-laws. She now saw her mother-in-law as someone who was depressed and in need of treatment—including somatic treatments. And she was no longer tempted to go to any lengths to get her the help. She decided in the face of her mother-in-law's reluctance to make an appointment, that she had done enough in finding a referral. Her mother-in-law would have to do the rest.

She didn't accomplish the same improvement in her relationship with

her parents, nor did she take any major steps toward normalizing her role as a married woman. Was the treatment not long enough? On follow-up she voiced that opinion. She declined the offer of a referral to a therapist in her area, and she did not want to renew treatment with the same therapist because of the difficulty in arrangements. Her priority was her job and saving money to move to be with her husband.

Another factor in not making more gains in the area of marriage was that of her living arrangements. As she and her husband resided on opposite coasts, there was no environmental pressure to announce to her family that she was married, nor to account to her husband for the discrepancy. There was an arbitrary limit on how much she could elaborate and expand on her ambivalence and no opportunity to test out and work through behaviorally (and otherwise) the problems with her husband. The course of the treatment conceivably might have been quite different had her husband lived in the area.

This case, then, demonstrates the possibilities and limitations of brief psychodynamic psychotherapy. The nature and extent of this patient's conflicts are more readily apparent, as well as her response to treatment. Three future treatment possibilities seem immediately apparent. The first would be no further treatment to assess her capacity to understand and work through issues on her own, combined with a now less conflicted

developmental push. Results from another follow-up in several months would provide the needed information.

The next two possibilities involve further treatment, the format, length, and setting depending on variables such as motivation and timing. Perhaps in the future this young woman will seek continued therapy on her now troublesome ambivalence and paralysis with regard to her husband. The format could once again be individual, but perhaps a marital format would now be more efficient in fostering a more direct exploration of her conflictual relationship with the mate she denies.

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Commentary: Common versus Specific Ingredients in Differential Therapeutics and Psychotherapy

Larry E. Beutler

Differential therapeutics as outlined by Frances, Clarkin, and Perry (1984) employs a decision tree procedure for assessing the appropriateness of treatments. The procedure represents a grand step forward in applying clinical wisdom systematically to the task of selecting among broad categories of treatments, of which individual psychotherapy is one. The broad-ranging objective of this approach is one to which few other eclectic models have been applied. Most models seek only to address variations in the application of group, individual, or family therapy. As noted by Clarkin and Rosnick, the decisional procedure of differential therapeutics was neither designed for nor is it well suited to predicting the application of specific technical procedures within the context of a program of psychotherapy. For this reason, the exploration of differential therapeutics within the context of a single treatment case loses the most unique and powerful elements of the approach.

Differential therapeutics has taken the position that once the format,

duration, and frequency of psychotherapy are set, the outcome of psychotherapy relies on the healing qualities which cut across therapeutic procedures—the "common" rather than the "specific" ingredients. If one accepts this assumption, little can be said about the particular psychotherapy approach illustrated in the case presented by Clarkin and Rosnick except as reflected in the "common" ingredients such as caring, understanding, and empathy. For the sake of discussion, however, let us propose that Clarkin and Rosnick are in error when they conclude that because research has failed to demonstrate differential effects of psychotherapy, no differential effects occur. The research to which Clarkin and Rosnick, as well as others who reject the value of technical specificity, allude is based on competitive assessments of different psychotherapies applied to single, heterogeneous patient samples. Relatively little research has been directed to assessing the differential effects of different psychotherapies when applied to contrasting patient samples. Although the average effects of psychotherapies may be indistinguishable, their efficacy with specific patient populations may be quite different. Clarkin and Rosnick are quite right in suggesting that strong evidence for this assumption is not yet available, but it may be unfair to reject such a persuasive clinical hypothesis because it has not yet been empirically tested.

AN ALTERNATIVE VIEW

Differential therapeutics allows selection among global treatments or

settings. The application of the decisional model allows the selection of non-psychotherapy as well as psychotherapy alternatives. When psychotherapy is selected, it encourages and directs choices among various treatment formats (individual, family, and group therapies), various levels of frequency, and variations in length of treatment. Unfortunately, application of the decision rules often does not result in a narrow listing of treatment alternatives. As observed in the case described by Clarkin and Rosnick, many patients can fit a number of different decisional criteria. The patient described, for example, was a suitable candidate for either individual, family, or group therapy, and the ultimate selection of the format, the frequency, and the duration of therapy was made more on the basis of external convenience than with specific patient determiners. It may be interesting, therefore, to see where a more specific psychotherapy model might take us in treating this patient. Once we assume that the patient has already been found to be appropriate for psychotherapy and attempt to select among specific therapeutic processes and procedures, the first and most persistent thing we observe is that the information provided by Clarkin and Rosnick is insufficient to make a determination of the available array of therapeutic procedures to be used. Let's illustrate this point with a view to my own decisional model of eclectic psychotherapy.

Systematic Eclectic Psychotherapy

In my model of systematic integrationism (Beutler, 1983), it is assumed

that the decision to initiate individual psychotherapy has already been made. The focus of the model, therefore, is on providing the therapist with information about how to define the patient's problem, how to establish a compatible and fruitful therapeutic relationship, and how to provide interventions that will accommodate the changes observed across the span of treatment. In this process, issues of patient and therapist compatibility, breadth and severity of symptoms, defensive style, and patient interpersonal resistance or reactance level (Brehm & Brehm, 1981) are assessed. It is difficult to apply this approach to the case described by Clarkin and Rosnick for want of information about these variables.

1. A compatible and potentially fruitful therapeutic match is based in part on the demographic and attitudinal similarities/differences between patient and therapist. Clarkin and Rosnick address this issue in a general way, but the systematic eclectic psychotherapy approach emphasizes the need for greater specificity. Ideally, patient and therapist should be matched in terms of similar demographic backgrounds but dissimilar evaluative beliefs with regard to the dynamic, interpersonal needs expressed in the focal conflict.

2. The next question posed by systematic eclectic psychotherapy concerns the symptom complexity and severity presented by the patient. In the case described by Clarkin and Rosnick, it is uncertain whether the problem represents a situational adjustment difficulty or a broad-band, personality

disturbance. It appears, however, that the therapist initially approached the matter as if it were a situational disturbance and accordingly adopted very focal objectives. Without systematic assessment of this dimension, however, it is possible that therapists may be misled by their own particular preferences for symptomatically focused or conflictually focused treatments. At the conclusion of this treatment case, for example, the therapist suggested to the patient that the problem may have been more characterological than originally thought, suggesting that the symptomatic focus of the treatment may have been somewhat less than ideal.

3. Clarkin and Rosnick suggest that the patient's defensive style is more internalized than externalized. However, they also discuss the patient as "acting out" against parents. This contradiction suggests that the patient either presents some discontinuity between the two very different defensive strategies, changed her defensive strategy over the course of therapy, or exhibits one defensive style within therapy and another outside of therapy. This matter is left unclear in the assessment process and, yet, may be important for determining whether the intervention should be focused on behavior change, insight, or emotional awareness. The treatment itself seemed to move from a behavioral (e.g., the early objective was for the patient to tell her parents of her marriage) to an insight focus (e.g., at the conclusion of therapy the treatment goals are judged to have been met because the patient has more awareness of the conflict even though she did not change her behavior).

If a careful evaluation were to determine that the patient's symptom of inhibition was circumscribed to a setting or relationship and that her most disruptive defenses entailed "acting out" against her parents, behavior change in the form of reduced acting out and increased self-assertion would be the principal focus of the systematic, eclectic therapist. If, on the other hand, the patient was found to have generalized (i.e., characterological) symptoms, the quest then would be to define the underlying conflict in some theoretically specific way. If the patient's accompanying defenses were found to emphasize internalization of anxiety, as initially suggested by Clarkin and Rosnick, the subsequent focus of treatment would be to focus either on enhancing affective awareness, if the particular defenses emphasize over-control of affect, or on cognitive control, if emotional intensity and liability is high.

The patient's interpersonal reactance level is a particular area of concern in the current case presentation. The therapist's initial injunction for the patient to tell her parents about her marriage clearly escalated her resistance. This resistance, subsequently, was quite rightly observed and addressed by the therapist, but never changed. The therapist pointed out, for example, that the patient re-entrenched herself and asserted more strongly that she would not tell her parents after the therapist had made the intervention. If initial assessment had revealed the patient to be highly reactant, such a directive intervention as that given in this case would not be considered appropriate unless the therapist had wanted the patient to do exactly as she did, reaffirm her boundaries and

resist telling her parents. If symptomatic change was considered desirable by the therapist, a reactance challenge may have been a suitable test, if it had been constructed around an activity that was not so central to the patient's symptoms. Such a test could include assessing her response to homework assignments or to an insight-oriented interpretation. Observing the high reactance of this patient, the systematic eclectic psychotherapist would have ordinarily responded either with less directive interventions than manifest by the therapist in this example, or by relying on paradoxical interventions which would capitalize on the patient's reactance tendency (e.g., prescribe the rebellious activity/symptom).

SUMMARY

Collectively, the differential therapeutics model proposed by Frances, Clarkin, and Perry (1984) lends a considerable amount of clinical wisdom to the process of treatment selection. Certainly, more than any other eclectic approach to treatment, it addresses the broad-band issues of selecting treatments from a variety of modalities other than individual psychotherapy. Its most valued contribution may well be in the definition of the treatment format, the setting, and the relationship of the primary treatment to adjunctive interventions.

The model is less specific in prescribing the most desirable and specific processes and technologies to be emphasized in psychotherapy. Its reliance on

an assumption of therapy equivalence, although possibly correct, does relatively little to assist in the definition of specific treatments for specific patients at a micro-analytical level. In this context, it might be suitably applied along with a variety of more specific eclectic orientations that are better suited to the prescription of differential psychotherapeutics. Certainly, the "nonspecific" emphasis of differential therapeutics takes a more conservative approach than those who emphasize specific models of psychotherapeutic change. As such, the treatment outlined is rational, sensible, and of immense potential value to both clinical practitioners and clinical researchers.

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Commentary:
Eclecticism Should Provide Versatility

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Organizing and integrating competing approaches allows and even requires comparison of alternative case formulations and interventions. It invites us to be both practitioners and at the same time investigators, selecting and acting on what seems appropriate in our sessions, and then critiquing our procedures, generating alternatives from other approaches, judging between them, and so broadening our perspectives and expanding our competencies. The advantage of eclecticism is its potential versatility.

The focus of the differential therapeutics method is on several pretreatment considerations which may be made implicitly in other approaches. Clarkin and Rosnick seek to specify the ways to match clients to treatment modalities. The client/patient in this case is surely suitable for outpatient treatment, and seeing her more intensively (twice a week) is a nice solution to the time limitations imposed by her graduation. The individual sessions seem appropriate initially, although one might have left open the possibility of seeing her later with her husband when he could get leave, or perhaps with her in-

laws.

The choice of a transference-focused brief psychodynamic therapy as the approach for this woman sets the parameters for the rest of the treatment. Integration can be by the selection of a single orientation matched to the client, as was done here, or by the use of many orientations as they apply to a case, which is the more usual method. The advantage of a single matched orientation is that it maintains the coherence and integrity of the single method, hopefully well suited to the particular client. The advantage of integration of orientations is that it provides a versatility of options with in each case which is not found in any single orientation.

In the single matched approach, the choice of the matching is especially important. Although a reasonable case was made for brief psychodynamic therapy, several alternatives could have been equally plausible. This woman may have done well with the support and gentle exploration of client-centered or humanistic therapy, the assertiveness practices of behavioral therapy, the confidence building of cognitive approaches, or aspects of other methods.

The authors mention that one should start with the treatment with fewer risks and less ambitious goals and then become more invasive and ambitious if the initial interventions are unsuccessful. It is a good point and possibly critical here, for it would argue against the method selected. The method as initially

proposed and as actually used in the case relies on ambiguity, anxiety, frustration, and the generation of a rather prominent transference reaction, all of which are quite unsettling to the client and would have higher risks than the more supportive methods from other approaches.

Aside from the initial method selection, the case itself is presented as a brief focal psychodynamic therapy treatment by a particular practitioner and not an illustration of differential therapeutics. My remaining commentary on the case itself introduces alternative perspectives for comparisons and suggest that some of the principles that can be used in organizing eclecticism can also assist here in clarifying the case and adding versatility to the treatment approach.

Each orientation has its own ways of conceptualizing things, and one of the problems in integration is in getting competing approaches to agree on any account of the principal phenomena. What one sees as a reliable observation strikes another as unfounded interpretation, and each approach uses concepts and terminologies that are foreign to the others. I see these same sorts of problems as I try to understand what went on in this case. Although some subjectivity is inherent, it behooves us to take precautions to improve the objectivity and reliability of the clinical observations we report. Specifics are usually more reliable than generalities, and ample case transcript material allows the readers to see it for themselves. Comments that are more

interpretative might be presented as possibilities rather than givens, placed alongside the viable alternatives, or backed up with supporting specifics. And some respect for our ordinary language concepts and conventions can help tune in a clearer picture.

Clarkin and Rosnick mention the importance of the therapeutic relationship, as do writers from various orientations, and a focus on the nature of the relationship established seems a good place to begin in understanding the case. The authors mention that therapist factors such as warmth, empathy, and nonjudgmental respect serve to create a therapeutic atmosphere and to establish an alliance with the client. These are usually termed nonspecific factors, in that they are common to various schools of therapy, but the choice of the term may be somewhat misleading. It is often possible to be quite specific about the sorts of interventions that contribute to these relationship factors or undermine them. We can often gauge which interventions would come across as empathic or respectful and which would not, and which interventions would appear supportive, and so cast us as allies to our clients, and which appear unsupportive or contentious, and so undermine the therapeutic alliance. Attending to the appropriate nuances, we should try to choose interventions which establish and maintain an alliance and avoid those which undermine it.

Rosnick uses the central issue of the client telling her parents to structure the treatment, and in so doing she sets the tone of the therapeutic relationship.

She specifically rejects using methods that might assist the client in this difficult task, such as advice or role playing, but attempts to pressure the client simply to do it on her own. Intervention tactics such as this could easily leave someone feeling both unsupported and forced, and the client responds not too surprisingly by digging in her heels and resisting the prescription.

The unsupportiveness and pressure are intended to create a transference reaction, which is to say to recreate in this client the same sort of attitudes and reactions toward the therapist as she has toward her own parents. The interventions are successful in doing just that: The client becomes ambivalent about her therapist but clearly mistrustful, is uncomfortable with the sessions with her, plays hooky from several of them, conceals information for fear of the consequences, and in other ways resists the therapist whenever possible. Rosnick then interprets these reactions not as situational reactions but as general characteristics of the client. Other sessions seem to continue in the same vein, with the therapist trying to force various viewpoints on the client and then interpreting her uncomfortableness and resistance to the interpretations and to the process of therapy itself.

A transference approach is necessarily a gambit, in that it sacrifices the immediate assets of the therapeutic alliance in the expectation of later gains from the interpretation of the transference reaction which it generates. A gambit is usually a losing game, unfortunately, for anything unplanned can foil

the expected advantage so that the loss at the outset translates into a loss at the conclusion.

Although the importance of a working alliance is acknowledged by advocates of transference cures, the extent to which the alliance is sacrificed by the transference is too readily overlooked. In this case the attitude the therapist created by being unsupportive and controlling overshadows an alternative view of her as an ally, and therapy proceeds without the benefits of a working therapeutic alliance.

The point of an eclectic integration is to pull the best from competing orientations. Where the various orientations are going the same way we look for general principles that underlie the practices, and where orientations are complementary we seek ways to combine them. But where the principles in one orientation are in direct conflict with principles from other orientations, we must compare and make hard choices on what to accept and what to reject. Some orientations emphasize the alliance for the direct benefits it has for clients, whereas others see it as a condition for adequate persuasive influence by the therapist. Either way, most agree that it is important to maintain an alliance. And to do that it seems clear that we must not willfully generate negative transference, but instead might challenge and counter transference reactions when they do occur.

How might a therapist have drawn from a broader array of therapeutic principles in conducting this case? Several intervention objectives are suggested here as alternatives to consider.

It would be good to be more supportive with this client. Having been raised by parents who were apparently aloof and at times controlling, this client is nonetheless quite open to others and appreciative of the support she receives. In entering therapy, it is a reasonable guess that she was seeking support and nurturance, and she did mention that she wanted a confidante from whom she did not have to keep secrets. Although looking to others does have its risks, it is neither wrong nor inherently pathological. Some of the strongest and best adjusted people are those who have established positive bonds with friends and family, and who rely on those relationships for support and meaning in their lives. So rather than trying to break this woman of her reliance on others, one could explore with her the advantages and the pitfalls and so try to guide her toward more balanced social relationships.

Clients often see themselves as unacceptable and weak, and it is good to identify and credit the positives and strengths they do have and to build from there. With this client the task would be an easy one. She sees herself as fun, strong, and generally able to deal with things—a view generally supported by her school record and her interpersonal relationships. Some of her transcript comments were insightful, and her laughter suggested an appreciation of irony

and a solid sense of humor.

In several instances I felt that she deserved more benefit of the doubt than was given, and that insufficient notice was taken of situational factors in accounting for her actions. Her marriage was interpreted as a hostile and vengeful act against her parents, which seems unnecessarily pejorative and which she never quite accepted. One might portray getting married as a reasonable action under the circumstances, and her parents' contentious objections made a quiet civil wedding without them the preferred option. She herself was interpreted as unconsciously hostile, but she does not seem hostile in her comments and surely not as hostile as someone else might be in her situation. The use of more positive interpretations would be supported by perhaps the majority of therapeutic orientations.

Steps might have been taken to make suggestions and interpretations more acceptable, and thereby maintain the alliance and avoid generating resistances. In suggesting that she tell her parents, one might portray the benefits and then deal seriously with her objections, so that she can weigh gains against risks and make up her own mind. When she sees that the benefits outweigh the risks, she would be inclined to tell them on her own and would not have to be forced. Perhaps she might try talking more with her close friends about her marriage, to gain some confidence and perhaps a new angle before telling her parents.

In focusing on her marriage one could mention that anyone might have second thoughts, especially when she and her husband are separated and have had to maintain a long-distance relationship. A comment such as this is supportive and would be easily accepted. The issue from there is not whether she has ever had second thoughts, but whether she wants to make the marriage work and how to go about it. It is a relationship issue, and a relationship-oriented approach should be used in dealing with it. Situations and relationships are emphasized in behavioral and family approaches, but are too often overlooked in analytical and psychodynamic orientations.

The outcome of the treatment this woman received was mixed. Major issues remained unresolved, and the client was apparently more apprehensive later in the sessions than when she began. Some of the added turmoil was apparently an iatrogenic consequence of the treatment approach itself, which should be a matter of more concern than was given to it in the case write-up.

The client did recognize that she tends to take responsibility for others, and took steps to curtail that tendency. This could be of considerable benefit in avoiding being used and worn out in various social relationships. She was feeling better several months after therapy, which could have to do with any of a number of factors. My guess is that she was benefiting from the greater responsibility and less forced reliance on her parents which comes from being out of school and having a job.

The authors recognize that some of the intervention was controversial in its usefulness and that the outcome was not particularly impressive. We can only "guestimate" the tenacity of the problems, but it would seem that a woman with as many strengths as this one might have benefited, and perhaps quite readily, from other therapeutic methods involving support, collaboration, and guidance. One of the strengths of eclecticism is its willingness to consider alternatives, and I would have wanted to see the authors provide their own views on what might have worked out better with this case.