CASEBOOK OF ECLECTIC PSYCHOTHERAPY

THE CASE OF JULIE:

An Eclectic Time-Limited Therapy Perspective

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Table of Contents

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The Case of Julie: An Eclectic Time-Limited Therapy Perspective

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This chapter presents a case in which the therapist followed a model of eclectic time-limited therapy (ETLT) developed at the University of Utah Counseling Center. In the first section of the chapter the approach is placed in the larger context of general time-limited or brief therapy, and the process stages and basic elements on which the model is based are introduced. The majority of the chapter presents actual case transcript material with elaborating comments added by the client, therapist, and model authors. At the end of the chapter, we have added a short description of a second case for comparative purposes, highlighting the potential for differing applications of the model. Hopefully, the chapter will serve as a good illustration of how the approach can be flexibly adapted to incorporate various theoretical concepts and intervention tactics.

SHORT-TERM PSYCHOTHERAPY

Several factors have contributed to the increasing interest in the

development and use of brief approaches to treatment. In their recent book, Gelso and Johnson (1983) suggested that some of those factors include: (a) an increasing demand for services, which taxes agency resources and results in long wait lists; (b) an increased awareness of the role of psychological factors on the part of the public; (c) an extension of services to groups other than the typically served verbal, middle-class group; and (d) an increased demand on insurance companies to pay for services.

These motivating factors are supplemented by empirical evidence regarding the consumer's experience and treatment outcome. For example, collected findings suggest that clients often hold expectations that they will improve within five to six sessions and recover entirely within 10 sessions (Coleman, 1962; Garfield, 1978; Garfield & Wolpin, 1963). Another area of study has indicated that patients who have been in treatment nationwide report an average of only five or six therapy contacts (Lorion, 1974), suggesting than many treatments are brief by nature. In addition, these findings can be considered in light of evidence accumulating from treatment comparison studies where it has been suggested that time-limited approaches are equal to, or occasionally, even superior to time-unlimited varieties of therapy (Bloom, 1980; Gelso & Johnson, 1983; Luborsky, Singer, & Luborsky, 1975). As a result of these and other factors, and the supportive empirical findings, attention to brief therapies has greatly increased in recent years, and a number of therapy models based on widely differing theoretical

perspectives have resulted (Budman, 1981; Butcher & Koss, 1978).

SYNOPSIS OF ETLT

The particular model of ETLT presented in this chapter was generated out of a set of pragmatic and theoretical considerations. Development of the model was stimulated by staff reactions to a relentless wait list. Discussions of the problem led to the conclusion that a brief treatment procedure should be considered as a possible remedy to the wait-list problem; so a small group of staff members, which included the authors, set out to examine options. Because of the interdisciplinary (counseling and clinical psychologists, social workers, psychiatrists) and multitheoretical (dynamic, social learning, existential-humanistic, eclectic) nature of the staff, we were looking for a model that could easily assimilate divergent perspectives. We thought that such a model would improve the likelihood that the approach would be adopted, especially if the staff members were not forced into a totally alien orientation or set of practices.

An exploration of the existing literature uncovered a number of well-developed models (cf., Malan, 1976; Mann, 1973; Mann & Goldman, 1982; Reid, 1978; Sifneos, 1979). However, we found that the models we encountered were organized around the tenets of particular theoretical orientations. As Butcher and Koss (1978) noted in their extensive review of

brief treatment, there are no broad-based models of brief therapy in existence that can accommodate divergent theoretical orientations. Therefore, we returned from our search without having found the hoped-for eclectic model and faced with the prospect of having to construct our own.

What we did find through the course of our exploration of the literature was a set of theoretical and/or empirically recommended elements of brief treatment that tended to recur across the orientations and models we examined (Budman, 1981; Butcher & Koss, 1978). A compilation of those elements resulted in a list that included: (a) client selection, (b) time limitation, (c) therapeutic focusing, (d) client expectations, (e) therapeutic relationship, (f) therapist activity, (g) emotional ventilation, (h) goal orientation, and (i) specific techniques. These elements appeared to be critical, common ingredients in the brief therapy process. Five of these regularly noted elements were selected to form the core of the eclectic time-limited model.

Time Limitation

The first element, time limitation, is by definition a central focus in any brief or time-limited model. The time limit not only serves as a demarcation of the end of treatment, but also provides an impetus for the work. There is some evidence (Young, 1977) that establishing a time limit increases the

expectation of therapeutic gain and that this heightened expectation subsequently leads to improved treatment outcome. However, depending on the purpose of treatment and theoretical orientation, the time limits established by practitioners in the literature range from 1 to more than 40 sessions (Bloom, 1980; Wolberg, 1980). In our particular setting, a 10-session format, including an intake session at the beginning and a follow-up session after the close of treatment, seemed more appropriate given the nature of agency resources and commonly presented client problems. This time-limit matched our particular agency's staff and clientele, and perhaps should be adjusted to match other settings and clientele.

Expectation

Attention to expectation sharing between the client and therapist in the model is based on the underlying assumption that explicitness increases the rate of progress within the restraint of an imposed time limit. Such explicitness is particularly well suited to the type of generally well-functioning client selected for ETLT. In addition, expectation sharing may serve to increase the client's sense of independence and responsibility, which is critical in maintaining and perpetuating change after the termination of treatment. Two specific types of expectations are attended to directly in the model: expectations about the course of treatment outcome (e.g., "Because of your characteristics and the nature of your problem, time-limited therapy

seems to be the treatment of choice for you"; "We will meet weekly for eight weeks") and expectations about the roles that client and therapist will assume during the course of the treatment (e.g., "I expect that we will both be quite active in the sessions to come").

Therapeutic Relationship

The emphasis on the therapeutic relationship in the model arises from a recognition that the client-therapist relationship plays a significant role in any brand of therapy (Bergin & Lambert, 1978). A solid therapeutic relationship may hold the client in therapy long enough to accomplish desired treatment aims (Heitler, 1976). The model assumes a collaborative relationship posture between the client and therapist which encourages greater involvement and activity on the part of both participants. This, again, is expected to heighten the client's sense of personal responsibility.

Therapeutic Focusing

Accumulating evidence suggests that developing a treatment focus early in therapy can lead to better treatment outcomes (Malan, 1976; Burlingame, 1983). Two major types of focusing are addressed in the ETLT model. The first type is concerned with the therapist's efforts to identify the focal aim or a conceptualization of the client's presenting complaint. In the ETLT model, the

focal aim is likely to be interpreted in ways that are consistent with the therapist's theoretical orientation. The second type of focusing applied in the model is called "focality," which is described by Malan (1976) to be the ability to concentrate the majority of the treatment activities around the identified focal aim. Focality is achieved through attempts to encourage the client to move from more general to more specific aspects of the presenting problem and by fostering directness and explicitness between the client and the therapist. This is done not only with respect to the content of interventions, but also with respect to the actual process of therapy. The focusing efforts of the ETLT therapist are intended to accelerate progress within the compressed time frame by concentrating both therapist and client attention on the purpose and process of treatment.

Client Selection

The client selection element takes on particular importance because of the level of participation required of the client in the model. All the preceding elements assume the client to be capable of operating collaboratively and actively with the therapist. In the ETLT model, client selection factors are considered during the intake session and the first treatment session. Both selection inclusion and exclusion criteria are considered. The inclusion criteria include: (a) at least one satisfactory past relationship, (b) a good premorbid adjustment, (c) the ability to form a relationship with the

therapist, (d) the ability to establish mutual expectations with the therapist, and (e) a relatively circumscribed problem. Clients are excluded from ETLT if they: (a) are severely depressed; (b) present anger as their main affect; (c) are currently or have recently been psychotic; (d) show signs of organicity; or (e) are presently medicated. These inclusion and exclusion criteria are meant to serve as a set of minimal entry conditions, which, if met, help to ensure that the client can take full advantage of the approach.

Rather than recombine these brief elements into a new theoretical formulation, which would have defeated our pragmatic purposes, we decided to provide a flexible, skeletal therapeutic structure upon which the elements could be overlaid, depending on the unique theoretical orientation of the practitioner. We drew the skeletal framework from the atheoretical therapy process model of Gerard Egan (1982). Egan proposed that, in general, successful therapy follows a progression beginning with a period of client self-exploration, moving to a mutual integrative understanding of the client's issues, passing through a series of problem resolving actions, and culminating in a final termination phase. Drawing on the common elements in the short-term therapy literature and Egan's work, the final model of ETLT proposed was based on a set of background process stages and process elements upon which the individual therapist could overlay his or her own foreground of theoretical understanding and technique. The content and sequencing of the five stages and the elements of the ETLT model are represented in Table 1.

CASE DESCRIPTION

The following case[1] was selected to illustrate the four therapeutic stages of ETLT as well as the mechanisms of change of focusing, collaboration, and expectations. The therapist in the present case was a psychologist with approximately eight years of postdoctoral clinical experience who had been trained in ETLT by one of the authors. Her preferred therapeutic orientation is psychodynamic, although she was clearly eclectic in her approach to the present case. More specifically, therapeutic interventions in the present case included dynamic linkage between an early childhood incestual experience and current interpersonal difficulties, behavioral rehearsal, homework assignments, and a modified bibliotherapeutic approach.

In addition to the eclectic nature of the interventions, the case was also selected because it involved a therapist who was relatively new to the ETLT approach. In contrast to demonstrating the "ideal" way the model might be applied, we thought selecting such a therapist might provide more insight into how one might integrate the ETLT approach within a well-established therapeutic style. Beyond asking the therapist to practice ETLT, both therapist and client agreed to videotape all sessions and provide us with a brief-session key-event summary report at the end of each therapy hour. This information enabled us, in a two-month follow-up interview, to have both therapist and client view and respond to videotape segments of therapy that

corresponded to specific aspects of ETLT and to key events they had identified during the course of therapy.

Table 1 Brief Psychotherapy Program

Therapeutic Stages								
Intake		Stage I		Stage II		Stage III		Stage IV
1st Session Exploration and assessment	→	*2nd Session* Role description, rapport building, and problem specification	→	*3rd session* Enhanced self-understanding and anticipated action	→	*5th Session* Active coping	→	*8th Session* Pretermination
				4th session Action planning		*6th Session* Active coping		*9th Session* Termination
						7th Session Active coping		*10th Session* Follow-up

Separate and conjoint debriefing interviews were conducted with the client and therapist. The conjoint interviews allowed us to ask questions of both client and therapist regarding: (a) rationale for a specific interventions, (b) the immediate, and (c) long-term impact of particular interventions on the client. The separate interviews provided their independent perspectives regarding: (a) the major events in the therapeutic experience, (b) thoughts regarding the change process (or lack of change) in ETLT, and (c) perceptions

regarding the developmental phases of the therapeutic alliance in ETLT.

In the pages that follow we will elaborate on one or more of the mechanisms of change from each stage of ETLT. In doing so, we will draw heavily from transcripts of the debriefing interviews and actual therapy sessions. In addition to these verbatim accounts, a short commentary will be provided to integrate the therapeutic events and concomitant interventions with the mechanisms of change in ETLT.

Identifying Information

Julie was a 26-year-old Caucasian female, employed as a physical therapist in a local hospital. At the time of treatment she was living in a one-bedroom apartment on a large university campus (married student housing) with her husband of 2 *V2* years and a nine-month-old daughter. She was in her first year of employment after recently finishing her master's degree. Her husband was in his last year of work on a master's degree in computer science.

Family History

Julie was born and raised in a conservative Protestant home in the Midwest. She was the youngest of five children, with three older brothers and one older sister (eight, seven, two, and five years older, respectively). Her

father, a traveling salesman, was absent from the home for long periods of time while she was growing up, resulting in a family constellation similar to that of a single-parent home.

Julie reported that her mother went through a number of severe manic-depressive episodes during Julie's late-childhood and early-adolescent years (9 to 14 years old), some of which required hospitalization. During this time, Julie reported her mother having mood-congruent hallucinations at home (e.g., messages received through the television and/or radio), which frightened Julie a great deal. During the times when her mother was incapacitated, Julie's older brothers and sister managed the home.

In addition to her mother's mental disorder, Julie's maternal grandfather purportedly suffered from an agitated depression resulting in abusive behavior toward her and her siblings. The only sibling who appeared to have any similar problems was Julie's brother John, who was nearest to her in age. He was consistently truant during the time of his mother's illness (late elementary and high school), accumulating a lengthy police record (e.g., aggravated assault, larceny, and public intoxication). John's violence at home was manifested in a variety of ways such as smashing the TV, tearing the phone off the wall, or striking his mother. At the time of treatment, he was incarcerated in the state penitentiary. On the other hand, Julie's other brothers and sister had all obtained higher-education degrees and were

productively functioning either at work or at home.

Psychiatric/Medical History

At age five, Julie took a deliberate overdose of an unknown number of pills from her mother's medicine chest. In recalling the incident she reported wanting to get sick so she could get her father's attention on a Saturday morning. Her memory of the incident, although vague, included an image of her stomach being pumped.

Prior to treatment, the client's only other formal contact with the mental health community was when she was 12 years old and had three or four visits with her mother's therapist. She remembers her mother's therapist as "loud, kinda young, who smoked and swore a lot." Her mother suggested that she go to talk over her feelings about her brother's violent behavior in the home and fears that she might have regarding being hurt by him. Julie's account of this experience is that she basically did not talk with the therapist because she did not seem very understanding or kind. Examination of the client's medical history produced an uneventful profile with the exception of a mild premenstrual syndrome in late adolescence.

Case Overview

The client's presenting complaint revolved around interpersonal

difficulties with two "older" male colleagues in the facility where she was employed. She was referred by a co-worker who felt that there was "more to her problems than just interpersonal differences." The therapist to whom she was referred conducted a standard ETLT initial assessment interview. During the interview, the client discussed her problems at work, anxiety, and interpersonal distrust as well as the fact that she had been an incest victim. After assessing the client's appropriateness on the ETLT selection criteria, the therapist introduced the idea of time-limited therapy and the opportunity to participate in a treatment evaluation project, to which the

client agreed.

During the course of ETLT, three primary issues were consecutively examined: (a) a four-year incestual relationship with her delinquent brother, (b) obsessional thoughts of being and/or going crazy, and (c) the impact of her dependent or "victim" stance in current interpersonal relationships. At the two-month follow-up the client reported that her interpersonal relationships had significantly improved and that she was generally less anxious. This self-report improvement was also supported psychometrically by pre-to-post changes on complementary MMPI clinical scales (T-score reductions of 17 on Pa, 11 on Si, and 12 on Pt and A), suggesting that the client perceived relief and demonstrated change psychometrically.

The following case will be examined within the stages of the ETLT model. In reviewing the case, four types of transcripts will be examined. The first will be drawn from actual therapy sessions. These transcripts reflect interactions from actual therapy sessions that were videotaped and then viewed conjointly by both therapist and client at follow-up. The second set of transcripts reflects the therapist, client, and an interviewer[2] discussion of these videotape segments. These transcripts essentially represent retrospective comments from the client and therapist regarding what was going on "in their heads" during a particular part of a session. The videotape segments were selected primarily from therapist and client comments regarding key events during the therapeutic enterprise. The third and fourth set of transcripts represent separate interviews conducted with both client and therapist. These interviews were conducted two months after the termination of treatment in an attempt to get independent perspectives regarding the course of events during therapy. The various types of transcripts will be designated parenthetically or in the text.

ANALYSIS OF CASE

Intake and Assessment Stage

The primary therapeutic objective of this stage is to assess the appropriateness of the client for ETLT on the aforementioned selection

criteria. The first task pursued by the ETLT therapist in the present case was to ascertain whether any severe psychopathology was present. This was especially pertinent given the family's psychiatric history. The absence of any severe psychopathology was assessed in two ways: MMPI profile and psychiatric interview. The conclusion from the data generated from both sources was that no severe psychopathology appeared to be present.

The next task in this stage is to assess the presence of the five inclusion criteria. To a great extent, the five inclusion criteria parallel the three mechanisms for change emphasized in the ETLT model: focus, collaboration, and expectations. Thus, the review of the intake session will be structured according to these three components.

Focus

The ETLT therapist is encouraged to "let the client tell his/her story" completely enough so that a determination can be made regarding whether one can arrive at a circumscribed focal aim for treatment. More specifically, the focal aim can be thought of as the therapist's reformulation of the client's presenting complaint into a treatment plan. This presenting complaint often includes a variety of symptoms, a precipitating event, and related past events. Based on theoretical orientation, the ETLT therapist then develops a focal aim which includes probable etiological factors and the necessary therapeutic

steps required to remediate the problem behavior (cf., Fuhriman, Paul, & Burlingame, 1985).

After arriving at a tentative focal aim, the therapist determines whether it is circumscribed enough to work on in ETLT based on four criteria: (a) pervasiveness of disruption in client's life, (b) acuteness of onset, (c) client ability to engage in disturbing material that is central to focal aim, and (d) feasibility of creating a treatment plan to address the focus.

In addressing the development of focal aim in the present case we will begin with the client's pretreatment focus. The importance of taking into consideration the client's pretreatment focus in ETLT is twofold. First, there is evidence that many early treatment terminations are linked to a client belief that the therapist is not responding to the primary concern (Epperson, Bushway, & Warman, 1983). Hence, clients give up on therapy before it begins. Second, given extant models that delineate the process of focal aim development (cf., Burlingame, 1983; Malan, 1976), the client's pretreatment focus is invariably the first piece of information to be carefully considered. The client described her pretreatment focus in the separate debriefing interview[3] as follows:

> C: Basically what I wanted in a therapy experience was to stop feeling lousy, angry, and depressed. I was also running from the issue of whether I was crazy primarily because my mother and some other members of my family have a history of hysteria and manic-depressive disorders, so I was really scared

> that I was crazy too, and that someone was going to find out that I really needed to be helped. . . . The incident that led to this therapy experience was starting a new job as a real professional. I finally had to face my colleagues and count myself as an equal.

It is important to note that although the client's childhood incest experience was an important part of therapy, this was initially not part of her original presenting complaint, nor was the fear of being "crazy" verbalized in the first session. Rather, the client's presenting complaints revolved around relief from her disruptive feelings and interpersonal difficulties at work. She explained it as follows:

> C: I really hadn't planned on talking about my incest experience primarily because I was not reliving it or facing each day. [At the time], I didn't remember the experience as something that really bothered me. . . . However, [looking at it now] I think it was a very big issue in my life and I was just fighting to keep it suppressed . . . I guess I wasn't in touch with what was making me angry and depressed. I was tired of having the feelings and wanted to get rid of them. I realized that some of my colleagues had the power to bring that stuff out of me. . . . But, I didn't understand where they [the feelings] were coming from.

In later interviews the client more clearly articulated that, rather than being "tired of having the feelings," she thought that these feelings might be the first signal that she was going crazy and that this frightened her a great deal. It is important to note that this fear of going crazy was the first issue addressed after intake. A second point to note from the client's perspective during the intake stage was her change in expectations regarding the focus of therapy. After discussing her incestual childhood experience during intake,

she stated in her session summary report:

> C: Today, I was able to admit that I was a victim of incest. [My therapist] asked me what I planned to gain from these sessions and I said I wanted to feel that everything would be all right. She immediately picked up a lot of emotion and pain and said "you sound like a victim of incest." Her facial expression, the way she leaned toward me and held me on the arm showed me that she understood and that it was okay to tell her. What made me able to let out an awful rotten secret was also her frankness which left me with no response other than "yes" or "no."

The therapist's goal in the intake interview was to develop a tentative focal aim and determine whether it was sufficiently circumscribed to warrant a time-limited contract. In developing the focal aim, the presenting material that she had to work with was a role transition with the apparent precipitating event being a difficult move from the role of student to professional. This precipitating event was coupled with symptoms of depression and anger toward her co-workers. In an attempt to understand related events, the therapist probed for more detail regarding the interpersonal disruption the client experienced with her colleagues. What unfolded was a consistent nonassertive interpersonal stance toward two male coworkers. On closer examination, the therapist discovered that the client not only responded seductively toward these men but also had sexually laden dreams about them. Another important fact was that, from the client perspective, these male colleagues had legitimate authority over her work activities.

After listening to the client talk about her sexual feelings toward these "authority figures" and the passive-dependent interpersonal stance, the therapist stated to the client that her interpersonal stance was very similar to that of victims of incest. She then pointedly asked the client whether she had been a victim of incest. This intervention appeared to be a critical high-affect event in the intake interview. The client then told the therapist about a four-year incestual relationship that she had had with her older brother during the time of her mother's breakdown. Shortly thereafter, the therapist ended the assessment session with a time-limited therapeutic contract being offered. The therapist's focal aim in the intake session is better understood after considering her comments about the case, which also provide insight into why she considered the incest experience circumscribed enough for ETLT.

> T: As I listened to Julie, and the interpersonal stance she took with male colleagues, it became apparent that she had some unresolved issues with authority and dependency. Her interpersonal stance was one that I had seen with several adults who had been sexually abused as children, you know, where they are quiet and just take anything that comes at them. That's where the question about sexual abuse came from. After finding out that she was a victim of incest, I began to think that the difficulties at work probably stemmed from unresolved issues with men. For instance, her dependent and seductive stance with men who were authority figures. . . .
>
> My strategy in dealing with her was very similar to my typical approach with incest victims. First the client has to acknowledge the affect attached to the incestual experience. However, most incest victims have blunted the affect attached to the incestual experience. Because of this, I generally take a less direct approach to uncovering the emotions attached to the incest experience. In Julie's case I did this by immediately assigning a

> book for her to read, *Sexual Addictions,* which is generally a nonthreatening, third-party way of approaching the subject. After the experience is acknowledged and the affect owned, I then move to the present in an attempt to identify symbols of the incest experience. With Julie, the symbols initially appeared to be her relationship with two male colleagues. After the symbols have been identified, I attempt to desensitize the client to the symbol by explaining its relationship with past events. . . .
>
> Julie did not report any similar past or present problem, and it seemed that her problem had a definable precipitating event, that is, her new job as a "professional." I was quite surprised that she could so easily engage in material that was obviously painful, which was a good sign for time-limited therapy, given my understanding of the model. Finally, I have worked with a number of incest victims and felt quite comfortable in understanding the steps needed to go through in resolving this traumatic experience. . . .

Collaboration

A collaborative therapeutic relationship is seen as a key mechanism of change in the ETLT approach. The potential for such a relationship is represented in three of the client selection inclusion criteria. The first criterion is an early and positive relationship with the therapist, which not only is considered a good prognostic sign for a collaborative relationship, but also enables the therapist to see how the client responds to the therapist's "work style." The second is the existence of at least one satisfactory relationship in the client's past or present, which suggests that the client is capable of the level of self-disclosure and intimacy required in ETLT therapy. The third criterion, good premorbid adjustment, not only portends the likely end point of therapy (i.e., return to premorbid adjustment level), but also

suggests that ETLT clients walk into the therapeutic encounter with enough resources that they can engage collaboratively with the therapist. An ETLT therapist should not expect a client to call on resources in therapy that have not been present before. If the client reports a history of inadequate coping skills, then it is likely that the client does not have the resources (good premorbid adjustment) to enter a collaborative therapeutic relationship and should be considered for an alternate treatment.

More specifically, the collaborative relationship in ETLT can be thought of as a horizontal relationship, which is in contrast to a top-down or vertical relationship. Vertical relationships typically define the therapist as a protagonist for change, whereas horizontal relationships emphasize cooperation and mutuality (Papp, 1983). ETLT is considered a catalytic rather than a curative treatment, with continued work expected on the client's part after therapy is terminated. Hence, the ETLT therapist is expected to inculcate an attitude of mutual responsibility for change, which is thought to encourage attributions of change to the client. This is in contrast to the therapist being seen the primary change agent (cf., Fuhriman et al., 1985).

Given these criteria, and the definition of the type of therapeutic relationship desired in ETLT, we turn to the therapist to better understand how she saw the above criteria fitting the present case and, more important, what potential she saw for a collaborative relationship with the client.

T: Julie struck me not only as someone who was ready to work, but also as someone who had a fair amount of inner strength. I experienced her as having more ego strength than her MMPI profile indicated [T score of 521. Her support system seemed adequate with an especially solid relationship with her husband. She reported relationships in the past where she had been able to share herself with others in a fairly intimate way, which made me think she had the necessary strength to successfully deal with the emotionally laden material that would be looked at in therapy. I guess another point along this line is that my first contact with Julie ended in me liking her. I could positively respond to being able to work collaboratively with her as a client.

Expectations

The setting of expectancies within ETLT is done in two primary areas: expectations about treatment itself (i.e., time and reasonable goals) and expectations regarding the roles of therapist and client. One way expectations are addressed in the intake session is the client's ability to arrive at a mutual set of therapeutic expectations with the therapist. An example of this in the present case is seen in the above transcript where there was an apparent shift in the client expectations from "getting her lousy feelings under control" to her examining the incest experience as part of therapy. After the therapist heard about the incest experience and began to tentatively link this with the client's current interpersonal difficulties, she immediately suggested that the client read the book *Sexual Addiction.* This essentially provided an early test of the client's willingness to address what the therapist saw as important as well as her goals (expectations) for therapy.

This assignment in the intake session was not only important with respect to the goals of therapy, but also had implications for the respective roles of the client and therapist in ETLT. The therapist began to behaviorally address expectations regarding client and therapist roles in the first session. More specifically, the client entered the intake session and left with a book to be purchased and read outside of the therapy hour, suggesting she was to take responsibility for her own therapy.

Commentary

As we examined the entire intake session, we noted some variations from the original protocol that seemed important. First, with respect to therapeutic focusing in assessment, the client entered therapy primarily wanting relief from emotional disequilibrium (depression and anger). However, this request is clearly not circumscribed enough to make a decision regarding appropriateness for time-limited therapy. Therefore, the therapist moved to a greater level of specificity and uncovered the prior incest experience and the similarity it had with the client's present interpersonal stance and introduced this as the focal aim for therapy.

When we first examined this focal aim, we felt that resolution of a past incest experience might be an inappropriate focal aim for ETLT, i.e., too involved and not circumscribed enough. However, as will become evident, the

therapist had a more specific focal aim. She was not striving for resolution of the myriad of problems often associated with an incest experience. Rather, she wanted the client to understand the typical interpersonal problems facing incest victims and how these might relate to the client's current life experience. Given the existence of particular client characteristics, the therapist was essentially operating on the assumption that ETLT is a catalytic rather than a curative experience and that therapy would be a beginning rather than ending point for the client to deal with her traumatic early life experience.

The case clearly meets the model's expectations regarding collaboration as demonstrated by the high degree of client self-disclosure in the first session. This level of disclosure often portends an early and positive therapeutic relationship. With respect to expectations, the therapist again provides a unique deviation from the model. ETLT therapists are typically advised to describe the anticipated client and therapist roles. However, this therapist went beyond an oral discussion and behaviorally defined the roles from the onset of therapy. By assigning the client independent work in the first session, the client was given a clear message that she was as much responsible for change as the therapist. This may have strengthened the therapist's stance, thus enabling her to push the client in later sessions.

STAGE I:

PROBLEM SPECIFICATION, RAPPORT, AND ROLE DESCRIPTION

The three tasks of this stage also parallel the three primary mechanisms of change in ETLT: focusing, collaborating, and expectation setting. In stage I the therapist is instructed to: (a) return to the tentative focal aim of the assessment session in order to assess its accuracy and feasibility for a time-limited contract, (b) reinforce the collaborative relationship begun in the first session, and (c) attend to client expectations about the therapeutic goals and behaviors.

Focus

The following transcript begins with the client returning to the topic of incest discussed in the previous session. In essence, this interaction illustrates the client, rather than the therapist, directing therapeutic attention onto the tentative focal aim identified in the previous session. What is also evident in this interaction is the therapist's "on-task" behavior and directiveness with respect to the tentative focal aim. Apropos to her treatment strategy, she attempts to have the client begin to "own" the incest experience by first labeling it as such rather than thinking of it as "something that happened with my brother." A portion of the interaction is transcribed below followed by elaborating client and therapist remarks concerning the client's primary and secondary response to therapist interventions and the therapist's strategy for using these particular interventions.

C: After I left your office last Tuesday night I went home and I was kinda okay, but I had never really come to grips with the things that had happened to me in my childhood. I can't even say it.

T: Do you have a name for it?

C: If I were going to call it anything, I would call it "what happened with my brother."

T: Would you call it incest?

C: I don't want to call it incest. I hate incest, it's gross. But if that is what I'm supposed to call it and if that is what I need to face then. . . .

T: Technically that's what it really is.

C: Yeah, but that is the worst, most gross thing socially that I ever thought anybody could do. I think it is really gross. . . .

T: Bad?

C: Yeah, bad. Real bad! It is one of those really bad things that happens to other people, and not you.

The remaining portion of the interaction involved the client describing the incest experience in great detail with the therapist primarily responding reflectively. This was followed by the therapist introducing general information regarding childhood incest (e.g., incidence rates, typical settings, etc.). We discussed the entire interaction with the client and therapist to better understand the impact of the directive therapist interventions aimed at having the client re-experience a traumatic event. The client described the

impact of this interaction as follows:

> C: The biggest impact [this interaction had on me] was that I could really relate to what was going on inside myself then. I was really being tortured inside but on the outside . . . I thought of two words that described what was going on inside. The first thing was that I was really angry. I was angry that I had to face this, I was angry that I had to talk about it, I was angry that it happened. The second thing I was angry about was that I was being so contrived and controlled in this session like "Guess what happened to me on the way to the store?"
>
> T: Were you angry at me?
>
> C: Yeah, but I was just angry at everybody then. Anybody I could blame it on. As I started to talk about it, finally, I think it helped me to begin to resolve it. I wasn't going to allow myself all the emotion in this session, but at least the talking was helpful in putting my experience into perspective. . . . I mean, that the experience is mine, this is what happened to me and it's not the end of the world. I haven't died. I admitted it. . . . I guess I started realizing all this when I began to say the word, incest. And what I felt the first time I said it was "Oh, I said it, now that's out." And then by the end of that interaction I started to say to myself, "This is getting better, it's better to face this now. I don't have to cover anything up anymore." But I also was really insecure about it. . . what am I going to think of myself from now on? And what if my husband really, really doesn't hang in there. . . .

The therapist is clearly working from the tentative focal aim of incest. This is illustrated by the therapist's description regarding the intent of the above set of interventions. The client elaborates more specifically on the impact of the therapist setting her incest experience within a larger framework.

> T: The biggest thing that I wanted to have happen in the above interaction was for

Julie to name it, acknowledge it, and be able to say, "Yeah, it was incest." I think this is the first and most important thing for an incest victim to do. I wanted to intensify Julie's affect around that, and then I wanted to de-intensify it a little bit so that it didn't seem so overwhelming. This is why I moved to providing the statistics . . . but I also wanted her to know I recognized her pain.

I: [turning to client] How did providing information in this interaction impact you?

C: I didn't feel as alone as I had, and I didn't feel as bad. Like it was my fault. All I knew was that I had done it with my own brother. . . . I also got a great deal of empathy from [therapist] which helped a lot.

Collaboration

The strength of the collaborative relationship in this stage is demonstrated in the above interaction by the client's willingness to immediately begin working on emotionally volatile material. It is also important to note that the client is initiating work very early in treatment, i.e., at the beginning of the second session. The client's perception of the collaborative relationship and what it represented for her in this stage is illustrated in the following comments:

C: I was looking at [therapist] body language and facial expressions and I could feel she was very supportive, so I guess that I didn't need to hear her say, "You're not bad." I also appreciated the way that [therapist] made me not depend on her in this session and let me be a separate individual . . . so that I was doing the work.

Expectations

The primary expectations to be addressed in this stage relate to the roles of both client and therapist (e.g., collaboration) and those that center around treatment procedures (e.g., length, objectives).

As will be discussed later, the therapist in this case did not explicitly discuss the role expectations in as great a detail as the model suggests. However, she did attend to expectations regarding treatment length and the goals of therapy. The impact of the time expectancies is shown in the following client statements regarding how time limit affected her behavior in this stage of therapy.

> C: Well, I guess the biggest thing I thought about] regarding the time limit] was that we had to really get busy, so I just got down to it. I would have been really frustrated if I had to go on for months trying to figure out each and every part of my life as it related to the incest experience. I really appreciated the fact that [therapist] pushed me to look at things in therapy quickly.

Commentary

ETLT therapists are advised to begin each session by reconnecting with the content of the previous session. The process of reconnecting session content is termed *therapist focality.* Focality often enables the therapist to move toward greater levels of specificity in targeted areas of the client's life. The resulting therapist directiveness and specificity push the client to consistently deal with material related to the focal aim of treatment, which, in turn, can lead to emotional ventilation.

In the present case, the client begins the session by addressing the incest content discussed in the prior session. The client's direct attention to this not only suggests the accuracy of the tentative focal aim identified in the first session (cf., Fuhriman et al., 1985), but also gives the therapist more license to push onto the next step in her treatment plan: an overt acknowledgment and description of the incest experience. The client responds to this invitation by describing the events during the four years that she had intercourse with her brother.

However, she also experienced two additional responses that are difficult to detect in the transcripted material. First, she experienced anger directed toward the therapist for reminding her of the incest. This anger may be partly explained by the directiveness of the therapist in asking her to quickly reconnect with the incest experience. This anger was not expressed in this session, due primarily to her second response, which was the avoidance of an overt expression of the affect. This avoidance response, as will be seen in later transcripts, is of great importance and determines the flow of therapeutic events for the next few sessions.

The client's perception of the collaborative relationship is reflected in her statement regarding the therapist's attempt to keep her independent and working on her own. In other words, the client perceived the responsibility and independence the therapist was attempting to foster, which, in part,

describes the definition of the horizontal relationship in ETLT. It is also important to note that the independence fostered by the collaborative relationship did not result in the client experiencing a lack of empathy during this session. In fact, she comments on how much caring and warmth she felt from the therapist.

In response to the client/therapist role expectations to be addressed in this stage, the therapist modeled the roles and behavior expected rather than explicitly discussing them with the client. This strategy, although powerful, may not be as potent as the oral discussion coupled with modeling suggested in the ETLT model. As will be seen in the next stage, the therapist and client get into a competitive relationship with respect to focus that might have been avoided, in part, if there were more explicitness with respect to "how we work in here." The exception to this modeling approach is the explicit discussion about length of therapy, i.e., expectations about treatment. For example, in the above debriefing interview the client clearly states her awareness regarding the explicit time limit. The result of this time limit, as predicted by the model, is a client perception that she had better get down to work because "there was not a whole lot of time to waste," which is essentially maintained throughout the course of treatment. Perhaps if there had been as much explicitness regarding the other ETLT expectations, some of the conflict between the client and therapist considered in the next session could have been avoided.

STAGE II:
ENHANCED SELF-UNDERSTANDING AND ACTION PLANNING

The primary objective of the second stage of ETLT is to provide a context within which the client can better understand the focal aim identified in the previous sessions. The principle governing this stage is that the interventions should result in an increased understanding of the intrapersonal and interpersonal issues surrounding the focal aim. This increased understanding is important in moving the therapist and client toward a clearer shared conception of regarding the work of therapy. In addition, the therapist is instructed to foster key aspects of the collaborative relationship (e.g., interdependence, increased responsibility, etc.) and maintain the expectations set in earlier sessions. In this stage, we will primarily examine an obstacle that developed in the present case with respect to the focus of therapy and how it affected the collaborative relationship and client/therapist expectations.

Focus

The model proposes that the three mechanisms of change act in a synergistic manner (cf., Fuhriman et al., 1985), and, that if an obstacle exists for one mechanism of change, it will create problems for the other two. This principle is clearly illustrated in the following interaction drawn from a stage II session. The collaborative relationship and expectations regarding therapy

were clearly effected as the client and therapist essentially miss each other with respect to the focus of therapy. A retrospective examination of the second session (stage 1) revealed that the client experienced a great deal of affect but also recognized that she was controlling it by presenting a "really contrived personality." It is clear from her comments that she had connected this observation with her fear of going crazy, and that she returned to the third session (stage II) wanting to do things differently than they had been done in the last session. However, the therapist returned to the session with an agenda dictated by the model (i.e., increasing client understanding around past incest experience) and a desire to move onto the next aspect of her focal aim, i.e., identifying here-and-now symbols associated with the incest experience. The following is the interaction that developed immediately when the two agenda collided.

> C: I'm feeling real scared about last week. It feels like we went up to the edge of a cliff and then you walked away and just left me there, or I went to the edge of it and said, "Yeah, I could jump," and then walked away . . . you know, I was at the verge of something that really scared me, . . . you know, that I could go crazy. That's really scary to me, [pause] that's so scary to me.
>
> T: Yeah.
>
> C: I left thinking. . . . I caught myself comparing our relationship to the relationship that I have with my clients [at work]. You know, when a trauma victim comes in and they have brain damage and I'm there as the therapist. I know they have a problem, but they don't know if they've got a problem. Do you know what I mean. That's scary to me. I just sat there with you last week, and I didn't know what you were thinking . . . probably it was, "she has a problem but she doesn't know she's got a problem." You know, there's

always a chance that I've got a problem.

T: A problem like?

C: Well, like I am crazy or that emotionally something is wrong with me and that you are treating me and know what it is. Does this all sound weird?

T: No, it doesn't. [Therapist gives two-minute discourse on the difference between problems in living and people who have mental disorders or are crazy using example of thought disorders. She ends this discourse with the following statement to client.] I don't think you're crazy.

C: I guess I needed to hear you say that.

T: Maybe I should have said it last week . . . but I wanted you to sit with your feelings.

C: I think I'm going to cry, because, you know, I think I'm aware of relating to you and I think you know the weak spots that I have. Who knows, I could be totally tetched, you know, really nutty.

T: What does real nutty mean to you?

C: I guess emotionally not being able to cope. I guess losing track of reality. Doing weird things that scare other people. . . . [Client gives example of misplacing her books in the library when she was pregnant and was unable to find them for two hours. She ends this with a statement that that's an example of crazy behavior.]

T: Okay, but losing your books is not crazy or psychotic.

C: No just weird. I guess that's a problem, you know, I just. . . . [Client goes on to give two more examples where she lost her temper and went out of control at home and then describes some of the similarity between this behavior and what she remembers as a child about her mother's behavior right before she was hospitalized.]

T: . . .. So, the crazy part is that you say to yourself, "I have a lot of crazy stuff underneath?" just like my relatives?

C: Yeah, I guess the crazy part is a feeling of losing control.

T: So, you feel like you're losing your emotional control?

C: Yeah. . . .

T: So if I pushed you hard enough you might. . . .

C: Right now I feel like I could cry. [Begins to cry.]

T: Okay, so the scary part in you is "Gee if I let go of my emotions in here, then they will make me go out of control and then I'll be crazy outside of here too."

C: Yeah, it seems crazy to laugh and cry at the same time or to be giggling when I really feel like I need to be crying and sobbing . . . to me that's crazy . . . [Client then goes on for several more minutes and discusses several examples of when she had a highly emotional experience and tried to not show her emotions because she was afraid of them. Each time the therapist responds by stating that expressing strong emotions does not mean that you are crazy.]

Commentary

Up to this point, the case had gone almost letter perfect with respect to the ETLT model. The client had: (a) met the exclusion and inclusion criteria; (b) begun to work collaboratively from the beginning of therapy; (c) accepted the expectations of ETLT regarding therapist/client roles and the treatment contract; and (d) presented with what the therapist thought was a circumscribed focal aim. In this session, the client is moving in an entirely

different direction from that of the therapist. In terms of ETLT nomenclature, the client was raising new and seemingly pertinent information with respect to the focal aim. However, the therapist is essentially missing the client's cue that what she is talking about is important. The client describes the impact of this interaction as follows:

> C: At the beginning of this session I was thinking: "What did you [therapist] think you were doing to me letting me walk out last week with all those feelings." I was really mad because . . . she had left me in a lot of pain. I was also angry because I wanted her to tell me whether I was crazy or not. At that point she said something like, "Do you want to know what I think?" I thought, "Hallelujah, yes, I want to know" . . . I was really pushing her by saying, "Are you sure you don't think I'm crazy?" I was saying that with every question. And then when I was talking about all the stuff that made me think I was crazy, I just got more mad . . . I was overwhelmed by everything I'd shoved inside and I didn't know how I was going to deal with it. . . I think that I was trying to say, "So, you don't really think I'm crazy even after I told you all this crazy stuff." And then at the end I asked her again if she thought I was crazy even after I had told her all that stuff. . . I don't know what effect it would have had if she'd said, "Well what are you like when you're really crazy?" I think you could really tell how desperate I felt about reassurance. Maybe it would have been a relief if I'd understood but I kept asking.

Retrospectively, it is easy to see the intense impact of the client not being attending to in the session. Julie had immediately begun to work on emotionally volatile material (incest), which, in turn, allowed her therapist to quickly identify a focal aim for treatment and begin to work on it. However, as the client began to relive the incest experience, the affect associated with it raised an underlying fear that she had about herself. Namely, when she

experienced strong emotions she associated this with insanity, i.e., represented by her early life experiences with mother, brother, and grandfather. In addition, these fears were further fueled by the incongruity she was experiencing between what she felt like on the inside and what she was expressing on the outside.

The unresolved fear essentially made it very difficult for her to work any further on the incest; however, what her therapist saw was Julie resisting the agenda of focusing on the incest experience. A frequent problem with new ETLT therapists, which is exemplified in the above interaction, is that the structure of the stages, and moving the client through these stages, begin to take importance over client concerns. The potency of the structure is evident in the following therapist's comments regarding the above interaction.

> T: Well, as I watch it now, I'm real surprised that I didn't go after her affect in that interaction. . . . I had about five or six choice points where I could have said, "Tell me more about that," or "What are you feeling?" I think what happened here is not at all like me. I don't know if I was pressed by the time limit or what. . . I guess I was impatient in this session.

It is apparent from the therapist's initial interventions that the direction the client was going was not in her "therapeutic game plan." She first responded with a few reflective interventions (e.g., "yeah," "a problem like") and then quickly moved to cognitive interventions in an attempt to allay the client fears regarding her being crazy so that she could get back on track, i.e.,

deal with the incest. The therapist's strategy appears to have been a simple and directive message: "You are not crazy, so let's get on with the rest of therapy."

ETLT therapists are counseled to use selective attention in guiding their interventions (focality) across the course of therapy. However, they are also instructed to use three principles identified by Luborsky (1984) to refine the initial focal aim through stage II of treatment. Two of these principles would have assisted the therapist in responding differently to the client in the above interaction: redundancy of themes and contiguity of content (cf., Fuhriman et al., 1985; Luborsky, 1984). In each of the prior sessions one can find interactions regarding the incest experience that were immediately followed by comments regarding the client's family "craziness." Clearly, this interaction might have evolved differently if the therapist had taken note of the redundancy and contiguity of content associated with the client's fear of being crazy. Given our experience in training and investigating this mode of therapy, the interaction illustrated above represents a frequent mistake and consistent danger in the ETLT model, i.e., therapist inattention to content and issues that are important and relevant for the focal aim of treatment.

Nevertheless, the therapist's shift in intervention emphasis in the latter part of the transcript demonstrates her recognition of the client's need to deal with her strong affect and the need to refine the focal aim of treatment. This is

demonstrated not only in her summary reflection regarding the client's experience of strong emotion, but also in the majority of her interventions in the remainder of the session.

It is clear from both client and therapist remarks that the level of "we-ness" that characterizes the collaborative relationship was absent in the early part of this session. This was probably a function of the therapist and client having different agendas and the resulting collision of these two. It also underscores an issue raised by the authors of the model concerning the synergistic manner in which the three mechanisms for change work together.

More specifically, the focus of this session differed for client and therapist (e.g., fear of going crazy versus incest), which, in turn, violated some of the expectancies set earlier in the treatment contract (e.g., cooperative client/therapist roles, single focus, etc.), which, in turn, made the therapeutic relationship competitive rather than cooperative (e.g., vertical rather than horizontal relationship). Nevertheless, the dissonance created by the collision of agenda was productive, as will be seen below, in modifying and refining the focal aim of treatment as well as redefining how the therapist and client would work together in the remaining portion of the therapy experience.

STAGE III:
ACTIVE COPING OR WORK STAGE OF THERAPY

The objective of the third stage (sessions 5 to 7) of ETLT is characterized by "doing and reviewing." The working assumption in this stage is that the focal aim of treatment has already been collaboratively refined and modified in previous sessions. This process was illustrated in the above interaction in a less than ideal manner. The primary therapeutic task identified in stage III is for the therapist to maintain a high level of focality. More specifically, this means that the therapist's interventions should be consistently targeted on the focal aim rather than exploring "new material," which often characterizes time-unlimited approaches (cf., Fuhriman et al., 1985).

This stage provides the therapist with the least amount of guidance with respect to specific therapeutic tasks, which results in stage III being the point where the therapist's unique style and orientation becomes evident. Therefore, the unique style and orientation of the therapist in the present case will be highlighted, with the three mechanisms of change essentially providing a backdrop for this discussion.

From a process perspective, the client and therapist in the present case were moving into stage III during the fourth session. This early movement was probably stimulated by the interaction just examined, which appears to have resulted in a clearer identification by both the client and therapist regarding the work of therapy. More specifically, the therapeutic work now

included the client's fear that she was going crazy when she experienced strong emotions. This shift can be seen in the client's end-of-session report for session 3.

> C: In this session, I was able to identify my fear of being crazy or someday losing my mind by discussing my mother's and family's mental and emotional problems and behavior which I thought was "nutty." Then I was able to identify my behavior which I thought was "nutty" and analyze how I was perceiving myself.

This insight is important because it not only opened the way for increased understanding regarding the incest experience, but it also enabled the client and therapist to more freely examine how this event might be linked to the passivity and dependency noted in her current interpersonal relationships. In fact, the client understood this insight well enough at the end of the third session (stage II) to act on it in an interaction with both her father and husband during the week. The fact that the client was doing work outside of therapy further underscores the degree to which she took the collaborative relationship seriously.

Although it would be impossible to fully represent the work of the next four therapy sessions, we have selected two excerpts from two different therapy sessions that highlight the therapist's unique style and orientation. In these excerpts, the client's dependent interpersonal stance was manifested and discussed in two ways: (a) dependency within the therapeutic session,

and (b) etiology of the dependent stance, which led back not only to memories of the incest but also to memories of child neglect experienced during the time that her mother was hospitalized and her father was absent from the home.

The therapeutic style and typical interventions evident in these interactions included: (a) a here-and-now or present oriented interpersonal stance on the part of the therapist; (b) a moderate amount of interpretation and labeling of events for the client, and (c) a directive and active stance that often looks didactic and problem solving in intent. The therapeutic orientation or, more specifically, the principles of change that the therapist appears to be operating from were mixed and included: (a) a belief in the psychodynamic principle that early conflict (incest) helps explain present dysfunctions and that insight into this conflict is an important aspect in change; (b) a belief that information or changing one's beliefs and cognitions regarding an event (incest) helps; and (c) a belief that immediacy with self and client, or an interactional approach, will lead to catharsis, which, in turn, becomes an important part of the change process.

Beyond using interventions tied to the above principles of change, the therapist incorporated a modified bibliotherapy approach with the client as well as using role rehearsal techniques to help the client begin to behave in a more assertive manner in interpersonal relationships. The client practiced

these new skills and roles both during the session and through parallel homework assignments. The impact of these techniques is seen from the client's perspective through a review of end-of-session client reports and the debriefing interview. Although the model does not espouse the use of any particular interventions, it does encourage the therapist to use a variety of techniques in addressing the focal aim of treatment, which is clearly seen in the transcripts that follow.

The first excerpt, taken from session 4, illustrates the interpretive style of the therapist where links are made between in-session dependency and events in the past. In addition, the here-and-now style of the therapist is seen in the following excerpt, with attention being paid to interactional events as they occur in the session ("Are you mad at me?"). The content that preceded this excerpt was a highly cathartic memory of childhood neglect during the period when Julie's mother was in and out of the hospital. The interaction that follows quickly moves from remembering these unmet needs as a child to expecting the therapist to anticipate, acknowledge, and meet her needs during the therapy hour.

C: Am I supposed to feel it some more? I don't want to.

T: I know it's painful but it's not going to just go away.

C: We really do need tissues here.

T: Do you have some in your purse? I'll be sure to bring some next time.

C: I'm all right. . . . [crying some more and then wiping her nose on her hand], . . we are really going to have a problem this time.

T: Do you want me to get some?

C: Where's the clock? [locates clock] Oh, we only have 20 more minutes.

T: I would but I need you to ask me more directly. If you don't ask me for what you need, you won't get it, because I don't read minds very well, [pause] My guess is that what we're doing right now represents one of your issues in the present. If you don't get what you need when you want it, then you think it's because people are just unwilling to give it. Julie, they may not know what you need.

C: Well, it's pretty obvious that I need a tissue, [delivered angrily]

T: So if something is obvious, you can't ask for it?

C: Well, I don't even know if I want it now. Does that make sense? [pouting]

T: No, I want you to follow that.

C: A lot of times I'm not very direct. . . . It is hard for me to decide if it is worth it or not for you to go get tissues. . . . My direct request would have been, maybe you need to go get tissues. That is as direct as I could be.

T: Is it hard to say, "I need some tissues. Will you go get some?"

C: Yeah, I don't know why that is hard.

T: We could probably guess, maybe when you were growing up every time you asked for something, you didn't get it.

C: I really don't want tissues now, I'm fine. I guess what sent me into a trauma was that *you* thought I needed a tissue.

T: So it's not your need, it was what I think you need that's important. Heck, that can get you into a lot of trouble because I don't know what your needs are. But you apparently assumed I thought you needed something.

C: Yeah. I'm trying to think whether this happens a lot, you know, not just in therapy, but in other places too.

[Client then goes over a few outside situations, e.g., with child care, where she expects other people to just know what her needs are without telling them. This is then followed by about one minute of silence, which is broken by the following client comment.]

C: I'm waiting, trying to figure out what's going on, what to do next. . . .

T: What's going on inside right now?

C: I'm feeling depressed right now. I'm feeling really lost. I'm getting really mad at the core of this whole thing. I want someone to understand what I'm feeling and where I'm coming from and what has happened in the past. I guess

I expected you to understand my feelings. You know, if you can't understand them, then I can't either.

T: Are you mad at you or me?

[Client says she is mad at therapist. Therapist then moves to increase client's anger at her and later points out that she not only experienced anger at therapist without going crazy but that the relationship did not suffer as a result.]

The therapist's interventions in the above interaction are clearly aimed at having the client recognize her dependency assumptions in relationships, part of her original presenting complaint. One result is that the client, once again, experiences strong emotions toward her therapist. However, as the

client elaborates on this interaction below, we see other results including a desensitizing of the client to strong emotions, as well as the intended result of increasing awareness about her dependent stance in relationships. The client explains the impact of this interaction as follows:

> C: I guess I wasn't going to deal with my feelings here . . . I just wanted to pass it on to somebody else. I'm realizing in this session that I just can't do that and it's just really painful . . . I have to take responsibility for and it makes me feel alone. I think in this session I saw for the first time how I was trying to shovel out my needs to somewhere where I didn't have to deal with them, and for a while it was on my therapist. I was kinda saying, "Here, you take care of this, you wade through it. You explain it to me. . . ." Another thing that I was thinking with the tissues thing was "Why are you picking on me, I'm so mad, can't you just get me the damn tissues? You're pushing me, I want you to fix my problems for me and tell me what to do next, but you directed me back into myself. I guess I'm getting the message that I'm really out of touch with myself and I guess it's time to get back in touch."

The collaborative relationship in the above interaction is evident in the manner in which the therapist interacts with the client. More specifically, the therapist took a peer-like interpersonal stance with Julie in this session by essentially saying, "Heck, thinking that I can read your mind regarding your needs can get you in a lot of trouble because I'm mortal just like everyone else in your life." By being spontaneous and admitting that she was just an "everyday person," the therapist essentially shed the therapeutic mantle. The intentional use of immediacy in the therapeutic hour, coupled with "therapist-like" roles at other times (e.g., interpretations) continually turned the client inward, which was part of the focal aim stated at the beginning of treatment.

From the client's perspective, this led to the increase in self-reliance which she describes as follows:

> C: Well, I was certainly more self-reliant after that session. I had no choice but to face my own feelings and work through everything myself. . . . I think if I would have had six months I would have given up. I would have gotten confused and frustrated. It seems like the eight weeks kept me centered. I also think that. . . my therapist was task-centered and focused, and I realized that I had to make a go of it in the eight sessions.

Another point to note in the above client perspective is the strength of the time expectancy and its continued impact. The client once again reiterates that the eight sessions kept her centered on resolving the issues that brought her into therapy. Interestingly enough, she also describes the therapist as task-centered and focused, which provides a validation from the client perspective of the presence of therapist focality.

In stage III, the therapist not only identified current symbols of dependency, but also tried to identify past incidents that reflected a dependent style. This, in essence, reflects the psychodynamic principles of change from which the therapist at times seemed to operate. In the second therapy excerpt below (session 5), the therapist pushes for more insight by interpreting past symbols of dependency (driving a car), while also moving the client to experience more affect in the session. The intent in increasing affect seems to be to underscore her beginning disassociation between experiencing strong emotion and going crazy. This separation is evident in

the client's end-of-session report from the prior session:

> C: In this session I told [therapist] about something significant that happened during the week. I was able to stand up to my father on the phone and tell him my honest opinion about the sob stories he always gives me about how hard his life has been. During the week I was also able to pinpoint with my husband why I was feeling angry about something rather insignificant that had happened. We found that what seemed to be an irrational response was based on some things that I had done in earlier years. I was able to verbalize to him [husband] that I was not feeling crazy, and that I had been afraid of being crazy like my mom for a long time. The fact that I had resolved the long-standing issue of craziness was rewarding because I knew I had begun to make some progress and the hard work had paid off.

The therapist enters this session with apparent confidence that the client could now experience higher levels of affect. This is illustrated by the fact that the therapist essentially goads the client with a rather sarcastic comment, "Here we go again, come on now, give me a break," when she talks about being tired of feeling and talking about painful events in the past. The result is an increase in affect coupled with more vivid memories regarding painful past events.

In addition, the following transcript reflects the aforementioned therapist belief that immediacy (statements like "I'm tired of this") leads to catharsis. Finally, the interaction ends with the therapist essentially encouraging and rewarding the client for the hard work she is doing or reinforcing the process being used for self-discovery and catharsis.

C: When I was 19 and 20 years old I would say things like this is where we are and this is where we need to go, and remember where we were going. . . . I used to have to be behind the wheel and drive it 10 times before I could find my way down to the corner store.

T: Do you think that's another symbol of trying to . . . get someone to shelter you?

C: It protected me from making a mistake. . . .

T: Do you understand why you're that way?

C: Well, kind of. . . [shakes her head no]. . . .

T: Not really?

C: I'm not feeling it. I know I could dig it out and say, Hey, . . . but it's probably the things that happened to me in my childhood, but I'm not feeling it. . . .

T: That is about the fourth time that you've said you're tired of feeling. . . . [sarcastically] come on give me a break. C: I'm tired of thinking about it.

T: Is that why you don't want to talk about it?

C: Uh huh. [cries] [Client then talks with a lot of catharsis about what it was like to be neglected as a child and not feel loved. She describes in great detail incidents where she would ask her father for affection and he would tell her that she needed to stand on her own two feet or he would sexualize her request. The therapist reflectively responds to this for about 15 minutes and then responds in the following manner.]

T: It's really painful to hear about this. . . .

C: I didn't use to remember any of this.

T: I guess it's like you have opened a door to the past and a bunch of dominoes have started to fall into place?

C: Yeah. . . . It was just so strange; when I was a teen-ager I always thought my daddy was my closest friend. I used to think that he loved me so much, I really don't think he loved me now though.

T: He couldn't, or wouldn't?

C: I don't think he knew how, I mean they [parents] just didn't know how to take care of me. It makes me so angry. It's so stupid, [cries] What am I supposed to do with all of this?

T: Keep on doing what you're doing.

The potency of the client re-experiencing these painful past events is illustrated by this interaction being selected as a "key event" in the client's end-of-session report. This report reads as follows:

C: In this session, I was able to admit that I had been neglected as a child and to acknowledge and verbalize the loneliness I felt as a child. The events that led to this realization happened during the week as I thought over what I had discovered in last week's session. I felt that [my therapist) was empathizing with what I was saying and knew what my feelings were. Maybe even felt them before herself. She cried several times while I was telling her about my pain, which made me feel like she was with me and my pain.

An important point, found in this report with respect to the above interaction, is the client's perception regarding therapist empathy. Even though the therapist was pushing the client rather hard, illustrated by Julie's report that her therapist was "task-centered and focused" she also reported experiencing a great deal of empathy. The latter perception is probably due to the long periods when the therapist primarily responded with reflective

interventions when the client was experiencing a high level of emotion, as well as the noticeable impact that the client's experiences had on the therapist.

Both the above excerpts illustrate some of the major interventions used by the therapist to address the dependent interpersonal stance of the client. More specifically, these interventions were targeted at the primary presenting complaint of the client, i.e., interpersonal conflict with men at work.

Another therapeutic strategy used in this case, a modified bibliotherapeutic approach, was directed more specifically at the client's incestual experience with her brother (initial focal aim). In summary, beyond the early session where the therapist specifically dealt with the client's early incestual experience, the remaining in-session interventions essentially revolved around the client returning to therapy with questions about the assigned reading material on incest. The therapist responded by helping the client understand how her past experience matched, or didn't match, the specific content of the book.

In addition, she occasionally made links with this material and the dependent interpersonal stance that they were working on in therapy. As the client's fear of expressing emotion decreased, she began to reconnect with

some of the affect associated with the incest experience in later sessions. The client elaborated on the impact of the literature assignment strategy as follows:

> C: Reading the book was helpful. It brought up a lot of issues that were very fearful to face. It helped me put a lot into perspective like where my sexual impulses came from and what I could do to stay up on them. It also helped me to look at my childhood and be real frank about the things that had happened to me. . . . It helped me to face the hard times and rough times I had as a child, like being left alone. I was able to see how people can get out of control, and just do impossible things that they wouldn't ever think of doing just because they're lonely and because of what happened to them when they were little.
>
> It also made me realize that sexuality is a part of us and it's not something that's bad. It's just a part of our being. Bad things can happen to a person and screw them up, but that person is not a bad person and it's not their fault. It helped me to understand my impulsivity a little bit better. Although mine was not out of control, at times I was impulsive, and it taught me to see where that was coming from. I got the message from the book that impulsivity is often created from loneliness and empty feelings and a fear of dealing with core issues in your life. So I guess it helped me better face the real pain.

After modifying the focal aim to include the client's fear of experiencing strong emotion, the therapist essentially dealt with the incest experience as just one more place that she had learned to take a dependent stance in relationships and keep powerful emotions inside. From the above client perspective, it appears that she made some progress on issues relating to her incestual experience. However, as will be seen below, the primary unfinished business that was discussed at the end of therapy were issues regarding her

dissatisfaction with her current sexual behavior.

The final set of interventions used by the therapist in the present case involved in-session role rehearsal and homework assignments regarding assertiveness in interpersonal relationships. Rather than report on a fairly standard behavioral intervention, we have noted the client's progress notes outside of therapy by including her end-of-session reports for the seventh and eighth therapy sessions. These illustrate her not only being more assertive, but also being more aware of her emotional state and being proactive with respect to strong emotions experienced during the week.

> C: During the week I was able to identify a concrete example of my new-found ability to experience and be aware of my feelings, face the issues that were causing my anger, and then actively change or deal with the situation at hand. I feel that the actions which enable me to do this were based on things I had better understood in the past few therapy sessions.
>
> I was able to identify, by myself, why I had been feeling angry and overwhelmed during the week. I named all the issues, worries and events that were precipitating my feelings of panic and I realized the many demands which were being placed on my time and energy. From this point, I was able to deal with these stresses and put my feelings into perspective. I think the setting [therapy] and the fact that I was consciously trying to pinpoint my feelings were what enabled me to do this. I also verbalized that the relationship I have sexually with my husband is separate from things that happened in my childhood.

The last session report alludes to the unfinished business of her sexuality. In essence, the client is anticipating future work, which is the

primary objective of the final stage of the ETLT model.

STAGE IV: PRETERMINATION, TERMINATION, AND FOLLOW-UP

This stage marks the end of treatment and often the beginning point of testing the self-reliant attributions that have hopefully been inculcated in the client's attributional system over the course of treatment (cf. Burlingame, 1985). More specifically, the objectives of this stage are to provide closure, review the therapeutic goals and progress, and relate them to the client's future functioning. By reviewing the progress to date, the client recognizes there is still work to be done, anticipates potential stresses, and determines strategies for dealing with increased independence. During the follow-up session, which in the present case represents the debriefing interviews, the client and therapist review the goals of therapy and what has occurred since termination (cf., Fuhriman et al., 1985).

In the present case, the client left the therapeutic experience having changed her belief that experiencing strong emotions was comparable to going crazy like her family members. This insight enabled her to better recognize her emotional states and handle them in a more productive manner. In addition to recognizing when she behaved in a dependent, non-assertive manner, she also gained insight into why dependency had been part of her interpersonal style for so long, primarily generated from the dynamic

perspective painted by the therapist. These insights also helped her to examine more seriously her sexual behavior in the present and the past.

As can be seen from the client's comments during the follow-up interview below, she had initially identified two areas as "unfinished business." The first area was learning to establish a normal adult relationship with her parents. The second revolved around her sexuality and being able to disassociate her incestual relationship with her brother from her current sexual relationship with her husband. These transcripts also indicate some of the successes of therapy and how she was behaving differently around the original presenting complaint, difficulties with older men at work. Finally, they illustrate proactive behavior around her second area of unfinished business, sexuality.

> C: As I was coming to therapy—maybe about a month in—I started to deal real directly with my colleagues at work, I just went right for them, verbally and nonverbally, and just decided it wasn't going to happen anymore. A couple of weeks after that, I started to work more professionally with these people —like a colleague, like I actually had a professional relationship and was respected and if I developed a new theory they would listen to me. It's getting quite positive at work. . . .
>
> I: Are there one or two events in your therapy that are extra-important to you?
>
> C: I think being able to face the issue that I was going crazy was real important . . .. Facing that and analyzing it and realizing that I wasn't crazy and being able to say that I am not crazy . . . made a real big difference. It took several sessions to come to that. . . . I think a lot of it came from growing up with my mother. . . . I watched her just lose control and lose track of things. At one

point, she was out of control for years and years, having hallucinations, making statements that were not in touch with reality, and I thought, gee, I'm her daughter and I could be that way and I probably will be that way because I am her daughter. . . .

I: Do you think that you have begun to put some of the trauma with the incest to rest?

C: After a certain point in therapy, I got to feeling like I could actually go up to a man and really try to get to know him. I have seen a change now. I am more interested in the other person and . . . and I don't mind letting them get to know me. I'm more open now and interested in making friends with them. . . . The fact that I was able to tell my husband about the incest, you know, and get everything out in the open means I'll never have to worry about it again. Now I can be close to him and in a number of ways I was not allowing myself to be—just in case he found out.

The fact that I understand where part of my craziness comes from was important. . . . I still have strong emotions but now I'm able to identify them more and understand where they are coming from and what's causing them and to deal with the issues before they get big. That's priceless. My life is a lot more turbulent. There is a lot more anger in my life right now and frustration and pain and those kinds of things, but somehow I feel more in control and more safe. I mean I can handle it. I think it was really beneficial. . . .

One thing that really helped me deal better with things now, and that made me frustrated before, is that I had not been dealing with my emotions for at least 20 years. So I feel like now I'm beginning to catch up in those 20 years. The good things that help are to look at them and analyze them now. . . . In here I pointing to heart I is something that's okay to look at now. . . . I'm not going to go crazy if I look at my emotions. As I begin to find out what happened to me and get it out, then I feel better.

I: Are there things that are still unfinished with respect to what you worked on in your therapy?

C: One of the big things that was unfinished when I left therapy was the relationship that I had with my parents. I am now beginning to say that they tried as hard as they could, but they just didn't know how. I am not going to continue to personalize that. I find that there are other people that had the experience that I did. The thing with my parents is getting more and more resolved now as I begin to think that they probably did love me. I am also beginning to stay more current with the stuff I am doing with my parents.

Another thing that was unfinished was my sex life. Since therapy ended, I have been to my gynecologist. I think part of the explanation for lack of enjoyment is that I have the symptoms of PMS. I'm beginning to explore that more with my physician. Although I am sure that the stuff that happened with my brother is also part of the explanation for why I was unable to enjoy sex with my husband, I am getting to the point where I don't think about my brother when I'm making love with my husband. One important thing that happened one night toward the end of therapy was when my husband just broke down and said:

> I can't stand making love to you when you are being angry about your brother. If he were here I would probably kill him, but he is not. I can understand that you are angry with your brother but all I feel from you is anger when I make love with you. I just can't make love with you when you're feeling angry. I'm feeling guilty for wanting to have pleasure with you and I am wondering if I should be doing this when it is just agony for you. I just hate feeling your hesitation. I just feel like he is there in our bedroom and that you are reliving it each time. I just don't understand why you can't relax and know that I love you and just share our love instead of thinking about your brother and realizing that it is just the two of us together now. What we are doing is because we love each other and it has nothing to do with your brother.

You know, when he said that, it really helped me to see what I was doing to him. Right after that, we made love and it was us together . . . it was very good. Once I had that experience it's been very good. I have been able to have that experience and move closer to him each time.

Commentary

A number of things can be noted from the follow-up interview. The most prominent involves the catalytic assumption regarding ETLT. More specifically, given the type of client selected, it is assumed that ETLT provides a stimulus for change rather than moving the client to the end point of change. In the present case, the client ended treatment being able to more fully face two emotionally laden troublesome areas in her life: her relationship with her parents and her sexuality. In fact, she describes her ability to live with her emotions as the most important result of therapy. The proactive movement seen in both these areas (relationship with parents and sexuality) at the two-month follow-up not only supports the catalytic principle of ETLT, but further validates the early shift in focal aim, the fear of going crazy with strong emotion.

The client clearly shows a change in perspective regarding her relationship with her parents. She has recognized that what happened as a child was unfortunate and unfair, but appears to be moving past her anger toward her parents. The fact that she dealt with some of this anger in the latter portion of therapy and is now attempting to establish an adult-to-adult relationship with her parents is seen as a prognostically good sign. The client also demonstrates proactive movement with regard to her sexuality. She initiated work with a gynecologist in an attempt to separate the biological

problems associated with her sexuality from the psychological problems. In addition, the follow-up interview was the first time that the client talked about the interaction recorded above with her husband, which can also be seen as proactive movement. The fact that she productively dealt with her husband's anger not only demonstrates the movement she made in dealing with emotions, but also portends a successful end point for their future sexual relationship.

Another promising aspect from the above transcript is the client rapprochement with men in general. She clearly states that she is not only trying to get to know men from a different perspective, but is also being more open to letting men know her as a person. During this session, the client provided several behavioral examples to support these statements, thereby making it difficult to dismiss her report as a halo effect. Finally, we see the client's report of her life being more turbulent as positive. This turbulence was better understood by further questioning. Given her prior interpersonal stance, her more assertive posture at work and home essentially resulted in more turbulence in interpersonal relationships, primarily because she would no longer let people "take advantage of her."

A CASE COMPARISON

One of the features of the ETLT approach is its applicability to a variety

of theoretical orientations. Because of the limited amount of precise structure that is placed on the therapist and the broad, general principles that are suggested, it becomes important to identify how therapists of differing persuasions apply the model. For this reason, we examined two cases, the first being more explicitly presented and the second, more comparatively.

In the case of Julie, the therapist was described as having a therapeutic style that was directive, active, interpretive, and that exhibited a high degree of therapist presence. The therapist conceptualized the case in psychodynamic terms but utilized therapeutic techniques that ranged across a variety of orientations. The therapist gave interpretations, provided information and opinions, elicited catharsis, and focused not only on the then-and-there, but also on the here-and-now experiences of the client and, to some extent, of the therapist.

In the comparative case, the therapist style was active, patient, reflective, speculative, and also displayed a high degree of therapist presence. The therapist conceptualized the case from a client-centered orientation but also used a variety of techniques representative of other therapeutic models. The therapist reflected client intentions, ideas, and feelings, probed, presented metaphors, shared insights, and confronted the client's incongruent messages.

In examining the application of the ETLT approach to these two cases, the comparative-case therapist adhered more explicitly to some of the specific instructions such as reviewing the process at the beginning of the sessions and commenting on the amount of time remaining in therapy. In a sense, regarding the application of the model, Julie's therapist used the approach in a more fluid and general manner, whereas the comparative-case therapist implemented the approach in a more consistent and specific manner. The variability in application may, in part, have been due to the perceived differences in client characteristics and diagnosis. The following is a brief description of the comparative client:

> The client was a 24-year-old, Caucasian female who was employed as an accountant. Her presenting complaint was an agitated depression precipitated by her husband asking her to leave his house after two years of marriage. At the time of treatment, the client was in the process of divorce proceedings.

We tend to believe that the two styles are more representative of the therapists' typical therapeutic style with some adaptation relating to client characteristics.

A clearer comparison of the therapeutic process in these two cases is best described by examining how the elements of the ETLT approach were implemented. The differences between these two therapists become more distinctive when the interaction is analyzed through the elements of focus,

collaboration, and sharing of expectations. This distinctiveness illustrates how the model can be applied in principle while using differing techniques to complement and enact the principles.

Focus

Both therapists directed and emphasized focusing throughout the therapeutic process. The two were similar in their emphasis on staying on task, the task being the focal aim as determined by the client and therapist. Julie's therapist directed the interaction by introducing and making more explicit the topics of incest, relationship with co-workers, and fear of going crazy. The comparative therapist provided focus by reflecting and by extending the direction of the interaction through questions that required logical and linear responses. Two differences in the therapists' focusing were evident: the focal aim was narrower in the comparative case, and in the later sessions, the comparative therapist centered the discussion more often and more specifically on the target complaint. These resulted in more interventions by the comparative therapist directed toward focality.

A difference in client characteristics and diagnosis may also have accounted for the need for or display of focusing by the therapist. Julie was task oriented and concomitantly more focus oriented herself, thus alleviating the need of more therapist focus. The comparative client's diagnosis was

acute rather than chronic with the presenting problem less connected to long-standing issues, thus lending itself to a more specific response from the therapist. These two cases illustrate strikingly different ways and means for the therapist to accomplish the task of focusing.

Collaboration

In the application of the element of collaboration, there is also quite a distinct difference between the two therapists. Julie's therapist presented both behaviorally and attitudinally more of a presence of collaboration than did the comparative therapist. The point of view of Julie's therapist was egalitarian; the style was spontaneous and matter of fact. The therapist conveyed this view by sharing opinions, experiences, and values and displaying somewhat casual, nonverbal behavior. The attitude and personal style of the therapist conveyed the collaborative element in a predominant manner that overrode the impact of the authoritarian techniques of interpretation, homework assignments, and directiveness.

The comparative therapist's personal style was more formal, and perhaps more traditional. The therapist did not take off the "therapeutic mantle" and thus presented a less collaborative style. On the other hand, this therapist adhered to the directions of the ETLT approach and involved the client in explicit discussions of where they were, what they were doing, and

where they wanted to go. Thus, the collaboration, as conveyed through dialogue, was more explicit and more frequent in the comparative case. An interesting pattern begins to develop between these two cases. Once again, the model is implemented by Julie's therapist through attitude and presence, whereas the comparative therapist implements through specific techniques and dialogue.

Expectations

The two therapists are more distinctive in their implementation of the element of expectation sharing. Julie's therapist almost exclusively shared and elicited expectations regarding diagnosis, hope, and impact of information; in addition, there is more evidence of the therapist's expectations being shared than the client's. The comparative therapist specifically raised the issues of the time limit, the process of therapy, and the client's involvement in therapy. This therapist not only shared self-expectations regarding these issues but elicited more sharing of client expectation. The comparative therapist was also more explicit in focusing on what was unfinished and what was helpful in therapy. The sharing of expectations on these two topics also demonstrates collaboration and exemplifies the catalytic nature of the approach.

The main focus in this comparison has been on therapist differences in

implementing the eclectic approach, but there are a number of similarities that existed between the two. Probably the most striking similarity is the therapists' value or belief that client insight is an important component of healing, and that one reaches insight through cognitions and catharsis. Although the two therapists held the same value, each worked to generate insight in their clients through differing methods and techniques. Both therapists valued the here-and-now focus in therapy, but the here-and-now value also was demonstrated in different ways. One therapist confronted the client with the effect of the therapist on the client, whereas the other therapist confronted the client with her in-session incongruities.

In comparing these two therapists on their application of the ETLT approach and their methods of implementing the elements, it becomes apparent that differing theoretical orientations and styles can be accommodated within the model. Therapists in these orientations can also be successful in both model implementation and client outcome. The two cases also illustrate how client characteristics and diagnoses can affect how the therapist creates the elements of focus, collaboration, and expectation sharing through style and technique.

IN RETROSPECT

Analyzing the interaction of these two cases has been instructive

regarding the application of the ETLT approach. In addition, insight was gained into some dynamics of the therapeutic process. As both therapists applied the model, some strengths of the approach were highlighted. For example, both therapists seemed to apply the model with relative ease. Also, one of the intents in designing the ETLT approach was to make it applicable across varying theoretical orientations; these two cases illustrate some accomplishment of that intent. It also became apparent that therapist style can compensate for the absence of techniques specified in the model.

Insight gained by the examination of these two cases may relate not only to brief therapy, but to therapeutic interactions in general. It became obvious that if a therapist has broad, general principles to guide him or her, these principles, in turn, can be fulfilled using a variety of therapeutic techniques. This may represent a means of linking theories and discovering core themes across them. Finally, client selection is deemed important in ETLT, in part owing to the collaboration that is required and the specificity of diagnosis necessary for focusing. However, in these two cases, the client characteristics illustrated the importance of what the client contributes to the therapeutic enterprise, and how the therapist can adjust style and technique to client need and contribution.

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Notes

1As per typical case study protocol, client identity has been protected not only by using a pseudonym, but also by changing pertinent identifying information, i.e., occupation, husband's occupation, etc.

2 The interviewer who debriefed the therapist and client separately and conjointly was the first author.

3 Unfortunately, because of technician error, videotapes from the original intake interview were lost. Therefore, content from this session is based on therapist and client account in the debriefing interview.

Commentary: Time-Limited Therapy and the Stages of Change

Carlo C. DiClemente

Short-term and time-limited psychotherapy are not identical. As the authors of" The Case of Julie" point out, many therapy encounters are short-term in nature with an average of 5 to 10 sessions. Most often brevity is a result of premature termination rather than design. A multitude of reasons for the brevity have been proposed. Frequently, the cause is assumed to be a mismatch between client and therapist along particular dimensions of personality, expectations, relationship, or interventions. In some way what the client and therapist are doing during the session is incompatible. As a result, the client actively or passively terminates therapy. A second reason for brevity may be the nature of the problem. Psychotherapy makes demands on the client to be analytical or engage in cognitive or behavioral activities. If the problem is so incapacitating or the person so limited as to be unable to perform these activities, the therapy will be truncated. Client motivation is a third often-cited cause for brief therapy. Clients may lack sufficient desire to acknowledge or take action with their problem, want to solve the wrong problem, or are too oppositional. In any case, developing a working relationship is problematic, and the course of therapy is sporadic or very brief. A final cause of the brevity of

therapy would be that the problem is resolved rather quickly or the brief assistance given by the therapist is considered sufficient for the client to go on his/her way with little thought of any long-term contact with the therapist.

The case of Julie provides an instructive example for a discussion of short-term therapy in general and the eclectic time-limited therapy (ETLT) model in particular. Strengths and weaknesses of the ETLT model are interrelated and will be discussed from the more general transtheoretical eclectic approach presented in Chapter 4 of this Casebook and elsewhere (Prochaska & DiClemente, 1984, 1986). The ETLT model provides a framework for a consciously designed, time-limited intervention and offers some basic concepts to assist the therapist in structuring the therapy. It accomplishes this by concentrating on the common elements or preconditions for therapy of expectation and relationship (Prochaska, 1984) and by patient selection.

Focusing, collaboration, and congruent expectations are assumed to be the common mechanisms of change which are intensified by the short-term nature of the therapeutic contract. These key elements seem to be clearly illustrated in the case of Julie.

Although the authors clearly illustrate the four stages of brief therapy, I would like to discuss their work in terms of the stages of change: precontemplation, contemplation, action, and maintenance. In its emphasis on

patient selection and on swift movement to action planning and active coping, the ETLT model concentrates almost exclusively on the action stage of change. As the authors acknowledge, Julie comes to therapy rather fully prepared to take action. She had already accomplished on her own many of the tasks of the precontemplation and contemplation stages of change prior to entering therapy, at least with respect to difficulties with her male colleagues. Julie appears to be a capable, resourceful woman seriously engaged in the process of change even prior to therapy. The assumption of the model and the assessment of the therapist were in agreement. Julie would be open to action strategies of reevaluating current and past experiences and becoming more assertive.

Client selection ensures motivation and capability as well as increasing the probability of a good match between therapist and client. In this way the ETLT model avoids many of the problems that lead to premature termination. Matching action strategies with a person in the action stage of change offers the best chance for successful short-term intervention. This perspective may also explain the rather intense anger Julie experienced in the therapy. While in action around some issues, it seems that Julie wanted to spend more time in contemplation for the incest problem. She seemed to want more support and a more thorough cognitive exploration of the issue. The action orientation of the time-limited therapy seemed to short-circuit this exploration, creating frustration and anger. Julie was open and resourceful enough and the therapist sensitive enough to address that issue in the therapy and move ahead.

While concentrating almost exclusively on action strategies (stages II and III) the ETLT model does give some consideration to the issue of maintenance. The work of stage IV of the ETLT approach essentially promotes maintenance of changes made during stage III. The time-limited nature of the therapy leaves much of the work of maintaining change to the client. In this case Julie seems to be doing a good job of both maintaining changes and generalizing them to other areas of her life. Thus, the ETLT model relies on self-change for the movement from precontemplation to contemplation, assists in the final movement from contemplation to action, intervenes in the action stage, and assists in maintenance relying again on self-change.

In many ways Julie does not appear to be a "good" or typical short-term therapy client. Her current problems with work relationships are integrally connected to an early traumatic incestuous experience which impacts self-concept, relations with all men including her husband, and her role as a woman. The combination of a sensitive, well-trained therapist and a client who is a resourceful self-changer in or very close to the action stage of change makes the ETLT model work well in the case of Julie. The perspective of the therapist and the interventions or processes of change she employed provide the eclecticism. The model provides the structure for a time-limited, action-oriented therapy approach. The authors could profitably explore whether the model could be used for promoting change at any of the other stages of change and how a less well-trained therapist would do with the model since the model relies on the

therapist for the active coping interventions.

Time-limited therapy, because of its brevity and its focus, could easily lend itself to a rather rigid, locked-step, single-system approach to psychotherapy. To their credit, the authors of the ETLT model have resisted the more dogmatically defined approach in favor of an eclectic one. The case of Julie and the comparison case at the end of the chapter demonstrate the ability of the ETLT model to discuss in detail the common structure of time-limited therapy while allowing for an eclecticism in problem definition and process interventions. Adding a stage of change perspective could help in the definition and development of the ETLT perspective.

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Commentary: Advantages and Drawbacks of Generic Eclecticism

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There are at least three different ways in which the term eclecticism is applied in the field of psychotherapy. In what I have referred to in this book's companion volume as selective eclecticism (Messer, 1986), the therapist is prepared to call on one of several distinct therapeutic approaches from his or her repertoire that seems best suited to the client or problem at hand. Integrative eclecticism, by contrast, attempts to wed one kind of therapy to another. We may have, for example, combinations of psychoanalytic and behavior therapy (e.g., Wachtel, 1984) or individual and family therapy (Pinsof, 1983). In a third approach, the common elements eclectic model, those ingredients that seem to be shared by many psychotherapies are extracted and sculpted into a single approach (e.g., Prochaska & DiClemente, 1984). In one variant of this model, the focus is on therapeutic techniques that are held in common by the various therapies and that are considered to be the most efficacious. In the other variant, a generic model or general scaffold is constructed to encompass a variety of therapeutic approaches. It is the latter model that is employed by Burlingame, Fuhriman, and Paul in their version of

short-term therapy, which they call eclectic time-limited therapy (ETLT). They developed it out of a pragmatic need to encompass the varied theoretical predilections of a particular clinical staff. "We thought that such a model would improve the likelihood that the approach would be adopted, especially if the staff members were not forced into a totally alien orientation or set of practices" (p. 97).

Given this particular aim, the authors have succeeded very well in constructing a system that is straightforward, beguilingly simple, and reasonably neutral theoretically. It can be employed by a broad range of mental health practitioners without the necessity for much further training, which is an advantage of a generic-eclectic model. In addition, they have extracted some major elements of short-term therapy that most experts would agree are critical aspects of that enterprise. We have been treated to a fascinating case which illustrates how much can be accomplished in a planned short-term therapy with a well-selected client. For their second case, however, I would have preferred the application of ETLT within a strongly differing theoretical orientation in order to illustrate the broad applicability of the model.

The advantages of genericism notwithstanding, it is important to consider whether something is not lost by adopting a generic model alone. Such models, and ETLT is no exception, must of necessity be general or else they fail to be generic. But, being generic, they lose the kind of specificity in theory and

technique that makes the non-eclectic, non-generic models so useful. To illustrate this, I will examine the case presented and try to show how the application of an informed short-term psychodynamic therapy framework could complement the generic model employed.

The focus as conceptualized by ETLT in the case of Julie is incest. ("The therapist is clearly working from the tentative focal aim of incest," p. 108). As a very general statement of focus, this may be acceptable, but as a psychodynamic focus, it is much too general and cannot serve as a useful guide. How would brief psychodynamic therapists proceed? They would note the following: Julie's presenting complaint of interpersonal difficulties with two "older" male colleagues, which involved her responding seductively toward them and having sexually laden dreams about them; her incestuous experience with her brother during the time of her mother's breakdown; and her fears of going crazy when some related feelings recurred in connection with her male colleagues. From her early history it would be noted that she took an overdose of pills when she was five in an effort to gain her father's attention; that her father was often absent from the home; that her grandfather was abusive; and that her mother went through a number of severe manic-depressive episodes for which she was hospitalized during Julies late childhood and early adolescence.

How can this material be woven into a narrative that makes psychodynamic sense and that can serve as a focus for therapeutic

interventions? Starting with the developmental information, we can say with some assurance that Julie was a deprived and abused child who had so desperate a need for parental attention that she even resorted to taking an overdose of pills. Her father was rarely available, so when her mother was hospitalized she was left bereft, making her an easy and willing victim of her brother's sexual advances. In other words, she acted out her unfulfilled dependency needs in this deviant way. That she recently started having sexual fantasies about older male colleagues and that she confuses husband and brother in love-making point to the continued existence of conflictual feelings about these earlier events and her need to reenact them. Given the strangeness to her of her feelings in the current context, and the background of having a "crazy" mother, we can well understand her fear that she, too, is going crazy.

Some version of this dynamic focus seems to have been implicit in the therapist's work, but formulating it in this way helps keep the therapy focused and sensitizes the therapist to the context for the client's associations. It also helps to alert the therapist to the connections between relationships from the past (e.g., to father, mother, grandfather, brother) and current relationships (older male colleagues, husband), and to the developing relationship to the therapist (transference). Malan (1976) has demonstrated empirically a positive correlation between the number of transference-parent links and the outcome of brief, dynamic therapy. By spelling out the nature of the interconnections of past, present, and transferential relations, the focus, as presented above, aids

the therapist in making such links in a considered and informed way. Thus, the incest experience was not "just one more place that she learned to take a dependent stance in relationships. . . (p. 119), but rather it was a way in which Julie expressed her very strong need to be close to and loved by a close family member.

Although the dependency needs were brought to light in Julie's therapy, they were not emphasized as much as the above psychodynamic focus and linking technique would require. This may be why Julie left therapy feeling that the issue of the relationship to her parents was quite unfinished.

Besides focusing and drawing the transference-parent (and transference-current relationship and parent-current relationship) links a short-term psychodynamic therapy stresses the importance of the termination phase of the therapy much more so than ETLT. In his version of brief dynamic therapy known as time-limited psychotherapy, Mann (1973; see also Mann & Goldman, 1982) capitalizes on the universal problem of separating from important people in our lives by emphasizing the termination date and listening for the themes that it elicits, especially in the last few sessions. In a therapeutic relationship as intense as Julie's, and in a client who suffered repeated separations from her father and her mother, we would expect the issues of separation and dependency to be particularly acute at termination. Yet the case presentation hardly mentions these issues as central during the final sessions. The

termination phase would have provided an excellent opportunity to focus on the dependency feelings as they were manifested in the transference and then to link them to past events.

The point is not to pick out flaws in this particular case presentation (which one can always do no matter how brilliant the work), but to demonstrate that a specific theoretically based model has certain advantages over a generic model in formulating a game plan for therapy. Is there some way of combining the advantages of a generic model and specific, theoretically based models? I believe there is. The generic model, like ETLT, can be useful in orienting a heterogeneous staff to short-term therapy, particularly if it extracts successfully, as does ETLT, common elements from among those orientations adhered to by the staff. It is also a useful way of illustrating the overlap of the different approaches, at least in broad strokes. This is conceptually interesting and can also improve staff appreciation for the models adhered to by others. It can even influence their own work in therapy. But within the broad ETLT frame, therapists, in my view, should learn in greater depth a short-term therapy model that will allow them to employ most usefully the theory and skills they already possess. This is what I have tried to illustrate in my commentary on Julie's therapy.

Burlingame et al. could argue that theirs is an eclectic model, not only in the generic form, described at the outset, but also in the "integrative" sense.

They, presumably, would not want therapists to follow one theoretical orientation too closely. ". . . the model. . . does encourage the therapist to use a variety of techniques in addressing the focal aim of treatment, which is clearly seen in the transcripts that follow" (p. 115). Thus, we have the therapist engaging in non-analytical techniques such as assigning a book, in-session role rehearsal, and giving homework assignments regarding assertiveness in interpersonal relationships. How, then, does this mesh with the dynamic focus as outlined above? One could view these importations from other therapeutic approaches as dependency gratifications which could make the dependency needs that much harder to analyze. (Of course, one could also view them as cementing the therapeutic alliance or as supplementing the verbal insight achieved.) But in either case, there is a need for the ETLT model to spell out the nature of its integrative eclecticism lest it deteriorate into an "anything goes" attitude.

Finally, the authors are to be congratulated for encouraging end-of-session reports by both client and therapist and conducting follow-up interviews in order to "unpack" the text of the therapy. This is rarely done and gives the reader a particularly rich view of this instructive psychotherapy and the model on which it is based.

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