Using Control Mastery Therapy to Treat Major Depression and Posttraumatic Stress Disorder

Nnamdi Pole
Polly Bloomberg-Fretter

Reprinted from Clinical Case Studies
Volume 5, No. 1, February 2006, pp. 53-70

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NNAMDI POLE
University of Michigan

POLLY BLOOMBERG-FRETTER
Private Practice, Berkeley, California

Abstract: We present the successful application of Control Mastery Therapy, a cognitive-psychodynamic-humanistic therapy, to the 16-session treatment of major depression and posttraumatic stress disorder (PTSD). The client was a 41-year-old European American woman who was the victim of multiple traumas including severe neglect, childhood incest, rape during adolescence, and physical and sexual abuse in adulthood. Her major goal for therapy was to get help in achieving her lifelong dream of becoming an artist, a dream that was initially interrupted by rape trauma and that had subsequently been difficult to attain because of psychological factors. The case outlines the pre-therapy assessment, case formulation, treatment (including verbatim transcript material), post-therapy assessment, and follow-up assessments for 6 months, 12 months, and 18 months post-therapy. The client met her major therapy goals and achieved clinically significant reduction in her depression and PTSD symptoms.

Keywords: Control Mastery Theory; depression; posttraumatic stress disorder; case study

1 THEORETICAL AND RESEARCH BASIS

Control Mastery Therapy (CMT) is based on a theory of psychopathology and psychotherapy developed by Joseph Weiss, Hal Sampson, and the San Francisco Psychotherapy Research Group (Weiss, 1993). The control mastery view of psychopathology is that problems commonly seen in private practice settings (e.g., depression, anxiety, failure to reach typical developmental milestones) often result from negative early-life

AUTHORS' NOTE: This research was conducted as part of Nnamdi Pole's doctoral dissertation and was funded in part by National Institute of Mental Health Dissertation Research Grant R03 MH058474. Nnamdi Pole wishes to thank Robert W. Levenson (the dissertation chair) for his generous support of this research; Kathleen Donohue, "Bonnie," Wendi Lyn Siebold, Kim McCoy, and Nicole Roberts for their critical contributions to these data; Karin Arndt, Tania Mara Miller, and Rebecca Stoller for their helpful comments on this manuscript; and Delores Carter Pole for her special contributions. Correspondence concerning this article should be addressed to Nnamdi Pole, University of Michigan, 525 East University, 2260 East Hall, Ann Arbor, MI 48109-1109; e-mail: nnamdi@umich.edu.

CLINICAL CASE STUDIES, Vol. 5 No. 1, February 2006 53-70
DOI: 10.1177/1534650103261200

experiences (e.g., trauma) with primary caregivers. Because young children are so dependent on their caregivers for survival, they are strongly motivated to seek strategies to maintain their attachment to caregivers even under difficult circumstances. One such strategy is to develop irrational beliefs that justify their negative experiences. For example, a child who is abused by a parent might develop the belief that she deserves to be abused. Although in the short run these beliefs serve the seemingly adaptive function of maintaining parental attachment, they can become pathogenic in the long run if they are carried into adulthood and generalized to other significant relationships. For example, the hypothetical child described above might maintain the belief that she deserves abuse and therefore might seek abusive adult relationships. Pathogenic beliefs are thought to contribute significantly to the patient's presenting complaints by interfering with his or her ability to achieve desired, developmentally-appropriate goals (e.g., finding a satisfying intimate relationship or selecting a suitable career) and by fostering traditional "neurotic" symptoms (e.g., anxiety and/or depression).

CMT is also guided by propositions about how the psychotherapy process helps patients to overcome their problems. Chief among these is the idea that patients come to therapy with an unconscious plan for their own recovery, which serves as the ultimate arbiter of which therapeutic interventions are helpful or harmful. For example, a patient who has had a long series of abusive relationships may come to therapy with an unconscious plan of disproving her pathogenic belief that she deserves to be abused. Usually, an important aspect of the patient's plan is to invite the therapist to disconfirm the pathogenic beliefs. Patients give their therapists the opportunity to challenge pathogenic beliefs by testing the therapist in a number of ways (Rappoport, 1997; Weiss, 1993). The two most common types of tests are "transference tests" and "passive-into-active tests." In the transference test, the patient will symbolically recreate conditions from his or her prior relationships to determine if the therapist will act as others have in the past. For example, the abused patient may behave in a dependent or needy way to determine if the therapist will become emotionally abusive (e.g., hostile or critical). The therapist can pass this kind of test by responding with appropriate warmth and support while also affirming that the client's neediness is not a justification for abuse. In the passive-into-active test, the patient will also symbolically recreate conditions from prior relationships, but now the patient symbolically takes on the role of the "victimizer" by, for example, becoming hostile and critical with the therapist. The therapist can pass this kind of test by directly addressing the patient's hostility and by insisting that the patient seek more appropriate ways to express discontent. From this, it is expected that the patient will learn not only that such hostility was inappropriate in the past but also that such hostility is inappropriate in his or her current relationships.

Because both testing and the plan are outside of the patient's awareness, the CMT therapist attempts to anticipate the patient's tests by formulating the patient's plan based upon clues from the patient's history. The therapist judges the accuracy of his or her formulation by observing the patient's response to his or her efforts to pass the patient's tests and his or her other plan-compatible interventions. CMT does not prescribe particular

techniques, such as thought stopping or transference interpretations, in the conventional sense. Instead, CMT assumes that there are many ways to be "plan compatible" and to pass tests. When the therapist's interventions (e.g., comments, advice, interpretations) are "proplan" (i.e., compatible with the patient's plan and counter to his or her pathogenic beliefs), the patient should infer that it is safe to pursue his or her goals and to respond with increased relaxation, insight, and boldness in working toward his or her goals. On the other hand, when the therapist's interventions are "antiplan" (i.e., in opposition to the patient's plan and reinforcing of the patient's pathogenic beliefs), the patient is predicted to infer that it is dangerous to pursue his or her goals and will respond with increased constriction, defensiveness, and anxiety (Weiss, 1993). Based upon the patient's response, the therapist may modify his or her formulation about the patient's plan.

Although CMT is novel in many ways, it also can be viewed as an integrationist theory that combines features of psychodynamic, cognitive, and humanistic theories (Pole, Ablon, O'Connor, & Weiss, 2002). CMT is psychodynamic in the sense that it emphasizes unconscious mental processes and posits that early childhood experiences are the source of many clinical disorders. Yet, unlike conventional psychodynamic theory, CMT does not assume that patients can only achieve insights through the therapist's interpretations. Instead, CMT proposes that the therapist can often facilitate insights by adopting a proplan attitude or by offering corrective emotional experiences. CMT is also cognitive in that it considers irrational beliefs to be a major "pathogen" and challenges them to be an important focus of treatment. Yet, unlike most cognitive theories, CMT's pathogenic beliefs are mostly unconscious and are thus best addressed in the transference. Finally, although the CMT therapist is not as "genuine" as what might be advocated by some schools of humanistic therapy in the sense that the CMT therapist focuses on contradicting pathogenic beliefs rather than on always disclosing his or her true feelings, CMT shares with humanistic theories the view that psychotherapy patients have an inherent "drive" to overcome the inhibitions prescribed by their pathogenic beliefs in order to lead happier and more fulfilled lives. Psychotherapy is one means to that end. The concept of the plan is based on the idea that patients both consciously and unconsciously want to overcome pathogenic beliefs and to meet their normal developmental goals. To this humanistic perspective, CMT adds the assumption that patients, and indeed all humans, are powerfully motivated by unconscious altruistic concerns, especially reluctance to outdo close family members. This concern usually manifests itself in one or more varieties of interpersonal guilt (O'Connor, Berry, & Weiss, 1999) that can act as strong inhibitions against achieving normal developmental goals.

Several studies support the basic tenets of CMT. Indirect evidence shows that experienced clinicians can independently and reliably infer a client's plan (e.g., Curtis, Silberschatz, Sampson, & Weiss, 1994). There is also evidence from a series of quantitative single-case studies that plan-compatible interventions and passed tests are ameliorative agents. Patients respond to CMT techniques with immediate increases in boldness, insight, involvement, relaxation, emotional experiencing (Fretter, Bucci, Broitman, Silberschatz, & Curtis, 1994; Messer & Holland, 1998; Silberschatz &

Curtis, 1993; Silberschatz, Fretter, & Curtis, 1986), positive in-session affect, better therapeutic alliance, and ultimately better session and treatment outcomes (Norville, Sampson, & Weiss, 1996; Pole et al., 2002; Pole & Jones, 1998; Silberschatz et al., 1986).

2 CASE PRESENTATION

We will present a brief CMT for major depression and posttraumatic stress disorder (PTSD). The treatment was conducted by a graduate student therapist as part of the first author's dissertation and was supervised by the second author, an experienced researcher and practitioner of CMT. The client, Bonnie, was a 41-year-old European American, twice-divorced, unemployed, bisexual, single mother who was raped as a teenager while studying to become an artist. She subsequently dropped out of school and had difficulty returning to her studies for many years. When she began therapy, she had finally completed her education but had noticed that she still felt very "blocked" in taking the steps necessary to start her career. She also reported several psychological and interpersonal problems that she wanted to address in therapy.

3 PRESENTING COMPLAINTS

Bonnie's main impetus for beginning therapy was to get help with her longstanding difficulty in achieving her career goals. After twenty years, she had finally earned an art degree. Yet she continued to feel "held back" in taking the steps necessary to start working toward her lifelong dream of becoming an artist. This intrapsychic struggle was complicated by an ongoing interpersonal struggle with her father and stepmother. Bonnie's father had long opposed her career choice and even now was urging her to seek a more "practical" job, ostensibly out of concern for the welfare of Bonnie's young daughter, Kate. Bonnie's stepmother added to her problems by openly competing with Bonnie for Kate's affections, usually by spoiling Kate with expensive gifts and trips that Bonnie could not afford to provide. Bonnie also complained of depression and posttraumatic stress symptoms, which she collectively referred to as her "pain."

4 HISTORY

Bonnie grew up as the eldest of three children in a household run by unhappily married and neglectful parents. Bonnie felt closest to her father, who by all accounts was critical and tyrannical. She says that she "never bonded" with her mother, who Bonnie described as uninvolved and emotionally unbalanced. Bonnie's mother earned several academic degrees and, in her youth, translated Russian for the CIA. She had aspirations

of becoming a professional journalist, but Bonnie's father obstructed and ultimately thwarted her plans, insisting that she pursue a more "practical" job in order to help with the household expenses. Bonnie's mother begrudgingly complied and became a nursery school teacher. But shortly thereafter, she began exhibiting signs of a serious, yet undiagnosed, mental illness, which apparently included both psychotic and dissociative features.

At age 11, Bonnie was molested by her paternal grandfather. Although she complained to her parents about it, they refused to believe her. Instead, they became more deeply embroiled in an increasingly acrimonious marriage. When Bonnie was 13 years old, her parents divorced, and her father moved out of the house, leaving Bonnie and her brothers feeling "sad" and "abandoned." Following the divorce, her mother's symptoms worsened. She frequently screamed in public as if in agonizing pain, she drove erratically, and she lost interest in cooking, cleaning, shopping, and other activities of daily living. Bonnie felt that she and her siblings were "totally neglected." They received "no supervision and no help" during their adolescent years. At first, Bonnie assumed most of the household responsibilities, but by the age of 16, she opted to graduate from high school early, move away from home, and enroll in community college.

At age 19, Bonnie decided, against her father's wishes, to move to South America to pursue her dream of studying art. While there, she was brutally raped at gunpoint by a man who broke into her apartment and dragged her across her concrete patio. After her attacker fled, Bonnie reported the crime to the local police, who literally laughed at her and refused to help. She had no close family or friends to turn to in South America, so she wrote a telegram to her father asking for help. At the time of her intake interview, she "could not recall" whether he ever replied to her. Her emotional distress rose to the point that she decided to drop out of school. About a month later, she developed hepatitis. At that point, her father sent money for a plane ticket home. Shortly after her return to the United States, she was diagnosed with diabetes mellitus. Her parents continued to be unsympathetic and disinterested in her welfare.

In her early adulthood, Bonnie had a series of sexual relationships with both men and women in which she was sexually and physically abused. She married her first husband when she was 23 years old. He was a gay man who was trying to "please his parents by getting married." Bonnie thought that she could "save him." Their marriage, which was plagued by serious financial problems, ended after one year. Bonnie subsequently became involved with a homeless, violent, drug dealer, who had been recently released from prison. This boyfriend had an explosive temper and kept a gun around the house, which led Bonnie to feel frightened all of the time and to use illegal drugs to numb her anxiety. During this period, she earned a living through professional massage but was pressured by her boyfriend to offer sex to some of her clients for higher fees. After being arrested once for this activity, she withdrew from the massage business.

Bonnie began working an office job that she hated. Her work hours were filled with daydreams about earning a living through her art. She vowed to clean up her life by giving up drugs, but when she stopped taking drugs, her traumatic memories resurfaced.

She intrusively re-experienced her grandfather's sexual assaults, her father's leaving home, her rape in South America, and her being neglected as a teenager. She also began dissociating and having panic attacks. She cried constantly and had great difficulty working. She sought therapy for the first time at age 30 to manage these symptoms.

Bonnie married her second husband when she was 35 years old. He had cerebral palsy, was confined to a wheelchair, and was never physically abusive. Although they had a child together, Kate, their marriage also ended in divorce. Bonnie continued to work toward an art degree on a part-time basis during her thirties. It was a long and frustrating process with many stops and starts. She ultimately completed her training when she was 40 years old, around the time that her mother died of cancer. Approximately two years later, she began the present treatment.

5 ASSESSMENT

Prior to beginning therapy, Bonnie participated in a semi-structured diagnostic interview, which resulted in the following multi-axial DSM-IV diagnosis:

Axis I: 296.31 Major Depressive Disorder; Recurrent; Mild
309.81 PTSD; Chronic; Moderate
Axis II: 799.9 Deferred
Axis III: 250.01 Diabetes Mellitus; Type I/insulin-dependent
Axis IV: Lack of social support; Unemployment
Axis V: GAF = 55 (at intake)

She also completed several self-report measures, including the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis & Savitz, 2000) and the Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), and achieved scores indicating clinically significant elevations of the following target problems: depression (SCL-90-R Depression Scale); posttraumatic stress symptoms (SCL-90-R Crime-Related PTSD Scale; Saunders, Arata, & Kilpatrick, 1990); difficulty being assertive (IIP Hard to be Assertive Scale); difficulty being sociable (IIP Hard to be Sociable Scale); and being overly-exploitable (IIP Overly-Exploitable Scale). We also obtained continuous measures of her heart rate during each therapy session as an objective index of PTSD hyperarousal symptoms. Data on these measures are presented in Table 1.

6 CASE CONCEPTUALIZATION

From a control mastery perspective, a patient's stated goals are the most important clue to his or her plan for therapy. Bonnie stated four goals: (a) making progress on her art career; (b) finding relief from her pain; (c) resolving conflicts with her father and step-

TABLE 1
Changes in Symptom Measures in the Case of Bonnie

Measure	*Pre-Therapy*	*Termination*	*6-Month Follow-Up*	*12-Month Follow-Up*	*22-Month Follow-Up*
SCL-90-R Depression	2.00	.38	.23	.46	.46
SCL-90-R CR-PTSD	.79	.32	.14	.32	.39
IIP (Hard to be Assertive)	2.33	1.05	1.14	1.10	1.33
IIP (Hard to be Sociable)	1.83	.78	.83	1.33	1.06
IIP (Overly-Exploitable)	2.00	1.00	1.13	1.13	1.00
Heart rate (beats per minute)	90.20	80.60	82.40	76.40	91.00

NOTE: Non-patient norms for the above measures are as follows: SCL-90-R Depression (M = .46, SD = .52); SCL-90-R CR-PTSD (M = .39, SD = .41); IIP Hard to be Assertive (M = 1.48, SD = .57); IIP Hard to be Sociable (M = 1.30, SD = .68); IIP Overly-Exploitable (M = 1.47, SD = .65). Resting human heart rate is usually in the range of 60 to 80 beats per minute.

mother; and (d) attaining a satisfying, supportive, and healthy intimate relationship. It is not uncommon for patients to state more goals than can be realistically addressed in a brief therapy. Typically, as the therapy unfolds, they prioritize their goals. In formulating the plan, a CMT therapist considers the patient's given reasons for not being able to achieve his or her goals but ultimately assumes that unconscious pathogenic beliefs are the primary obstacle to the patient's progress. For example, Bonnie reported feeling held back from pursuing her art career. To a control mastery clinician, this suggests an unconscious warning against pursuing the healthy developmental goal of fulfilling her career ambitions. The CMT therapist closely examines the patient's negative life experiences, especially those that occurred relatively early in life, in order to further clarify the content of the pathogenic belief. For example, Bonnie's mother was unable to overcome her husband's efforts to thwart her career goals, which contributed to her mental illness and unhappy life. Consequently, Bonnie may have unconscious "survivor guilt" about outdoing her mother by achieving her own career goals. As with many psychological symptoms, this belief may be over-determined by a number of aggravating factors including: (a) Bonnie's antipathy toward her mother; (b) her father's disapproval of her career choice when she was an adolescent; (c) the brutal rape that she endured while following her career aspirations; (d) the cruel dismissal and mocking that she received from local authorities when she complained about the rape; and (e) her father's continued lack of support of her career goals in adulthood. Her mother's death, which coincided with the completion of her education, probably both exacerbated her feelings of survivor guilt and raised existential awareness of her own mortality and opportunity to have a better life than her mother had. This conflict may have played a major role in motivating her to seek therapy at this particular time with this particular primary goal.

Bonnie's other goals can be linked to pathogenic beliefs in a similar fashion. For example, Bonnie's trouble in resolving her conflicts with her father and stepmother may also be related to her early experiences. The burden of caring for the family fell on Bonnie as a child. She may have consequently developed the pathogenic belief that she

is required to take care of her parents' needs instead of her own. Bonnie's difficulty finding appropriate intimate partners probably had its origins in her rape by her grandfather and her parents' subsequent failure to acknowledge it or adequately protect her. This probably generated pathogenic beliefs about her sexuality and her worthiness to have a nonexploitive sexual relationship, beliefs that were probably only further entrenched by the bizarre recapitulation of this event in South America, where she was again raped and again not protected by the authorities. At some point, Bonnie probably began to believe at an unconscious level that she deserved to be sexually abused and actually sought environments where sexual abuse was likely to occur (as is suggested by her first marriage). In addition to complex pathogenic beliefs about sex, Bonnie probably also had pathogenic beliefs about basic emotional intimacy. For example, she seemed to hold the pathogenic belief that she is deeply damaged and would be a great burden to anyone who tried to share her life. This belief may have resulted from her parents' gross neglect of her needs as a child. In order to avoid viewing them as incompetent, which would have been overwhelming to her, she developed the pathogenic belief that her needs were overwhelming to them. Because she maintained this pathogenic belief in adulthood, Bonnie sought out partners who similarly neglected and exploited her.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Bonnie received 16 weekly, 50-minute psychotherapy sessions, which were videotaped in their entirety, at the Psychology Clinic at the University of California, Berkeley. Her therapist was a 30-year-old, European American, female clinical psychology graduate student with four years of prior clinical experience.

During the first session, Bonnie spoke predominantly about the severe neglect that she had experienced from her mother. Ironically, because Bonnie's therapist was nervous about being videotaped, the therapist was somewhat emotionally distant throughout this initial session. Bonnie experienced the distance as being similar to her mother's neglect and antithetical to her therapy plan. Consistent with the formulation, Bonnie became more depressed following this session. Although Bonnie had not openly attributed her worsening symptoms to the therapist's emotional distance, her therapist understood the failed test and began the second session by apologizing and by explaining the reasons for her emotional distance. Bonnie was visibly relieved and responded by describing times that she had been upset by previous therapists who seemed not to take responsibility for their behavior. Bonnie also discussed her current difficulties with her father and stepmother (whom we will refer to as her "parents" from this point forward). She emphasized their failure to support and respect her wishes about how to treat her daughter. Yet, somehow Bonnie found herself excusing their behavior. Her therapist offered the following intervention:

Therapist: You know it would be great to be able to understand why your parents have not been good parents to you.

Bonnie: Yeah, it would be [sighs].

Therapist: But the truth is they've been lousy parents to you. You know, you can look and say, "What happened?" because obviously something happened to them when they were kids right? You can do that. But I mean what's important is that they are not there for you and they haven't been there for you.

Although this active and non-neutral intervention is contrary to what many psychodynamic approaches might advocate in a second session, CMT prescribes this type of intervention to counter Bonnie's unconscious conviction that she deserved her parents' neglect.

During the third session, Bonnie asked to reschedule her regular therapy time in order to take an art class. Some branches of psychodynamic theory would see this as resistance and discourage any alteration of the therapeutic "frame" so early in treatment. However, in CMT, this request was viewed as a test to see whether the therapist would prioritize Bonnie's career development. Her therapist, therefore, gladly rescheduled and encouraged Bonnie's efforts to hone her artistic skills.

During this period, Bonnie also worked to set limits with her parents with regard to their spoiling of her daughter. They repeatedly ignored Bonnie's wishes and blamed her for the conflict. Bonnie's therapist supported setting firm limits with them to ensure that Bonnie's needs were met. From the CMT perspective, Bonnie's needs as a parent take precedence over the grandparents' wishes.

Bonnie: [crying] I remember thinking if you know, if I ever had children that I just wouldn't even have them have anything to do with my father. I don't know, you know, it's like maybe, maybe it would've been better.

Therapist: Look, you've protected Kate. You've always looked out for what is best for her and you thought it would be best for her to have contact with a bigger family and that's why you did it. And you did it carefully, and you watched them to make sure it was a good thing for her. But it would not be good for Kate, for you to resolve things with your dad too quickly or in a way that is not good for you. It has to work for you first.

Bonnie: Yeah, that's true. And I've done that so many times. I've been upset with the ways things are and I've set limits and they haven't respected them and I've, you know, let them see her anyway.

The therapist then interpreted Bonnie's unconscious motive for maintaining this dissatisfying relationship with her parents. This interpretation, which is typical of CMT, drew Bonnie's attention to some of the altruistic motives that may underlie her behavior.

Therapist: It seems to me that your relationship with them is constantly putting you in a position where you're the one to be blamed and—if you're the one to be blamed—it's like you're protecting them from being blamed. If you're the bad guy then your father is not the bad guy, your stepmother is not the bad guy. Even though we talk about ways that they're treating you terribly—somehow still you're the one that's blamed again and again and again.

Bonnie: Yeah, that's true.

Therapist: But sometimes there's even almost a safety in being blamed, in being the bad one, and I wonder if that's one of the reasons why it's hard for you to think about really cutting off from them. You feel like you can tolerate their criticism of you but that if you actually cut off from them that would be too much.

Bonnie: Well, I mean there's also the issue of hurting them. I mean, I know it would hurt them.

Therapist: You need to take care of them.

Bonnie: Yeah, and I need to take care of them because that's what I've always done.

Therapist: That's what you've always done from when you were a little kid.

Bonnie's therapist took a vacation during the following week. At the beginning of the next session, Bonnie announced, "I feel like I am going to fall apart," which she attributed to her hormones. She also explained that she had been feeling very alone and helpless. Although she reflected upon the many relationships in her life that were not providing her with needed support, she never mentioned her therapist. Her therapist viewed this material as a disguised message about Bonnie's feelings of abandonment during her vacation, so she responded with the following:

Therapist: I was on vacation. We had little phone check-in times but we didn't have our regular meeting. Given that you felt, your whole life, that you have to do everything by yourself, I think that the break might have exacerbated your feelings because we were really, you know, beginning to work together and then, for me to be gone might have triggered more of those feelings that you have to do it by yourself. You have to do it. You can't depend on anyone. It's got to be all you.

In the following session, Bonnie focused on her increasing financial stress. She proposed that maybe she should give up efforts to seek a job in art and instead should settle for "just any job." Her therapist viewed this as a test to see whether the therapist would act like her father and encourage Bonnie to seek a "practical" job rather than follow her true passion. Her therapist explicitly advised Bonnie to avoid falling prey to the critical voice of her father.

Therapist: So you're feeling like there's no space for your art now.

Bonnie: Yeah, yeah. There's a little space, but there's not a lot and financially things have not been going well. So, that makes it more difficult.

Therapist: Sure. That's a huge stress. There's no question about it. Yet, I hear your father's voice in this talk a little bit. You know, "Just get a job. Just get a job!" You want to respond to that and say, "No. I need to do something that I want to do."

Bonnie reported that she went on a "successful" job interview for an administrative job but found herself becoming intensely depressed afterward. The therapist discouraged accepting the administrative job and supported her pursuing an art career. Bonnie reported that she was feeling desperate, alone and without help. The therapist challenged Bonnie's belief that she has no current support:

Therapist: But these feelings about being all by yourself, about being alone, these are old feelings.

Bonnie: They're really, I mean they're really, really old feelings.

Therapist: They are and that doesn't make them less painful obviously, but now, you're not alone. You find people, you find support, you find friends. The aloneness, the aloneness is the old feelings. It's from when you were a kid.

Bonnie: Yeah, you know it's really amazing. Actually, I've gotten pretty close to one of the people in my group that I go to on Monday night and she knew that I didn't have the money to pay for the group and she paid it for me, for the whole month, which was you know, I mean, I wasn't expecting anybody to do that. If I can't pay I just don't pay it on time, and then I just pay it later.

Therapist: People like you.

Bonnie: Yeah they do.

Therapist: They do, and they want to help you.

Bonnie began the seventh session by asking her therapist about how she chose a career in psychology and whether she had a career prior to becoming a therapist. Although some schools of psychodynamic thought might eschew requests for self-disclosure, CMT would frame this request as a useful test for Bonnie to pose. At an unconscious level, Bonnie may have wanted to know whether her therapist was pursuing her career passions in the way that Bonnie's mother was unable to do and in the way that Bonnie was now struggling to do. Her therapist volunteered her career history, which involved a few years of experimenting with paralegal work before settling on her true goal, clinical psychology. Bonnie responded to this disclosure by telling her therapist that she feels very close to her and very comfortable talking to her. This could be taken as evidence that the therapist passed this test. Bonnie then began to talk in depth about her disappointments and problems with her father including her father's continued denial that his father molested her, her father's physical and emotional abuse of her as a child, and his continual verbal attacks and pathologizing of her. Of her father, she said:

Bonnie: There is a way he wants me sick, unhappy, and a failure. I don't have to give him that. I'm not gonna be miserable on his behalf.
Therapist: Your success will mean giving up on your father.
Bonnie: I don't want to but I don't know what else to do.

Bonnie noted that although her father was difficult, he was an important source of support. Her therapist advised Bonnie to seek more outside support. Toward the end of the session, Bonnie announced that some of her artwork was to appear in a local art show.

In session ten, Bonnie mentioned that she had accepted a lunch invitation from her father. She sheepishly admitted that she concealed the lunch from her therapist because she feared that the therapist would not approve. Bonnie also mentioned that her mother tried to keep her away from her father, suggesting a transference of the hostility that she had felt toward her mother to her therapist. Bonnie then began to share her deep feelings of rejection by her mother, which were extremely painful. Her therapist indicated that this would be a difficult issue to tackle in the few sessions that remained in the therapy. Furthermore, she wondered whether getting embroiled in this issue would only serve to further block her progress toward her other goals. Bonnie suggested that they focus instead on her original goals for therapy: beginning her career and reducing her emotional pain.

Bonnie revealed that she enrolled in a class on how to start a small business, but she felt uncomfortable about spending money from her mother's estate to start her business. Bonnie's therapist saw this as an opportunity to interpret Bonnie's survivor guilt:

Bonnie: Well, I have noticed one thing and that's when I see what some women are going through in terms of being in a recovery program, or being homeless, or being HIV positive, or whatever it is that they're dealing with, I do feel really lucky but I also feel guilty sometimes.
Therapist: Guilty how?
Bonnie: Well, I think it's just that I really want other women who've been through what I've been through to um. . . to have a good life [crying].
Therapist: It's like a survivor guilt, isn't it?
Bonnie: Yeah, I know it's like I was embarrassed when I got the money from my mother, and then I bought the house. I felt like um [crying] that in a way it didn't seem fair that I could do that and somebody else maybe couldn't do that.
Therapist: One thought that I have about this idea of doing better than other people who have a lot of trauma in their lives too, is that you're also doing much better than your mom who had a lot of trauma in her life.
Bonnie: Yeah she did, she did. . . .
Therapist: That's another kind of survivor guilt that some people feel. When is the anniversary of your mom's death?
Bonnie: Oh, oh my goodness um, it's um September 24th, so it's coming up.

In the twelfth session, Bonnie reported that she was doing and feeling well. She discussed her post-termination treatment plans, which included beginning family therapy with her father. She noted that her father had become more affectionate recently. Her therapist was pleased but advised caution. Bonnie also reported that she felt ready to start her art business, which her therapist strongly encouraged. In a subsequent session, Bonnie demonstrated how she was able to put some of her insights from therapy into practice to protect herself from a potentially dangerous situation:

Bonnie: Well, I took a big step this week, I went to talk to the owner of the local sauna about working there and then I realized after I thought about it a little more, that I really didn't feel comfortable with it. Part of it, was about working with men and, you know, what would I do if they made an inappropriate gesture or comment or whatever. The owner said to me if that's a problem for you that then maybe you should think about whether you wanna work here or not. But I didn't, you know, I really wasn't able to think it through right at that moment. So, I pretty much agreed to do it. Then later I realized that I really didn't feel okay about it. That it was really not okay with me at all for something like that to happen. And that I really didn't want to deal with it you know, even if nothing really came of it. So, I got back to her and I talked to her about it and she was disappointed because she said that she would have enjoyed working with me. But you know, she also respected my decision so that was good.

Therapist: So you felt like this was a positive move on your part, that you were kind of saying what you really felt.

Bonnie: But also it was just like, "Why am I doing this? Why am I putting myself in this situation if I know that it makes me uncomfortable and I don't wanna do it?" I mean if I'm gonna go in somewhere and accept a job, it better be because I feel really good about it and really excited about it and I didn't feel that way. I mean I didn't feel negative about it. There have been times recently when I've gone for job interviews and it's triggered a depression. It was so horrible. It wasn't that. It was more just, "This is not right for me and why am I doing this to myself?" Then realizing that I didn't have to go through with it just because I said that I would. I could change my mind.

In general, Bonnie was attending more to her adaptive, healthy drives. She became clearer about her career interests and more confident about how to achieve her goals:

Bonnie: I took the Illustrator and Pagemaker class and I realized I don't really like these programs. This is not really what I wanna do. I kept thinking that if I can learn these programs then I would be really desirable because that's what they want you to know, doing graphic work. But I'm not a graphic artist, really. I'm a textile artist. Even though to other people it may seem insane. I can just take what I already know and just go ahead and do it.

Therapist: You have enough skills already.

Bonnie: Yeah, I have enough skills. I mean I've gone to school a lot. I have a good sense about how things work and if I need to get some information I know where to get it. And there are people who I know who can help me. You know, I know people who are accountants. I know people who do marketing. I guess just, you know, just realizing that I can just go ahead and do it. I don't have to go through all this. So, that was a really liberating thought, a very liberating thought.

Therapist: Yeah. You know what you want. You just need to do it.

Bonnie postponed her final session for 2 weeks. She began her termination hour by talking about wanting to go back to school, which could be viewed as an unconscious wish to have more therapy. Her therapist responded with optimistic encouragement, "You're ready to be finished." As a termination gift, Bonnie offered the therapist a card featuring a beautiful textile pattern that she had designed. Her therapist gladly accepted the card and acknowledged that it was an important symbol of their work together. Bonnie spent the balance of the final session reflecting upon the gains that she made in therapy:

Bonnie: It's been a really amazing period of time. I mean this period of time didn't turn out being what I thought it would be but things are starting to fall into place. I'm noticing one thing that's really different is that I don't walk around in pain all the time and that's a really huge thing. Of course, there's this little voice that's saying, "But just wait. It's just coming and it's gonna come back. It's going to get you. Because it always does." But you know, on the other hand, I'm realizing that there are other people out there who have managed to get to a place where they're not in pain all the time anymore so maybe it's possible. Maybe it's possible to live a more quote normal life.

At termination, Bonnie no longer met DSM-IV criteria for major depression or PTSD and made clinically significant improvement on the SCL-90-R Depression and Crime-Related PTSD Scales and the IIP Hard to be Assertive, Hard to be Sociable, and Overly-Exploitable Scales, as defined by being within two standard deviations of the normal non-patient mean score (Jacobson & Truax, 1991; Table 1). Her mean heart rate was also lower, which is consistent with diminished PTSD hyperarousal symptoms (Buckley & Kaloupek, 2001). She reported a "dramatic reduction" in her pain and progress in her ability to set limits with her parents. Her father agreed to begin family therapy with her. She also achieved progress with her career. She used money inherited from her mother's estate to put down a deposit on an art studio and received a contract from her first client. Her only remaining major unfulfilled goal was finding a romantic partner to share her life with.

8 COMPLICATING FACTORS

The main complicating factors in this treatment were a result of the less-than-ideal fit between Bonnie's level of need and the constraints imposed by the research protocol. The research design limited clients to 16 therapy sessions. On the one hand, Bonnie's extensive trauma history and high level of distress made her a questionable candidate for such brief therapy. On the other hand, her low income and lack of health insurance made it unlikely that she would receive any other kind of treatment. We addressed this conflict in three ways. First, we supplemented her weekly therapy sessions with brief phone sessions, which served primarily to monitor her distress level but also helped to challenge pathogenic beliefs about neglect by keeping her therapist's support alive between sessions. Second, we advised Bonnie to seek a medication consultation to address some of her treatment refractory symptoms. She obtained but never filled a prescription for antidepressants because her symptoms began to improve without them. Third, because we considered 16 sessions to be insufficient treatment, we supported Bonnie's decision to seek additional treatment after our therapy. Both the fact that we considered our treatment incomplete and the fact that she received additional treatment complicates the interpretation of our follow-up data.

9 FOLLOW-UP

Bonnie was scheduled for follow-up interviews at 6 months, 12 months, and 18 months post-therapy. At these times, she was also asked to complete the same psychometric measures that she completed at intake. Her heart rate was also monitored continuously during the follow-up interviews. These data, which are presented in Table 1, suggest that Bonnie maintained most of her gains over the follow-up period. However, she seemed to show some signs of relapse by her final follow-up assessment.

At 6 months post-therapy, Bonnie had started her own textile design company and was so busy that she was turning away customers. She was displaying her art in a solo show and in local magazines. Although she found her burgeoning career to be quite exciting, she was mildly concerned that the venture was not yet profitable. Her relationship with her father continued to improve. For the first time, he told her that he loved her. She attributed the change in her father's interest and affection to the fact that she was beginning to demonstrate some success in business, which he saw as "practical enough." She reported greater enjoyment in her relationship with her own daughter and in her role as a mother. She was actively dating but had not yet found a satisfying relationship. She reported occasional bouts of depression, which she treated with a combination of group therapy, thought field therapy, and St. John's Wort.

During her 1-year follow-up interview, Bonnie announced that she had exhibited her artwork in several local shows and had sold a few of her prints. She was becoming

more concerned about earning a profit from her business because her mother's inheritance was beginning to run out. She indicated that some months prior she had experienced a brief relapse of depression and anxiety triggered by the news that her daughter's father was going to be moving 2,000 miles away to pursue a graduate degree. This news triggered memories of the feelings of abandonment that occurred when her own father left. At around the same time, Bonnie reported that she had a new memory of childhood abuse by her grandfather. This memory brought up intense dysphoria that lasted for weeks. On a positive note, Bonnie also began a new and exciting romantic relationship with a woman, thereby meeting the final goal of her therapy.

Bonnie postponed her 18-month follow-up interview because she was feeling "too depressed." She agreed to come in for an interview 4 months later. At 22 months post-therapy, she complained about some symptoms of depression but did not meet criteria for full major depressive disorder. She reported that she had experienced PTSD-related anxiety and flashbacks. Her artwork was being shown in multiple exhibits. Her romantic relationship became more serious, and she was contemplating moving in with her partner.

10 TREATMENT IMPLICATIONS OF THE CASE

A successful control mastery treatment of a woman with major depression and posttraumatic stress disorder has been presented. The content of the therapy sessions focused on what the patient considered to be her primary complaint, a 20-year struggle to realize her career ambitions, a struggle that her own mother was unable to win. Psychotherapy patients often present with similar problems that they view as primary to their psychological symptoms and clinical disorders. Yet, current empirically supported treatments (Chambless & Hollon, 1998) only offer remedies for psychiatric syndromes. CMT, which is empirically supported by several quantitative case studies, offers a way to formulate and treat problems that revolve around a seeming inability to attain a normal developmental milestone. In the case of Bonnie, this approach was not only helpful in moving her toward her career and interpersonal goals but it also led to changes in depression that were comparable to the changes reported by large randomized clinical trials of empirically supported treatments (e.g., Elkin et al., 1989).

Bonnie's post-therapy relapses should not be considered evidence that CMT was only a superficial "quick fix" that failed to address the underlying basis of her problems. Rather, it is more reasonable to note that her post-therapy course is consistent with findings from large randomized clinical trials of brief therapies for depression (Shea et al., 1992) and points to the real limitations of most brief therapies to bring long-lasting changes. This is likely to be a particular problem for patients who suffer from exposure to multiple traumas and comorbid psychiatric diagnoses. In sum, Bonnie's improvement and therapeutic accomplishments were remarkable considering the brief duration of her treatment. In some respects, the premature termination with her therapist may have

been somewhat iatrogenic, leaving Bonnie with the familiar feeling of abandonment. If Bonnie had been treated in a private-practice setting and had been permitted to have additional CMT, then we believe that her gains would have been further solidified.

11 RECOMMENDATIONS TO CLINICIANS

Consider unconscious guilt. Many clients present with vague complaints about feeling held back in achieving normal developmental milestones. If the impediment seems more psychological than practical, CMT would direct the clinician to inquire about close relatives (especially parents or siblings) who were also unable to achieve similar milestones. Clients may be unaware of how guilt about surpassing relatives may inhibit their normal development (O'Connor et al., 1999).

Neutrality isn't neutral. A key idea in CMT is that patients usually interpret their therapist's behavior in terms of their pathogenic beliefs. Bonnie's therapist was quite neutral in the first session, but Bonnie interpreted this behavior as neglect because of her childhood experiences. If Bonnie's parents had been intrusive and meddlesome, her therapist's emotional distance might have been experienced as optimal. What is crucial to the course of therapy is not a therapist's neutrality, or lack of it, but rather the client's experience of the therapist's behavior (Pole, 2001).

Self-disclosure can be proplan. One of the major dilemmas for beginning therapists is knowing how to respond to patient requests for self-disclosure. Whereas traditional psychodynamic therapists avoid self-disclosure at all costs, and whereas traditional humanistic therapists engage in self-disclosure at every opportunity, CMT would advocate making decisions about whether or not to self-disclose based upon the patient's plan. Bonnie's therapist understood that it was proplan to tell Bonnie about her own educational history and career choices because this information would challenge Bonnie's pathogenic belief that it is dangerous to pursue one's career passions. On the other hand, if the therapist had been unresolved about her own career choices, then it would probably not have been helpful to disclose this information to the client. CMT offers a rational approach to making decisions about self-disclosure.

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Nnamdi Pole, Ph.D., is an assistant professor of psychology in the clinical psychology program at the University of Michigan, Ann Arbor. His interests include psychotherapy research, posttraumatic stress disorder, psychophysiology, and minority mental health.

Polly Bloomberg-Fretter, Ed.D., is a clinical psychologist in private practice in Berkeley, California. As a 25-year veteran of the San Francisco Psychotherapy Research Group, she is a psychotherapy researcher as well as a clinician, and she participates in a variety of clinical and research studies of psychotherapy.