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EXTENDING COGNITIVE BEHAVIOUR THERAPY
IN PRACTICE

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This portfolio is submitted in partial fulfilment for the degree of Doctor of Psychology (Clinical).

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December 2002
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**Extending Cognitive Behaviour Therapy in Practice**

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My gratitude goes to the clients I have worked with who have taught me so much and to the mentors and supervisors who guided me along the way.
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OVERVIEW

The professional portfolio of this thesis discusses the need for the inclusion of alternate therapeutic elements, borrowed from traditional therapies, into cognitive behavioural practice giving particular attention to the treatment of anxiety and depression in both adolescents and adults. Gleaned from clinical practice and illustrated by case examples, discussion centres on several issues that challenge clinicians attempting to treat clients using orthodox CBT practices.

Chapter one discusses the cognitive-behavioural formulation of anxiety and depression and examines the current status of CBT in research and practice. It also provides a critical examination of several mediating difficulties that may arise for clinicians in attempting to apply cognitive-behavioural strategies. These include the particular world view or culturally derived cognitive style of the client, predominant and challenging personality traits, transference and counter-transference, and resistance. Four case studies are provided to illustrate the complexity of treating anxiety and depression within the constraints of a single therapeutic modality, highlighting issues that are not regularly given credence or acknowledgement within CBT practices. The names and identities of these clients and their families have been altered to guard their confidentiality and anonymity.

Chapter two describes the case of PL, a 16 year old male, who presented with a
particular personality trait that posed a challenge to smooth CBt treatment of his depressive and anxiety symptoms.

Chapter three describes the case of MD, a 17 year old female from whom the issue of transference was illuminated. Chapter four presents the case of FW, a 42 year old woman with Factitious Disorder and depressive and anxious symptomatology who evoked strong counter-transference issues in the therapist with discussion around the place of therapist reactions to clients within CBT. Chapter five presents the case of SY whose cognitive style related to her culture of origin made her largely unresponsive to a CBT approach in treating her social anxiety symptoms.

A brief background history and formulation are offered for each case and a discussion of clinical impressions and issues that arose from interacting with these clients is given. The issues raised highlight some limitations of CBT in clinical practice that are often over-looked, poorly addressed or dismissed in treatment manuals and in clinical training. It is not the aim of this paper to dismiss the benefits of CBT or to dispense of the treatment, but rather to advance an integrative approach to CBT by way of addressing the limitations of CBT in practice.
CHAPTER ONE

1.1 The development and current status of cognitive-behavioural therapy

Cognitive-behaviour therapy (CBT) has progressed over the past four decades to be one of the most popular, most widely used, and well-respected forms of psychotherapy (Vallis, Howes & Miller, 1991). The benefits of CBT have been highlighted as being its brief, structured form (Beck, 1995), that it is theoretically driven with strong and effective clinical applications, (Vallis, et al., 1991), and is flexible and adaptable to different client populations (Ellis, 1997; Vallis, et al., 1991). CBT also represents the move away from traditional psychotherapies in which the therapist was positioned as an all-knowing holder of answers, to a more collaborative, problem-solving paradigm in which client and therapist jointly seek practical solutions to problems (Beck, 1995). Initially developed with a focus on treating anxiety and depression (Beck, 1995), CBT has been expanded over the years through both research and practice to be applied to a range of psychological disturbances across a variety of settings with a range of client groups (Beck, 1995; Vallis, et al., 1991).

CBT was born of an era in which discontent was growing with traditional psychotherapies that were lengthy and cost-inefficient, and often failed to address the very symptoms with which clients were grappling (Ellis, 1997). It would be inaccurate to say that CBT developed as a reaction to traditional psychotherapies, as
other important historical developments were taking place at the time that spurred the
development of this new theory and practice. Firstly, behaviourism was taking hold.
During the 1970's, behaviour therapy flourished such that behavioural principles
were widely validated and accepted and behavioural techniques were readily applied
to a range of psychological problems (Salkovskis, 1989). As such, behaviour therapy
became the treatment of choice for many disorders particularly in vivo exposure for
phobias, panic and obsessional disorders (Salkovskis, 1989). Interest with
behaviourism in clinical practice grew also with the findings that Pavlov's operant
conditioning paradigms could be applied to covert events such as cognitions (Dobson,
1988), such as in the treatment of obsessions in obsessive-compulsive disorder.

Despite the burgeoning of behavioural techniques, discontent began to rise among
treating clinicians who, accepting the benefits of behaviour therapy, took note of the
treatment failures within strict behaviourist formulations and management. Through
close examination of those areas in which behavioural treatments were largely
ineffective, such as in treating depression (Salkovskis, 1989), it came to be
recognised that cognitive factors were often involved in maintaining the symptoms.
From this recognition, the importance and need for inclusion of cognitive therapy into
behavioural treatments grew (Salkovskis, 1989).

As behaviour therapy developed, a strong movement of cognitive therapies also grew
from the works of Albert Ellis and Aaron Beck (Vallis, et al., 1991). The prolific
growth of these two separate streams of theory and practice eventuated in their combining to produce a form of treatment that targeted both cognitions and behaviours in affecting therapeutic change (Yankura & Dryden, 1990). From this time, CBT developed in theory and practice such that currently, CBT is the treatment of choice for most anxious and depressive disorders included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: APA, 1994; Nathan & Gorman, 1998; Salkovskis, 1989). While there may be variations in foci and protocols for treating different anxiety disorders such as PTSD or OCD, the fundamental principles that underlie CBT remain and apply to the treatment of anxious and depressive symptoms that feature within these disorders.

1.2 The cognitive-behavioural (CB) model of depressive and anxiety disorders

Beck’s cognitive-behavioural formulation of depression and anxiety begins with the premise that early experience leads people to form assumptions and frameworks through which to view and understand themselves and the world around them (Beck & Emery, 1985). Information received is filtered through these schemata and organised accordingly. In turn, behaviour is largely governed by these schemata and guided by the assumptions held within.

Schemata, or assumptions, allow us to form rapid predictions and assessments in order to guide action. But when fundamental assumptions are rigid, extreme and resistant to the addition of evidence and to change, they can impede normal
functioning and become ‘dysfunctional’. An assumption such as ‘the world is really a
dangerous place and people must not be trusted’ is likely to lead to thoughts and
behaviours that keep people at a distance, that foster isolation and protectionism, and
that may promote the development of social anxiety or poor interpersonal relations.
Rigid extreme beliefs do not, however, lead to depression or anxiety alone.
Importantly in this model, difficulties occur when such assumptions are associated
with certain critical incidents. The belief that ‘the world is a dangerous place’ could
lead to depression and/or an acute stress response when the individual is faced with a
violent encounter or a personal attack. Once these negative assumptions have been
triggered they produce an upsurge of ‘negative automatic thoughts’ so called because
they are involuntary and seemingly enter the person’s mind uninvited and provoke
negative emotion. Negative automatic thoughts are understood to be the spontaneous
mental material that manifests the core assumptions the person holds (Salkovskis,
1985). They may relate to something from the past, a predication about the future, or
from an interpretation of a current event. In turn, they lead to negative emotion and
other symptoms associated with depression or anxiety.

While it can not be asserted that certain schema cause the development of depressive
or anxious disorders, it is proposed that an individual’s attributional styles, their
typical way of interpreting events, may predispose them to developing anxiety or
depression, increasing the likelihood of their occurrence given other relevant
conditions (Beck, Rush, Shaw, & Emery, 1979). As lowered mood and anxiety
develop, negative automatic thoughts become more frequent and greater in their intensity setting in place a vicious cycle of negative/threat related thoughts and corresponding symptoms.

1.3 Cognitive-behavioural treatment of depressive and anxiety disorders

Cognitive behaviour therapy is “an active, directive, time-limited, structured approach...based on an underlying theoretical rationale that an individual’s affect and behaviour are largely determined by the way in which he structures the world” (Beck, et al., 1979, p. 3). It follows then that the central problem and the remedy are both concerned with the person’s thinking and behaviour. Such a focus does not ignore the primary impact of depression or anxiety as an emotional state but rather sees that the alleviation of negative emotion comes via the alteration of negative thinking and maladaptive behaviours.

The fundamental principles of CBT commonly apply to treating all anxiety and depressive disorders although, as mentioned in section 1.1, there may be variations in foci for disorders such as PTSD, OCD, and bi-polar II disorder (Salkovskis, 1989). The main principles of CBT can be summarised as being:

- based on a coherent set of well-defined techniques aimed at specific objectives;

- based on collaboration in problem-solving between client and therapist;

- structured and directive;
- 8 -

- a brief and time-limited intervention with clear aims and objectives that do not focus on origins and causes as much as maintaining factors and outcomes;
- directed at imparting skills to clients so that they may be able to manage and guide their own independent problem-solving;
- reliant on processes of questioning and hypothesis testing and less on insight oriented methods;
- homework based in which most active therapy occurs outside of formal sessions and within the normal environment and context of the client;
- with a focus on education and demystifying around the nature, causes and remedying of depression and anxiety.

1.4 Non-traditional elements of treatment

Although the efficacy of CBT for depression and anxiety in both adolescents and adults has been repeatedly demonstrated in the research literature (see Nathan & Gorman, 1998), the process of treatment can bring with it elements and factors that are not typically addressed within CBT protocols but must be addressed or incorporated in order for CBT to be effective. The areas of resistance, transference and counter-transference, client characteristics, and personality traits are five broad areas that are often not given priority of consideration within a CBT framework but can be argued to have a notable impact on therapeutic process and outcome.

Different schools of therapy will view each of the aforementioned constructs
differently in terms of their place, value, meaning and positive or negative connotations within treatment. While other forms of therapy may view the presence of these phenomena as positive and necessary to therapeutic process, they often run counter to the easy and smooth administration of CBT and therefore could be considered in these terms to be obstacles to treatment. The criticisms of CBT in practice rather than theory which follow relate therefore to the inability or failure of strict CBT protocols to allow for, provide language to discuss, facilitate the understanding of, and offer methods for working with observed phenomena that occur within the therapeutic relationship.

In advance it is acknowledged that the degree to which each of these five areas is given credence and attention in practice will often depend on the personal approach of the clinician. Many CBT practitioners are able to integrate an understanding and method of dealing with these areas into their practice, and probably do. However, it is the experience of the author that, in terms of training, instruction, research and practice, for a young clinician these areas are often overlooked and discounted. Orthodox approaches to CBT are typically taught with little direction offered to incorporating alternate constructs. These ‘alternate constructs’ will be discussed in the following sections.

1.4.1 Characteristics of the client

Cognitive-behavioural techniques are best suited to people who have the capacity for
introspection and for reflection (Ellis, 1997). The particular task of challenging negative cognitions can be something of an intellectual exercise. This is especially so given that identifying and labeling particular thoughts, forming hypotheses and seeking out evidence to confirm or refute hypotheses in such a precise and deliberate way as is demanded by CBT strategies are skills that are not automatically practiced by many people. Such clients, who are less psychologically minded, less able to reflect and challenge their own thinking, and less able to engage in the intellectual task of weighing evidence to confirm or refute one’s own view will be less amenable to CBT. In fact, Albert Ellis, one of the most well-known and ardent protagonists of Rational Emotive Behaviour Therapy (a form of CBT) argues that these techniques are best suited to “YAVIS-type individuals- Young, Active, Verbal, Intelligent, and Successful” (Ellis, 1997, p. 57). Indeed, while such client qualities may be desirable for all forms of therapy to achieve optimal therapeutic outcomes, the heavy reliance of CBT on cognitive strengths and abilities makes this pre-existing attribute especially important.

Further, some clients are simply not able to grasp the cognitive-behavioural model because they are not able to distance themselves from their emotions and thoughts in order to view objectively the contribution that these are making to their depressive or anxious state (Klosko & Sanderson, 1999). This may particularly be the case in adolescents and children who are not always able to identify their mood or feelings clearly but can only report behaviours and more external manifestations of mood such
as "getting angry at my mum" or "bored with everything."

Similarly, certain clients can be myopic in their view of their own situation and life patterns and are unable to perceive their behaviour and the consequences of their behaviour more globally. This also presents a challenge to CBT techniques where general categories, broad underpinning beliefs and practices are identified and targeted in treatment. If a client is unable, or resistant, to viewing common themes and patterns rather than isolated, albeit recurrent events, it is unlikely that they would benefit from an approach that has this as a strong focus.

A treatment modality, in its most rigid form, whose very principles and techniques rely on such personal attributes of clients to be young, active, verbal, intelligent and successful in order to be most effective is restrictive, limiting and inappropriate for most mental health settings. Indeed Ellis himself notes that the application of cognitive techniques to individuals who are less educated, less psychologically sophisticated or less intelligent is a valid criticism of the theory and approach (Ellis, 1997).

1.4.2 Challenging Emotion with Reason

Some clients sense that cognitive-behavioural techniques do not affect them profoundly enough or touch them on a deep, intrapsychic and personal level that reaches their core. It could be argued that CBT is aimed at changing surface level
structures and manifestations of depression (such as symptoms and negative thinking patterns) but fails to make fundamental and enduring changes. There is something of a lack on the part of CBT techniques (particularly REBT) which aim to point out the errors of one’s thinking, to respond to deeper needs to be understood, heard, supported and contained as the individual searches and strives for their own resolution. Indeed, many people may not find comfort in being challenged to consider whether their fundamental beliefs are flawed. Even as patients learn to use and to adopt CB tools themselves, some express sentiments like “I know my thoughts are irrational and that I’m not really a bad mother because my behaviours are not consistent with being a negligent mother, but I still feel guilty and bad inside” (verbatim: client during individual treatment for depression, 2001).

One may question the merits of confronting negative emotion with reason in all cases. It is worthwhile to consider other circumstances in life whereby beliefs and emotions could be changed with logic and reason. Consider, for example, the person who, coming from a broken relationship, still feels in love and holds dearly to the belief that their former partner is the only person they can love. Confronted with logic and evidence that their relationship was dysfunctional on many levels is unlikely to touch or convince the person that they want to let go of the relationship and the belief that reconciliation could occur. On the contrary, when confronted with such challenges to emotionally laden beliefs, many individuals would be inclined to defend their view and moreover, rally reasons in support of their belief. Equally, to work towards
demonstrating to a client the illogical premises of their thinking by presenting them with Socratic dialogue and compiled evidence to invalidate their beliefs with the aim of altering their emotional state may not be what will affect a person deeply. Furthermore, when such techniques are not successful there is often a tendency to lay failing with the client as they are encouraged to “keep practicing” the techniques with the idea that change will come if only they persist, work harder, and come to accept changes in their thinking and feeling.

In response, where profound and enduring change do not occur, strong cognitive-behavioural supporters might be inclined to argue that the therapist has not succeeded in uncovering core beliefs but is operating on a more superficial level and failing to identify the appropriate automatic thoughts that channel to the deeper level of core beliefs. On a case by case assessment, it is difficult to determine whether therapeutic failures are attributable to inabilities or lack of motivation in the client to adopt or practice the techniques, whether the therapist is unsuccessful in guiding the client towards uncovering automatic thoughts and targeting core beliefs, or whether there is some fundamental lack on the part of CBT to go to the core of a person’s distress. It may be that CBT is an insufficient tool to affect change at a deeper level. To ignore or dismiss the feelings of clients that “there must be something more to why I feel so guilty” is to disavow the experience of that person and in so doing, fails to address the psychological and emotional needs of the client in a holistic sense.
1.4.3 The role of personality characteristics in impeding CBT for anxiety and depression

It is likely that many clinicians would attest to the view that some clients are difficult to work with using a CBT approach because of the predominance of certain personality traits that somehow impede or even sabotage effective treatment. These individuals may not be personality disordered, that is, they may not meet full criteria for a comorbid Axis II diagnosis but do nonetheless render the treatment of anxiety and depressive symptoms challenging due to their personality style. For example, it is the expectation of CBT therapies that clients will go forth and, with direction from the therapist, make necessary changes to aspects of their lives. Yet there are those clients for whom taking a proactive and assertive role in their own mental well-being and life circumstance is an enormous challenge. This may be apart from the complicating role of their anxious or depressed symptomatology and may well be the very reason they are experiencing emotional distress. CBT is likely to fail until these aspects of the person are worked on in treatment. As such, the notion upheld by CB therapists that most therapeutic work takes place outside of the treatment sessions (Beck, 1995) in the course of homework assignments may need to be paused whilst therapy aimed at altering some (for example) passive-avoidant, histrionic or perfectionistic practices is carried out in-session.

It can often appear as though personality traits act as a strong fortress in defending the individual against assaults on their self-esteem. In such cases, the process of
acknowledging negative or unhelpful thinking styles, observing problem patterns of
behaviours and interactional styles and challenging one's own beliefs is bound to
produce strong dissonance.

1.4.4 Issues of resistance

On entering therapy, most clients are likely to feel a degree of ambivalence. On the
one hand they seek symptom relief and resolution of problems that are causing
distress and dysfunction in their lives. On the other hand, this process of identifying,
exploring, discussing, and being exposed to core problems, beliefs and behaviours
can lead to anxiety and discomfort. When clients begin to feel discomfort at
therapeutic advancement, they will invariably begin to oppose the therapeutic process
in some way. Opposition often finds expression in various attitudes and behaviours
that in some way impede smooth, meaningful and effective therapy. This opposition
represents a push-pull within the client. Despite hoping for change, many clients
resist and fight to maintain status quo. This general state of being is understood to
form the essence of what is termed resistance in the psychotherapies (Arkowitz,
2002) and many theorists would agree that it is present in most therapeutic
encounters, if not all.

Some common categories of resistance identified by Arkowitz (2000) are: refusal or
failure to complete homework tasks that are encountered in cognitive-behavioural
work, conducting oneself in ways that are against agreed contracts made during
therapy, strongly expressed emotion towards the therapist such as open hostility, passive-aggressiveness or flirtation, avoidance during sessions such as refusal to answer questions directly, long silences, shifts away from important topics, and deviations from core issues and refusal to consider suggestions by the therapist or continuous rejections of observations or reflections made by the therapist. Arkowitz (2000) also identifies as forms of resistance, frequent relapses into previous ways of thinking or behaving when anxiety increases or new challenges are presented, repeatedly misinterpreting the therapist’s comments in a negative fashion, failures to attend sessions, arriving late to sessions continuously, not returning phone calls, terminating therapy prematurely, and an over-reliance on the therapist by attempting to prolong treatment and deny self-reliance.

There are major disagreements between the schools of therapy about what causes resistance, how to understand it, how to work with it and even what is being resisted (Arkowitz, 2002). The term ‘resistance’ in psychotherapy was first coined by Freud in *Studies on Hysteria* (see Streak, 1990 for review). He noted, “whatever interrupts the progress of analytic work is a resistance” (cited in Streak, 1990, p. 3). In dynamic terms, when clients cease to produce material in therapy and stop examining themselves, this behaviour is known as resistance. Resistance is not however, created by the therapeutic process, rather, therapy activates anxiety in response to which the client then employs habitual mechanisms to oppose both the therapist and therapy (Streak, 1990).
Freud's notion that resistance is used to defend the client against some painful or anxiety provoking material continues to be accepted in some form by many clinicians (Arkowitz, 2002). Most might also agree that resistances are stubborn, at times intractable, recurring, take many forms, and are invariably rationalised away by the client (Stern, 1990). It is perhaps because of the fact that the notion of resistance in therapy has emanated from psychodynamic writings that few other theories have given credence to the construct and have not acknowledged the process in the same way, perhaps to the exception of family systems therapists who acknowledge the inherent desire within families to maintain homeostasis (Jones, 1993).

Despite the school of thought that guides one's practice, at some point in a clinician's professional life they are likely to come across certain behaviours and attitudes in their clients that appear to disrupt, sabotage or lead away from core issues and the examination of intense emotions. It can be argued then, that while one may reject the notion of ego defenses and resistance as understood psychodynamically, many clients maintain a degree of ambivalence throughout treatment. This ambivalence represents in them the push-pull dilemma of whether to be treated and face difficult and painful fronts, or not to be treated and maintain the status quo of distress and symptomatology. The difference lies then in the manner in which resistance is dealt with and the language with which it is described and further, the degree to which it is given prominence. Resistance can take many forms and each individual is likely to
present with their own collection of resistances in the course of therapy. What they have in common is that they “either temporarily or continuously distract or detract from the process of therapeutic change, at the same time providing a potentially rich source of information about the client that can be used therapeutically” (Newman, 2002, p. 167).

Proponents of CBT do not typically speak in terms of resistance. Some may see it as a dubious construct belonging to the realm of Freudian and neo-Freudian theory with no place in contemporary, empirically based treatments. Others acknowledge that at times throughout the course of treatment, clients display behaviours that are counter to effective therapy but speak of these in terms of “therapy interfering behaviours” (Linehan, 1993). These tendencies are likely to be viewed in Behavioural terms and explained as avoidance behaviours that are engaged in by the client when confronted with anxiety provoking stimuli such as memories of past events, discussion of present situations and feelings, or examination of core beliefs. Many CBT texts, with some notable exceptions (see Newman, 2002) do not account for the sources of these behaviours or attitudes and do not query the reasons why a client avoids or sabotages exploration and treatment. To the inexperienced or unattuned therapist, resistances are likely to be seen as obstacles to be overcome as expeditiously as possible. Others however, will view resistances as “…an indicator of something important either in the client, the therapy relationship, or both” because “[w]hen people erect obstacles to personal change, they are doing so for reasons that are valid and important, whether
or not these reasons are available to conscious awareness” (Arkowitz, 2002, p.220).

Viewed not as obstacles, clinicians can attempt to work with resistances using them as indicators, sources of information around the individual’s core beliefs and issues, and avenues for targeting treatment.

To summarise, in criticism of CBT, it is argued that the phenomenon of resistance is often not given credence and does not provide language with which to understand and discuss the nature of this important construct. Clinicians are left without clear methods and directions for working with resistances and hence, fail in an important area of treating the client as a whole and in treating presenting problems.

1.4.5 Transference in CBT

Regardless of the therapeutic approach of the therapist, many would acknowledge that with each client a relationship develops. And further, many therapists would concede that the nature of this relationship and the responses of the client to therapy and to the clinician can leave an impression or can evoke certain feelings in the therapist. The ebb and flow, the nuances, the subtle changes and the overall relationship that occurs between client and clinician during the course of therapy is a topic that has been given much consideration in classical psychoanalytic writings and little in modern cognitive-behavioural approaches.

For analytic therapists the nature and moreover, the interpretation of the feelings of
the client expressed towards the therapist is the raw material of therapeutic action and the primary focus of therapeutic work and is termed transference (Blau, 1996). In classical psychoanalysis, therapists would aim to make themselves as neutral as possible in relation to their clients so as to present themselves as something of a ‘blank screen’, the aim being to reduce the likelihood of reactions of the client to the therapist allowing a more pure and freer flow of feeling from the client. In promoting the free-flow of feelings from the client to the therapist, it is assumed that the client is bringing forth into the therapeutic space, feelings and associations from the past, namely from childhood relationships with parental figures (Blau, 1996).

Further defined, transference is the “unconscious shifting to the analyst of feelings and fantasies that are reactions to significant others in the client’s past” (Blau, 1996, p. 113). The aim of traditional therapies is to identify, interpret and gain insight to transference so that the client is provided with the opportunity to understand the origins of their current problems leading on to reconstruction and the possibility of working through to therapeutic resolution (Stream, 1990). Theorists differ on whether to place this phenomenon under the category of transference or whether to relate to it as simply the nature of the relationship that unfolds and occurs between therapist and client without ascribing it any particular importance. Generally however, while working with transference is central to psychoanalytic work, cognitive-behaviourists typically give this process limited weight beyond acknowledging that a certain relationship exists with a client.
As with discussion of resistance, although emanating from dynamic works, transference can also be discussed in broader terms and the main assumptions can be summarised without adherence to any one particular school of thought. The basic premise that underlies transference is that each of us brings with us a history of personal experience, emotional interactions, intimate relationships, situations and beliefs that guide our present interactions and relationships. Situations and interactions that have left and indelible mark on us are carried through to the present. Within the therapeutic relationship these same relational tendencies are expressed by the client towards the therapist. While this may be the case, the question remains as to whether there is any therapeutic value in identifying transference, and if so how to make use of it in treatment.

Orthodox adherents to cognitive and behavioural therapies may claim that the mechanisms of change operate independently from the therapeutic relationship between therapist and client. It is proposed however, that being mindful of transference, addressing transference and working with the client on transference issues can be productive and meaningful, and does not need to exclude or eliminate the use of CBT. While what one does with the transference relationship will differ between psychoanalytic and cognitive-behavioural therapists, the information that is provided by observing and attempting to understand the way in which a client behaves and expresses themselves towards the therapist can enhance and promote
good clinical practice. This may be indicated more with some clients than others but can give an important understanding as to the way in which the client conducts themselves in relationships, what needs they struggle to have met in their lives, and what may be preventing them from attaining goals in life.

1.4.6 Counter-transference

A transference relationship between client and therapist can often ignite particular feelings and responses from the therapist towards the client. Therapists too, bring with them experiences from the past that colour their present interactions and relationships with people. Therapists too, will project feelings and attitudes onto clients in the same way that clients do to therapists. The reaction of a therapist to a client is known as counter-transference (Strean, 1990).

Objectivity is one of the qualities that is expected and developed in all treating clinicians regardless of their particular theoretical orientation. When counter-transference reactions are such that they interfere with this objectivity, the capacity to empathise, or the ability to maintain appropriate boundaries, it is important for the clinician to acknowledge and act to change or work through their reactions to the client. It would be a mistake however, to assume that all reactions to a client are counter-transference reactions and similarly, to assume that all responses of the client to the therapist are transference reactions. The responses may be true reactions to current aspects of the therapeutic relationship and may not be representations of past
relationships. A client’s anger towards a therapist may well be a function of the therapist’s behaviour and not related to transference issues. The goal then, is to identify which feelings and responses belong to the client and which to the therapist—that is, which feelings are direct and reasonable responses in relation to a client’s behaviour and which emanate from the therapist’s own conflicts and relationships outside of the therapeutic relationship.

Again, a cognitive-behaviourist may question the benefit of integrating thought and practice around counter-transference into their clinical work given that it is held that the mechanisms of change do not lie primarily within the therapeutic relationship but with the independent techniques indicated by the theory (Ellis, 1997). The reaction one has to a client can provide important information to understanding the world and machinations of the client. If a therapist reacts with irritation to a client, they may use this response to inform them about how other people may react to the client and may highlight a relational pattern of the client that is impeding their progress and change. In this way, counter-transference can be seen as a potentially useful tool in any clinical work, including CBT.

1.5 Conclusion

Cognitive-behaviour therapy is currently the psychological treatment of choice for anxiety and depressive disorders (Nathan & Gorman, 1998). Given the efficacy of
CBT in treating anxiety and depression that has been amply demonstrated in the research literature, one could be led to believe that CBT is always indicated and smoothly applied to any client. While CBT may still be the best available tool at present for treating anxiety and depression, there are limitations and obstacles to its smooth and effective delivery.

Often, theorists and research clinicians do not examine the various obstacles to CBT in practice, perhaps because they are not well-defined constructs that are easily quantified. Furthermore, concepts such as transference, counter-transference and resistance that have their roots in psychodynamic theory are not given credence in modern writings and are rejected along with the theory and practice as a whole. This may be to the detriment of clinical practice where therapists invariably experience these phenomena in their work and are ill-prepared to know how to deal with and integrate these aspects into their cognitive-behavioural practice because many are not trained to recognise and manage them. What is more, clinicians are often without language to discuss these phenomena and to identify them during the course of their cognitive-behaviourally oriented work. In so doing, many are left without a clear framework for making sense of them. Ignoring the impact and importance of these experiences in clinical work can mean ignoring a valuable source of information about a client’s interpersonal relations, current life problems and their world view, all of which are important and targeted aspects of CBT.
It is argued then, that particular relational elements are present in CBT work as much as any other form of therapy. These relational elements are not often acknowledged in theoretical and clinical writings. Secondly, that they are not acknowledged invariably means clinicians who are CBT trained are left without guidance or a framework with which to understand and work with these phenomena and to integrate them into their therapeutic practice. It is argued that this is to the detriment of clinical work as whole and to clients and practitioners. A model of CBT in which transference/counter-transference and resistance are acknowledged and incorporated would enhance therapeutic practice. Finally, an examination of the obstacles to CBT with regard to personality variables could allow for the broadening of CBT to include other therapeutic modalities, such as psychodynamic, family systems therapy, and person centered therapy, which may better facilitate therapeutic change.

In the following chapters, four cases are presented with the aim of illuminating these points further and offering potential solutions to integrating CBT with alternate therapeutic strategies. Chapter two describes the case of PL, a 16 year old male, who presented with narcissistic personality traits that posed a challenge to treating his anxiety and depression using a standardised CBT formula. Chapter three describes the case of MD, a 17 year old female for whom issues of transference were prominent within treatment; effecting the therapeutic process and possibly the outcome. Chapter four presents the case of FW, a 42 year old women with Factitious Disorder and depressive symptomatology who evoked strong counter-transference issues in the
therapist. The case of FW allowed for the examination of clinician reactions to clients and the ways in which observation of these reactions could be useful within treatment. Chapter five presents the case of SY where cultural factors made her unamenable to a strict CBT formula requiring the inclusion of alternate elements in treating her social anxiety and depressive symptoms.
CHAPTER TWO

The case of PL

PL was a 16 year old young man of Australian/European background who presented with anxiety symptoms, several depressive symptoms, and some unusual behaviours reminiscent of a psychotic disorder. PL came from a family background of depression and anxiety and he struggled with peer relations. He held certain personality traits that made it difficult to progress in CBT work with him during the course of his treatment. The following case history is presented with a formulation and discussion of his treatment and obstacles during its course.

2.1 Reason for referral

PL was referred to a youth mental health service by his Year 9 coordinator who reported that PL was displaying some odd behaviours such as asking fellow students about the Ten Commandments despite having no religious background himself. He also tended to have unusually strong interests in topics such as U.F.Os that would preoccupy him to the exclusion of academic requirements.

2.2 History of presenting problem

PL presented to the service with a 12 month history of anxiety and depressive symptoms characterised by amotivation, disturbed sleep pattern, irritability, low mood and feelings of hopelessness and helplessness occurring every day, for most of
the day. He also described panic-like symptoms such as increased heart rate, shallow, rapid breathing, sweaty palms and racing thoughts.

PL also reported having difficulties at school, feeling unmotivated and unable to concentrate such that he had fallen behind and was at risk of failing. PL was quite concerned about not doing well at school and would become preoccupied with the chain of events that might follow, namely, that he would not get a good job and would not be able to get married and support a family. He considered this would be a “failure”.

Reports from teachers indicated that PL would often spend inordinate amounts of time researching topics of his own choosing on the Internet. Over recent times he had become interested in UFOs and then moved on to Viking history. PL would write essays on these topics that interested him instead of those that were expected by teachers. He would hand in these essays in lieu of work that the rest of the class was doing and would seem disappointed and thought it unreasonable when he would either fail the assignment or be asked to do it again. PL would also tend to write extremely long essays with the belief that he would be exempt from completing the next assignment given that he had worked so hard on the first.

Collateral history from family suggested an overall change in PL’s functioning and behaviour dating back five years when the family moved house. This move resulted
in a change of school for PL and a loss of childhood friends. PL found this very hard and used to cry every morning as he missed his friends and old school. PL’s parents were very protective and did now allow him to socialise outside of the home. He was never interested in sports. PL reported that after the move he was allowed a little more freedom in that he was allowed to walk to school on his own. At the time of treatment, he was not allowed to catch public transport on his own and did not often go out with friends but saw them at their home. From age 13 he began to increase his level of socialisation however he claimed that he had “always been picky about friends”. He believed his chosen friends were the kinds of people who were also very curious about extra-curricular topics and were very intelligent and capable people.

2.3 Past psychiatric history

PL reported no previous psychiatric treatment although he had been seeing the school nurse for counselling over the past two months, which he found helpful.

2.4 History of substance use

PL had not experimented with any type of recreational drug including tobacco. On asking about his drug use he seemed amused and balked slightly at the suggestion that he may have tried marijuana or alcohol. PL believed that this type of activity was “beneath” him and he had no desire or need to experiment and could not imagine himself associating with anyone who would use or sell drugs.
2.5 *Past medical history*

No significant medical events had occurred during PL's life.

2.6 *Family history*

Separated 1999

![Family Tree Diagram]

PL reported to have a close relationship with his father, a maintenance worker, who continued to be involved in the lives of the family members despite being separated. He would spend quite a bit of time at the family home and would often take PL's younger sister out after school. Each time PL was phoned at home by his case manager his father was there, despite not living in the house any longer. PL's father was living with his parents, PL's paternal grandparents, and PL himself would often spend time there also.
PL's mother was a 40 year old homemaker who had not been employed since PL was born. She had a long-standing history of anxiety and depression treated with medication over 16 years. PL described his relationship with his mother as “distant” and detached. His mother would spend as many as 12 hours a day on the Internet. PL complained that at night she would play loud music, which PL said would interfere with his study and sleep.

PL's younger sister missed six-months of kinder during the period that her parents were separating as she refused to go and her mother was happy to let her stay at home. She had since missed a lot of school also and her mother was not insistent that she attend when she really didn’t want to. PL spoke fondly of his little sister and would take her to the park after school. He described himself as self-sacrificing and benevolent in doing this but stated that he didn’t expect any thanks from his parents because it was just in his nature to help out where he could. He explained that he was the kind of person who would do things for people he cared about, but only those he thought deserved it.

When PL was 7 years old his maternal uncle, with whom he was very close, had a motorbike accident. He was in a coma and was in hospital for almost a year. During this period PL missed a lot of school and consequently had to repeat Grade 4. According to PL, having to repeat Grade 4 was “traumatic” and his uncle’s accident
“devastated” him and he believed that event had a profound impact on him and formed his outlook on life.

2.7 Mental Status Examination (first meeting)

PL arrived early for his initial assessment interview in the company of his mother. His mother did not drive so his father had driven them both to the appointment but dropped them off outside and left to run errands. PL presented as a slightly overweight young man of average height. He was appropriately dressed according to age, gender and the weather, in shorts and a shirt and a large silver chain around his neck. He appeared nervous as he sat agitated and jiggling his leg. He sat upright but made little eye contact as he looked ahead when he spoke. Despite appearing uncomfortable, PL was not verbally reticent and was keen to express and explain himself. He spoke in a slightly pedantic and stilted manner using unnecessarily large and expressive words that he would sometimes use inappropriately. His speech was fluent with normal rate, tone and volume.

PL denied any perceptual disturbance and there was no evidence of formal thought disorder, obsessions or delusions. He was alert, oriented and maintained good concentration throughout the interview. PL displayed certain personality traits throughout the interview that could best be described as narcissistic. For example, despite the fact that he had not been performing well at school, PL was not willing to acknowledge that he had difficulties with the work itself or that he needed extra help.
Rather, he reported that the teachers were not very good. Furthermore, although PL admitted to worrying and to some anxiety symptoms, he denied being unable to manage this, despite the fact that he had presented for treatment. Instead, PL suggested that it could be useful to learn some techniques to cope with anxiety should it ever happen to him “properly”. When PL spoke of his peer relations he described himself as not having many friends because he was “picky about people”. PL explained that he preferred to spend time with people who were intelligent and curious, like him, and not many people were like that and so he preferred to be on his own. PL would also tend to use elaborate explanations and complex words that were not typical of an adolescent. PL appeared to want to present himself as highly intelligent and articulate and was scornful of other adolescents at the service who he saw as “not as capable as you or I might be”.

2.8 Formulation

PL was a 16 year old young man who was living with his mother and his younger sister. He presented with a twelve-month history of anxiety and some depressive symptoms such as rumination, irritability, and decreased concentration and memory. Of primary importance to PL was his worry around school work and not being able to get homework done on time.

Predisposing factors for PL included his mother’s 16 year struggle with depression and anxiety. PL described his mother as someone who worried a lot and also
described their relationship as “distant”. Her anxiety impacted on PL significantly in that she worried about what might happen to him. Previously, she would not allow him to go out of the house alone but PL reported that this was no longer a problem. However, this no doubt restricted his ability to socialise with friends in the past and potentially impeded his social development.

When PL was 7, an uncle to whom he was very close had a motorbike accident from which he suffered a coma. PL reported that he was “devastated” by this and believes that the impact of this event was so profound that his “view of life started here”. He missed a lot of school during this period and as reported by PL, had to repeat Grade 4 due to this. The precise reason for PL missing school is unclear but it may be speculated that PL experienced significant anxiety around this event and preferred to stay at home with his mother who was happy to allow this. PL may have felt the need to be near her to alleviate his own anxiety despite the fact that he described his mother as “distant” and “anxious”; a need, which perhaps also met his mother’s need.

At age 11, PL and his family moved from one suburb to another. PL found this very hard and reported crying every morning as he missed his friends and school. This may have provoked an anxious reaction in PL and led to some separation anxiety.

Precipitating factors for PL include his parents’ divorce two and a half years ago.

PL’s parents had difficulties in their relationship for 3-4 years following the move, during which time there was a lot of arguing and stress within the family. PL’s father
continued to spend time at the family home and was still very involved in their lives. PL felt that their separation had a very strong impact on him and held strong views about marriage and families. He believed that if a person decided to marry someone, and they had children, they should stay together no matter what and should make every effort not to argue so as to keep the family together. Without voicing any direct criticism towards his parents, he stated that he did not understand how someone could have children and then leave. He, on the other hand, would stay with his wife no matter if he loved her or not and was very decided on this topic.

PL felt that his low mood over the past six to twelve months was primarily due to anxiety about failing Year 9. He described trying hard at school for several years until this year where he began to feel the work was more difficult and he was having trouble completing it on time. PL also admitted to handing in assignments on the topic of his choice rather than that which is asked of him. He also reported not doing his homework at all which may have been related to a fear of failing that he had expressed. He was unable to offer any clear explanation for why he was unable to complete his homework other than that he would get “stressed out” and felt overwhelmed by it. He described feelings of guilt related to his poor performance at school.

Perpetuating factors for PL included his mother’s anxiety which potentially fostered anxiety in PL and did not provide a balanced and strong support for him from which
to manage his own anxiety. PL also appeared to display some strong narcissistic traits, which may have been both perpetuating factors in his anxiety, but also protective in that they at times shielded him from potentially stressful experiences.

For example, PL seemed to have an inflated view of his academic capabilities, which did not appear to match his level of academic achievement. This was despite reports from school that he was an average student who appeared to struggle with the work. PL’s anxiety may also have been perpetuated by his study practices. He preferred to study his own material and would spend a lot of time researching various topics of interest such as Viking history and U.F.Os. It may be suggested that many of these behaviours were avoidance strategies that prevented PL from performing well at school and in so doing served to maintain his inflated perception of his academic abilities when poor grades could be attributed to other causes. Also, when PL presented for the first treatment session he reported that things were going well for him and his reason for attending the session was to let the treatment staff know how he was going and to keep them informed for their benefit. This appeared to be more acceptable to PL than to express a need for help.

Protective factors for PL included his willingness to attend for treatment and his acknowledgment that he could see some benefit in it. He was amiable, polite, and cooperative. PL also thought about things between sessions that had been said in treatment, demonstrating that he was engaged in therapeutic work to some degree. PL’s narcissistic traits could at times be protective for him. His inflated view of his
own abilities may have provided a buffer against anxiety-provoking situations and potential failures that may have exacerbated his low self-esteem. These same traits also provided him with the sense that he was capable of achieving. PL's father also appeared keen for PL to attend for treatment, despite difficulties in bringing him regularly, and he believed that counselling had helped him in the past. Support, at least in principle, from his father with whom he had a good relationship may have served as a protective factor.

In summary, PL was a young man who had a history of anxiety and some depressive symptoms. Although PL described himself as always having been a “worrier” and having come from a highly protective family environment with a mother who also suffered from a long history of anxiety and depression, it appeared that his current concerns are precipitated by the separation of his parents and the changing family system that this had brought. PL also had a strong fear of failure which he suggested may have developed when he was forced to repeat Year 4, something he described as “traumatising”. PL worried about not doing well at school and held fears of not being able to find gainful employment with which to support a family. This concern carried with it the implicit notion that he would be alone if he were not able to provide well for a family in the future. PL did not socialise well. Although he described himself as “picky” in his selection of friends, his slightly odd manner and his highly protective family may have stood as barriers to his social functioning.
2.9 DSM-IV Diagnosis

Axis I: 296.21 Major Depressive Disorder, single episode, mild type.
300.02 Generalised Anxiety Disorder

Axis II: Diagnosis deferred on Axis II

Axis III: No diagnosis on Axis III

Axis IV: V62.81 Problems with Primary Support Group

Peer Relations problems

2.10 Treatment

Although it seemed that there were several areas of PL’s functioning, including family and interpersonal relations, that could be considered for treatment, he identified his main concerns at the time as being worries about failing Year 9. He also felt that he would like to learn some anxiety management techniques to help him to become less stressed over things and to cope better with his anxiety, even though he believed his anxiety was not “as bad as other people’s”. While this approach seemed restricted given the perpetuating factors of his mother’s anxiety and depression, difficulties with peer relations, and fixation on certain areas of interest outside his academic requirements, there were several justifications for focusing primarily on anxiety management. Firstly, PL’s father was very reluctant to bring him to the service as this required him to take several hours off work in the afternoon. As a low-income family this was a concern. Secondly, PL was often unwilling to concede difficulties in other areas. While to the therapist it appeared that poor peer relations,
family difficulties, social skills deficits, and lack of support were also primary concerns that exacerbated and contributed to a general decline in functioning and ability to cope, PL would assert that it was really only help with anxiety management that he needed.

It was planned that CBT for anxiety and depression would be the treatment of choice for PL. Using a treatment manual, the CBT model of anxiety and depression was presented to him. PL appeared to understand the concepts involved in the CBT approach and seemed to grasp the interaction between thoughts, feelings and behaviours. Given PL’s significant narcissistic personality traits, which were not sufficient to reach criteria for diagnosis of Narcissistic Personality Disorder (APA, 1994) yet still prominent, this treatment plan was rendered less straightforward and less likely to be effective than if he had only an Axis I disorder (Beck & Freeman, 1990).

PL would often refute suggestions that, for example, his worries about seeking help from teachers were related to a fear of being negatively judged and thought of as incapable of doing the work or as not very bright. Instead, he felt his worries around this matter were related to the fact that teachers weren’t very able themselves but were in a position to determine his future and this caused him concern. PL was reluctant to concede any core beliefs around feeling like a failure or lacking confidence in himself and his abilities despite indications that he did have difficulties
in managing his work. His anxiety around this matter alone was strongly suggestive that PL held fears of failing due to his inability to cope with the work. However, his narcissistic traits both protected him and prevented him from accessing core beliefs or underlying anxieties around his own level of competence and ability.

With regards to PL’s depressive symptoms, he believed that these only occurred in the context of anxiety around his school work. It was thought by the therapist that PL’s depressive symptoms extended to more profound aspects such as his parents’ separation, the distant relationship with his mother and the lack of support he received, the enormous amount of pressure he felt from his father to do well at school, and his fears of not being able to achieve at school and later in employment. PL was unwilling to concede or to seriously consider the impact of these events on his thinking and feeling, despite having identified them as problem areas previously. Again, PL’s narcissistic traits prevented him from being receptive to suggestions that he did not generate himself or that would place him in a situation of weakness or vulnerability. When PL was willing to generate hypotheses himself around what factors were impinging on his well-being, he was only able to discuss them guardedly and without deep insight. When the therapist suggested the very same factors as those suggested by PL, they were refuted by PL. It appeared that for PL to explore any thoughts or beliefs, he would need to produce them himself. Furthermore, despite describing a number of symptoms that were suggestive of dysthymia if not a depressive episode, PL denied being depressed. When PL first entered treatment after
several weeks lapse following his initial assessment and hand-over between case
managers, he reported that he was no longer depressed, although he might have been
before. When asked why he had chosen to attend for treatment, given that he believed
he was neither depressed nor particularly anxious at present, he explained that he
thought we, the treatment team, were probably interested in how he was going. He
decided to return to let us know where he was up to and what was going on for him
for our own benefit, just to keep us informed.

PL was always ready to align himself with the therapist. He liked to highlight the
"expertise" of the therapist and to suggest that contributions made were valuable and
guided by a wealth of wisdom, even if he did not choose to take them on board.
Again, PL's narcissistic traits were difficult to penetrate to allow access to thoughts,
feelings and beliefs. He also liked to make mention of the therapist being a
"professional" and "expert" or "very intelligent" and would often comment that it was
nice for him to be able to have a conversation with someone like that for a change.
This tendency to identify with and to value those in positions of relative authority or
of certain status is an aspect of narcissism (APA, 1994) that was evident in PL.

2.11 Evaluation of treatment

Overall it could be said that the treatment goals outlined by PL together with the
therapist were not achieved. There are several reasons why this may have been the
case. Firstly, PL's attendance at sessions was intermittent and unreliable. This was
due to his father's reluctance to drive him to the service and to commit to regular, weekly appointments. PL was positive about his contact with the service and seemed to engage well with the therapist. He appeared to enjoy having someone to talk to and share his ideas with, even though they often deviated from the treatment plan. Because of the lack of regular attendance it was difficult to make steady progress with PL.

Secondly, PL had an unusual habit of refuting suggestions put to him by the therapist, including suggestions that something made him feel sad, depressed or angry but would instead put forward the same idea himself using slightly different terminology. It seemed as though PL needed to generate these ideas himself and was reluctant to concede very much. This pattern was not overtly obstructionist but instead seemed to form part of his narcissistic style whereby he saw himself as different to other people and more intelligent and preferred to be defined uniquely. For example, when asked whether he had ever experienced a panic attack or anything similar such as feeling really anxious with an increased heart rate, sweaty hands, tingling sensations, and rapid breathing he proclaimed that “no, I’ve never had anything like that. I’m sure other people do but I haven’t. I do sometimes feel like I can’t breath properly though and I get a bit trembly and feel really nervous and I worry a lot”. Arguably, the symptoms proposed by the therapist were the same as those nominated by PL but he was reluctant to concede and preferred to propose his own descriptions.
2.12 The role of narcissistic personality traits in treatment outcome

PL displayed some strong narcissistic personality traits that made CBT unlikely to be effective. PL often preferred to spend treatment sessions discussing interesting ideas or topics that he believed most people he knew wouldn’t be equipped to understand. He enjoyed what he considered intellectual discussion and seemed to align himself with the therapist and with others in positions of relative authority. He often felt that teachers weren’t able to comprehend or to handle situations well and this he cited as the reason for part of his difficulty at school and his fear of failing. It was not, he reported, because he worried that he wasn’t able or because he struggled with some aspects of the work. Instead, it was because teachers wouldn’t explain things properly, wouldn’t accept his assignments written on topics other than that which was asked of him, and wouldn’t provide sufficient time. He worried that they had the power to determine his future and this is what made him anxious. He denied that he felt any sense of concern that he might not be able to manage the work or that his anxiety was related to beliefs about his own ability to achieve, fear of being evaluated negatively, or being thought of as “dumb”. It was difficult to penetrate these narcissistic traits to access core beliefs or to even discuss the possibility of personal fears and anxieties. In this way, PL maintained inflated views of his own abilities and defended against blows to his self-image.

The case of PL illustrates how particular personality styles, or traits, may act as impediments to CBT. Adhering to a manualised treatment protocol with PL proved
ineffectual as his narcissistic style precluded him from examining his own fears and anxieties and acknowledging negative core beliefs. This was despite the fact that he demonstrated an understanding of the CBT model and was able to discuss its premises and concepts. It is difficult to estimate what kind of therapeutic work would need to occur either in tandem or as a precursor to CBT with PL but, suffice to say that his particular presentation and personality did not conform to the smooth administration of CBT for depressive and anxious symptoms.
CHAPTER THREE

The case of MD

MD was a 16 year old female of Anglo-Australian background who presented to a Child and Adolescent Mental Health Service out-patient clinic feeling suicidal and depressed. She had a history of emotional disturbance since the unexpected death of her mother five years previous. Since this time MD had developed an increasingly conflictual relationship with her father with whom she lived. She felt alone in the world and rejected by all those around her.

3.1 Reason for referral

MD was referred by her school welfare coordinator (SWC) after disclosing to him that she felt suicidal and had self-harmed by superficially cutting her wrists with a razor blade. The SWC felt he was not able to manage MD’s escalating distress and behaviour and also felt that some kind of family intervention was needed.

3.2 History of presenting problem

MD described the onset of symptoms when her mother died. On the morning that her mother was to be admitted to hospital for a routine procedure, MD had argued with her over getting ready for school. Her mother’s medical procedure had resulted in sudden and unexpected complications that left her in intensive care for three weeks.
During this period MD had chosen not to visit her mother and had avoided visiting her on every occasion. When her mother died, MD did not attend the funeral and her father believes that she has not grieved openly or "properly". MD had had a very close relationship with her mother and had never spent the night at a friend's place or gone on school camp as she had not wanted to be apart from her parents. This was never considered to be a problem by school or family but rather she was simply deemed to be a "clingy" sort of girl who liked to be close to her parents.

Over the past six months, MD had become withdrawn, irritable and according to her father "a complete bugger to get along with". Her relationship with her father was also a source of considerable and on-going stress and sadness. Since her father had entered a new relationship with a woman that MD could not tolerate, she felt he had disassociated himself from the family and from her care. According to MD, her father began to neglect her needs, often leaving the home for days at a time and not bothering to ensure that there was food in the house or that MD was able to get to her casual work on time. As they lived in an isolated area with limited public transport, MD was often late for her shift at a fast-food restaurant and could not rely on her father to arrive home to take her or pick her up.

Although she continued to go to school, MD found it impossible to concentrate and most of her work over the past six months had been handed in late or not at all. Consequently her grades had dropped over this period and she struggled more and
more to meet demands. Relations with her friends began to suffer as she tended to over-burden them with her low mood and would become very irritable when they did not meet her heavy needs for support, attachment and affirmation. More and more, MD's mood declined until she felt she couldn't cope, couldn't function properly, and wished she were dead. MD described feeling suicidal at least three times a week. She reported that although she didn't have a plan in place she spent a lot of her time thinking of ways she could kill herself if she wanted to.

3.3 Past psychiatric history and intervention

MD had regular contact with her school counsellor over a twelve-month period but would often become annoyed with him when he was not available to see her on call or would somehow not meet her needs, leaving her feeling rejected. Because of this pattern of engagement, the school counsellor reported contact had been intermittent and on-going work had been difficult to maintain. He no longer felt he was able to manage her suicidality and fluctuating moods and requested clinical intervention.

MD had a previous episode of care three years prior following a series of fainting spells that occurred at school. Neurological assessments could not find any evidence of organic problems and it was suggested by the school that she seek psychiatric help for what they considered to be a grief reaction. MD had not engaged with the service at this time and following several missed appointments was eventually discharged without having received on-going intervention.
3.4 Substance use history

MD reported that she occasionally drank alcohol with her friends and had become drunk on several occasions. She reported that she had never blacked out due to alcohol nor had she ever been unable to remember events from the night before after drinking. She did not smoke cigarettes or marijuana and reported no other illicit drug use and was not keen to experiment with other substances.

3.5 Medical history

When she was 14, MD experienced a series of “spells” that resembled seizures. She was found to have experienced a mild form of epilepsy that was not considered to be severe enough to warrant preventative medication. MD felt that she was able to monitor when she was about to have a seizure and felt she could manage herself well in that situation. Medical examination determined that the previous fainting spells that had precipitated her last episode of care were not seizures and were unrelated to her epilepsy.

3.6 Family history

MD lived with her father in an outer area. MD had an older sister whom she had never really got along with. MD’s father believed that her sister was the main protagonist in their conflictual relationship and that she had always been a difficult child where MD had been easy and well behaved. Twelve months earlier, her sister
had moved out of the home with her boyfriend and their new baby, leaving MD and her father in the family home.

3.7 MD’s father, JD

MD’s father was a 47 year old man with an older brother with whom he had little or no contact. His mother, who was very elderly, lived nearby but he felt as though she was of no support during difficult times as she was so elderly and unable to relate to or understand their struggles. JD worked casually as a security guard. Two years ago he had suffered a fall whilst at work and had damaged his back preventing him from working at times. When he was debilitated he would become irritable and frustrated. The family was of low income and he was often concerned about money. Six months previous he had begun a relationship with a woman, the first since his wife died. As MD detested this woman the climate at home would become very tense when she was around and JD would feel stretched between the two women. According to MD, he “always” sided with his partner and left his daughter to be ridiculed and insulted by her. MD felt that he had come to neglect all his duties as a father, spending days at a time at his partner’s place and not returning to check on MD and failing to leave her money for groceries. This situation was markedly different from the childhood she had known when her mother was alive.

3.8 MD’s mother, LD

Little was said about LD other than that she and her husband shared a good
relationship and loved each other. MD had been very close to her mother and as a child would only go to her. LD had been reluctant to have other people care for her daughters and so had chosen not to work outside the home. LD grew up inter-state where her extended family and her family of origin remained. When MD was younger the family used to take trips to spend Christmas with the family and MD had very fond memories of these times being surrounded by uncles, aunts, cousins and grandparents.

3.9 Genogram
3.10 Developmental history

MD remembers a comfortable and happy childhood where she was close to her parents. She had always fought with her sister and this had only worsened over the years. MD was considered by her parents to be the “good one” who was easy to manage and get along with in contrast to her sister who was often provocative and irritable and unpleasant to be around. According to her father MD was always “clingy” and he believed that they were partly responsible for this as they wouldn’t allow others outside of the family to care for their children. She achieved all milestones within a normal period and did not display any early difficulties in learning or socialising.

MD remembers pre-school and school being good experiences but had some difficulty in Grade 5 with a teacher she didn’t like. Having grown up in the one place MD had a group of friends she considered close and could name one or two best friends. She also played in a sporting team, which was one of the few activities she still enjoyed, and also worked a part-time job and was doing well there. She had made some friends from work and had also been successful in entering a program with her place of work at a fast-food restaurant that allowed her to gain accreditation points that would go towards her final year high school certificate (VCE).

3.11 Premorbid personality

MD described herself premorbidly as an out-going and happy person who had good
relations with her friends and her parents. She felt she could always make her friends laugh and was fun to be around. Academically she was average but worked hard and achieved her goals. She had not been oppositional as a child and got along well with teachers although they too had described her as being somewhat over-attached and tended to rely on them more than most students her age.

3.12 Mental state examination (first meeting)

MD presented as a heavy young woman of Anglo-Australian appearance with long blonde hair and dressed in school uniform. She appeared tired but was co-operative and did not show signs of shyness or anxiety. She spoke with a loud voice and tended to laugh a lot, somewhat inappropriately, which was incongruent with the mood she described and the hopelessness she felt. MD would often give flippant, throw-away remarks such as “it’ll all be good” and “oh well” which made it difficult to maintain a tone of seriousness and genuineness during the assessment. MD would also present as somewhat immature as she giggled and used sarcasm in an attempt at humour to deflect away from difficult topics and to appear casual and at ease. MD arrived for her first meeting accompanied by her father. She presented at the out-patient service in crisis having told her father and school counsellor that she wanted to die and was planning to kill herself. At times, when her father spoke about her difficult behaviour at home she would roll her eyes and was deeply resentful of the way she believed he presented himself as a caring father when in reality, she believed he neglected her at a
crucial time.

There was no evidence of delusional thinking or perceptual disturbance. MD did not report any specific anxieties or phobias. She did not report any homicidal ideation but did express suicidal ideation and confessed to some self-harm behaviours on several occasions over recent months. With regard to insight she was able to recognise that she was very unhappy and had changed from her usual self in this respect but was either unwilling or unable to identify her own feelings of rejection, abandonment and loneliness in her current situation. She did not want to talk about her mother’s death nor about the fact that she had not visited her in hospital nor attended her funeral.

3.13 Formulation

MD was a 16 year old girl living with her father who presented with significant depressive symptoms including suicidal ideation. MD’s presentation seemed to be precipitated by several factors. Firstly, MD tended to rely heavily on support from her friends at school who were usually keen to listen to her troubles and to sympathise with her. Recently however, MD’s friends had begun to grow tired of her moodiness and her tendency to over-burden them with her problems. One of her close friends had told her that she needed some time away from her because she needed to take care of herself, as MD was starting to impact on her negatively. MD took this very badly and felt rejected and unsupported. MD’s relationship with her father had been deteriorating over recent months with the involvement of a woman with whom JD
had begun a relationship. MD resented the presence of this woman in the home and resented the amount of time her father would spend with her. The more acrimonious her relationship with her father’s partner, the more her father spent time away from the home leaving MD to look after herself. Both these events left MD feeling alone, rejected, unsupported and depressed. Also, as her mood deteriorated, so too did her concentration and motivation with her school work. Her grades began to suffer where previously she had been an average but motivated student. This was further cause for stress and worry as she felt unable to cope with the demands and to keep up with what was required of her.

MD seemed to have a long history of separation anxiety and over-attachment. Her father described her as always having been a “clingy” child who wouldn’t go to anyone else. By the age of fourteen she had never spent a night away at a friend’s place and preferred to be at home with her parents. Despite this, MD was not a retreating girl but was quite loud and vibrant. She had a group of friends and seemed to socialise well at school and also at her part-time job and with her sporting team. Nevertheless, she seemed to depend heavily on relationships with others and was not able to tolerate separation well, particularly from her family.

The impact of her mother’s death on MD could only be gauged by the subsequent decline in her functioning. Although MD did not outright refuse to discuss her mother’s death she gave the impression that she did not want to talk about it or its
impact on her. It was difficult however to appreciate the profound sense of loss she still felt over her mother's death and the heavy grief she carried. Further, her mother's death came at a time when she was individuating and beginning to find her place in the world. Given this enormous loss, it could be suggested that her mother's death carried with it a loss of security and guidance at a crucial time in her life.

Perpetuating her depressed mood was the fact that MD's relationship with her father was worsening as he became more and more resentful towards her of her interference in his new relationship. As this situation continued, JD became more verbally aggressive towards MD and the climate of tension and animosity in the household increased. This made MD feel more isolated, more alone and deeply hurt and rejected by her father. Also, MD struggled with a number of day to day situations that made life more difficult for her. She worked a part-time job, the meager income from which she relied on to pay for her internet costs, her school lunch, her bus fares and other small expenses. As her father spent longer periods away from the home and was often unable to be contacted because he turned his mobile phone off, MD would be forced to miss shifts and would have great difficulty finding a way to get to and from work at late hours. As she lived in an outer area which was not at all well serviced by public transport, this was an ongoing problem that caused her significant stress and anger. Similarly, MD complained that her father would spend money on his new partner and had become less and less reliable in providing for her basic needs. She complained that often there was no food left in the house and JD would not leave her
money to buy groceries or make himself available to take her shopping for food. MD reported that she would sometimes not eat at all for this reason. These difficulties exacerbated her stress and served to make her feel uncared for and unsupported at a time when she was most in need.

Protectively, MD was a warm and bright person who would laugh a lot, although at times inappropriately to mask anxiety or embarrassment. Despite feeling unable to manage her situation, MD was quite resourceful and had succeeded in caring for herself, seeking out help and support, holding a part-time job, maintaining her involvement with sporting team and having an active social life. In many ways, MD coped well with the difficulties she faced. She also held on to plans for her future and set her sights on various goals. Whether it be saving money to visit her grandparents interstate, getting to the grand final in her sport or entering a VCE/workplace program she worked towards achieving her goals and progressing.

3.14 DSV-IV diagnosis

<table>
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<tr>
<th>Axis</th>
<th>Diagnosis</th>
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<tr>
<td>Axis I</td>
<td>296.21 Major Depressive Disorder, single episode (mild type)</td>
</tr>
<tr>
<td>Axis II</td>
<td>799.9 Diagnosis deferred on axis II</td>
</tr>
<tr>
<td>Axis III</td>
<td>v61.20 Parent-child relational problem</td>
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3.15 Treatment

Treatment with MD began with an assessment of risk as this was the most crucial and
pressing issue. It appeared that once she had been acknowledged and her distress heard, suicidal ideation decreased. During the initial two sessions rapport was established easily and MD was willing to share and talk about her problems, her feelings and her difficulties. She attended sessions on time and seemed to enjoy the time spent talking.

During the second session the CBT rationale was presented to MD and she received it with lukewarm enthusiasm. While she did not seem to have trouble in grasping the concepts presented to her, and was able to demonstrate that she understood the connection between thoughts, feelings and behaviours, something about the model did not appeal to her or her sense of what she hoped to gain from treatment. Nonetheless, it was agreed by MD and the therapist that therapeutic work would endeavour to reduce her depressive symptoms by identifying faulty thinking patterns that led her to feel and behave in certain ways and in so doing to perpetuate her depression.

During the following session, it was planned that MD would work towards identifying goals for treatment in conjunction with the therapist. MD had some trouble in identifying goals more broadly and tended to be circumstantial wanting to describe current problems and concerns to do with her father and her friends at school. By the fourth session MD had still not been able to identify specific goals for treatment and it became apparent to the therapist that this pattern was likely to
continue. With each session MD brought with her a litany of recent events and situations that had increased or prolonged her distress such that sessions were spent counselling and attempting somewhat unsuccessfully to isolate common themes or areas that could be targeted in CBT.

A further issue emerged with MD with respect to attachment. It was hypothesised by the therapist early on that MD would hold some strong core beliefs related to rejection, the need for attachment and validation through dependent relationships. Given the series of losses she had contended with, coupled with her co-dependent tendencies and strong need for attachment, it was anticipated that many of her current difficulties would centre on themes of dependence and rejection. When the therapist informed MD that she would be on leave for three weeks, MD became cool in her manner and seemed annoyed by this. MD was offered two sessions with another clinician with whom she had already met and spoken during the assessment interview but declined. Noting some change in her manner, the therapist attempted to discuss what it meant to her that she would be away for three weeks. MD denied any significance and ended the session a little before time.

On return from leave, the clinician made an appointment for MD, but she did not attend. On speaking to her over the phone, MD casually explained that she had forgotten about the appointment. MD arrived 15 minutes late for the following appointment and offered only a vague explanation for this. It seemed that MD was in
some way trying to “punish” the therapist for having left her for those three weeks and also trying to assert the notion that she wasn’t too invested in therapy.

After seven sessions over three months, the therapist explained to MD that she would be leaving the service in three weeks time. At this point MD became angry and stated that she would “add that to my list of rejections”. With this statement at the end of treatment, MD finally came to express her fears and feelings of rejection, this time from the treating clinician. She was unable to engage any further and would not discuss her reaction to this news. She would not allow the therapist to discuss the possibility of three more sessions to allow for closure or to engage with another therapist at the service. After expressing her hurt and anger and being “dumped again” she got up and left. MD did not respond to phone calls or to a letter that was sent to her.

3.16 Evaluation of treatment and the role of resistance and transference

Over the course of treatment it became apparent that a fear of abandonment and rejection guided much of MD’s interactions with those around her. MD avoided many attempts to discuss this pattern in her life and also to explore the interpretations she had made of the losses she had experienced. The emergence of strong resistance when confronted with these topics indicated to the clinician, in hindsight, that these were in fact the issues paramount to her decline. Resistance in MD’s case was manifested in several identifiable ways. Firstly, she would repeatedly block attempts to discuss this
area by bringing with her crisis after crisis, such as a break-up with a friend, not being able to pay for a textbook and getting into trouble, or an argument with her sister, to be dealt with each week and subverting the course of treatment. Despite attempts to draw her back to the goals set out for each session, MD would divert attention away from the core issues and prefer to spend the time detailing negative events over the past week.

MD transferred her great need for attachment and her fear of rejection on to the therapist and subsequently ‘punished’ when these needs were not met by failing to attend for appointments and arriving late. Via the attitudes expressed through her actions and manner, it could be argued that MD was transferring on to the therapist her hurt and anger towards her mother, father and friends for having been abandoned by them. In this way, MD was re-enacting her response to her mother’s leaving her and also demonstrating how she is likely to respond to her father when she perceives him rejecting her. Freud (1926 cited in Strean, 1990) pointed out that unless a therapist understands the way in which they are experienced by their client they will not be able to help the client to work through obstacles and difficulties in their lives. While it is arguable whether this might apply to all clients who enter therapy, in the case of MD it had resonance.

In the spirit of dynamic theory, it is the task of the therapist to help the client see how and why they respond to and experience the therapist in the way they do. However,
the same notion can be carried through to a CBT formulation if the same behaviours and attitudes are understood in terms of learned responses and core beliefs. The difficulty here though, was that MD denied she had any reaction to the therapist’s absence and without acknowledgment from the client of core beliefs and attitudes, CBT aimed at challenging these core beliefs was likely to be unsuccessful. MD’s response to the absence of the clinician provided important information to understanding how she reacted and conducted herself when faced with perceived rejection and abandonment. This information was used by the therapist to guide understanding of the pattern of MD’s interactions with her father and with her peers. But unfortunately, without knowledge of the concept of resistance and the role of transference in therapy at the time, the clinician was without means for making sense of MD’s behaviours and without understanding of how to navigate it.

It must be considered that a number of other potential factors stood in the way of an effective outcome in MD’s case. Firstly, systemic issues were contributory where caseloads were heavy and strong justifications needed to continue working with clients who did not attend regularly or whose episode of care extended beyond the expected twelve weeks. Such a system is not set up to provide the option of long-term treatment which was indicated for this client. Given these constraints from the outset, there is pressure to administer brief, focused CBT to provide fast symptom relief irrespective of the individual case.
The complexity of this case was such that this type of service provision was inadequate and ineffective. Further, the inexperience of the trainee clinician in this case is likely to have impeded the management of MD’s behaviours that often appeared to sabotage smooth delivery of CBT. A more senior clinician may have been able to contend effectively with the transference issues and to also maintain fidelity to the CBT protocol in treating the depressive symptoms and perhaps successfully combining the two. For this clinician however, the resistances demonstrated by MD were such that they impeded effective application of CBT and the client discharged herself in the absence of symptom amelioration. Given that MD terminated treatment without any demonstrable amelioration in her depressive symptomatology, treatment could be said to be unsuccessful.
CHAPTER FOUR

The case of FW

FW was a 41 year old woman of Greek-Australian background who was a regular patient of a private in-patient unit. She had initially presented for treatment following a critical incident at work which triggered in her a collection of psychological symptoms and a severe deterioration of functioning. Being treated with anti-depressant and anxiolytic medications and with on-going psychotherapy, she presented for brief, focused behaviour therapy during a planned in-patient admission.

4.1 Reason for referral

FW had numerous previous inpatient admissions over a period of two years since a critical incident in the workplace. On this particular occasion she felt she was not coping at home and believed that an admission would give her some respite and offer her some intensive support and care. FW could not identify any particular event or situation that had precipitated this latest admission but stated that she just felt she wasn’t coping.

4.2 History of presenting problem

FW clearly identified the onset of her symptoms as two years previous following a critical incident in the workplace that she described as a “trauma”. FW held a managerial position and recounts that one afternoon she came back to her desk to find
that a fellow employee had typed a message on her computer screen that was personal, sexually explicit and offensive. Although it was later determined that this inappropriate and offensive comment was intended to be a joke, at that moment, she described, her “brain shut down” and she experienced a psychological “trauma” that left her bereft of internal coping resources and affected her very deeply.

From this point onwards, FW experienced a rapid and severe decline in all aspects of her functioning. She described depressive symptoms of amotivation to the point where she was unable to care for herself at all, and her partner and parents were required to tend to her every need. She also reported feeling tearful, and crying most days, especially when she was unable to do something that she had previously been able to do. Most of her symptoms however, were general anxiety-type symptoms including trembling and feeling panicky, feeling nervous all the time, feeling dizzy and confused, and experiencing diffuse pain in various parts of her body (eyes, head, limbs and chest). FW would also report a wide range of physiological symptoms that she ascribed to her anxious state or directly to her “trauma”. During her earlier admissions, FW had on more than one occasion experienced blindness and paralysis. Medical and neurological investigations revealed no identifiable cause for these symptoms and it was deemed that FW was experiencing a neurotic conversion-type disorder. During the current admission, FW did not report periods of blindness or paralysis, but did at times report weak and wobbly legs that would barely carry her into the treatment room. She would claim that her anxiety was such that she was
unable to walk, to go outside, or to cope with the rigors of the hospital routine.

Aside from physical complaints, FW also reported various cognitive impairments that she held were directly related to her “trauma”. She believed that at the moment her brain had “shut down” she had forgotten large pieces of information and was required to “re-learn” most tasks. These included how to prepare food, how to drive, how to manage domestic duties, how to make telephone calls, how to read and write properly, and the meaning of words.

4.3 Pre-morbid personality and functioning

During treatment sessions FW would often lament the loss of her previous level of functioning and the way she used to be prior to the work-place incident. She described herself as having been competent, out-going, able, independent and ambitious. She had held a managerial position up until the incident. She had also completed a Bachelor degree with the idea of moving into teaching and training. She enjoyed a comfortable standard of living affording her activities and outings with her partner and girlfriends.
4.5 Family and medical history

FW is the youngest of a sibship of two. She did not report an especially close relationship with her older sister who was married with children. Her parents were still married and maintained a close and involved relationship with FW taking a substantial role in looking after her during her two-years of illness. FW, now in a de facto relationship, had not been previously married and had no children. She had a small dog that she referred to as her “baby” and talked about him and his antics in fond and animated terms.

FW did not report any history of significant medical illness or any history of medical or psychiatric illness in her family of origin. No collaborative reports were obtained from her family during this admission and no development history was obtained.
4.6 SB, FW's partner

FW had been with her partner, SB, in a de-facto relationship for five years. SB worked for a large company and was reported by FW to be under a lot of pressure with work. He would often be required to bring work home with him and work on it over the week-ends. SB had been married previously and had not divorced from his wife, only separated. The reasons for the decline of his marriage were not shared during brief treatment with FW. Reports from FW's psychiatrist who worked with the couple together on occasions reported that SB's former wife was suffering from cancer and was increasingly unwell as her oncological treatment intensified. For reasons that are unclear, and were not reported by FW, SB was involved in the care of his wife to some degree and would spend time visiting her in hospital, running errands for her, and tending to her when she was unwell.

4.7 Mental state on first meeting

On first meeting, FW presented as a slight woman who was well groomed and suitably dressed. She entered the room slightly hunched and explained on greeting that her anxiety levels were high and this sometimes led to her legs becoming weak making it difficult for her to walk normally. Despite her reported anxiety, she was responsive and reactive, maintained good eye contact, smiled and was co-operative and amicable throughout the meeting. FW had an interpersonal style that was immature and coquettish. She would tend to drop her head and peek out from behind
her fringe of hair with a doe-eyed expression. She would tend towards histrionic
descriptions of her current state using exaggerated terms that were incompatible with
her presentation "extremely anxious" and "completely overwhelmed".

4.8 Personality assessment

FW was referred for personality assessment by her psychiatrist to assess her level of
emotional and psychological adjustment and predominant personality traits. On
testing using the MMPI-2, FW scored extremely highly on the "Lie" scale, which
forms part of the validity scales. This scale taps the extent to which the individual is
responding to the questionnaire items in an honest and frank manner and may indicate
that the individual is attempting to describe herself in an unrealistically positive light.
FW's high score may have been interpreted as a conscious attempt to deceive and
could therefore have served to invalidate her personality profile, or it may have
reflected an unrealistic view of herself. High scorers on this scale often appear as
inflexible, unoriginal, and unaware of the impression they make on others and may
perceive their world in a rigid and self-centred manner. Their rigidity may lead to low
tolerance of stress and since they are unwilling to admit to any flaws in themselves,
they are likely to have poor insight. This extremely high score also suggested that FW
experiences difficulties in relationships.

Scores on the F scale indicate the extent to which a person answers in an atypical or
deviant fashion. It is typical that high scores on this scale are accompanied by high
scores on the clinical scales. FW’s score on the F scale was extremely high suggesting that she was either malingering or exaggerating her difficulties. While this could have served to invalidate the personality profile, her score was still within the range considered to represent a valid profile. On the K scale, used to identify individuals who may be describing themselves in overly positive terms or misrepresenting their symptoms, FW scored within the Low range suggesting again that she may be exaggerating her pathology.

FW scored most highly on the Hysteria and Schizophrenia scales. Elevations on these two scales usually suggest that the patient is likely to have specific functionally related somatic complaints. A combination of denial, somatisation and dissociation are often used. Insight into behaviours is often low as individuals with this elevation often have a strong tendency to see themselves in extremely favourable terms. In particular, they may be perceived as naive, immature, childishly self-centered, and impulsive. They will have strong needs for approval, support and affection but will attempt to obtain these through indirect and manipulative means. Also, a high score on the Schizophrenia scale suggests persons who have unusual beliefs and may experience difficulties in focusing their attention and concentrating. High scores on this scale do not necessarily suggest a diagnosis of schizophrenia but are more likely to reflect unusual experiences in unusually anxious people, or else malingering in relatively well-adjusted persons. Together, these elevated scores present a profile of someone who experiences symptoms of anxiety, depression, and somatic complaints
such as headaches, gastrointestinal disturbances, and numbness. Persons with this configuration can be described as having strong needs for attention and affection and are also immature and dependent.

4.9 Cognitive impairments

As part of her in-patient treatment, her private psychiatrist requested that FW undergo cognitive assessment to ascertain her current level of functioning. During the assessment FW presented as very well groomed, well-mannered, calm and composed although she did express that she was feeling anxious. Despite her anxieties, she appeared to be enthusiastic about the prospect of cognitive testing. Throughout the course of the assessment, FW reported a list of somatic complaints, such as trouble seeing properly, trouble with her limbs, and other bodily sensations that she felt impaired her performance on the cognitive tests and also in daily functions and activities, particularly in the home. She also reported that her memory had been considerably impaired following her critical incident and she was often apologetic for her difficulties in completing sections of the assessment.

Overall, FW appeared reasonably calm, was articulate, and verbose and co-operated throughout most of the testing although she did appear to lose interest and motivation towards the end.
4.10 Test results

On administration of the Wechsler Adult Intelligence Scale-III (WAIS-III), FW obtained a Verbal IQ in the Borderline range, and a Performance IQ and Full Scale IQ in the Extremely Low range of intellectual functioning relative to her age related peers. There was little intra-scale variability presenting a fairly consistent pattern of scores across scales and subtests. FW’s highest score was on the Digit span subtest which assesses concentration, attention and working memory. Her highest index score was the Verbal Comprehension Index on which he scored within the Low Average range. These subtests tap into and assess crystallised intelligence or information stored in long-term memory. Her lowest score was on the Comprehension subtest in which the examinee is required to answer questions relating to everyday social and moral situations. This subtest is presented towards the end of the assessment by which time FW had appeared to lose interest and become fatigued which may partially account for her reduced performance. Her score on the Processing Speed Index was within the Low Average range and her score on the Perceptual Organisation Index and the Working Memory Index was within the Borderline range.

The results of the cognitive assessment were inconsistent with FW’s educational and employment history. Her full Scale IQ score falls within the Extremely Low range of intellectual functioning suggesting a significant degree of intellectual impairment. However, as far as can be ascertained, there is no history of head trauma or evidence to suggest dementia which would help to explain a significant decline from pre-
morbid levels of functioning. Further, the Vocabulary subtest is a strong measure of pre-morbid functioning and is fairly robust against cognitive decline due to even severe psychological and organic impairment. FW's score on this subtest falls within the Low Average range of functioning and is therefore highly inconsistent with her previous level of intellectual functioning as evidenced by her employment and educational background. It is also inconsistent with her observed use of vocabulary and verbal comprehension during testing. At times, FW was able to describe the meaning of a word but was unable to pronounce it, or vice versa. For example, while she was able to explain the meaning of the word "obstruct" she was unable to pronounce it when asked. This pattern of responding is difficult to explain in terms of cognitive impairment particularly given the phonetic spelling of the word.

4.11 Formulation

FW was a 41 year old woman who lived with her de facto husband. She was not employed but had on-going income from Workcover following a sexual harassment incident in the workplace. FW won a substantial amount of compensation along with regular Workcover payment. Her treating psychiatrist referred her for an in-patient admission as she felt her anxiety was unmanageable at the time of admission and she was not coping well. It was anticipated that her admission be brief during and that she would engage in focussed treatment to help her to gain some coping skills to manage her anxiety, as well as to increase her level of activity and the range of tasks she was able to achieve.
FW was not able, or willing, to identify any possible precipitants for her recent increase in anxiety. Reports via her psychiatrist suggest that FW’s partner was finding himself less and less able to cope with the demands of her care together with his work demands and his duties towards his ex-wife during her illness. He had recently experienced what was termed by FW a “breakdown” feeling himself totally overwhelmed, over-burdened and unable to maintain this level of support for FW. It may be hypothesised that as SB’s motivation and availability decreased or became more and more channelled towards the care of his ex-wife, FW displayed a corresponding increase in her own symptomatology which served a functional purpose for her. Her on-going illness ensured the care, attention and control of her partner leaving him less available to offer care to his former wife. It is likely then, that FW’s admission was precipitated by a corresponding retreat from her partner who had been less available to her over preceding weeks.

The impression was given that FW had always been supported greatly by her parents who appeared to have a somewhat over-involved relationship with FW given her age and her capabilities as demonstrated by her previous employment status. In almost vain terms, FW would describe the affection with which her parents would care for her and the pet names they would call her. It could be suggested that this level of protection and care coupled with an interactional style that fostered immature and coquettish behaviour in FW were predisposing factors to her current decline and
presentation. It could also be suggested that FW has long been rewarded for such a style and such behaviours and had often had her needs met by presenting as needy, immature, and unable to fend for herself. Without knowing more about FW's family of origin, her social relations or her developmental history it is difficult to hypothesise other predisposing factors.

It is suggested that SB's on-going care and liaison with his ex-wife was a primary perpetuating factor in FW's state and presentation. It appeared that as his time became less available FW's symptoms would experience a resurgence requiring intensified support or, as in this case, an in-patient admission. Furthermore, the nature of the care provided both by her family and the private mental health service could also be suggested to stand as a perpetuating factor. Both, it could be said, do not foster independence but rather encourage reliance and accommodation of symptoms as opposed to a challenge to symptoms. FW appeared to enjoy her time as an in-patient and the care and attention from professionals and family members that this afforded, and it may be that this environment spurred the continuation and maintenance of her symptomatology.

4.12 DSM-IV diagnosis

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<th>Axis</th>
<th>Code</th>
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<tr>
<td>I</td>
<td>300.19</td>
<td>Factitious Disorder</td>
</tr>
<tr>
<td>II</td>
<td>799.9</td>
<td>Diagnosis deferred on axis II</td>
</tr>
</tbody>
</table>
4.13 Treatment

It could be argued that there were many areas of FW’s personality and interpersonal functioning that required treatment. FW’s symptoms appeared to serve her well in having her needs met by those around her, gaining attention she craved and thrived on, fostering dependence that made her feel secure and maintaining control over a situation she felt unable to manage otherwise. While to many the behaviours through which she achieved this and the very needs themselves may appear dysfunctional, to FW they were indeed effective and sustaining. Hence, the motivation for symptom amelioration did not appear to be present for FW despite expressing some desire for wellness. What was pressing for FW however, was that her relationship with SB was at stake. This was the first time he had reached crisis point and FW seemed unable to manage herself well in the face of this. Firstly, strong narcissistic traits prevented her from perceiving his distress as a response to her demands and the lack of reciprocity between them. She could only view his “break-down” in terms of herself. She would claim that “it is terrible for him to see me so unwell and in so much pain and that really hurts him. He just hasn’t been able to cope lately seeing me like this because when you love someone and they are in pain you feel it”. Whereas FW’s behaviours have been effective for her in the past they were fast becoming the source of malcontent and disruption in her primary support and her relationship with SB. To address the underlying issues that led to FW presenting as she did, the personality issues, and the factitious disorder were not the aim of this treatment plan as FW was
receiving individual psychotherapy from her psychiatrist who was attending to these matters.

The aim of this intervention was to provide FW with some highly structured, graded tasks to help her to recoup, or re-learn, previously learned tasks that would facilitate her functional improvement and in so doing, improve the situation with SB. In this matter, FW was willing to acknowledge the enormous strain that SB had been under in caring for her and running the home, and she felt that she had to learn to help around the house again to relieve the pressure from him. Although she was not able to admit that the relationship might be in trouble, she could recognise that his breakdown was partly due to the burden of caring for her and this provided the impetus for change in her.

During the first session with FW, the objectives of this brief intervention were clarified and agreed upon. FW had a number of tasks that she was keen to work on including 1) doing laundry, 2) catching public transport, 3) sitting in a café by herself, 4) getting out to engage in leisure activities on her own, and 5) cooking a simple meal. These options were discussed and agreed on and a ‘goals sheet’ drawn up. It was decided that FW would begin with the task of laundry as she felt this was the easiest of the tasks and also one that would make her parents and partner proud of her if she were able to achieve it. The individual behaviours and tasks involved in achieving this were discussed and written up in collaboration with FW. For example,
it was outlined that to complete her washing she would have to:

Find out which items of clothing were clean and which were dirty. This was easy for FW as she was quite ordered and kept her dirty laundry separate.

Separate the white items from the coloured and take one load to the laundry room in the hospital.

Ask one of the nursing staff to show her how to use the machine and which buttons to press. It was agreed that she take notes of this so as to remember for future reference.

Add washing powder using the measure cup provided.

Set the machine as shown by the nurses

Return 25 minutes later to retrieve washing and hang it on the line.

FW felt confident that she could manage this task and understood the steps involved. She was excited about the prospect of doing her laundry and announcing to her parents that she had done it. Normally, her parents would come to collect her laundry and do it for her and return it to her. Time was spent going over relaxation strategies and positive coping statements that FW had been taught and had used effectively in the past. FW came the same afternoon to say that she had achieved this task and felt very pleased with herself despite reporting enormous anxiety initially thinking she wouldn't be able to work the machine. Given her rapid success at this task it was decided that treatment would be directed at something more challenging.
During the second session the same format was followed in that a task was agreed and the steps needed to complete that task were broken down. With help, FW identified to which point she felt she could manage and succeed. FW expressed that she would like to be able to go out on her own for an afternoon. Time was spent planning the route she would take, the trams she would catch and how she would go about these tasks and manage her anxiety throughout. It was expressed to the therapist by the treating psychiatrist that it was their implicit objective that FW spend as much time outside of the hospital during the day as possible. In keeping with this plan, it was agreed that FW would go to a nearby shopping district and spend an afternoon wandering the shops. She would also attempt to sit in a café and enjoy a drink by herself. Again, much time was spent in preparation and in talking about the various steps and the likely corresponding anxiety. By the end of the day FW had achieved her aims and had taken public transport to a shopping area and spent an afternoon wandering around and doing some shopping. She also sat in a café and had a drink by herself before she came back to the hospital for the evening. Again, FW achieved more than her anticipated goals for the day and enjoyed the praise she received from hospital staff and family for this.

At session three FW felt she was too anxious that day to do any of the tasks despite encouragement from the therapist. The time was spent reviewing her progress and trying to identify what was making it difficult for her to continue with the program on that day. Future goals were re-evaluated and a plan made for the following week. As
FW was going home on weekend leave, it was agreed that she could spend the afternoon looking through some magazines on the ward to find a simple recipe that she might be able to attempt over the weekend at home. She agreed that this was something she could do and would be working towards her next goal of being able to prepare a simple meal for her and her partner.

The following week FW reported that the weekend had gone well and she had had a relaxing time at home. She did not go out on her own at all and did not quite manage to prepare a meal, or to help at all in the kitchen because she felt she needed a rest after all the work she had done the week previous. She explained that it was not so long ago that she could not even turn the chops under the grill when her partner asked her to because she could not remember how to do it since the “trauma” but became highly anxious and incapacitated at this request. During this session however, it was agreed that FW would continue to work towards planning a meal for the end of the week when she would next be returning home. She would 1) find a recipe in a magazine that had a small number of ingredients and was something she knew she had been able to cook in the past (i.e. spaghetti bolognese), 2) make a list of the ingredients she would need to buy, and 3) walk down to the local supermarket, not far from the hospital, and purchase the ingredients she needed. FW felt she was able to achieve all of these tasks and it was further discussed that she would recruit some help from her mother or sister when it came to preparing the meal. It was asserted that she was not to let them take over but only to guide her.
The fifth session was spent, as per usual, reviewing progress from the previous session and discussing obstacles that had prevented full compliance with the program. On this occasion, FW had not achieved her goal of preparing a meal but had helped her mother in the kitchen in preparing a meal for her and her partner. Although this was counter to the aims of the program, FW felt that she had done well. Time was spent discussing what had prevented her from preparing a simple meal herself and allowing her mother to take over. FW would describe in grandiose detail her symptoms that she used to avoid challenging herself and working on the tasks set. With only one session left it was agreed that FW would continue to work on cooking at home, a task that she acknowledged would help her partner enormously if she were able to achieve and therefore ease some of the stress in the relationship. Some positive coping statements were suggested to help FW press on with the task even when she felt anxious. She maintained that she had been practicing her relaxation techniques throughout the program and that these had helped.

The sixth and final session saw the end of FW’s in-patient admission and the end of the brief cognitive-behavioural behavioural program. The first part of the session was spent reviewing the tasks she had successfully achieved and what had made them achievable to her. FW believed that she had only been able to achieve those tasks successfully because she felt good on those days but was less inclined to acknowledge her own coping mechanisms or motivations as factors contributing to
positive outcome. FW had little insight into what had made the task of preparing a meal difficult for her but again ascribed success or failure to the remission or presence of symptoms on the particular day. Although she was very positive about the program, about her progress, and about her new found abilities, she continued to lack insight into the obstacles to her development and progress. FW had attended numerous CBT-based programs, group workshops, and individual treatment sessions over the course of her admissions and so did not appear to have gained anything new from this intervention in terms of strategies. She did however appreciate the support, the attention, the guidance and the reiteration of these CBT strategies.

4.14 Evaluation of treatment

FW's treatment was designed to be brief and task focused with the view of improving her functioning at home and to re-establish former activities that she had previously been competent at performing.

It would be difficult to ascertain to what extent the intervention was truly effective, firstly because it is questionable to what extent FW was truly functionally impaired. One could argue that her need to be seen as unwell was indeed her impairment but to FW, this was not the source of her difficulties. FW attributed all her symptoms and problems to the "trauma" (as she referred to it) that had occurred two years before. As there was nothing related to that event, no definable clinical diagnosis to directly account for her deficits, the application of CBT techniques to help her to regain
certain skills and tasks was questionable as there was no clinical indication that she had in fact lost these abilities. On the other hand, FW did perform a number of tasks that she had previously not engaged in, for whatever reason. Using this measure, the intervention was effective and the outcome positive. Whether FW continued to perform these tasks even in the face of reduced attention from her partner or increases in the care of his ex-wife is uncertain as there was no follow-up. This would have provided a better measure of treatment success.

This type of behavioural intervention did not of course, address any of FW’s underlying issues that were believed to drive her symptoms and for this reason the treatment plan was somewhat superficial. Again, on the other hand, the intervention permitted FW to see and experience that she was able to perform these tasks. For FW to suddenly drop some of her symptoms and ‘miraculously’ regain abilities would not fit with the needy patient persona she had constructed. But she did want to make changes as she sensed the growing desperation in her partner and the precarious balance she was maintaining in keeping him near and attentive but also driving him to despair. FW needed to regain these abilities through treatment rather than through a spontaneous remission that would have threatened her credibility as being in need of special attention with her carers. So in this manner, intervention provided her with the means to find wellness that she could not have allowed herself to find on her own.
4.15 Counter-transference issues in treatment

Throughout this treatment process strong counter-transference issues were present and apparent for the therapist. It would be difficult to truly assess the impact, if any, these had on the treatment process and outcome. Considering the nature of the intervention, task oriented, goal focused, brief, strongly behavioural and highly structured, it could be argued that these undercurrents of emotion were not as perceptible through this medium. However, whether FW detected any of the feelings of cynicism, of frustration, of incredulity and distaste that she and her behaviour evoked in the therapist and whether this would have reached her is uncertain. Had the intervention been conducted on a more effusive, emotive, or cognitive level in which feelings and thoughts were discussed, the negative impact of these feelings is likely to have been more apparent and detrimental. Instead, the intervention seemed to stand alone and operate in spite of, or apart from, the transference and counter-transferences present within the therapeutic milieu. That the purely behavioural aspects of treatment were on some level effective does not detract from the importance of observing and using counter-transference responses in treatment. Had therapy with FW progressed, the response she invoked in the therapist could be used to gain insight into the feelings of frustration and hopelessness described by her partner. Or, left untended the transference reaction may have been greatly detrimental. It could be suggested that FW’s way of presenting herself to the world was a kind of defence against rejection and abandon. The more she detected the threat of abandonment through the negative counter-transference responses of the clinician, the more she may have ‘upped the
ante' and reinforced her maladaptive behaviours in her much-rehearsed fashion, serving to buttress and strengthen the belief that being unwell wins attention. Left unchecked, it can be speculated that this would have greatly impaired treatment progress and produced negative outcomes.

It can be difficult for a therapist to admit that they do not like their client. To own such a state is counter to the broad therapeutic ideals of objectivity, positive regard and respect, and compassion and empathy for the client. Without the language of counter-transference to enable discussion and analysis of these responses to clients, clinicians are left without direction in managing, describing and making sense of these reactions and emotions to the possible detriment of both clinicians and clients.
CHAPTER FIVE

The case of SY

5.1 The case of SY

SY was a 15 year old young woman of African background who presented for treatment with a range of symptoms suggestive of social anxiety and major depression. Her case illustrates some of the difficulties in applying CBT techniques when a client's world view, or individual cognitive style is in conflict with the treatment approach.

5.2 Reason for referral

SY was a 16 year old girl who migrated from Eastern Africa to Australia with her mother and younger sister when she was six years old. Her father was still living in Africa and it was unclear whether he would be granted a visa to join his family in Australia.

SY was referred to an out-patient adolescent mental health service by her GP due to concerns around her lowered mood, feelings of worthlessness, poor concentration, loss of appetite, disturbed sleep, loss of weight and reduced attendance at school.

5.3 Presenting problem

SY changed schools in year 9 from an all-girl Muslim school to an all-girl
predominantly Anglo-Australian government school. She made this move because two of her friends were going to this school. She reported that she had considerable difficulty adjusting to being in this new school environment and was highly self-conscious about her appearance. She was particularly concerned by the fact that she was of darker skin colour and wore a head scarf and that others would think she was ugly and that her clothes were “wrong”. Once she changed schools, her two friends began to ignore her and teased her about her appearance. SY changed schools two more times over a period of one term, each time leaving because she felt that people were talking about her and thinking she was ugly.

SY reported symptoms consistent with social anxiety disorder. She reported a 12-month history of persistent, marked fear of most social situations in which she would be exposed to possible scrutiny by others. Her fear of saying or doing the ‘wrong’ thing, or embarrassing herself or of being perceived negatively by others was present with both strangers and people she was familiar with. SY also described significant anxiety when in public or with others outside her immediate family including panic-like symptoms of sweatiness, dizziness, increased heart rate, difficulty breathing and racing thoughts when she believes someone is looking at her. She reported one panic attack in six months while she was waiting in a doctor’s surgery and believed that other people in the room were looking at her and judging her negatively. SY would stay home on weekends and would not go out other than to school. Over the past six months she had begun to miss school and was absent one to two days each week due
to anxiety. SY felt that her anxiety and preoccupations were excessive but felt unable to control either.

SY also avoided a number of situations that were particularly anxiety provoking to her including catching public transport during peak times, asking questions in class and talking in front of peers. She avoided contact with peers during lunch times and spent this time on her own in the library. She also reported worrying about her own social performance when speaking to others such that she could not concentrate or respond appropriately. When she did spend time with peers, she reported being hyper-vigilant to subtle social cues that she may be saying or doing the wrong thing.

SY also described a number of depressive symptoms consistent with a major depressive episode including a 15 month history of depressed mood, a significant increase in irritability, weight loss over 12 months (7kg), decreased appetite, restless sleep with early insomnia over 15 months, increased fatigue and decreased energy and concentration. SY also reported psychomotor retardation and anhedonia. She described feelings of worthlessness and guilt ("I'm not good enough and will never reach my goals") together with suicidal ideation on a daily basis. SY reported that she did not want to die but felt overwhelmed by her negative thoughts and feelings and would get desperate. She reported some minor self-harm including pinching her skin and pulling her hair to relieve distress and emotional pain.
Significant negative findings included no evidence of obsessions or compulsions, no eating disorder symptoms of dieting or purging, and no ideas of reference or formal thought disorder. SY reported no previous psychiatric history, no significant medical history and no substance use.

5.4 Recent interventions

SY had been seeing the school counsellor intermittently over a period of six months. Her teachers had noticed a deterioration in her affect and her school performance, including excessive school absences, and encouraged the school counsellor to refer her to a GP. Sy was referred to her local GP who made the referral to a specialist mental health service.

5.5 Family history

SY, her mother and her younger sister immigrated to Australia from Eastern Africa when she was six years old. Her family’s migration was sponsored by her maternal uncle but, for reasons which SY does not know, her father remained in Africa and was unsuccessful in obtaining a visa to emigrate to Australia and join his family. There was much confusion on SY’s part about the reasons for the delay in her father’s arrival and she felt her mother did not want them to know what was happening. SY also felt some anger towards her mother whom she felt did not understand her problems and was unable to help her. SY had a second younger sister who was born in Australia after a visit her mother made to her father whilst he was in the Middle
East.

SY reported that she was close to her father because she was the eldest. She had fond memories of him and was deeply pained and grieved his long-term absence. She was able to speak with him very occasionally over the phone for a very brief period. She reported that she used to write to him but later felt that there was no point, as he would never make it to Australia "so why bother?" SY's grief over this situation was deeply evident during interview.

5.6 Genogram

![Genogram Image]

5.7 Developmental history

SY described early memories of living in Africa as being carefree and of enjoying a
strong community where all the children played together while all the adults in the area gathered to drink tea and talk. She remembered immigrating to Australia at age 6 where she attended an Islamic girls' school from grade 2 to grade 8, which she enjoyed and reported doing well academically.

In year 9 she changed schools to a government secondary college because two of her friends were changing schools also. Once the term commenced, her friends began to ignore her for reasons she did not understand and she did not make new friends at this school. Some peers teased her about her appearance and her clothes. During the second term she changed schools for just three days before returning to her second school. She reported that she was very anxious and unable to tolerate attending class as she felt others were perceiving her negatively. In year 10 she changed schools again to a government all girls school and was reasonably content with this school. She had some friends and liked her teachers.

5.8 Pre-morbid personality

Premorbidly, SY described herself as someone who was not usually shy or avoidant. She loved being with friends and enjoyed playing basketball and reading books. According to SY, things didn’t worry her the way they do now and she was much calmer in general.
5.9 Current level of functioning

SY lived with her mother in an inner-city public housing apartment together with her two younger sisters. She attended year 10 at an all girl’s school. She had a few friends at school she talked to but did not go out on the weekends or socialise with any of them.

5.10 Mental state exam (on first meeting)

SY presented as a 16-year-old young woman of African background. She was of slender build and medium height. She wore a headscarf covering all but her face, a long skirt and long pants underneath. She was dressed in attire suitable to her age, gender, and cultural background. She maintained good eye contact throughout. Although she would wring her hands, take deep breaths and expressed that she was nervous, she conversed well in a clear and audible voice. At times she became tearful.

SY was somewhat guarded when talking about her family. Otherwise she was generally frank and open and a good rapport was established early. Affect was dysthymic and restricted but congruent to discussion. Her speech was normal in rate, volume and tone. SY had a slight accent indicating that English was not her first language. She spoke English fluently and articulately.

SY reported preoccupations with how others would perceive her and with her own social performance. She was worried and angry about why her father had not been
able to join them and why there was a delay when other non-African students at her school had relatives arrive in Australia months after they applied for a visa. Although there was no evidence of violent or homicidal thoughts, SY reported daily thoughts of death. Two weeks previous she had attempted suicide by trying to jump from her apartment window before her mother stopped her. She was able to guarantee her safety and expressed that she didn’t really want to die but wanted her mother to take more notice of how unhappy she was and to help her.

No disorders of perception were elicited and she was oriented to time, place and person. She maintained concentration throughout and was estimated to be of at least average IQ. SY had moderate insight into her excessive anxiety and her depression but demonstrated less insight into feelings about her family situation and how this may have impacted on her difficulties. She was motivated for treatment.

5.11 Formulation

SY was a 16 year old girl who migrated to Australia from Eastern Africa at age 6 with her mother and her younger sister. SY lived with her mother and her two younger sisters in an inner-city public housing high-rise and attended year 10 at an all girls’ school. Her father was not in Australia and SY is unclear about the reasons for this. She understood the problem to be with immigration but had no details on this.

SY described a two year history of marked and persistent anxiety and fear of social
situations where she felt she would be negatively evaluated because of her appearance or her behaviour. SY avoided these situations where possible and had experienced some panic-like symptoms when forced to be in a social situation. Her fears extended to most situations with strangers, peers, teachers, extended family members and neighbours. She reported an almost constant state of heightened anxiety and this had disrupted her social and academic functioning.

SY reported that when she changed schools from her familiar Islamic girls’ college to a secular government school, many of her troubles began. She reported that the friends for whom she had changed schools to be with separated from her and ostracised her. This appeared to be the precipitant for her presenting troubles. Several family stressors including confusion around her father’s failure to be granted entry to Australia and the level of hope she maintained together with frustration, pain and uncertainty were likely predisposing factors. Also, being of a low-income family, SY felt guilty about the pressure she put her mother under to buy her new clothes. She felt that if she were to have different clothes she would be able to look better and in turn feel less concerned about her appearance. The financial stress of a single low income from her mother, part of which was sent to support her father in Africa, was likely to be another predisposing factor in SY’s presenting problems.

SY’s problems were difficult for her mother to understand. SY believed that although her mother tried to make her happy she did not understand the nature and depth of her
problems and this left SY feeling isolated and without support. She would become angry towards her mother for this and conflict would erupt, perpetuating her level of depressed mood and tension. Her avoidance of all social situations would also perpetuate her anxiety.

Protectively, SY was an intelligent young woman who was willing to seek treatment for her problems. She had the support of her mother who was invested in her care and was open to helping her where she could, although she struggled at times to understand how best to help her.

5.12 DSM-IV Diagnosis

Axis I: Major Depressive Disorder, single episode (moderate)

  Social phobia

Axis II: Diagnosis deferred on axis II

Axis III: Diagnosis deferred on axis II

Axis IV: Difficulties in primary support

Axis V: GAF 61-70

5.13 Treatment

Treatment with SY was aimed at challenging her negative cognitions around herself and her appearance. It was anticipated that a standard CBT manual for social phobia
could be applied in treating SY as her diagnostic profile was relatively uncomplicated, and she was verbal and appeared intelligent.

Treatment with SY began with identifying the things she would most like to change and formulating goals for treatment. For this, SY nominated that she would: 1. “like to stop worrying about the way I look”, 2. “like to stop worrying about what everyone is thinking about me”, 3. “like to feel better”, and 4. “like to speak clearly in front of other people”.

During the first session, the CBT model of anxiety was presented and the role of negative thoughts in impacting on mood and behaviour was explained. SY appeared to take this well and appeared to understand the inter-relation of thoughts, feelings and behaviour. Over the following week, SY put this into practice and found some benefit in changing her thinking when she was faced with a situation that she found anxiety provoking. Although SY was motivated to try to change her thinking she expressed some reservations about how the model presented could really make her feel different “deep down”.

Over the next two weeks, SY continued to monitor her thoughts, to practice challenging her negative thoughts and to observe any subsequent changes in mood. In conjunction with work on cognitive restructuring, SY was taught progressive muscle relaxation and some guided imagery techniques that she was to practice at home each
night. SY reported that she had found these relaxation techniques the most helpful so far in relieving her tension and anxiety, particularly she noted, the imagery. She found that when she was able to take note of indicators that she was becoming anxious and irritable at home with her family, she could take herself away to another room and practice her relaxation, which she found made a lot of difference. This way, explosions of anger and tears that added stress to the family and invariably left SY feeling guilty afterwards were avoided.

By the fourth week, SY reported that she had found the relaxation helpful in avoiding eruptions of anger and conflict between herself and her family, and that she had been able to challenge her negative thoughts in some cases. However, overall she felt that something was missing, and was prone to asking “what else should I do, what else can make me feel better?” During the fourth session, discussion turned to the situation with SY’s father and the confusion around his ongoing refusal from entry to Australia. This provoked a tearful response in SY as she described how she missed him, how angry she felt when other children in her class from non-African backgrounds announced that another one of their relatives had been granted entry to Australia from abroad after a relatively short application process, and how she was confused about the situation and the reasons for his failure to join them after eight years. SY sobbed and her grief and hurt were expressed keenly. At this time, clearly, a CBT approach was not called for or necessary. SY needed to be heard and supported as she talked openly about her loss and grief. At the end of the session, she
reported that she felt remarkably better even though nothing had been resolved per se, that is, the situation was unchanged. She expressed that having the opportunity to talk about what was most painful to her and what she felt she could not express openly in her family, made her feel more at peace “deep down”.

The following session SY reported that she had had a better week and that she had attended school most days, which was an indication of improvement for her. She reported that she had been trying to use the cognitive challenges that she had been taught and while the idea seemed to make sense to her, something about it didn’t seem to hold therapeutic value for her. The session was spent trying to help SY uncover some of her core beliefs by examining her automatic thoughts that she had written down in her thoughts diary. Just before leaving SY asked if it would be alright next time if she brought her mother with her.

The next week, SY and her mother came in to the session together. They both shared how the week had been for SY at home and at school and talked about the incidents and arguments that had arisen during the week. SY’s mother held her hand while she spoke of SY’s angry outbursts and how she felt she didn’t know how to help her and what to do. Given this opening, and using the advantage of having a family member in the room, the clinician asked SY what she thought her mother could do to help in these difficult times. SY answered that she thought sometimes her mother didn’t understand just how unhappy she was and that she felt she needed to erupt to try and
invigorate action in her mother. In turn, her mother responded that she had tried to do what she could for SY and just wanted her to be happy so that sometimes, when she saw her feeling a bit better, she believed that things were okay again and didn’t ask her how she was feeling because she was afraid of upsetting her. SY responded that she did have ups and downs but just because she was feeling a bit better didn’t mean that everything was alright. SY effectively expressed to her mother that she felt frustrated by her inactivity and that her angry outbursts were attempts to invigorate a response and action from her mother to help her.

The exchange and dialogue between mother and daughter was done with very little direction from the clinician. SY and her mother came to the end of the session both feeling as though they had made progress in understanding some of SY’s troubles and each of their responses around the issues and in relation to one another. Both left feeling more positive about the week ahead once they understood one another better.

The next session, SY brought her mother with her again and this time, her two younger sisters as well. She had decided to bring them so that they could talk about SY’s problems like she had done with her mother the week before. Together the family discussed how the week had been for SY and how it had been a better week with fewer fights and SY attending school every day. SY said that although things had improved she still felt very anxious in situations and this made it hard for her to go to school. When there, she found it hard to concentrate, became frustrated and
upset and this made her feel depressed. She felt she was not coping with the schoolwork and this made her feel guilty, as she wasting opportunities for education which made the future look bleak to her. She aspired to be a journalist but “how many black, Muslim, women do you see in the media?” she asked. Her younger sister shared that she felt like that too sometimes when people would look at her in the street because, she believed, of the head scarf she wore, and she too wondered how she could hold a career in a society where she was set apart from others by her culture and appearance. The family discussed this together and agreed that it was both difficult and daunting to make their way in a culture that they did not feel wholly a part of. SY’s mother spoke about how she had felt this herself but managed to find value in the work she did teaching English to new migrants. SY and her sister’s expressed that they had not heard their mother speak about her own anxieties and struggles before and didn’t realise she shared similar problems to them.

SY and her family attended for four more sessions during which time the family spoke about SY and her social struggles, her school problems, and struggles within the family. At each session they resolved to do something differently between them and came to understand each other better, the roles they performed within the family, the impact of SY’s problems on each of them and what needed to change. At times they would refer to the therapist to offer suggestion or make comment.

At the final session, SY reported that although she still felt anxious when she
perceived herself to be under scrutiny either at school, in public or amongst peers, she felt she could manage her anxiety better. On asking what she had found useful and what had made the most difference to her, she reported that the relaxation had been useful and that sometimes she could change her thinking to help her get through a difficult situation but overall, “sharing problems is the best way” she stated. “When people in your family understand you then they can help you and everyone can help together,” she said. Essentially, what SY was conveying was that the individualist and self-driven approach of CBT had not been useful for her. Bringing her problems to her collective, sharing them and having the opportunity to seek resolution between herself and her family members had been the most meaningful and most therapeutic process for her.

5.14 Treatment outcome

At discharge, SY reported a reduction in all areas of symptomatology. Her mood had improved, she was less irritable, was able to concentrate better at school (although still struggled with this at times), was more motivated to be consistent with her school work and attendance, and felt better about herself. She still felt anxiety in social situations and would often assess her social performance when with peers and worry about being viewed negatively, but this too, she reported had lessened and she felt she could talk herself out of it most of the time. SY attended school regularly and had become involved in a community-based group for young African women from disadvantaged backgrounds. With this group she socialised with other young Muslim
women and began playing basketball with them.

Overall, treatment was assessed to be effective given the significant reduction in symptoms and a reintegration into social activities and school.

5.15 Cultural issues in treatment: individualism versus collectivism

A family systems approach to formulating the problems and issues for SY and her family was most applicable given the collectivist nature of African culture (Hofstede, 1980). In brief, the concept or dimension of individualism implies "a loosely knit social framework in which people are supposed to take care of themselves...while collectivism [its opposite] is characterised by a tight social framework...they expect their in-group (relatives, clan, organisations) to look after them..." (Lago & Thompson, 1996, p. 47). The family systems approach, albeit loosely applied, met the expectations of SY and her family of what therapy would entail. It also matched the cultural values of this family and made the most sense to them. CBT was been useful in treating some of SY's anxiety and she reported that she did find benefit in challenging her thinking and this helped her to go into an anxiety provoking situation and learning to relax when she became anxious. Ultimately however, this individualist, self-generated and cognitive-behavioural approach did not have resonance for SY. For her, therapy lay in sharing the problem with those around her, talking and receiving supportive help and involving the family in seeking resolution to her mental health issues. This case highlights that an individual's particular
cognitive style may be inconsistent with CBT approaches. While cross-cultural issues were primary here, it can also be highlighted that an individual's idiosyncratic view of the world may be at odds with a CBT approach to treatment and this may also present obstacles to the effective delivery of CBT.
CHAPTER SIX
Discussion and conclusions

It was the aim of the discussion and the case studies presented to illuminate several areas of clinical practice that can emerge as obstacles to the effective delivery of CBT, and to present the case for including alternate constructs of resistance and transference/counter-transference into CBT practices. The types of phenomena discussed were not of a nature generally addressed in CBT texts and protocols and do not generally receive close attention in academic or research literature.

The case of PL presented the role of narcissistic personality traits in impeding CBT for anxiety and depressive symptoms. Because of his particular personality style, he was less disposed to adopting and working within the framework of CBT. His narcissistic tendency to deny inadequacies, failings, negative evaluations, and feelings of threat made the examination of core beliefs and automatic thoughts difficult. It may be that PL would have responded better to a more behaviourally oriented approach with parallel focus on his interpersonal style and the function of his narcissistic tendencies in protecting him from assault on his self-esteem.

The role of transference in CBT was explored via the case of MD whose great need for attachment and her fear of abandonment dominated her interactions with the clinician and prevented her from responding to a straightforward CBT approach.
These issues of neediness and fear of rejection needed to be addressed therapeutically, possibly in a process oriented way as put forward in Cognitive Analytical Therapy (CAT). CAT uses the transference in session to illuminate for the client behavioural patterns outside of therapy and aims for resolution to those feelings and behaviours.

Therapy with FW provided insight into the experience of negative counter-transference. It was found that whilst treatment centered largely on behaviour, these negative counter-transferences presented less of a threat to the therapeutic relationship and outcome but had treatment followed a more equally balanced cognitive-behavioural path, might well have been detrimental to treatment if left unintended. This aside, the recognition of negative counter-transferences permitted insight into the function of FW’s symptoms and provided understanding of the way in which she conducted herself with those around her and how others were likely to respond to her. Should longer-term therapy have been offered, this could potentially have offered a rich source of material to work with on a more cognitive and/or process oriented level.

Finally, the case of SY brought into consideration the role of cultural factors and cognitive style in determining suitable therapeutic modality. It also raised the issue of tailoring treatment styles to suit individuals. Given the collectivist nature of SY’s culture of origin and the understanding emanating from this, that problems are solved
by sharing them and dealing with them between family members, the individualistic, independent problem-solving nature of CBT made it inconsistent with SY's individual cognitive style. It also failed to meet her expectations about what therapy would involve and where therapeutic benefit was found. While CBT was useful to SY in some areas, most therapeutic effectiveness was found via a more family systems oriented approach.

Given the approach of this analysis, the points raised are largely impressionistic and subjective and it is acknowledged that anecdotes and personal observations do not make for fact and substantive claims. Some of the areas of clinical work raised however, namely resistance, transference and counter-transference, do not conform easily to empirical validation. By their very nature they are impressionistic and subjective and make for unwieldy research material. Perhaps for this reason, the CBT revolution has overlooked or disregarded these phenomena in favour of firmly validated principles and practices. It is also proposed here that, just as the behavioural movement experienced a shift away from orthodoxy to include cognitive components (and perhaps vice versa), strict CBT practices and principles are expanding to incorporate humanistic, systems theory and analytical elements. It can be argued that these elements of therapy as a whole have previously been discarded in reaction to the dominance of Freudian and neo-Freudian doctrines and practices in the past. Having enjoyed a period of relative dominance itself in strict and theoretically pure form, CBT is slowly evolving to meet the needs of clinicians and clients that extend beyond
the bounds of structured CBT protocols.

Of the various cases presented, most were largely unsuccessful in attaining their treatment goals. It was not the intention of this work to suggest that the identified obstacles to the smooth delivery of CBT in these cases were solely responsible for less than satisfactory treatment outcomes. It is likely that a number of factors contributed to limited treatment outcome in these cases, some systemic, some to do with the inexperience of the clinician, and some to do with the nature and complexity of the clients' presenting problems. It was however, the aim of this paper to present observed difficulties encountered during clinical training in applying CBT to anxiety and depressive disorders and to explore the benefits of integrating elements from alternate therapeutic modalities. To neglect these aspects, it is argued, leaves clinicians without framework to understand and work with important aspects of client-therapist interactions and therapeutic process.
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