CASEBOOK OF ECLECTIC PSYCHOTHERAPY

RADICAL ECLECTICISM:

Case Illustration of an Obsessive Disorder

Malcolm H. Robertson

Commentaries by
Sol L. Garfield & J. Kevin Thompson

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Radical Eclecticism: Case Illustration of an Obsessive Disorder

Malcolm H. Robertson

PERSONAL BACKGROUND

To paraphrase the title of a motivational film of a few years ago, "who I am is where I've been." And in the beginning, about 30 years ago, I was pretty much like everyone else, a psychodynamically oriented clinician. The first bend in the road came during my doctoral study, during which I was trained in a loose merger of neo-analytical and learning theory, as set forth by Neal Miller, John Dollard, Joe Shoben, and others of that era. After graduation and for the next 10 years, I cultivated this hybrid form of psychotherapy, but basically my energies went into doing what one does to make one's mark as an academician.

Then I had two impactful experiences, both of which were peripheral to my professional ambitions, but in retrospect had pivotal significance for my career as a psychotherapist. The first was participating in one of those "touchy, feely" marathon group encounters so popular at the time; the other was a six-month stint overseas as a Peace Corp "shrink." I'm not sure, but I

think what happened is that I belatedly started to define myself in terms of my experiences rather than in terms of a set of externally defined values. To come to the point, as a psychotherapist I opted to become present-centered, feeling oriented, with a focus on learning by doing. Concurrently, my academic priorities shifted from teaching and research to community consultation, training students to do psychotherapy (rather than to learn to talk about it) and, on the side, teaching myself to do the kind of psychotherapy that I sensed I was cut out to do.

My self-taught program led me from workshop to workshop, from institute to institute, like a wandering therapist in search of the therapeutic grail. At a point about 10 years ago, I simply burned out trying to imitate and emulate the master therapists whom I had observed. I had to admit to myself that I was never going "to pull the rabbit out of the hat," as they so deftly demonstrated time and again to spellbound audiences. At this juncture I decided to ask myself the questions which for so long I had asked of others. What is it you do? How do you do it? Why do you do it?

RADICAL ECLECTICISM

Radical eclecticism is an atheoretical approach. Selected interventions from current systems are applied sequentially to foster therapeutic movement in the client, or two, at the most three, specific interventions are

integrated and applied as a single intervention unit in order to effect change in thought-feeling-action patterns (Robertson, 1979). It is atheoretical in that interventions are organized not according to a formal theory base, but around the objectives or goals they are designed to help the client reach (Barker, 1984). The therapist selects interventions that clinical judgment and experience suggest are therapeutically potent for the presenting problem. Radical eclecticism differs from synthetic eclecticism, which I would describe as a synthesis of current concepts and principles for conceptualizing client problems and therapeutic outcomes. It differs from technical eclecticism (a term coined by Arnold Lazarus), which I would characterize as a poly-method/single-theory approach. And it differs from systematic eclecticism, which I understand to be an integration of concepts, change strategies, and specific interventions from several major systems into a new conceptual framework.

To develop and maintain a therapeutic relationship, I rely on interpersonal interventions, most of which are derived from person-centered psychotherapy (Egan, 1982). Examples are empathic reflection of explicit and implicit feelings, needs, values/beliefs, and goals; confrontation to identify conflicts and inconsistencies; therapist self-disclosure of personally or professionally relevant experiences; relational immediacy, i.e., communicating about the therapist-client communication or about the overall relationship; clarifying/summarizing; giving information directly, or

indirectly, e.g., metaphors, images; and selective probes. I have found these interventions helpful: (1) to explicate problems and generate alternatives for the client to consider, and (2) to develop a therapeutic relationship that differs from the client's social/personal relationships, which so often maintain and perpetuate rather than challenge or change well-established, albeit maladaptive, interpersonal behaviors (Roberston, 1979).

To give clients a different perception of their problems, I use two neutral terms: (1) themes, e.g., recurring feelings, needs, thoughts/beliefs, actions, and (2) issues, e.g., thematic feeling of anger, thematic need for approval, thematic belief in subordinating one's needs, thematic unassertiveness. Following the identification of themes and issues, specific changes are planned with the client. Based on the literature and my experience, structured interventions are selected to implement the planned changes, e.g., relaxation/positive emotive imagery to relieve thematic anger, cognitive restructuring to suggest alternative ways to satisfy a thematic need for approval, Gestalt two-chair dialogue to challenge a thematic belief in subordinating one's needs, behavior rehearsal to develop assertive actions. An important component of the intervention work is to discuss with the client the immediate impact of the intervention and, if positive, to plan how the positive outcome may be used outside the session.

Additional features of my approach are: present-centered with an

emphasis on emotions; flexibly structured with an agenda tailored to the client, the session, and the stage of therapy; tentative time limits correlated with progress reviews; and contractually based with between-session assignments. My therapeutic role is fourfold: interpersonal model, conceptualizer of information, change agent, and "professional" friend. I use the early stage (first session or two) of psychotherapy to develop a collaborative relationship, to gather and conceptualize information, to formulate therapeutic goals, and to begin formal intervention work. The middle stage consists of applying and evaluating interventions, planning between-session practice, and attending to impasses that arise within or outside the sessions. In the termination stage sessions are less frequent, difficulties in transferring and maintaining changes outside the session are addressed, and a self-help program and follow-up contacts are planned.

Several of my personal and professional values are reflected in the therapeutic relationship. The relationship is an egalitarian, collaborative partnership in which client and therapist have their respective responsibilities, are mutually self-disclosing, and are willing to confront and negotiate differences that arise during the course of therapy.

Although radical eclecticism does not have a formal conceptual framework, clinical decision making is guided by three assumptions. One is that psychotherapy is a reflective learning-by-doing for both client and

therapist. The client learns by trying out unfamiliar behaviors within and outside the sessions and by evaluating the outcome in relation to his/her goals. The therapist learns how to change a particular client with a particular problem by conducting both planned and improvised interventions and by being modified by feedback from the client. A second assumption is that increasing clients' awareness of self and others creates a readiness to make and implement new decisions about how to live their life. A third assumption is that assessment and change are ongoing, interactive processes in psychotherapy, in which seeking therapy is the first (but hopefully not the last) change. Relatedly, clients are always in a process of change, part of which may be a response to their experience in psychotherapy (Efran & Lukens, 1985, p. 72).

The author limits his practice to adults with mild to moderate problems of living who are referred by colleagues. Instead of doing diagnostic testing beforehand, I rely on information gained in the first session or two. Based on an abbreviated version of an assessment strategy developed by Hulse and Jennings (1984), I assess strengths and limitations on the following client variables: expectation of and motivation for therapy, cognition, affect, behavior, health, current and past interpersonal relationships, developmental maturity, and communication style. From this information a tentative intervention strategy is drawn up to implement therapeutic goals and is later modified in response to client progress or lack of progress. The decision to

use a group, couple, or family modality, concurrent with or in place of individual therapy, may be made at any point in the course of therapy. Generally, I use a group modality if I believe the client would benefit from peer support and peer confrontation, and from having a miniature social situation within which to try out new interpersonal behavior. A marital or family modality is utilized if significant others have problems closely related to those of the primary client and are willing to participate in conjoint therapy.

At present, I do not have an ongoing research program for radical eclecticism, which, in addition to other limitations, precludes determination of the contribution of each intervention to therapeutic progress. I do conduct a psychotherapy training program in individual, group, couple, and family therapy, in which graduate students are trained in radical eclectic psychotherapy (Robertson, 1984).

The remainder of the chapter is a presentation of radical eclectic psychotherapy with a client whom I saw for nine sessions over a four-month period. He is similar to other clients who are referred by colleagues.

THE CLIENT

The client, who will be referred to as Steve, is in his early thirties, has been married for nine years to the same wife of approximately the same age,

and has two pre-school children. He has a terminal degree in a health service field. His primary employment is administration, with secondary employment in clinical service and teaching. His wife, who will be referred to as Sandy, has a B.A. degree and is presently a full-time homemaker.

Motivation. Steve sought psychotherapy in order to make his life more balanced, i.e., by eliminating his workaholic behavior and by investing more time and energy in his marital and family relationships. He commented, "My work is taking over my life and I have to do something about it immediately."

Expectation. He expects that psychotherapy will be helpful, will require active effort on his part, and that change will be gradual.

Cognition. He is mentally alert and intact. His thoughts are organized, lucid, and convergent rather than divergent. A major cognitive theme is self-appraisal of professional performance.

Affect. Emotionally he is restrained, even inhibited, though his feelings are congruent with his thoughts, but not always with his actions, e.g., sometimes he "goes through the motions" or acts contrary to his feelings.

Behavior. He comes across as accommodating and compliant. He reports that he generally tries hard to do what he believes others expect of him and has trouble saying no. Overall, his actions suggest that he feels ill at ease in

interpersonal situations.

Health and physical appearance. He is of average height and slender stature, and his facial expression is serious, earnest, with a constrained smile. His health and medical history are satisfactory.

Past interpersonal relationships. Steve is the oldest of five children of parents of mixed ethnic and religious backgrounds. His mother was a nurse and his father was in the same health profession as Steve. The family moved frequently, partly in response to the vicissitudes of his father's professional life. Although compatible, the family was not close or demonstrative. His mother was the primary parent and household manager and also contributed to the family income. The father, frequently absent from the home, was on the periphery of his marriage and his family. Steve stated that he has always been studious, achievement-oriented, and somewhat isolated socially. His social/recreational life was curbed partly because of family moves, and partly because, as he was the oldest child (and probably because of his accommodating nature), his mother leaned on him for assistance in managing the home and taking care of the younger children. His father died unexpectedly when Steve was in his first year of professional training. His mother and brothers live in other parts of the country; three siblings are in professions and one is in a skilled trade. Steve began dating his wife during their senior year in college and they married shortly thereafter.

Current interpersonal environment. His life is centered primarily in his profession and secondarily in his family. His social/recreational life is limited mainly to friends and activities connected with his church. He reports being under considerable pressure at work to meet his self-imposed standards, and under pressure from his wife to devote more time to her and to family activities. Because of the stress and strain of parenting, their sexual relationship lacks the frequency and quality that it had in the earlier years of marriage.

Communication style. Steve's speech is deliberate, thoughtful, and laconic; he listens well, chooses his words carefully, and is a responder rather than an initiator.

Developmental maturity. Steve is above the norm with respect to professional identity, career development, and intellectual maturity; he is at the norm in terms of providing dependable financial support for his family and in parenting responsibilities; and he falls short of the norm in terms of marital and social adjustment.

Additional information. Steve suffered a moderate depressive episode during his third year of professional training, for which he did not seek professional assistance. Two years later, he had psychotherapy for three or four months for "general coping problems," and he described the therapy as

"somewhat helpful." My diagnostic impression is obsessive personality with moderate anxiety and depression.

First Session Summary

I gave Steve some administrative forms to complete and to return at the next session. I discussed confidentiality and obtained permission to tape the sessions. I explained the procedure that I would follow if I wished to use any part of the therapy material for professional publication.

I told him that I preferred weekly sessions, but the frequency could be negotiated as we went along. I described my professional style as informal, suggested that we use first names, and encouraged his feedback on what I was doing and how I was doing it. In the following tape excerpt I explain my approach.

> My approach is straightforward. I find out what the client wants to change and then use the sessions and between the sessions to work toward those changes. I use a formula, awareness plus decision plus action equals change. That is, I help the client to become aware of what he is thinking and feeling, and how he is acting, and then what thoughts, feelings, and actions he wants to change and how to go about it. I also find that in making changes, it's helpful for clients to change what they are in the habit of attending to or not attending to . . . so let's see first of all what you want to change, and why . . . what you'll gain from it, and what you'll have to give up, because with most important changes you have to give up something as well as get something.

In the remainder of the session, I focused on what changes Steve wished to make, what was happening in his life that made the changes desirable or imperative, and what the changes would entail. I used empathic responding to identify important feelings, needs, values, and goals; clarification to specify and particularize his comments; confrontation to underscore discrepancies, conflicts, and obstacles to change; self-disclosure to draw him out; and relational immediacy to comment on how we seemed to be communicating and how I experienced him at a particular moment. Thematic feelings included: feeling controlled by his work, feeling anxious about success, and feeling guilty about shortchanging his family. Thematic needs included professional recognition and achievement and fulfilling expectations of others. Thematic thoughts included being prepared and being on top of problems. Thematic values included professional accomplishment and family loyalty. Thematic actions were those of trying harder, pleasing others, and getting bogged down in details.

The session closed with an agreement that we would work together to reduce his anxious preoccupation with his job, and to become more available emotionally and conversationally to his wife and children. In preparation for the next session, I decided to use a behavioral prescription because (1) it was relevant to the identified problems, (2) he was cooperative, and (3) he was a "doer." He agreed to set aside the last hour of his work day "to put the day to rest," by reviewing what had been positive and negative, readying himself for

the next day rather than doing so at home, and then planning what nonjob activities he would do at home in the evening.

Following is an excerpt from the second half of the session. I use relational immediacy to change the question-answer exchange to a more spontaneous expression of his concerns; self-disclosure to check out additional feelings; confrontation to emphasize the conflict between needs and actions; and imagery to convey an additional perception of the problem.

T: Could you talk about the problem in a freewheeling way. I'm concerned that my questions are not drawing you out. I'm feeling a need to back off and let you express yourself in your own style . . . you. . . .

C: Okay, maybe I can describe what happens . . . I get home from work and these problems are still there, and then I'm still trying to hash these problems out and situations at work, and I'm . . . difficulty in thinking . . . my wife and kids ask me questions and I answer them and I'll ask them questions, and soon as I ask these questions . . . and I don't hear their answers . . . and it stays that way throughout the evening and night. I can't seem to break away from it . . . been going on for about a month . . . gotten to the point where I can't stay asleep. I wake up around four or five. The only other time was when I had a major depression when I was a junior in School, and that's a signal things have gone too far. Also I'm not able to enjoy doing things at home, like working in the yard, just talking to my wife. I can't seem to listen to her. I know it's important for her sake and for mine and I just couldn't do it. . . you . . . so it's obviously a major problem now and something needs to be done.

T: There are some similarities to that period in School.

C: Yes, things haven't gone well at work. I rush around from one thing to another . . . can't sit back . . . can't get organized like I did before, and I get discouraged

and this interferes with ability to solve problems.

T: You want to be able to be there for your wife when she needs you, to be there, but on the other hand, you can't do it. C: Right.

T: You can see her, but you can't reach her.

C: And I feel that way about my children, like I'm there in body but not in spirit.

T: But I hear you say you really want to be.

C: Right. The problem is I don't know how to get there.

T: How to overcome that distance between where you are and they are.

C: Yeah.

T: As you talk, it almost had a dream quality .. . the image I have is of someone in a field . . . you can see people and start going toward them, but like in a dream you try and can't and you don't really move.

C: Yeah.

T: Like being impotent. You can't do what you want to do.

[C: doesn't comment.]

T: If I were in your situation I would feel out of control. You withdraw from where you are and you feel unhappy with the place where you are withdrawing to.

After the session, I felt satisfied with what we had accomplished and optimistic about being able to work with Steve. I was also conscious of how I had had to struggle with a similar problem of balancing career and family life,

and of my successes and failures in trying to work out a satisfactory balance.

Second Session Summary

My objective was to explore similarities and differences between his work/family life now and in the past. I used empathic reflection, confrontation, clarification/summarizing, and selective probes to obtain the following information.

He enjoys his present job more than the previous ones, but feels more frustrated now because he can't leave the job at his office, and he is not as successful as he wishes to be. He is conflicted about the job preoccupation that he experiences at home. On the one hand, he feels relieved that he can plan and ready himself for the next day, yet he feels guilty about doing it at home, and also feels controlled by the rumination because he can't stop or diminish nagging worries. He also disclosed that he is away from home more than he should be, because of his secondary employment of teaching and clinical service. He drew a parallel between a period during his professional training when he worked hard, felt dissatisfied with his performance, and would come home to assume household responsibilities because his wife was ill during the pregnancy of their first child, and his current life in which he works hard, feels dissatisfied, and returns home to relieve his wife who is emotionally exhausted from 10 hours of child care. He acknowledged

recurring, depressive feelings, though not as strong as the depression he had during his training. He noted that since childhood "I have always been a worker at home," especially helping his mother with his younger siblings. He identified a long-standing need to anticipate and be prepared for problems that threaten to overtake him. He stated that, like childhood, his present life is characterized by an incessant drive to achieve and to be prepared for any and all problems, which in turn restricts his social/recreational life.

Midway through the session, I decided to use an imagery intervention in order to help him verbalize issues concerning his self-definition as a person. My rationale was that imagery would elicit reactions of which he was now only marginally aware, and that he would respond well to imagery because of his verbal skills and introverted personality. Following a brief relaxation exercise, I had him visualize, as vividly as he could, first a tree and then a house near the tree. After five minutes of visualization, we discussed the experience and made connections between the imagery and his current life. The intervention was not as productive as I had expected it to be. It revealed personal traits which he felt he lacked, but which he had the potential to develop given a less stressful work and home environment.

I gave him three assignments to do before our next session. The first was not to struggle against the intrusive thoughts. I explained that, paradoxically, struggling against an unwanted thought often strengthens the

thought. At the same time, I instructed him to look around the house for something to attend to sensorily, as this might counteract the intensity of the rumination. The second assignment, which was based on his suggestion, was an extension of the first-session assignment of "putting his work day to rest." He would go to a nearby library on his way home and spend 15 to 20 minutes reading his favorite newspaper columnist. The third assignment was to draw his family of origin and bring the drawing to our next session. The purpose of the drawing assignment was to examine how unpleasant experiences of the past are influencing his present life.

After the session, I sensed that he left feeling unfinished, as if he were ambivalent about saying something more. I made a mental note to use relational immediacy in the next session if I sensed the ambivalence. I noted that even with strong verbal skills, he seemed to have difficulty in this session and in the previous one in talking spontaneously and in elaborating on personal issues.

Third Session Summary

Steve reported that he had gone to the library twice during the past week, and found it helpful in putting his work day to rest and in preparing emotionally for the transition to his role as husband and father. I stressed the importance of making the library interlude an integral part of the passage

from job to home.

He then presented his family-of-origin drawing that depicted a holiday scene in which family members were gathered together for the holiday meal. He guessed he was about 10 at the time. By using empathic reflection, clarification, selective probes, and relational immediacy, and sharing my perceptions of the drawing, I centered his attention on what was happening in the scene that distressed him then and now. The following excerpt is noteworthy insofar as it marked the first time that he displayed significant, affective arousal. He was visibly moved as he recounted the unhappiness that accompanied holidays. The source of the unhappiness was mainly the behavior of his father, who suffered from manic-depressive episodes.

T: What was your mother's role in the family?

C: Well, she was, you know, continually working . . . keeping things going.

T: Well, she was continually working . . . and then what wasn't she doing?

C: You mean, like spending time with us?

T: Okay, with you, and when your dad was there, what was his role?

C: Well, he was . . . physically but not psychologically . . . he was there but. . . .

T: What do you remember of this time when he was there physically but not psychologically?

C: Whenever we'd eat supper . . . he'd eat through his supper . . . then put his head

on his hands . . . and wouldn't talk.

T: What was going on?

C: Well, [long pause] he was a manic-depressive.

T: That must have worried you.

C: Well, yeah.

T: As a child, it must have been scary . . . what's wrong with Dad now . . . what did I do . . . did I cause it.

C: Well, it was just the way things were when he was home.

T: What did your mom do?

C: Keep up a front.

T: Like a buffer . . . her part was to protect him . . . to be a buffer . . . to spare him the commotion at home.

C: Yeah, that was pretty much it.

T: You knew not to make demands on him.

C: Yeah, right.

T: How old were you when you found out he was a manic-depressive?

C: I guess about 10.

T: How did you know that?

C: Well, my mother told me he was ill.

T: What that connects for me is the theme of uncertainty . . . father who is ill . . . the kind of illness that's not like a physical illness . . . uncertainty about what is going to happen . . . how will he be today . . . tomorrow . . . will he be home and how will he be if he does come home?

C: Well, I long pause] there were certain periods when he never came home . . . other periods he'd come home but just not be available psychologically to us.

T: Sounds like your mom tried to provide the consistency that he couldn't.

C: Yeah.

T: Do you remember worrying about your dad when you found out he was ill?

C [long pause]: Ah . . . ah . . . I remember worrying because we were told that he wasn't going to be able to work, or might not be able to work anymore.

T: That would do it. . . there again is the uncertainty.

C: Yep, yes.

T: So your mother became the one you could count on and depend on. If someone was going to keep the family together, it would be her.

C: Right.

T: Everything pretty much depended on her.

C: That's right.

T: When doing the drawing, did you get any kind of memory or association as you were doing it?

C: Nothing that hasn't occurred before . . . Christmas was a very unpleasant time . . . always has been . . . and always since then . . . not as bad now as it used to be.

T: How do you mean that?

C [long pause]: Well, it was a very unhappy time. I'd often wonder why other people enjoyed Christmas and I didn't.

T: How come they and not me.

C: Yeah. I had some resentment about that.

T: You feel resentful . . . and sad also . . . perhaps a lot of sadness.

C: Yeah.

T: And you've had to work through the sadness and resentment.

C: I feel bad right now.

T: I know that. . . it's still a living memory . . . sometimes you have to deaden those feelings, but you don't deaden them completely . . . and they come back at you.

C: Yeah. I guess so.

Steve elaborated on his resentment of having to assume a caretaker role in the family because of his father's frequent absences and impaired functioning when he was at home. Connections were made between his caretaker role as a child and his caretaker role as an adult, both at work and at home. I pointed out the vulnerability he felt as a child in response to the uncertainty surrounding his father's illness, and the vulnerability he feels now in response to ever-present uncertainty, and to the pressure to anticipate, to be prepared, and to be in control of whatever may befall him.

As the session drew to a close, we shifted to the resentment he presently feels in functioning as a caretaker, especially at home. He agreed with my observation that he and his wife are more like compatible business partners. Each is busy as a caretaker for the children; both are suffering from caretaker role fatigue; the relief from the caretaker role is achieved separately rather than together; and the result is a lack of an intimate, sharing relationship. No assignment was made other than to allow time to process what had come up in the session, and to explore how his current lack of fulfillment is related to experiences of the past.

Fourth Session Summary

Because of Steve's cancellation, the fourth session took place two weeks later. My objective was to respond further to the material of previous sessions and to formulate some therapeutic suggestions. To summarize, I pointed out how the anxious rumination at home, and the emotional distance from the family, signaled a lack of balance in his life. I emphasized the importance of making some specific, modest changes in order to intervene in the rumination and emotional distancing. I raised the possibility that he was focusing his strong sense of responsibility on keeping bad things from happening instead of making good things happen. I suggested that at work he delegate more responsibility, enlist support from others in dealing with problems, scale down his expectations of what he thought he and others should accomplish,

and schedule some brief, winding-down periods. When at home, I suggested that he engage in activities with his children that he enjoyed doing instead of accommodating to what they wished to do.

After the session I wondered if I had been too directive, even "preachy." I felt a mounting pressure to get back to the changes we had agreed to work on, and to encourage him to experiment with alternative ways of relating to his job and to his family. I decided against an earlier plan to use a Gestalt two-chair dialogue to address unfinished elements in the relationship with his father. He seemed unresponsive to working on that issue, and I sensed that an experiential intervention might stiffen rather than relax his resistance to exploring strong affective reactions. Because of the time-consuming procedure, I chose not to use systematic desensitization to relieve the anxious preoccupation. I also thought that a cognitive restructuring intervention might reinforce thinking rather than acting. If direct suggestions and behavioral prescriptions did not impact sufficiently, I decided I would use behavior rehearsal to experiment and practice alternative behaviors. I also recalled a remark he made as he left the session, to the effect that he was going "to wait on his marriage for the next couple of years." I wondered if the real reason for seeking therapy at this time was to deal with a decision to remain in his marriage.

Fifth Session Summary

Much of this session had to do with bringing me up to date on what had happened during the previous three weeks when he was out of town much of the time. He reported that he and his wife had talked at length about how to schedule more time together away from or at least out of the presence of the children. He had discovered that he could spend some of his parenting time doing what interested him, and that also appealed to his children, e.g., outdoor activities, cabinet making. He stated that he was delegating more responsibilities at work, was taking nonworking lunch breaks, and was enlisting the assistance of others in coping with job problems.

I brought up the comment he had made in the previous session about a time period for his marriage. He clarified the remark by stating that in two to three years he would not be as busy professionally as he is now, and therefore he could invest more of himself in the marital relationship. I cautioned him about the risk of waiting too long to restore the intimacy that he and his wife had had before the arrival of the children. I shared a comment which Cliff Sager had made at a workshop, that sometimes it is too late for a husband and wife to recover intimacy, even though both are committed to do so. I also told him of my struggle with the same issue of shortchanging my marital relationship, because of a drive to establish a productive career, and because of the parenting demands generated by three preschoolers.

Later in the session, I used relational immediacy to point out the

difficulty he was having in responding to the session focus. I found myself asking many questions in response to frequent silences, like priming the pump, yet he seemed unable or unwilling to stay engaged conversationally. The following is an excerpt of that exchange.

> T: I just want to check out with you about how our communication is going . . . it could be what you mentioned about things going pretty well for you now, and there's not the pressure to focus on problems. On the other hand, I'm wondering if I'm the kind of person you find you can relate to conversationally . . . because with some people it's easier to talk to and with others it's hard. Some persons we click with and others we don't. Anyway, I'd like to check this out with you in terms of how you and I click or don't click.
>
> C: That's a . . . hard question to answer . . . 'cause the kind of issues we talk about. . . I don't talk about with others—I won't. Some people I'm very good friends with, I'll not even talk about personal issues with.
>
> T: Yeah. One thought I had was that I might remind you of someone you found it hard to be at ease with.
>
> C: Well, the kind of issues we talk about. . . I've always had trouble talking about those . . . and that was true for the other therapist I saw.
>
> T: Okay. I just wanted you to feel free to suggest any changes I could make that would make it easier for you to talk with me . . . but it sounds like it's the personal issues rather than my style.
>
> C: That's pretty much it.

Steve then commented that his problems were not pressing now, and that some headway had been made. He suggested a "maintenance schedule"

of biweekly sessions in case the positive trend did not last. He reiterated the point in the above excerpt that it was hard for him to self-disclose, especially about feelings. After the session, I thought about the possibility of using an imagery exercise next time to deal with the impasse concerning self-disclosure of feelings. Briefly, the exercise is one where the therapist first shares his/her imagery of the therapeutic impasse (likens it to something removed from therapy) and then translates the imagery into the therapy situation, at which point the client follows suit (Klagsbrun & Brown, 1984).

Sixth Session Summary

Steve reported that the positive changes at work were still in effect, and that he was doing fairly well at home in controlling the intrusion of work-related thoughts. He also mentioned that he was taking his lunch breaks at home, and with one child in kindergarten, he and his wife had found some time for quality conversation. He had decided not to accept any more part-time teaching. He was also considering how he might spend less time in administration and more time in service work. The latter was more stimulating intellectually and more satisfying emotionally, and also allowed social interaction with colleagues "who are more on my wavelength" than are his colleagues in administration.

Near the end of the session, he commented that although he had

initiated psychotherapy, he did so as much in response to pressure from his wife as in response to his concerns. She had asked him repeatedly to cut back on his work, and to be more communicative with her. For reasons I am unsure of (and I still am), I decided to do a brief monologue with his wife as if she were sitting in the chair next to him. The following is an excerpt of that monologue.

> T: Sandy, what could you do or change that would make it easier for Steve to be emotionally available to you? He has to become more available emotionally, and how could you facilitate that. . .what could you do or not do that would bring him closer to you?

Afterward, Steve inquired about the possibility of my seeing them as a couple. We decided that I would see his wife alone next week, and then we would schedule two or three conjoint sessions. Because of the change in our plan for the subsequent sessions, I decided to postpone using the imagery exercise I mentioned in the previous session summary.

Seventh Session Summary

Sandy came willingly to the session. My agenda was twofold: (1) to learn what progress she had observed in Steve, and to assess the role of the marital relationship in Steve's workaholic behavior and emotional withdrawal at home. She reported that the sessions seemed helpful to his adjustment at work and to the time he spent with the children, but the

problem with which she was most concerned, their marital communication, had not improved perceptibly.

She is an intelligent, articulate person, affable, and on the surface unflappable. She described her family of origin as closely knit and demonstrative. She noted her weight problem and reported considerable anxiety and stress over child management issues. She appreciated their compatibility, but she was disappointed in Steve's lack of interest in relationship-focused conversation, as well as his lack of interest in conversational interactions with other couples. She valued his deep conviction about life, his calm, rational problem-solving approach, his willingness to make personal sacrifices for what he believed in, and his acceptance of her criticism of their lack of communication. In talking with her, I relied mainly on empathy, personal/professional self-disclosure, clarification, selective probes, and occasional confrontation of her conflicting feelings and needs.

Eighth Session Summary

My purpose was to observe their interaction and to make a few specific suggestions to improve their relationship and their parenting, which they could try out during the next four weeks when the family would be out of town.

I presented the idea of how a marital-relationship problem is sometimes converted into a parent-management problem, because the former is too threatening to confront. They did not think this idea fit them, and they emphasized that indeed they were faced with two very strong-willed children who preempted most of their time and energy.

The following suggestions were made and accepted by both. First, they would take a firm, united stand with their children on bedtime. Second, they would arrange more family activities outside the home, as both reported much less stress in dealing with their children outside the home. For example, they agreed that since dinnertime was especially stressful, they would take the family out to dinner more often, at least during the week. Third, they would identify positive conversational topics that they had in common and would make an effort to pursue these topics. Fourth, when she became overstressed with the children, she would tell Steve what she needs from him, which in most cases is to be listened to rather than to have the problems solved (as Steve often believed he had to do). Fifth, a blend of symptom scheduling and contingency contacting was suggested, whereby they would agree on a time period when Steve could engage in his job ruminations, and then another time when he would be available for you-and-me talk. The following excerpt reveals a recurring problem in their interaction, and how it might be partially resolved.

T: What do the two of you need to nourish your relationship—to enhance it?

H: Spend more time together . . . by ourselves.

W: There are times when [inaudible] . . . it's a comforting attitude I need [inaudible] . . . sometimes I don't need you, but it's nice to know when I do that you'll be there . . . not so much that you're doing anything, but that you're there.

T: How do you react to what Sandy just said?

H: Well, it's [inaudible] . . . a thing . . . like things are just fine with you, and then. . ..

W: I think . . . it's a sense I don't want to burden you with what's going on in me . . . maybe it's like you're one of the kids and I don't need any more problems [laughs],

T: I think a couple of things are operating at these times. I do experience you being protective of Steve. Also, because he hasn't been there emotionally for you, you think "I have to do it myself. . . I don't know if he will be able to step in . . . he's preoccupied and maybe it's all up to me" . . . so it's partly protective and partly feeling you're going to have to handle it without him anyway.

W: I think so . . . [inaudible]

T: So what do you need from him?

W: [inaudible] . . . it's nice to have someone there . . . just like holding hands, like getting a backrub . . . [inaudible] . . . like the other night when I needed solace, comfort, [inaudible]. . . and you teased me [laughs], I was scared, totally scared—no ability to go to sleep . . . I tried to talk myself out of it. . . for a while . . . but not for long. I was panicky.

T: That's the way it is with an anxiety attack.

W: Is that so?

T: Then you came downstairs.

W: Oh, I was having trouble breathing, feeling very uncomfortable, so I decided to go downstairs and see what you were doing, [inaudible]

H: You said you were nauseous.

W: Oh, yes, and you said, "Oh, you're always nauseous about something"—and this really ticked me off.

H: You said you were nauseous from [inaudible] . . . you get nauseous easily, and I meant it seriously.

W: I think you said something about you're always nauseous.

H: Well [inaudible].

W: I went back upstairs . . . and you came up later. I tried to lay down in bed and the breathing became more difficult.

T: When you came downstairs, what did you need from Steve?

W: I think . . .just physical closeness . . . warmth . . .just [inaudible], . . .

T: So you didn't need a solution—just some physical contact.

W: Yeah. . . . Yeah . . . [inaudible],

T: Like you just wanted to regress—just curl up.

W: Yeah [laughs]. Yeah [laughs]. After the anxiety went away, I had this intense desire to go into the kids' room and get that big teddy bear [laughs] . . . I almost did, but I didn't want to wake the kids, and I thought it might disturb you because you were asleep by then.

T: So, Steve, you're saying we need to spend more time together, and Sandy, you're

saying there are times when you just need to feel Steve's physical closeness and support.

W: Yeah, that's pretty much it.

T: You're not looking for a problem solver—it can be Steve just being there . . . and if Steve realizes that he doesn't have to solve any problem or come up with any answers, that will take pressure off him. I think you need to make it clear at those moments just what you do need from him.

W: [inaudible]

H: So I did come around and say something about having a backrub—I had no idea that was what you wanted earlier.

T: I think that is a good example of what Sandy and I talked about last week, and what Steve and I talked about earlier. He needs to be there for you, and you need to tell him what you want, and it may be nothing more than just sitting next to you or being quietly supportive. W: I think it's good that Steve sees these attacks I've been having lately . . . to what extent I'm overdrawn . . . you're seeing my limits . . . how overwhelmed I am . . . he realizes my need, and as a result I have more freedom to say "Help!"

Ninth Session Summary

Both reported that the vacation trip had been stressful in terms of the children, but they concluded that their stress was a function of the circumstances of the trip. They reported a modest improvement in their conversational relationship, and in coping with the children since returning home. We agreed that this session would be our last, and that they would contact me about future sessions, alone or together, if they so desired.

Follow-up and Client Impressions

I sent Steve the following evaluation form six weeks after our last session. Six months later I sent him the tape excerpts for review and for permission to use in this chapter and included a one-page evaluation form to assess different components of the therapy and my overall style. He authorized use of the tape excerpts, but did not complete the six-month evaluation form, because of his vague memory of the sessions and his current preoccupation with some critical issues at work.

Psychotherapy Evaluation

1. What in particular was helpful?

   Focusing on ways to divert attention from work-related activities

2. What in particular was unhelpful?

   Not sure any of it was unhelpful

3. What would you have liked more of?

   Perhaps more focus on dealing with my fundamental attitudes toward work and appropriately prioritizing it in my life

4. What would you have liked less of?

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5. To what extent did you receive what you expected?

I expected to receive help in breaking the "hold" that my work held over me in terms of my preoccupation with it. The therapy did accomplish this for you.

At last, here it is. Hope you're doing well.

CONCLUDING COMMENTS

My overall evaluation of the therapeutic work is mixed. Steve had made some progress in terms of coping with job stress. He was less anxious about his ability to manage people and to handle the politics of his job. Relatedly, at home he had gained a modicum of control over job-related preoccupations, insofar as he was able to reduce the frequency and duration of his ruminative thinking. A commitment to improve the marital relationship had been established, and he was more willing to implement suggestions which he and his wife negotiated.

Belatedly, I had become aware of the magnitude of Steve's problem in initiating and maintaining personal communications within and outside the therapy sessions. I regretted that I had not given this problem a central focus in our sessions. In retrospect, I can see that my failure to achieve, at least a partial resolution of the problem, set limits on how much positive influence we had on each other. In addition, if unresolved, the problem will continue to

be a source of dissatisfaction for his wife.

With a few exceptions, I believe that I was consistent in demonstrating radical eclectic psychotherapy, which I described earlier in the chapter. I selected interventions I judged to be therapeutically potent for Steve's two presenting goals of relieving the anxious preoccupation with his job and being more available emotionally and conversationally to his wife and children.

At various junctures, I used imagery, the family-of-origin drawing, interpretation of past experiences on present functioning, paradoxical directive (not to struggle against the intrusive thoughts), and conjoint marital sessions. However, I was surprised by how much I relied on behavioral prescriptions and the interpersonal interventions of empathy, confrontation, relational immediacy, self-disclosure, clarification/summarizing, and selective probes. In hindsight, I wish that I had used behavior rehearsal to address Steve's problem in initiating and maintaining personal communications, first with the focus on conversations outside therapy and later with the focus on our communication. To do so, we would have had to agree on a goal of improving communication skills. The interpersonal interventions, even relational immediacy, were not sufficient to modify Steve's communication style. Again in hindsight, I would have started conjoint marital sessions in the middle rather than in the late stage of therapy, with one or two sessions that included the children.

Consistent with my approach, the sessions were primarily present-centered with an emphasis on feelings, and contractually arranged with respect to within-session agenda and between-session assignments. I made a conscious effort to fit the interventions to Steve's stated goals and personality. I still believe that he would not have responded well to a Gestalt intervention or to protracted attention on earlier developmental experiences. Consistent also with my approach was the progression of therapy tasks from early to middle to late stages of therapy.

I thought that we developed an egalitarian and collaborative relationship, e.g., use of first names, negotiating goals and tasks, mutual feedback. The three assumptions to which I referred earlier, learning by doing within and outside therapy, increasing client's awareness of self and others, and blending assessment with intervention, were evident at least in terms of the agreed-upon goals.

Finally, I am persuaded that radical eclecticism is a viable example of eclectic/integrative psychotherapy insofar as interventions are tailored to a client's problems, personality, and environmental resources. I am equally persuaded that radical eclecticism needs an explicitly stated conceptual base, a systematically developed intervention strategy to decide which technique to use for a problem at a particular stage of therapy, and a program of research that addresses both process and outcome variables.

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Commentary:
Radical Eclecticism as Directive and Structured

Sol L. Garfield

This case report provides an interesting and frank account of one psychotherapist's approach to working with patients. Although the report naturally focuses on the therapeutic interactions with one patient, the reader gets some feel for the general approach that Robertson uses. It also illustrates that you can't really tell what a psychotherapist actually does in therapy by the designation used to describe or categorize his or her form of therapy. In the final analysis, one has to be informed about the actual operations of therapy. Being able to observe the therapy is, of course, the optimum way to know what actually takes place. This, however, is not always possible, and a case description with verbatim excerpts is a reasonably good substitute.

There are a number of items in the case report that I found to be of interest. There did appear to be quite a strong directive thrust to the therapy described despite the author's emphasis on the therapeutic relationship, the interventions derived from "person-centered psychotherapy," the mention of empathic reflection of feelings, therapist self-disclosure, and "relational

immediacy." It was interesting to me also that how we use language has a clear impact on others. For example, the author at one point states: "I used relational immediacy to point out the difficulty he was having in responding to the session focus" (p. 365). I did not believe that relational immediacy could or should be used simply as a technique—it seemed to make the relationship sound insincere, forced, or manipulative. However, as the author uses it, the term simply means that the therapist pointed to difficulties the patient had in communicating in the therapy session. At the same time, I would view empathic responding as more of a personal quality or style and not as a technique (p. 360).

A number of other aspects were of interest to me, and I can comment on only a few of them. Although the therapist clearly has some general scheme for conducting therapy and, as indicated, exhibits a somewhat directive stance, he refers to the relationship as egalitarian. Clearly, this is his view and represents his value system in this situation. However, as long as one individual is in the socially superior role and is being paid for his services, I do not believe the relationship can be truly egalitarian. For example, in the second session, the therapist used confrontation, clarification/ summarizing, selective probes, an imagery intervention, and a relaxation exercise, and also gave the client three assignments to do before the next session. This appeared to me as something other than egalitarian, but I am making no value judgment as to its goodness or badness. In the final analysis, the therapist does have the responsibility for conducting therapy, and this is a responsibility he/she must acknowledge.

I myself, do not tend to use imagery very much, but I wondered about its use in the present case. What rationale was provided to the client for its use? How were connections made between visualizing a tree and a house and the client's current life? Such information would have made these interventions more meaningful.

It is also of interest that despite a cancellation after the third session, some reflective doubts on the part of the therapist during the fourth session, and a three-week interval before the fifth session, the client in the fifth session "commented that his problems were not pressing now, and that some headway had been made. He suggested a 'maintenance schedule' of biweekly sessions in case the positive trend did not last" (p. 366). Two possible hypotheses come to mind. The client has received some help from therapy and wants to keep it going; also, the weekly sessions are too much for him and he would prefer to have them more widely spaced.

I was surprised, as apparently was Robertson, that he decided to carry out the pseudo-monologue with the client's wife, and in essence shifted the focus from the client to the wife. This led to the therapist arranging to see the wife for the seventh session and subsequently to see the husband and wife together for the last two sessions. There is no reason not to see the wife, although there are some possible dangers in suddenly shifting the focus (or responsibility) onto the wife, particularly in what appeared to be a sudden decision. I may have

preferred to discuss this further since the issue was brought up toward the end of the therapy session. On the other hand, the decision to see both individuals together was a reasonable one and probably should have been initiated sooner, as the therapist himself has stated. On the basis of the eighth session, it does appear as if the wife may have more personal difficulties than was apparent in her interview during the preceding session.

I believe that I would have tended to reflect the wife's "panicky" feelings more and to have her express her feelings more fully. In many ways she has carried responsibilities without being able to have the strong support of her husband. She verbalizes the continuing problem as one of marital communication; it is that but also something more than that.

Finally, I would note that Robertson felt that he had relied on too few "structured interventions" and wished he had tried some Gestalt interventions, as well as behavioral rehearsal. As indicated earlier, I received the impression that he was quite directive and actually used structured interventions, although, again, these terms may have different meanings to different individuals. I would have used somewhat less structured and directive procedures, and perhaps these are some of the differentiating criteria for radical eclecticism and just plain eclecticism. In any event, Robertson does reveal honestly and openly how one therapist functions and that decisions frequently are made quickly and sometimes spontaneously. Later, the therapist may conclude that he might have

done something differently. It is good that he attempts to appraise his work, and he is not alone in thinking, "I might have (or should have) tried something else."

Commentary: Perspectives from an Interpersonally Based Behavioral Therapist

J. Kevin Thompson

First, a few words about my own particular, emerging, psychotherapeutic approach—a position from which I will comment on Dr. Robertson's excellent presentation of radical eclecticism. During the past two years, along with Donald Williams, I have evolved an interpersonally based behavioral psychotherapy (Thompson & Williams, 1985; Thompson & Williams, in press). This approach emphasizes that the prior establishment of a positive client-therapist relationship is necessary for the maximal usefulness of behavioral techniques. This relationship is fostered by the creation of an accepting therapeutic environment by the therapist, who attempts to communicate to the client Rogers' three crucial therapist variables— genuineness, empathy, and unconditional positive regard.

Robertson's case nicely illustrates his facile use of a variety of techniques, chosen from various orientations. He uses Rogerian procedures (reflection, clarification) and other interpersonal techniques (relational immediacy, self-disclosure). He uses behavioral strategies (behavioral rehearsal, homework tasks, directive interventions) and cognitive approaches (cognitive

restructuring, imagery). Finally, he also tosses in a Gestalt technique (empty chair) and a psychodynamic procedure (projective drawing).

Of primary importance, and most impressive to me, is the fact that Robertson's madness has method. In each of the instances with his client, he supports the use of his chosen psychotherapeutic gambit. For example, if he feels the need to alter the session from a question-answer style to one that focuses more on the client's immediate feelings, he readily uses relational immediacy to increase the client's spontaneous expression of his concerns (p. 361). On the other hand, if the client seems resistive to an experiential intervention, he is adept at transferring to a specific behavioral approach (p. 365).

I believe that the case presentation by Robertson nicely illustrates how a therapist may alter the style and content of psychotherapy, based on the immediate needs of the client. However, to the extent that this case is typical of the radical eclectic approach (and I am forced to generalize based on this chapter), I have a major problem with Robertson's psychotherapy.

I am concerned that many clients will not feel a specific, focused, direction of therapy when confronted with the myriad number of things happening in Robertson's radical eclectic approach. My experience is that starting and stopping a variety of tasks, especially within a short psychotherapeutic time span (nine sessions for Robertson's case), usually leaves the client in a state of

confusion. Insight into the dynamics of a problem may occur quite rapidly, especially if the therapist acquires adequate information from the client and feeds the content of this information back to the client in an easily interpretable form (as I believe Robertson does). However, change in behavior patterns and belief systems proceeds ever so slowly, especially when the problem is one based on "personality" disorders. (Robertson labels his case an obsessional personality. According to DSM-III, the diagnosis would probably be "compulsive personality." I might also label the individual "type A".)

This is the case with Robertson's client. After the first session, the client is given "homework" to use the last hour of his workday "to put the day to rest" (p. 361). The efficacy of this plan is not discussed by Robertson, but he assigns further tasks to the client at the end of the second session, including: (a) distraction—for intrusive thoughts; (b) relaxation—the client is asked to read at the library; and (c) to "draw his family of origin" (p. 362). At the third session, the drawing is discussed, and Robertson notes that the client made two trips to the library; however, the distraction assignment is not discussed. These assignments are discontinued at the end of session 3—instead the client was encouraged to "process what had come up in the session" (p. 364).

In the subsequent sessions Robertson does a host of things, including: offering a variety of suggestions aimed at reducing workaholic behaviors and ruminations (session 4); dealing with the client's marriage and lack of self-

disclosure (sessions 5 and 6); interviewing the client's wife (session 7); and seeing both parties in therapy (sessions 8 and 9). Although some of these issues are followed up, in general, many issues are touched on, but none are given adequate attention and none are resolved at the time of termination. In many ways, I feel that I've read nine sessions of an initial assessment—and now have sufficient information to conceptualize the case and choose an appropriate intervention.

I think that this concern is especially relevant given the client presented by Robertson. We are dealing with a fairly typical case of the compulsive workaholic who has ignored emotional needs (of self and significant others) and, instead, focused on productivity. One of the most important factors in treating these cases is to get the client to challenge their beliefs regarding what is worthwhile (work, success, etc.) and what is not (free time, verbal communication, intimacy, etc.). In addition, the relationship with these clients is extremely important; the therapist must demonstrate that he/she accepts them unconditionally—otherwise, these clients will spend much of therapy simply trying to please the therapist, in their perfectionistic, compulsive drive to be error-free. Therefore, these clients need a good deal of time in therapy—time spent focusing on a few basic issues, including a strong focus on specific strategies to break compulsive behavior and an emphasis on the client-therapist relationship.

I realize Robertson's presentation of his procedure is constrained somewhat by the limitations of presenting any psychotherapy within the confines of one client and one short chapter. I applaud any attempt to focus on behavior, cognitions, and affect in a single therapy. As it is presented in this book, however, I feel that radical eclecticism must deal with the issues raised in this commentary if it is to evolve into a widely accepted psychotherapy.

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