Although my primary orientation is that of a behavior therapist, I find that I can readily incorporate contributions from other orientations by using common principles of change as an organizing format. After translating the theoretical jargon associated with different therapeutic schools of thought into ordinary English, one may discern principles at a level of abstraction somewhere between the observable methods of clinical intervention and the higher order, theoretical speculation about why these methods might be effective elsewhere (Goldfried & Padawer, 1982). Such common principles of change include (a) the presence of clients' expectations that change is possible, (b) the existence of an optimal therapeutic relationship, (c) providing feedback to help clients become more aware of aspects of themselves and others, (d) the encouragement of corrective experiences, and (e) facilitation of ongoing reality testing.

An initial positive expectation that therapy can help, along with a certain amount of motivation to engage in the therapy process, is essential to change. It is a promissory note and represents a necessary but probably not sufficient step in the change process. Another common change principle involves the existence of an optimal therapy relationship, providing a safe con-
text within which change may be explored. The therapy alliance is particu-
larly important in that it implicitly or explicitly functions to encourage cli-
ents to seek out new ways of functioning, both within and outside of the
therapy session. Although they may do so in different ways, most approaches
to therapy attempt to increase clients' awareness. Clients typically encounter
problems in living because of antiquated and inaccurate views of themselves
and others. Using different intervention procedures (e.g., reflection, inter-
pretation, self-monitoring), therapy helps to provide clients with a clearer
view of their perceptions, emotions, actions, and needs. This increased aware-
ness can set the stage for what is perhaps the core principle of change, namely
the corrective experience. When clients have become more aware of their own
functioning and their relationships with others, they are in a better position
to take such risks and learn to function more effectively. These corrective
experiences may occur within the session (e.g., through the therapy relation-
ship) or between sessions (e.g., homework). What is ultimately required for
therapeutic change is for clients to continually become aware, have correc-
tive experiences to support this new awareness, and use these experiences to
give added meaning to their awareness, thereby providing a cycle of ongoing
reality testing.

The specific methods by which these several principles of change may
be implemented in the clinical setting vary from orientation to orientation
and from case to case. In a sense, how these principles are implemented cli-
cially may be thought of as reflecting the parameters of the more general
principles. The following case illustrates how these general principles of change
can guide a course of therapy that makes use of contributions from different
orientations.

CLINICAL CASE

In thinking about providing a case to illustrate how I work integratively,
I decided that a useful and true-to-life format would be to present the clinical
material as it was presented to me. Thus, instead of beginning with a descrip-
tion of the client, relevant demographic information, a case formulation,
and a general description of the therapeutic intervention, I begin with the
client's initial phone contact and then describe, session by session, the way
in which the assessment, formulation, and intervention unfolded.

Initial Contact

My first contact with Elaine consisted of a message she left on my an-
wering machine, indicating that she had been referred by a psychiatrist friend
that I knew professionally. I returned the call that evening and spoke with
Elaine. She indicated that she had been in therapy off and on for the past few
years, dealing with the deaths of both her parents. Unfortunately, this course of therapy had not helped her to deal with her grief, and other issues continued to persist. She indicated that I came highly recommended, which not only made me feel good personally but also provided some information about her positive expectations.

Session 1

Elaine appeared shortly before our scheduled session the following week. Sitting in the waiting room, she was busily reviewing material on her electronic organizer. She was an attractive, professionally dressed Caucasian woman who appeared to be in her mid-40s. I introduced myself, and we walked down the corridor to my office.

We began the session by my asking her to elaborate further on the reasons for contacting me. She openly described the issues that had been of concern to her and did so with somewhat pressured speech. She was articulate, and from the way she spoke, my overall impression was that she clearly was above average in intelligence.

She began by stating that she was dissatisfied with her relationship with her husband Mike, to whom she had been married for 22 years. Among the issues creating problems in their relationship was his criticalness, the decrease in frequency of their sexual contacts, and a general increase in emotional distance between the two. They had spoken about the possibility of couples therapy, but both agreed that additional individual therapy for her had a higher priority.

Additional reasons for seeking therapy at this time included “stress,” concerns about aging and loss, and lingering negative feelings about the fact that she had been adopted. Elaine indicated that she had experienced an increase in stress a little under a year ago, at which time her father-in-law was placed in a nursing home. She also reported a number of other stressors, which seemed to center around the theme of death and loss (e.g., her mother had died 4 years earlier, her father had died 2 years ago, her husband’s aunt had passed away about a year ago).

In describing more about her current life situation, Elaine indicated that she was 48 years old, had a 16-year-old daughter at home and a 20-year-old son in college, and was a real estate attorney in a law firm. Her husband, Mike, was 55, had an MBA degree, and worked in finance.

When asked if there were any other issues in her life that might be relevant, Elaine stated that for the past year, she had been suffering from lower back pain. Her orthopedist indicated that she might require surgery at some point, and the discomfort was currently being dealt with by means of cortisone injections. Her back problems occasionally affected her functioning, and she knew that she would need to face major surgery some time in the future.
As we got closer to the end of the session, I asked if she would like to continue our sessions. When she responded in the affirmative, I stated that I wanted to make use of the next two and perhaps three sessions to gather more information about her before discussing how we would proceed therapeutically. I indicated that I would be asking a lot of questions, at this point offering little in the way of information or suggestions. However, after I had a clearer understanding of the problems she wished to deal with (I hoped by Session 3 or 4), we would discuss how we might best proceed. When she nodded in agreement, I added that there were three factors that typically predicted successful therapy (i.e., the therapeutic alliance; Bordin, 1976). One was the existence of a good bond between client and therapist, which was reflected in her feeling that I was concerned about her welfare, that I understood her, and that we communicated well with each other. The second predictive factor was that we both agreed on the goals of therapy, and the third was that we both agreed on how to best reach these goals. I suggested that we could return to this once we were ready to plan the course of treatment.

My usual practice is to have the client complete a comprehensive personal data questionnaire before the second session, which asks for demographic information, a description of current life problems, past and current relationship with parents and siblings, past therapy experiences, and other assessment information that can be helpful in case formulation and treatment planning. I prefer not to have clients complete this information prior to the initial session, because I have found that asking to have this personal information described in such an impersonal format is best done after we have met in person. I gave Elaine the questionnaire and asked her to mail it back to me before our next meeting, explaining that it would help me to get more information about her without having to use as much session time. I also included a copy of the Beck Depression Inventory (Beck, Ward, & Mendelson, 1961) for her to complete.

**Personal Data Questionnaire, Beck Depression Inventory, and Session 2**

The personal data questionnaire reiterated some of what Elaine had told me in the initial session (e.g., age, education, occupation) but also provided additional information. Her concerns about getting older and dealing with issues of death had begun approximately 5 years before and had bothered her off and on since that time. To the question “What prompted you to seek help now?” she indicated that it was the result of discussions with her husband following her recent inability to attend a funeral. (“I was afraid I’d become too upset. It reminded me of my father’s death.”)

In describing problems in her relationships with her husband and children, Elaine indicated that she had withdrawn into herself during conversations. She had also found herself spending more time in the evening at the
computer, which she recognized was a form of escape. Her Beck Depression Inventory score was 16, reflecting a mild level of depression. Her tendency to withdraw had resulted in arguments with Mike, which often took the form of his getting angry and her taking on the blame. On more than one occasion, her husband commented that their relationship mirrored the relationship she had with her father.

In the questionnaire, Elaine indicated that her father, who was a businessman, had died of a stroke 2 years before. She described him as “strong-willed, caring, but things had to be his way.” Her mother, who had died of cancer 4 years before, was quiet and passive, typically deferring to her husband. Elaine indicated that she also wanted to work on her feelings about being adopted.

Additional demographic information provided on the questionnaire was the fact that she and her husband were Protestant and that she had a brother 2 years younger who lived on the west coast. Although she had been close to her brother when they were younger, most of their contact now consisted of periodic phone calls.

During the session itself, we reviewed the information provided on the questionnaire, and Elaine elaborated on a number of the issues. What became increasingly clear was a theme of loss in her life, consisting of the death of both her parents, the recent death of her husband’s aunt, and the need to place her father-in-law in a nursing home the previous year. She also mentioned that through her professional work, she knew of people who had died in the attack on the World Trade Center, which had occurred a little over a year earlier. Also related to loss was the strain and reduced sexual contact with her husband over the past 5 years and the periodic disruption of her functioning because of her back problems. She spontaneously indicated that one of her fears was that her husband or children might suddenly die.

The session also revealed that Elaine was competent in her professional work and felt confident in her abilities to get things done. By contrast, she tended to be unassertive in social contacts, apparently mediated by a need to please others.

Session 3

We explored her relationship with her husband, the ways it seemed to parallel her relationship with her father, and how her concerns about approval often led to her putting other people’s needs above her own. Although she recognized that her self-effacing stance often had a negative impact on Mike—he said he would like to have her take more of a stand on issues—she indicated that it was hard for her to openly express what she often felt or wanted.

Another problem Elaine raised was related to her future surgery, the date for which had not yet been set. She indicated that she had a blood
phobia, experienced considerable anxiety when her blood was drawn, and would typically faint. In many respects, she dreaded this more than she did the actual surgery.

Toward the end of the session, we revisited the topic of the therapeutic alliance that I had introduced during our initial session. We both concurred that we seemed to have a good working relationship thus far and then focused on the goals of therapy. I suggested that her depression, fears regarding death, and the pattern of losses in her life might best be approached with grief work. When she agreed, I added that working on this might also involve possible unfinished business with her parents, especially around her reaction to having been adopted. We agreed that communication issues with Mike could be the focus of therapy, which would involve learning to better express and assert herself. They had discussed the possibility of couples therapy, but she wanted to see how much of their relationship problem might be resolved through her individual therapy. Because it was unclear how much her relationship issues and withdrawal were a function of a complicated grief reaction, we agreed to begin with grief work. We also agreed that her blood phobia was something to which we could return.

Sessions 4 and 5

In discussing the issues of death and loss, a number of factors emerged that may have been contributing to Elaine's difficulty in accepting the death of her parents. This included the ambivalent feelings she had toward them and her fear of becoming too emotional ("I'm afraid that if I start crying, I won't stop"). However, during the week prior to the fourth session, she had attended her cousin's funeral and allowed herself to cry. At the end of that session, I introduced the idea that an empty chair exercise might be effective in helping her sort out the different thoughts and feelings she had toward her parents, because these might be complicating the process of mourning. She was reluctant at first, but after I acknowledged that I recognized the unusual nature of the intervention and emphasized that it has been shown to be effective (cf. Elliott, Watson, Goldman, & Greenberg, 2004), she agreed to try it.

During the following session, Elaine spoke to her father in the empty chair, telling him that although she tried to be a "good daughter," she felt "frustrated" by his controlling and critical manner. In addition to hinting at some negative feelings toward him, she cried in the realization she was talking to an empty chair and that her father was no longer there. The exercise seemed to help to bring some of her thoughts and feelings into awareness.

Sessions 6 and 7

Elaine acknowledged that the previous session had been helpful and that she felt a little "freer" as a result of it. In continuing the empty chair
exercise, she expressed confusion and annoyance to her father because of his emotional distance. In trying to help her better understand why her father had related to her as he did, I asked Elaine to sit in her father's chair and to explain why he was so distant (a useful method for helping clients reevaluate the motivation behind a significant other's actions). Although she initially had difficulty in verbalizing why he had treated her as he had, she (in the role of her father) eventually explained, "I was always afraid that you'd want to find your real parents and leave us."

We discussed how her relationship with her father was linked to the difficulty she had in expressing and asserting herself. She recognized that her tendency to emotionally distance herself from others was patterned after her father's interpersonal style. She was also able to appreciate her father's fear of rejection, because she saw this as a factor underlying her unassertiveness and her tendency to withdraw during disagreements with her husband. Although her father did not provide her with emotional closeness, Elaine acknowledged that he had cared about her welfare, worked hard to see that her physical needs were met, and supported her during college and law school. She also acknowledged that her passivity and unassertiveness in personal contacts were much like how her mother had related to her father.

Sessions 8 to 10

Elaine reported that she had been looking through some old pictures of her father, which brought back a number of bittersweet memories. While watching a TV program involving a daughter-father relationship, she had thought of him and cried. Because I had been to a particularly touching memorial service during the previous week, I disclosed to Elaine what was said and how I felt. (For the potential uses of therapist self-disclosure, see Goldfried, Burckell, & Eubanks-Carter, 2003.) Elaine related her own experiences during her father's funeral, started to cry, but then stopped herself. I commented on how she was interrupting her sadness and encouraged her to go with the sadness—which she did.

She became better able to forgive her father for not having given her what she needed emotionally. However, during an empty chair exercise, Elaine verbally expressed resentment toward him for never telling her directly that she had been adopted. She reported that she had learned of the adoption indirectly in her mid-20s, when she found her birth certificate. During the empty chair interaction, I encouraged her to ask her father why he had never told her about the adoption. I then asked her to switch chairs and, speaking as her father, to provide an answer (again, looking to see if she might be able to reduce her anger by reattributing his motive for remaining silent about the adoption). In speaking as her father, Elaine explained that he and her mother did not want to tell her about the adoption when she was younger, because they felt that she could not understand and would become too upset. How-
ever, they then felt awkward and fearful about telling her as she got older, because they were afraid she would be angry about never having been told. I asked Elaine what she would have done if her own two children had been adopted and when might have been a good time to tell them. After much thought, she confessed that she could not think of a good time, and perhaps there was no good time to tell them—or at least, no easy time.

Sessions 11 to 13

Elaine brought in pictures of her father and mother, which we used to have her recall some of the pleasant times they spent together. She was readily able to express her sadness over the loss of both her parents. Although she reported feeling sad during the process, her sadness was not mixed with resentment and was not overwhelming. My impression was that she was making progress on the working-through process associated with grieving. A potential complicating factor was that her father-in-law, who was in a nursing home, seemed to be deteriorating. Still, we agreed that a portion of our sessions might begin to focus on another agreed-on goal, namely her relationships with her husband.

As we explored the thoughts and feelings associated with her difficulties in asserting herself, Elaine indicated that she grew up with the image of being a “good girl.” This meant that it was important for her to please people with whom she was close, not impose her own will or beliefs, and avoid conflict at all cost. The paradox, however, was that her attempt to please others (particularly her husband and children) by her lack of openness often had a negative impact on them. In addition to a negative interpersonal consequence, this lack of expressiveness typically resulted in her feeling annoyed with herself. I suggested she read Alberti and Emmons’s *Your Perfect Right* (2001), a self-help book that can help to clarify frequent misconceptions about asserting oneself. I also suggested that she bring in a list of situations that involved the need for her to express her feelings, thoughts, and needs toward her husband.

During this period, Elaine’s father-in-law passed away. She openly cried at the funeral, both for him and for her own father. She was able to support Mike in his grief and felt good about being able to do so. Her fear of crying and experiencing the pain of loss appeared to have lessened. As a result of several corrective experiences, she had learned that if she let go, she would not cry forever.

Sessions 14 to 17

Elaine continued to experience occasional waves of sadness when reminded of her parents. Of particular importance is that the symptoms associated with her failure to grieve (e.g., depression, fear of her husband and chil-
children dying) had deceased substantially. We therefore agreed to spend most of the session time dealing with her relationship with her husband.

We reviewed the situations in which she wanted to become more expressive with Mike. In doing so, we identified and reevaluated the anticipatory fears that could block her from speaking up, and we began to use role-playing (with audiotaped feedback) to rehearse what she might say and how she might say it (Goldfried & Davison, 1994). To facilitate ongoing reality testing, each session involved a processing of the assertive and unassertive interactions she had had during the previous week and a preparation for what she would do during the following week.

From time to time, Elaine would manifest her unassertiveness in her interactions with me. When this occurred, I made a point of shifting the focus to her in-session behavior, thoughts, feelings, and wants and made the link to her inexpressiveness in her relationships with Mike and her children. I also encouraged her to be more openly self-assertive with me.

During this time, Elaine’s back problems flared up. Although no date had yet been set for surgery, it was possible that it could occur within the next few months. We agreed that as the time drew nearer, we would spend more time on her blood phobia.

**Sessions 18 to 21**

Elaine continued to make progress in voicing her opinions to Mike. As before, the format of these sessions involved reviewing between-session corrective actions and their associated thoughts, feelings, and needs, noting both the interpersonal and intrapersonal consequences and preparing for new experiences.

Although the primary focus of our work on assertiveness centered on Elaine’s relationship with her husband and children, she also became more aware that there were times when she held back voicing her opinion at work. It was also becoming increasingly clear to Elaine that her long-standing need to please others and the fear of not doing so continued to inhibit her expressiveness. We agreed that we would place additional focus on this issue.

**Sessions 22 to 24**

In dealing with Elaine’s fear that something terrible would happen if she did not please other people (especially significant others), we made use of a gestalt two-chair exercise (Elliott et al., 2004; Samoilov & Goldfried, 2000). The rationale I provided for using this method was that she was experiencing an ambivalent internal dialogue, which could be externalized and made more explicit by having each side speak to the other in the opposite chair. Using recently acquired corrective experiences, the 48-year-old Elaine spoke to the anachronistic, schema-based “good little girl,” helping to allay her
fears that disagreement with someone does not necessarily result in an end to the relationship.

The two-chair exercise served to further increase Elaine's awareness that being more open was not as dangerous as it seemed (i.e., change in cognitive–affective meaning structures). This awareness helped her to risk having additional corrective experiences in her relationship with Mike, especially those situations in which she disagreed with him (e.g., how to spend the weekend). These corrective experiences and their associated impact on awareness (i.e., ongoing reality testing) further helped her to revise her belief that not deferring to her husband and risking displeasing him would mean an end to the relationship.

**Sessions 25 to 28**

Elaine reported that her ability to express herself to Mike (and others) was continuing to progress. Instead of having to deliberately reevaluate her unrealistic fears of displeasing someone before speaking up, it was becoming easier for her to spontaneously say what she believed. Her openness typically worked out well, and she was feeling better about herself and more equal in her relationship with Mike.

A date had been set for her surgery approximately 2 months from then, and we agreed that the therapeutic focus would shift to dealing with her blood phobia. Issues related to grieving and loss no longer seemed to be much of an issue, and we agreed to briefly check on that during our sessions. Because Elaine had become better able to deal with assertiveness on her own, we also agreed to simply monitor that from time to time.

In gathering further information about her blood phobia, Elaine indicated that it was typically triggered by receiving injections, getting blood drawn, and having an IV. In addition to experiencing anticipatory anxiety, she described what was a vasovagal reaction, in which she would faint. I proposed an intervention to which she agreed. We would use relaxation and in vivo desensitization to deal with the sympathetic reaction associated with the anticipatory anxiety, and we would use distraction to cope with the parasympathetic reaction resulting in dizziness and fainting (Penfold & Page, 1999).

The relaxation training followed the procedures outlined in Goldfried and Davison (1994), in which the goal is to learn to use the relaxation response as a method of coping with anxiety. As the training progressed, we identified situations that were likely to create blood phobic anxiety and trigger a vasovagal reaction (e.g., seeing a syringe, having blood drawn). I also encouraged her to expose herself to hospital situations (e.g., watching ER on television, visiting a hospital), because she was apprehensive about these situations as well.

The in vivo desensitization and distraction was implemented in the sessions by having her use her relaxation to cope with a simulated situation.
in which I drew a blood sample. I had an actual syringe and alcohol, and we repeatedly rehearsed the procedure (using a pencil to simulate the insertion of the needle). During this time, Elaine not only relaxed, but also closed her eyes and distracted herself by imagining that she was at a ballet performance, watching her favorite ballet. We continued this procedure repeatedly over several sessions until she no longer experienced the anxiety or dizziness associated with injections, having blood drawn, or having an IV inserted.

Session 29

Three months later, following some brief phone contacts in which Elaine reported that the surgery had gone well and that she was recovering with the assistance of physical therapy, we had a session to discuss her experiences in greater detail. Much to her surprise and delight, she had handled it well, adding that she had even enjoyed her imagined visits to the ballet!

This was not our last session. Indeed, at the time of this writing, I am continuing to work with Elaine on her relational issues. Although assertiveness and expressiveness training has clearly helped her in her interactions with Mike, certain problems continue to exist. Whether or not couples therapy will be needed remains to be seen.

CONCLUDING COMMENT

As can be seen from this case illustration, contributions from different theoretical orientations can readily be incorporated into a course of therapy. Although cognitive–behavior therapy served as my starting point, experiential interventions (e.g., empty chair, two chair, a focus on in-session process) and relational interventions (e.g., linking the client’s relationship with the therapist to her unassertiveness with others) were used from time to time. The overriding rationale that holds these diverse procedures together is that they reflect certain common principles of change associated with different approaches to therapy: the expectation that therapy can be of help, the existence of an optimal therapy relationship, a facilitation of awareness, the encouragement of corrective experiences, and the presence of ongoing reality testing. The case of Elaine illustrates how these principles can be implemented. How I might implement them in another instance would be determined by the requirements of the case at hand.

REFERENCES


