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A CASE STUDY ILLUSTRATING DEPRESSION FROM INTERPERSONALLY  
RELATED ISSUES

Cheryl Scheurich

A Thesis

Submitted in partial fulfillment of the requirements of the  
Master of Arts Degree  
of  
The Graduate School  
at  
Rowan University  
April 19, 2002

Approved by \_\_\_\_\_  
Dr. Rina Maschler

Date Approved 5/8/02

## ABSTRACT

Cheryl Scheurich

A Case Study Illustrating Depression From Interpersonally Related Issues

2002

Dr. Rina Maschler/Applied Psychology

This thesis is a single subject case study of a 20 year old, single, white female conducted in a university counseling center setting. This female presented into therapy with symptoms of major depression disorder, single episode, with moderate severity, and some mood congruent distortions. The therapy extended over a nine-week period, but with only six actual treatment sessions. Therapy consisted of an eclectic approach and individualized treatments pertaining to Cognitive-Behavioral Theory and some Interpersonal Theory elements for treating depression. This case was conceptualized through Young's Early Maladaptive Schema Theory (1990) and Bowlby's Attachment Theory (1969, 1973, 1980) in accordance to this client's self-reported symptoms of depression, avoidance, intraparental conflict in divorce, low academic functioning, and low self-esteem and social functioning. Goals of therapy focused on 1) educating the client to symptoms and causes of depression, 2) identifying distorted schemas and maladaptive patterns pertaining to the combination of early maladaptive schemas, intraparental conflict in divorce, and attachment theory, 3) identifying individualized stressors and cues for depression, and 4) coping mechanisms and individualized cognitive-behavioral and interpersonal treatments for correcting distorted schemas and maladaptive relationship patterns eliciting her depression.

## MINI-ABSTRACT

Cheryl Scheurich

A Case Study Illustrating Depression From Interpersonally Related Issues

2002

Dr. Rina Maschler/Applied Psychology

This thesis is a single subject case study on a young female who presented into therapy with symptoms of major depression disorder. Therapy consisted of an eclectic approach of Cognitive-Behavioral Therapy and Interpersonal Therapy. This case was conceptualized through Young's Early Maladaptive Schema Theory (1990) and Bowlby's Attachment Theory (1969, 1973, 1980) in accordance to this client's self-reported symptoms of depression.

## Acknowledgements

Writing this thesis has proven to be one of the most extraordinary learning experiences of my life. During this experience, I not only learned a new way of thinking, living, and experiencing life, I also learned many lessons that I will practice on a conscious, continuous basis. With my conscious awareness, I accept the challenge and the opportunity to help others get to the genuine selves that they desire to be.

I wholeheartedly thank those of my family and friends who graciously allowed me to rearrange my priorities over these past eight months while I was writing my thesis. I know that it's not always easy to be steadily encouraging of another's endeavors when the endeavor is the cause for the disruption of one's attention. I thank Bria for being such a wonderful daughter, for understanding how important this was to me, and for growing up just a little bit faster "so Mom could do what she wanted to do." I thank Johnny for teaching me an important lesson in life: tolerance. I thank my Dad for being supportive and "on my side," and for being proud of me, which is actually quite inspiring. I thank Gail who I feel is one of my greatest fans. I don't even think she realizes how inspirational it is to me when she says, "If anybody can do it, you can." And I thank Jimmy because without his causing me to keep questioning and saying, "I don't understand?" I would not have chosen this field or learned to identify my own patterns. Thank you Jimmy for being challenging, encouraging, supportive, and fun.

I also wish to thank my teachers/advisors Dr. Maschler and Dr. Cahill who have guided and supported me in this endeavor. I especially wish to thank Dr. Rina Maschler for being kind, sweet, understanding, and encouraging in those "hard times" during these past eight months.

*I believe there are no limitations; only possibilities. A thought is like a garden that when given constant attention in ridding the weeds can blossom into the most beautiful reality.*

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## Chapter One

Names and identifying information have been changed or omitted in this summary in order to protect this client's privacy.

### Clinic Information

Client was seen in the context of a large university-counseling center where psychological services are offered free to attending students. The counseling center is located on campus. The center generally treats a variety of problems experienced by students in addition to hosting some specialized seminars and screenings on varying student problems throughout each semester. Client was seen in a comfortable, private office within the center. Client was not seen by other members of the staff. This counselor was under supervision by one of the existing members of the regular psychological team. This counselor also engaged in consultation with two teachers chosen to assist in guiding the internship and thesis project.

Client was selected to participate in this thesis project due to the specifics of her case. This counselor was seeking a client with depression and relationship issues, in an attempt to learn more about these issues for this thesis project. This counselor sought to learn more about the link between relationship patterns and depression and the treatment of related problems.

### Initial Assessment

#### Identifying Information

Client herein known as "Dee" is a single, white female, age 20. She appears to be of average-to-thin build. She appears clean, adequately groomed, and is dressed casually.

She is in her freshman year in college and was seen in a counseling center in a large university. A roommate referred her because of the abrupt change in her functioning.

### Presenting Problems

Dee presents to the Counseling Center reporting symptoms of depression. She explains the following symptoms have developed as of the past three weeks: Dee reports an inability to concentrate or focus. She has just returned to class after two weeks of not being able to muster the energy to attend. She claims to be crying daily and eating more than usual. Dee reports an increase in appetite – at least four full meals per day; however she reports no weight gain. She states that she feels helpless. She reports sleeping more often than normal, and has trouble getting out of bed. Dee claims to be socially isolating herself. She expresses feelings of being “scared of close attachments” with females as well as males. She also reports an increase in alcohol consumption. She says she has been getting “drunk” 3-4 times per week. She describes herself as being “depressed.” She reports this being her first time feeling “depressed” for this length of time. She states that she “just wants to feel better.”

Dee explains that her symptoms began about three weeks ago when she had gone to a party off campus. She reports meeting a “boy” there whom she liked. After having had a few drinks she reports that he exerted some pressure for her to engage in sexual activity with him, she became fearful and abruptly told him to stop. Reportedly he did stop his advances. Dee believes that this was a critical incident that led to her depression.

Dee reports a hypersensitivity to criticism. She becomes upset and defensive around others who may be prone to gossiping about her and worries about the loyalty of friends.



In addition, Dee reports being worried about her schoolwork. She feels that she is falling behind and wants help learning how to do research for two upcoming assignments. She states that she had never been taught research skills in high school, and she is worried that she will not do well. She also reports a lack of motivation for schoolwork. She states that she “wants to do well in school.”

Dee reports coming to the counseling center at this time because she had been unable to go to class or stop crying since the episode with the boy.

#### History of Complaint

Dee is currently seeking help as a response to the near sexual encounter of three weeks ago. She reports the onset of her depressive symptoms coinciding with this incident.

Dee expresses insight and awareness of her persistent pattern with relationships. She reports having difficulty getting close to anyone including friends and boyfriends in the past. She states that she “has a fear of anyone getting too close” and “wants to leave them before they leave her.” Dee explains that she fears that people who become too close will abandon her. She says she gets a “feeling of paranoia and has to shut down and push away to protect myself from being hurt.”

Dee links her fear of abandonment to warnings her mother offered her about men. She says that since the time she was about 6, (when her parents divorced) her mother has warned her that “men will just want to use you for sex and then leave you and hurt you.” She states that even though her mother has been happily remarried since a year after the divorce from her father, she still warns about men every time one is mentioned. Recently the warnings are more jokingly stated, but Dee gets the sense that her mother “still really

means it.” Dee reports that she has a “great relationship” with her mother. She says that she likes being in her mother’s company because “it makes her feel better.” She reports that she feels comfortable at her mother’s house and that she likes to visit there on weekends during her semester.

When asked about any past romantic relationships Dee has reported having one “real” boyfriend throughout high school. She notes he cheated on her one month into the relationship. She says that she took him back, and they stayed together for six months before she finally broke up with him. Dee also reports having only one long-term female friend throughout her years in school. She states that she also pushed away all her female friends. She has one friend in college whom she has known since February 2001. The girls became very close friends, but Dee has recently pushed this friend away too. Dee defines “pushing away” as avoiding contact and not return phone calls until one loses interest in associating with her. Dee reports two good friends currently as her only support group in school. She is not involved in any extra curricular activities or hobbies.

Dee states she is a virgin. She reports feeling guilt and shame over the recent near sexual incident. She states that she is disappointed in herself for having poor judgment. Also, she says that she “went home” for the weekend to her mother’s house, and that made her feel better. She says that she has not told anyone why she has been so depressed. Dee states that she has tried to visit friends during the past few weeks, but she breaks down and cries or “spaces out.” Visiting does help her to be distracted from her symptoms briefly, she says.

### Household Composition

Dee currently resides on campus in a dormitory with one roommate. She reports being “friendly” with her roommate at the beginning of the semester, but has grown apart from her since that time. There are other young women in her dorm that Dee reports are new “friends” as of this semester. The way she describes them suggests that the level of intimacy with them is quite limited.

Dee currently visits both parents, but lives with her mother when she is not residing on campus. Her mother’s home is located in a suburb about two hours away. In her mother’s home reside Dee’s mother, stepfather and two stepbrothers. Dee reports being very close to her mother, and “feeling safe and happy in her mother’s home.” Dee’s mother works full-time as a secretary for an animal hospital.

Dee occasionally visits her father, stepmother and their family. She reports that she does not visit very often because she “disrespects her father and does not like her stepmother.” She claims that she only visits to see her sister. Dee’s father is a mechanic.

### Developmental History

Dee parents divorced when she was young. She reports her father left her mother for another woman. She says that she used to be “Daddy’s Girl” until the divorce. She feels that her father had abandoned her. When her father left for the new “live-in girlfriend,” Dee reports feeling very jealous. She felt as if she was not as important to her father anymore. This idea has been reinforced by her mother’s statements about her father and about all men in general. Dee interprets that the her father’s girlfriend was “manipulative and scheming and tricked her father into marriage by getting pregnant.” She claims that her mother would always warn her about her father and has brought to

her attention that her father has a new little girl and a new family. Dee reports not wanting to visit her father unless she was forced. Dee explains that since she has gotten older, she no longer feels jealous. She now just “does not like her father.”

Dee states that the high school that she attended was “not very good.” She had worked with peer tutors in high school; however, claims to have limited skills and feels only minimally equipped for college. Now she is worried that she does not have the skills or motivation to do well this semester. She expresses feeling uncomfortable about talking to her teachers about subjects that she does not understand or for getting extra help.

#### Drugs and Alcohol

Dee reports regular alcohol use since she has been in college with an increase in consumption over the past three weeks. She reports her regular consumption of beer and/or “whatever is available” as one-twice weekly of about 3-4 drinks. Her recent drinking pattern has been to “drink until she gets drunk to feel better” as often as three times per week. There is no reported past history of excessive alcohol use, nor is there an addiction history in the immediate family.

Dee states that she does not use drugs. She also claims to only have taken medicine a few times during her life. She reports that her mother does not believe in taking medicine unless it is “absolutely necessary,” and Dee has also adopted this policy.

### Medical and Psychiatric History

Dee denies any psychiatric history for herself; however, she does report untreated depression in the paternal familial history. She reports no maternal familial history of mental health problems. There is neither report of relevant medical conditions nor current medications. Dee reports that she avoids taking medication unless absolutely necessary. She remembers taking antibiotics only a few times during her childhood for ear infections. Dee claims that her mother does not believe in giving her children medicine, and Dee also maintains this policy. Therefore, Dee refused any psychotropic medications as treatment for relieving her depressive symptoms.

### Education and Job History

Dee is in her sophomore year majoring in communications. She has had a few part time jobs and works full time during the summer as an aide in a nursing home

### Social Supports

Dee reports two female friends with whom she is able to communicate in a supportive manner. She also expresses closeness with her mother. However, she has not told anyone in her family, nor has she told her friends about the near sexual episode, that prompted her to seek counseling.

### Situational Stressors

Dee has entered therapy following an interaction with a male at a party, which led to confusion and distress. She describes a situation where she was interested in a “boy.”

The young man made a sexual advancement toward Dee. She ended up forcefully refusing his sexual advancement.

In addition, Dee states that when others (male or female) get “too close” she becomes scared and feels compelled to stop associating with them. Generally she experiences discomfort in relation to most people except a few select members of the maternal side of her family.

Schoolwork and the school situation in general are situational stressors as well. As mentioned above she feels ill equipped to handle the work load particularly when she is not absolutely clear about the concepts presented. Also she is negotiating the adjustment of being away from home and living in the dorm situation, with a group of peers she has only just met.

### Coping Mechanisms

Dee likes to listen to music, and visit her girlfriends on campus when she is trying to distract herself from stressful thoughts. During these visits she does not talk about the things that are leading to her high stress. She also reports that she likes to keep a journal. However, Dee reports using avoidance and “escape” as her most prominent coping technique for dealing with the stress of relationship issues. Avoidance is also evident in her academic problem. She avoids going to class when she feels bad and gets further behind. She then avoids asking for help from teachers so that she could get caught up.

### Mental Status

Dee maintained a fair amount of eye contact throughout the intake. However, she did look away and became tearful while talking about her near sexual encounter. She

appeared clean and neat. She spoke in an articulate, calm, and slow, but steady voice. Her posture appeared relaxed. Her facial expressions appeared sad, and she rarely smiled. She was able to be momentarily distracted and slightly uplifted at humor during the intake. Her overall mood and physical behavior seemed to be congruent with her stated symptoms.

#### Additional Information

Dee was seen in the setting of an on-campus, private office within the counseling center. It was explained to her prior to the intake process that she would be seen by a graduate intern student. She was also asked to sign the counseling center's basic consent form explaining standard confidentiality and rules of the center, a thesis participant consent form, which included consent for the possibility of completing some psychological measurements including the Beck Depression Inventory. Dee accepted and complied with all of the above.

## Chapter Two

### Diagnostic Impression

#### Axis I

Major Depressive Disorder, single episode, moderate with some mood congruent distortions

#### Axis II

None

#### Axis III

None

#### Axis IV

Acute incident with male peer  
Problems with primary support group  
Problems within immediate family (parental relationship)  
Academic difficulties

#### Axis V

GAF 50

### Differential Diagnosis Issues

Previous depression was not reported by this client when this evaluation explored past functioning. Therefore, it can be assumed that this is her first (single) depressive episode. In this case, the depression followed a precipitating incident as it does in an adjustment disorder, but the criteria was met for full Major Depressive Disorder. The only caveat to a Major Depressive Disorder diagnosis is the length of the episode. This client's depressive symptoms seem to have lasted for a much briefer period than the DSM-IV suggests for this mood disorder. Therefore, a diagnosis of Adjustment Disorder was considered. However, the criteria for Adjustment Disorder stipulates that the "stress-related disturbance must not meet the criteria for another specific Axis I disorder." Given



that Dee matched the full criteria for the diagnosis of Major Depressive Disorder (single episode), this diagnosis fit the best.

### Summary and Recommendations

Dee seems to be bright and insightful; however, she physically does seem to be in a depressed state. She expresses her goal for therapy as doing “whatever it takes to feel better.” She says, she “wants to succeed in school and in her relationships; and she wants to be able to trust and not be a coward.”

Cognitive-Behavioral Therapy is recommended to help relieve symptoms of depression and to identify distorted core beliefs and maladaptive behavioral patterns associated with Dee’s problems and fears with relationships, abandonment, defectiveness, and mistrust. Fearful avoidant attachment style should be explored and treated to relieve Dee’s symptoms of resistance to connecting with others. Further, it is recommended that Dee’s feelings about sex be explored for possible identification of additional, distorted core beliefs.

Moreover, Dee’s schoolwork may be improved through research and paper-writing skills; however, clarification is required to assess exactly which skill areas are lacking. Therapist is also willing to use an eclectic approach to treatment in addition to Cognitive-Behavioral Therapy, which includes some aspects of Interpersonal Therapy in as far as becoming an advocate for the client regarding school and learning aspects. However, research on fearful avoidant attachment style maintains that these individuals often experience academic problems (Vivona, 2000). Clarification will be sought for the source of Dee’s academic problem. Research suggests that relieving stress of attachment

issues may also relieve some of the stress of some academic problems if they are due to avoidant behavior.

Treatment efficacy will be measured through the Beck Depression Inventory scores, her attempts to reinterpret dysfunctional cognitions, overall mood and response to the therapeutic relationship as a connection, and Dee's behavioral changes in outside relationship connections.

### Negotiating the Initial Treatment Contract

After completion of the intake process, this therapist discussed with the clinic supervisor the possibility of taking on this client as a subject for this thesis case study. Although time would be limited to only nine possible sessions including the intake, supervisor and therapist agreed that this client would be a suitable subject to study. It was also agreed upon that an eclectic approach to treatment, which included cognitive-behavioral and interpersonal techniques for treating depression would be the most appropriate. In addition, supervisor and therapist agreed that depressive symptom relief would be most important in the initial sessions in addition to working on cognitive aspects that were likely to maintain these symptoms especially given the limited number of available sessions and the relatively severe impairment in functioning that she reported. For example, Dee had not been able to attend class. Therefore, it was agreed that some behavioral techniques aimed at symptom relief should be assigned as homework. It was also confirmed that the client had chosen to refuse medication as a treatment for depressive symptom relief.

This clinic's general confidentiality and center guidelines policies were discussed with and accepted by client through written consent. Moreover, the client was informed

that this therapist is an intern, and the client was given the name of the supervisor. The client was asked if she was willing to be the subject of a case study that would be used as this author's thesis. In addition, it was discussed that a weekly Beck Depression Inventory assessment will be given, and all sessions will be audio taped for supervision purposes. These aspects were discussed in detail and accepted by the client through written consent. These consent forms remain on file within the counseling center's private records. Client was instructed that sessions would be scheduled at her convenience in the course of one-60 minute session per week held at the campus-counseling center. Appointments are to be scheduled one week in advance; however, client was also informed that appointments are available in emergency situations if needed. Initially no limit was set for the amount of sessions, but client was informed that due to the length of this therapist's internship, sessions were to end at the end of this semester. Client was also informed of and had agreed to the option of continuing treatment with another therapist within this center if she chooses to continue therapy at the end of the internship. Also during this contracting period, client was given a number of educational brochures provided by the clinic on depression and symptom relief.

#### Preliminary Treatment Plan

The client's only self-reported goal was to "just feel better." This therapist questioned the client's simplistic goal in an attempt to provide more efficient treatment. The client seemed to have no other identifiable intent for entering therapy in this initial intake visit other than relief of her depressive symptoms. (Note: Client's and therapist's considerations regarding treatment are often different, and client's are usually lower.) This limited goal may be attributed to the client's existing sense of hopelessness, youthful

age, and unfamiliarity with the therapeutic process. However, in light of this client's self-reported, interpersonal interactions, familial history, and her recent near sexual encounter leading to the onset of her depressive symptoms, it was determined to use cognitive-behavioral and interpersonal treatment techniques exploring parental-induced schema development and resulting interpersonal themes, behaviors, and attachments linked to depression. It was anticipated that within therapy the client may become aware of and uncover interpersonal scripts pertaining to early loss experiences that have impacted her present identity and functioning.

## Chapter Three

### Literature Review

This literature review will address treatments for depression of a moderate level of severity. The depressive symptoms that this client reported seemed to be more severe at the intake as compared to her score on the Beck Depression Inventory one week later in her first session. In the first session, the client scored 18 on the BDI indicating moderate clinical depression. She also had made some behavioral progress in the interim between the intake and her first session. She reported going back to class and making an attempt to increase socialization and contact her support group. In addition, the highest BDI score during the entire therapy was only 19, and there was no evidence of psychotic symptoms. Therefore, the diagnosis of moderately depressed was decided upon.

### Medication for Depression

A common practice for treating clients diagnosed with major depressive disorder is psychotropic medication. The most effective antidepressant drug with the least side effects was the selective serotonin reuptake inhibitors (SSRIs). This group of medications include: Prozac, Zoloft, Paxil, and Luvox. The SSRI medications were reported to be non-addictive and had the highest efficacy rate with the least amount of dangerous side effects (Mazure, Bruce, Maciejewski, & Jacobs, 2000; Sommers-Flanagan & Sommers-Flanagan, 1996).

Other studies supported that some other psychotropic medications also have proven effective for treating depression. These include: the monoamine oxidase inhibitors (MAOIs) such as Parnate, and Nardil, and the tricyclic antidepressants (TCAs) such as Elavil, Norpramin, Aventyl and Pamelor. Other groups of antidepressants include such

medications as Wellbutrin and Effexor (Mazure, Bruce, Maciejewski, & Jacobs, 2000; Sommers-Flanagan & Sommers-Flanagan, 1996; Rivas-Vazquez & Blais, 1997).

Although some studies concluded that psychotropic medications were effective for about 2/3 of the patients, the Sommers-Flanagan & Sommers-Flanagan (1996) study concluded that 40% of a double blind, placebo-controlled study showed no significant difference between active medication treatment and placebo administration. Overall, even though antidepressant medications have been predominantly proven effective for treating most adult individuals with major depressive disorder, most studies conclude that antidepressant medication was more effective when prescribed in conjunction with some type of empirically validated psychotherapy for depression preferably Cognitive Behavioral Therapy or Interpersonal Therapy. This combination is concluded to be the most effective treatment for major depressive disorder (Sommers-Flanagan & Sommers-Flanagan, 1996; Vazquez & Blais, 1997; Mazure, Bruce, Maciejewski, & Jacobs, 2000; Bush, 2001).

*Despite “best practice” recommendations for treating depression with antidepressants in combination with psychotherapy, this client has refused medication because she does not want to rely on pills and has chosen treatment of psychotherapy alone. This issue may have been revisited had severe symptoms continued or increased, or if the client had changed her mind about her decision. However, the client’s quick improved elicited that this question did not require further pursuit.*

#### Cognitive Behavioral Therapy for Depression

Cognitive-behavioral therapy is one of several empirically validated treatments for depression as well as other distorted schema-related cognitions and resulting

behavioral patterns (Beck, 1967). CBT has been theorized to be effective in helping clients to become more secure in interpersonal attachments (Young, 1990). Using CBT with some aspects of interpersonal therapy has been chosen for this particular case study due to the client's self-reported symptoms of depression as a result of her inability to sustain healthy, secure, interdependent relationships and bonds with others. Each factor of cognitive-behavioral therapy is designed for a specific focus. Cognitive therapy has been found to be more appropriate for schema pathology and behavioral therapy may be better suited for interpersonally mediated mood pathology. Both aspects work together to produce optimal results in treating attachment related depression (Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001; Young, 1990).

Cognitive Behavioral Therapy allows for a variety of individualized techniques that provide education, understanding, and insight into the origin of stressor effects as well as providing a means for one to change the behaviors, affective state, and cognitions that have proven to be maladaptive. CBT has also proven to be quite effective as a treatment for most types of chronic interpersonal problems due to the variety of individualized techniques, and the fact that the treatment focus provides guidance on a variety of levels of functioning (Young, et al, 2001). Treatment incorporates identification of symptoms, and stressors and the reduction of symptoms through modification of automatic thoughts and associated behaviors or "logical errors that tilt objective reality." The result in an inflexible, distorted belief, which maintains maladaptive patterns of thought and maladaptive patterns of behavior (Corey, 2001).

### CBT Efficacy

Cognitive Behavioral Therapy for depression has been empirically tested by research and found to be at least as effective as tricyclic drug treatment for depression (Beck, Rush, Shaw, & Emery, 1979 as cited by Young, Weinberger, Beck, 2001).

Another recent study found the mean changes in the level of depression for outpatients following treatment termination was as follows: 66% for subjects who received cognitive therapy alone; 63% for those treated with tricyclic medication alone; and 72% for patients who received some combination of the two treatments (Williams, 1997, as cited by Young, et al, 2001). Bush (2001) concluded that cognitive therapy was superior to antidepressants and some other psychotherapy but was found to be equal to behavioral therapy. Cognitive therapy was concluded to be effective with patients with mild or moderate depression, and its effects were superior to those of antidepressants. The relapse rate for patients treated with cognitive therapy for depression have been found to be significantly lower than the relapse rate with a lower drop out rate for patients treated with antidepressants alone (as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001).

Paykel, et al. (1999) concluded that for clients who respond only partially to antidepressant medications, the addition of cognitive therapy significantly reduced rates of relapse (as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). Cognitive therapy has been concluded to be effective in reducing residual symptoms and relapses as well after termination of medications. However, if residual symptoms remain, they have been shown to increase the relapse rate (Young, et al, 2001). In addition, other studies have concluded that cognitive therapy reduces relapse and recurrence of depression in outpatients with no measurable signs of residual symptoms. Treatment of major



depressive disorder by cognitive therapy report less relapse overall than those recovering from antidepressant medication alone (Blackburn, Eunson, & Bishop, 1986; Evans, et al., 1992; Sheer, et al., 1992; Simons, Murphy, Levine, & Wetzel, 1986, as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). Cognitive therapy has also been hypothesized to reduce dysfunctional attitudes; however this has little empirical support to date (Barber & Debeis, 1989 as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). Moreover, several studies conclude that when cognitive therapy produces better results in long-term outcomes in comparison to psychotropic medications, dysfunctional attitudes do not differ (DAS; Weissman & Beck, 1978; Simon, Garfield, & Murphy, 1984, as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001).

Some general limitations that have been reported for CBT as well as for some other types of treatment include problems with the therapist-client relationship and problems that occur when the client expresses concerns relating to unsatisfactory progress of therapy (Corey, 2001). Problems due to the therapist-client relationship can involve: therapist misinterpretation of the problem, therapist's inability to remain nonjudgmental, client's negative misinterpretation of a particular intervention, client's inability to disclose certain information, or client's general resistance due to a variety of circumstances (Young, et al, 2001). It is also important to note that any technique can only be effective in the context of a trusting and accepting relationship.

#### CBT Techniques for Change

Cognitive therapist use techniques and strategies to help client identify maladaptive patterns of thinking (Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). The aim of cognitive therapy is usually seen as reducing belief in depressed thoughts or

dysfunctional assumptions, or changes in thought content. This research supports that CBT is designed to challenge the processing of depressive cognitive information to a more reflective and positive reinterpretation, which is primary to the goals of changing beliefs in thoughts or “automatic thoughts” (Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). Cognitive aspects for changing distortions include promotion of positive expectations for others’ goodwill and that others will be likely to be supportive. The therapist can assume with enough practice and rehearsal, cognitions and behavioral patterns are flexible enough to be collaboratively modified (Young, 1990, p. 5). In turn, one will experience relief of stress as a result of proximity to supportive others (Mukulincer, Hirschberger, Nachmias, & Gillath, 2001). As a treatment for depression, the Cognitive Behavioral Theory assumes that cognitions, behaviors, and affect are all important components of the depressive state. This theory works on the premise that if therapy can change the depressive cognitions and maladaptive behaviors, than the characteristics of mood will also change and improve (Young, et al, 2001).

Cognitive therapy acts through changes in cognitive structures or interpretative cognitive style. Cognitive therapy does not reduce the tendency for one to generate negative thoughts; instead it incorporates a set of cognitive skills that help one deal with the thoughts when they do occur (Barber & DeRubeis, 1989, p. 450, as cited by Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001). Cognitive therapy works by causing a shift in the cognitive set where negative thoughts approach. Research supports that teaching and helping the client process that the thoughts are only “events in the mind” that may or may not exist in reality is an effective technique in cognitive therapy for reducing depressive distortions (Moore, 1996; Teasdale, Scott, Moore, Hayhurst, Pope, Paykel,

2001). In addition, this technique is beneficial for disengaging one from self-perpetuating and depressogenic processing by automatic thoughts and is also recommended for preventing relapse. The repeated experience of keeping negative thought records that help the client to identify negative automatic thoughts and processing can be particularly beneficial in interrupting negative, habitual, schema-driven processing. Records should include an intentional, controlled process alternative thought in place of the negative one. This teaches the client to reappraise or have second thoughts in relation to depressive cognitions (Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001; Young, Weinberger, & Beck, 2001). This technique works best when the client learns through her own processing to train herself to preempt automatic processing thus offsetting the negative thoughts leading to depression.

Behavioral techniques are often used throughout cognitive-behavioral therapy, but generally receive heavier concentration in the earlier stages. They are especially necessary for treating more severely depressed clients who are socially withdrawn. Behavioral therapy provides for a variety of individualized techniques to help the client cope more effectively with situational and interpersonal problems. Some techniques include: learning interpersonal skills to promote support seeking that does not alienate others, helping people increase pleasurable social activities, and some problem-solving or physical relaxation skills (Mukulincer, Hirschberger, Nachmias, & Gillath, 2001; Beck, 1967; Young, Weinberger, & Beck, 2001). These techniques also work as a distraction for distress alleviation and depressive symptom relief. The behavioral techniques work through procedural rules for step-by-step behavioral changes to counter these interpersonal deficits. For example, if an obstacle is encountered, one can learn to

approach a significant or supportive other for help and receive it, work in therapy to increase one's repertoire of positive interactional skills, or become involved in situations that provides opportunities for practicing social skills (Mukulincer, Hirschberger, Nachmias, & Gillath, 2001; Beck, 1967). Therefore in this case, since depression is representative of a maladaptive cognitive pattern and related interpersonal behaviors, cognitive-behavioral therapy is accepted and has been concluded as the best treatment for interpersonal/attachment related depression as this client demonstrates (Schmidt, Schmidt, & Young, 1999, p. 142; Young, Weinberger, & Beck, 2001).

#### Interpersonal Therapy for Depression

The literature supports interpersonal therapy for depression to be an effective treatment especially for individuals experiencing depression as it relates to interpersonal matters. In interpersonal therapy, depression can be conceived of as arising out of social skills deficits, an inability to connect with others as a means of gaining adequate support or reinforcement within one's environment, or as a link to a perceived loss (Markowitz & Swartz, 2001; Blanco, Lipsitz, & Caligor, 2001). Interpersonal effects of depression include social withdrawal and irritability leading to alienation of support groups. The general goals of interpersonal therapy of depression include: identifying specific life events and interpersonal issues (deficits) related to the onset and maintenance of depression; understanding the connection between mood and life events; and learning that by improving one's interpersonal environment, one can improve mood and alleviate mood disorders (Markowitz & Swartz, 2001). Further, in the case where depression is due to interpersonal deficits, the client's relationships should be examined in terms of both their positive and negative aspects (Gillies, 2001). This client has self-reported an

inability to sustain interpersonal relationships in neither a romantic nor a friendship capacity. Therefore, the interpersonal theme of “interpersonal deficits” and some interpersonal techniques for correcting these deficits will be addressed herein.

The literature supports that IPT along with psychotropic medications is more effective for the treatment of depression than treatment alone (Weissman, et al., 1981 as cited by Gilles, 2001; Lataylor, 2001). Also within these studies, IPT showed significant improvement in social functions one year after treatment over the control group or the medication only group. In addition, according to a study by the National Institute of Mental Health Treatment of Depression Collaborative Research Program, there are no significant differences among IPT and other treatments including cognitive-behavioral therapy, the medication, imipramine with clinical management, and placebo with clinical management in the treatment of the less severely depressed group (Sotsky, Glass, Shea, Pilkonis, Collins, Elkin, Watkins, Imber, Leber, & Moyer, 1991).

Interpersonal Therapy as a treatment for depression has been recommended by a variety of studies for eliciting symptom removal, prevention of relapse, correction of causal psychological problems for secondary symptoms, and the correction of secondary consequences of depression (Weissman & Markowitz, 1994 as cited by Gilles, 2001; Teyber, 1992; Lataylor, 2001). In addition, IPT has been recommended by the American Psychological Association (APA) as a well established and empirically validated treatment for depression as well as some other Axis I disorders. IPT treatment has proven to be effective for adolescent depression as well (Gilles, 2001).

The role of Interpersonal Therapy as a treatment for depression is often viewed as an opportunity to examine the interpersonal relationships of the client, link them to

changes in mood, and discuss possible alternatives to the client's behavioral patterns (Blanco, Lipsitz, & Caligor, 2001). Some of the aspects of Interpersonal Therapy for depression focus on the "here and now" for the client to address interpersonal patterns, in addition to providing support for the development of a good working alliance between patient and therapist (Gilles, 2001). IPT emphasizes relationship issues and focuses on the psychosocial factors, which contribute to individual difficulties. This therapy's theme for interpersonal deficits addresses communication skills, which can affect one's interpersonal relationships causing negativity in interpretation (Lataylor, 2001). The primary goal of IPT is to allow the patient to become aware of and alter interpersonal interactions as they relate to a specific theme per the depressed individual. Because this therapy will be brief given the constraints of the college counseling situation, IPT may also prove to be beneficial in that in the final stages of this therapy, the focus is on educating the client about possible future relapse episodes of depression and reviews consolidated gains and benefits accomplished during treatment (Gilles, 2001).

#### IPT - Roles in Interpersonal Relationships

Developing one's interpersonal techniques for intimacy is a central task for young adults. The establishment of close social ties promotes personal well being, and the failure to establish or maintain such relationships, in general, and romantic relationships, in particular, serves to predict one's physical and emotional distress (Conger, Cui, & Bryant, 2001).

Research supports that it is possible for one experience in a secure relationship to foster change in an insecure interpersonal type regardless of gender of either partner in the relationship, and this experience can be achieved within the therapeutic relationship

between the insecure interpersonal (avoidant) type and the therapist (Teyber, 1992, p. 181; Mikulincer & Shaver, 2001; Young, 1990, p. 43). Researchers maintain that secure relationships can be manifested by those who demonstrate interpersonal deficits, but they must be actually experienced in order to foster this change (Teyber, 1992, p. 217). Other research supports that the sense of having a secure bond can be contextually activated by actual, imagined, or visualized encounters with available and responsive others, even among those with chronic doubts about secure attachments (Mikulincer & Shaver, 2001; Mukulincer, Hirschberger, Nachmias, & Gillath, 2001). Feeney & Collins (2001) in another study theorize that insecure (avoidant) individuals lack both skills and motivation necessary to maintain a positive, secure, and caring partnership due to the limited repertoire of care-giving strategies at their disposal. They report that given the opportunity to observe positive role models in one's own attachment history is one important way that individuals develop the requisite skills for caring. The therapist can model a secure attachment figure within the therapeutic relationship. To accomplish this, the therapist must demonstrate that interdependent relationships are possible with the client (Teyber, 1992, p. 180; Mikulincer & Shaver, 2001). *Note: Ideally the goal of treatment in this case study would be to give the client a sense of secure interactional bond. The therapist can begin to give the client a corrective emotional experience through modeling a secure base attachment.*

The therapist is seen as providing a model for a secure base, a process consultant, and a guide for constructing new experiences and new dialogue that redefine relationships (Johnson & Whiffen, 1999). Having a sense of a secure base allows people to open their schemas to belief-discrepant information (Mikulincer & Shaver, 2001).

Activation of interpersonal competence boosts positive models of self, which promotes feelings of control and mastery in dealing with others' plight, reduces self-related worries, and frees innate resources to attend to others' needs. This positive model of self also motivates people to reciprocate others' benevolence and/or behave according to a benevolent code. Further, contextual activation of secure attachment leads individuals to react to others' needs with more empathy and lower levels of personal distress (Mikulincer, Gillath, Halevy, Avihou, Avidan, Eshkoli, 2001).

Ideally, for a secure base of interpersonal interactions to develop in childhood or in adulthood, the primary attachment figure must first be available; and secondly, intervene judiciously when the person being cared for is heading for trouble. The therapist can take on the role as the primary attachment figure and "reparent" (in the form of correct recapitulation) the client in psychotherapy allowing for an actual experience with a sense of a secure base (Bowlby, 1977). Research supports that it is not uncommon for people to develop relationship-specific beliefs organized around these actual experiences. Rogers (1959) supports that people who experience an unconditional positive regard in relationships with others develop self-structure and feel satisfaction in her own self-value (Schimel, Arndt, Pyszczynski, & Greenberg, 2001). In addition, research implies that a situational, temporary activation of a secure base schema leads even chronically insecure people to react in a more accepting and tolerant manner (Mikulincer & Shaver, 2001). Since interpersonal roles can be altered positively by secure relationship experiences, the therapeutic relationship can actively serve as a secure bond for facilitating change, which in turn, may help to relieve depressive symptoms.



### Depression & Schemas as Internal Working Models

Schemas are mental templates which are proposed to have been created from historical experiences that serve to create cognitive generalizations about one's self and social experiences (Markus, 1977; Segal, 1988; Turk & Speers, 1983, as cited by Schmidt, Schmidt, & Young, 1999, p. 128). Some specific schema distortions are more likely to result in depressed individuals than others.

Dependency schemas are theorized to be the single best predictors for depression. Disconnected schemas (e.g., defectiveness) are at the opposite end of an interpersonal continuum of schemas, and depression is likely to occur from either. Individuals with a defectiveness schema may believe that they are unconditionally defective, or defective in a particular manner, or under specific circumstances. Therefore, individuals who feel both dependent and defective are at a much greater risk of manifesting depression (Schmidt, Schmidt, & Young, 1999, p. 139). Maladaptive schemas produce more negative, and more ambiguous perceptions of interpersonal feedback," and produce less effective reassurance-seeking behaviors. Thus, focusing on schema distortions and maladaptive interactional patterns is particularly likely to take precedence over other types of cues in explaining depression associated with one's intimate connections and relationship behaviors as does this client (Schmidt, Schmidt, & Young, 1999, p. 140).

The cognitive therapist seeks to identify domains of early maladaptive schemas for further exploration as a direction for identifying specific distorted schemas. Young (1990) and Beck (1967) suggests that the therapist explore cognitive (schema) patterns that are reflected in one's typical misconceptions, distorted attitudes, invalid premises, and unrealistic goals and expectations to identify domains containing specific early

maladaptive schemas. A complete list of schema domains and specific schema distortions may be found in Appendix A.

One's working models of interactions serve as a set of expectations about others' availability and responsiveness in times of stress and are organized around "schemas." It is theorized that attachment styles are schema-like entities in which different attachment-related schemas might be accessible depending on which kind of contextual patterns are most salient (Mikulincer, Hirschberger, Nachmias, & Gillath, 2001). For example, if one's contextual patterns (in this case interpersonal patterns) relate to a need for security, safety, or acceptance, and one believes that these needs will not be met in a predictable manner then one may be harboring distorted schemas such as abandonment, mistrust, or emotional deprivation. Therefore, these distorted schemas become the framework for one's attachment style and organizes one's interactions with others. Looking at these schemas provides a focus for further exploration within therapy (Young, 1999; Greenberg & Johnson, 1988). Young (1990) proposes that schemas termed "early maladaptive schemas" (EMS) develop during childhood through the relationship with primary caregivers. All schemas including those that have become maladaptive are the familiar, comfortable, and unconditional core of one's self-concept and are self-perpetuating and highly resistant to change (Schmidt, Schmidt, & Young, 1999, p. 130). Early maladaptive schemas are the deepest level of cognition and are much more closely tied to affect (Young, 1990, p. 10). Schemas are functional by humans through three unconscious processes or practices that serve as defense mechanisms for stabilizing identity. These processes are Schema maintenance, schema avoidance, and schema compensation. In addition, Young (1999) proposes that schemas may be identified

through the processes of current events, past memories, the therapeutic relationship, imagery, dreams, and homework assignments.

Since schemas are the frameworks for attachments in the focus of cognitive-behavioral therapy, the ability to identify maladaptive schemas and the defenses this client uses to perpetuate them is extremely influential for processing and facilitating change. Identifying the patterns one normally uses to maintain, avoid, or compensate for schema distortions serves as a guide for this therapist's treatment focus. Challenging one's distorted schemas as a result of interpersonal attachment related depression will be discussed herein as aspects of challenging attachment framework. Therefore, understanding the workings and effects of these attachments is a necessary element of this case study. *Note: In this case study, these theories seem to be particularly relevant. This client verbalizes and demonstrates salient behaviors supporting her sense of undeserving, betrayal, injustice, fear, low self-worth, and constricted interpersonal interactions in addition to confirming the negativity and sense of abandonment she has felt since her father's leaving the family and remarriage. These behaviors, verbalizations, and schema identifications will be highlighted and discussed specifically within the session review.*

#### Attachment Overview & Links to Depression

Attachment theory proposes a "wired-in" evolutionary survival system originating from the attachment of child to primary caregiver, which, in turn, results in an internal working model for interpersonal interactions (Greenberg & Speltz, 1985, p. 193; Belsky & Nezworski, 1988). Attachment styles are not just strategies for attachment relationships, but involve rules for processing and organizing attachment information

(Bowlby, 1988, as cited by Johnson & Whiffen, 1999; Baldwin, 1992; Bretherton, 1993, as cited by Johnson & Whiffen, 1999). Bowlby (1977) maintains that one's experience with primary caregivers carries forward in development and emotional-cognitive mental schemas or working models (Cortina, 2001; Vivona, 2000). One's schemas and assessments of themselves are dependent on how significant caregivers respond to needs and communication. These schemas serve to maintain the experience of self, and others that help plan and forecast significant interpersonal exchanges. Attachment patterns are developed in infancy, childhood, and adolescence and continue to grow through experiential reinforcement, which persists relatively unchanged into adulthood and then held to partners acting for them as the attachment figure (Hazan & Shaver, 1987; Bowlby, 1977). Hazan and Diamond (2000) conclude that attachment theory is illustrated particularly in two relationship situations: child or adolescent and primary caregivers and adult romantic partnerships. Further, these models guide emotional regulation, appraisals and interpretations of partner's responses, and how one communicates and responds. These regulatory interpretations perpetuate into cycles of fear, anger, sadness, and low self-esteem, which become working models of one's self in relation to others and past experiences in attachment relationships (Johnson & Whiffen, 1999; Teyber, 1992, p. 180). After maturity of the neural, affective, cognitive, and behavioral components of the attachment-exploration system, any stressful or fearful condition will activate attachment behaviors. In turn, other emotions then can be elicited such as shame, humiliation, pride, jealousy, and envy. These emotions have a powerful regulatory and dysregulatory effect on the attachment relationships, peer relationships, and other intimate relationships (Cortina, 2001). In addition, people often hold on to conflicting internal models of certain

relationships. They may have limited or no conscious access to one or more of these models regardless of how strongly they may affect behavior and personality (Bowlby, 1980, as cited by Greenberg & Speltz, 1985, p. 193). *Note: No information is provided or evidenced of Dee's mother as an attachment figure during infancy, but it is hypothesized that in congruence with the above research, her mother's modeling of attachment has contributed to Dee's attachment development, in addition to this client's self-reported, memorable events leading to her present depressive condition.*

Some studies have investigated the correlation between low or insecure attachment style and depression (Berman & Sperling, 1991; Kobark, Sudler, & Gamble, 1991, as cited by Vivona, 2000). Insecure attachment organizations may reflect core beliefs that one is unable to get attachment needs met by others or that one does not merit getting his/her needs met. These negative expectations contribute to similar low self-worth, negative explanatory styles, and vulnerability, which correlate with depression (Cummings & Cicchetti, 1990, as cited by Allen, Moore, Kuperminc, & Bell, 1998). In addition, Beck, Epstein, & Harrison's (1983) cognitive model for depression suggests that vulnerability is related to these underlying dysfunctional attitudes or assumptions. Therefore, in congruence with this client's avoidant attachment style, it becomes relevant that if the client believes that highly desired outcomes such as relationship satisfaction are unlikely to happen or that highly aversive outcomes such as partner abandonment are likely to occur, and that she is helpless to affect the outcome, then manifestation of hopelessness and depression are most likely to occur (Schmidt, Schmidt, & Young, 1999, p. 127). This individual learns to become emotionally detached and becomes unable to maintain a stable affectional bond with anyone (Bekker, 1993, as cited by Vivona, 2000).

Humans have been known to display three major types of attachment styles for interpersonal connections: secure attachment style, and the insecure styles of anxious attachment style, and avoidant attachment style (Bowlby, 1969). A more specific breakdown in avoidant attachment style occurs in two levels: avoidant-dismissal type and avoidant-fearful type (Bartholomew & Horowitz, 1991, as cited by Johnson & Whiffen, 1999). It is not unusual for insecurely attached individuals to switch between a dominant style and manifest strategies of another style under stress of behavioral interactions (Johnson & Whiffen, 1999; Mikulincer & Shaver, 2001). Insecure attachment models tend to predispose people to selectively attending to and defensively distorting information. This case study focuses on aspects related to avoidant attachment style.

#### Challenging Insecure Attachment Related Depression

Recent research suggests that approximately 30% of individuals with insecure attachment styles do change and that women are particularly likely to change. Further, individuals with avoidant attachment style of either dismissal or fearful types can learn to modify fears, cognitions, and behaviors by experiencing new interactions with a secure individual, as long as their overall personality is relatively open and accessible. An important task in bringing about change from negative experiences is to formulate a coherent overview of a relationship that allows for the revision of perceptions and expectations (Johnson & Whiffen, 1999). As discussed in the aforementioned section regarding aspects of interpersonal therapy, research supports that one can use the therapeutic relationship as a model for an experience in a secure attachment. This is facilitated by providing the client with a sense of unconditional acceptance and provision

of consistent and predicable availability. It is also important to explore ruptures in the relationship (Teyber, 1992, p. 181; Mikulincer & Shaver, 2001; Young, 1990, p. 43).

In addition to the therapeutic relationship itself accounting for the actual experience, positive imagery of a secure base romantic or parental experience also assists in change facilitation. The imagined sense of security also helps to relieve some depressive symptoms from schema related issues. One can also use this imagery or visualization as a distraction technique for coping with attachment distress (Mikulincer & Shaver, 2001). Moreover, since research concludes that visualizing a secure attachment with a specific other heightens one's sense of self-evaluation, research also supports techniques for imagery to activate a particular memory of a secure attachment figure by asking a person to think about a relational episode in which she has felt secure. The memory may: 1) remind the person of similar memories; 2) inhibit incongruent memories of attachment insecurity; 3) bring to mind relationship-specific and generic schemas that are representative of a sense of a secure base; and 4) inhibit incongruent memories of attachment anxiety and avoidance (Mikulincer & Shaver, 2001). It should be noted, however, that research has also posits that imagery or visualization of negative interactions with attachment figures that hold negative beliefs about one's self and others of painful separations can bring to mind unresolved memories of rejection, separation, and loss. This visualization may result in infusion of negative affect, which may counteract positive affect produced by any sense of secure-based progress (Mikulincer, Hirschberger, Nachmias, & Gillath, 2001).

Other suggested individualized techniques for countering depressive symptoms with avoidant behavior include: 1) guiding the client to process her own patterns of

avoidance through process-oriented questioning; 2) individualized techniques for dealing with stress as a precursor for her avoidance (Teasdale, Scott, Moore, Hayhurst, Pope, Paykel, 2001) problem solving and coping skills for handling stressful situations (Beck, 1967; Teyber, 1992); 4) teaching one to identify cues for the onset of their own specific patterns of avoidant behavior (Schmidt, Schmidt, & Young, 1999; Young, 1990; Cortina, 2001; Dozier & Kobak, 1992, as cited by Johnson & Whiffen, 1999); and 5) imparting psycho-educational information (Beck, 1967; Teyber, 1992)

Since this client's reported interpersonal patterns that matched what was described in the literature on avoidant attachment, literature on avoidant attachment behavior in therapy was researched. If one's attachment experiences have been negative and unchanging and reinforced by experience throughout childhood and adolescence, research supports that these attachment patterns become increasingly rigid and difficult to change (Cortina, 2001). These individuals tend to assimilate any new person with whom she may form a bond, such as spouse, child, friend, employer, or therapist into her existing model. It is theorized that this individual will usually continue to do so throughout life even when the model seems inappropriate or contradictory. It is further theorized that this person often distorts situations and interprets them into her existing beliefs until misunderstanding and conflict evolve, all the while remaining unaware that she is being biased by past experience (Bowlby, 1977). Bowlby (1977) maintains that these individuals are severely distrustful of close relationships and terrified of allowing themselves to rely on anyone else, in attempt to avoid the pain of being rejected.

This therapist discovered that it is not uncommon for these clients to discontinue therapy prematurely once depressive symptoms are somewhat relieved. Teyber (1992)



claims that too often the therapist gives up on the avoidant client and does not follow through and directly or effectively addresses this behavior by the client. Often times, the client is subconsciously testing the strength and dedication of the therapist to assess whether it is safe to go on to more threatening issues within therapy. Research recommends that the therapist who is treating an avoidant attachment individual anticipate and be prepared for transference in that the client may eventually begin to avoid the therapist (Mikulincer & Shaver, 2001). When the client pushes limits or avoids, it is probabilistically a test to see if the therapist will perform ineffectively as the client's primary caregiver/partners have done. Teyber (1992) proposes that often therapists inexperienced in avoidant attachment behavior "give up" too easily. Some therapists recommend the use of process comments within therapy as a means to explore other avenues for relationship satisfaction by the client. The therapist can note responses elicited in him/herself from client during therapy to get a clearer picture of emotions client may elicit from others in interpersonal relationships. The therapist and client can work together to discover new ways to resolve problematic patterns. In accordance with the literature, being prepared for the avoidant attachment personality to escape when therapy and the therapeutic relationship begins to feel "too close" is of primary importance. In this case, it was predicted that there was a high likelihood that this client would run from the relationship, and that exploring this behavior and associated cognitions will be a pivotal part of the treatment process.

#### Depression and Its Links to Divorce with Intra-parental Conflict in Divorce

Since it is believed that early schema development is a reflection of experiences within one's family setting, parental relationship factors such as divorce, intra-parental

conflict, and attachment style can contribute to a variety of maladaptive patterns. Behaviors of parents toward child have been studied and identified as the best predictors of later development of interpersonal competence (Conger, et al, 2001). Due to this client's attempt to link her own depression to her relationship issues and problems associated with conflict from her parents' divorce, it was important to investigate the literature links between these concepts as well. This client seems to have some insight as to the origin of her dysfunctional patterns and provides a direction for the therapist's further literature exploration.

The effects of parental divorce and remarriage appear to be a relevant factor in the adaptability of some individuals over time. Even though not all individuals show visible signs of trauma or distress, some do; and the effects can be quite devastating and troublesome to those who manifest specific patterns due to their parents' separation and the possible addition of new members in their family constellation.

Divorce with intra-parental conflict and hostility can be extremely damaging to the developing child and her schema development (Brennan & Shaver, 1993). Research supports that insecure attachment style is more likely to occur if one's parents divorce with conflict during early childhood (Hamilton, 2000). Stark, Schmidt, & Joiner (1996) demonstrated that parental messages to children about the child, others, the world, and the future were predictive of depression and one's subsequent view of self, others, the world, and the future (as cited by Schmidt, Schmidt, & Young, 1999, p. 141).

In addition, research illustrates that repeated and unresolved exposure to intra-parental conflict results in a continuous process for decreasing trust in parents and decreased optimism about the benevolence of partners, dating, marital relationships, the

world, and all people in general. Moreover, college students of divorced parents maintain a greater fear of being betrayed in present and future romantic relationships as well (Franklin, et al, 1990). The fear of being betrayed is a direct link to identifying a maladaptive schema for mistrust (Young, 1999).

It is important for this client to make changes in her interpersonal patterns and prescribed roles ingrained by her past experiences in an attempt stop the perpetuating cycle of avoidance in her relationships. This is especially significant because the literature supports that a person with neglectful or abandoning parents may seek and be attracted to partners with matching patterns. Often, they will unconsciously seek someone who will not meet their needs as did the primary caregivers (Greenberg & Speltz, 1985). Therefore, cognitive schema-focused techniques (discussed previously) for identifying and processing distortions are appropriate for addressing parental divorce related depressive issues (Beck, 1967; Young, 1990), in addition to interpersonally oriented techniques (also discussed previously) for corrective recapitulation and addressing interpersonal skill deficits (Teyber, 1992). *Note: This client has evidenced information supporting her distorted schemas and maladaptive patterns facilitated by intraparental conflict, perceived abandonment by her father and the subsequent divorce, disparagement of her father by her mother, inhibited social functioning for a young girl of her age, and possible enmeshment with her mother. These aspects will be discussed in detail within the session review.*

#### Depression and Interpersonal Avoidance: Links to Problems in Self- Image

Low self-esteem/self-image has been correlated with depressed individuals who demonstrate interaction-avoiding behavior (Johnson & Whiffen, 1999). Even though

often avoidant individuals escape relationships as a means of defense, damage to the self-image is postulated as a result of one's state of "aloneness," related fears, and negative thought patterns. Focusing on the effects that avoidance elicits in self-esteem is relevant in helping to divert the avoidant individual's manifestation of negative mood and thus subsequent and/or concurrent depressive symptoms.

Often people who exhibit avoidance are also hypersensitive to criticism and become easily frustrated (Teyber, 1992, p. 156). Social rejection in the form of criticism is perceived as negative evaluation especially among those with defectiveness schemas. This results in a hypersensitivity to detecting criticism and a more negative interpretation of these cues. Therefore, those with maladaptive self-schemas are likely to selectively "reinforce" maladaptive views of self. The negative thought record technique (discussed early) is also suggested to help challenge negative interpretations (Schmidt, Schmidt, & Young, 1999, p. 131; Young, 1990; Johnson & Whiffen, 1999). *Note: This client has provided some evidence within sessions that she may have a propensity to be hypersensitive to criticism as discussed within this literature review. She seemed to hone in on more negative than positive feedback as she has described in her interpersonal interactions. This factor will be addressed in detail within the session review.*

Low self-esteem is likely to occur in individuals who demonstrate negative interpersonal behaviors due to the repercussions of the disappointing response of others. Theoretically, these individuals learn to accept the feeling of being inept as an integral part of who they are and how they operate (Beck, 1967, p. 275). Research concludes that most often people accept a mood or behavior that they view as typical of themselves, and they are likely to express a desire to maintain rather than the desire to change it regardless

of its unpleasantness (Mayer and Stevens, 1994, as cited by Wood, Marshall, & Brown, 2002; Beck, 1967). Thus, one learns to expect these results. Expectations are central to models of motivation and self-regulation. People who are insecurely attached with low self-esteem may feel compelled to sacrifice the goal of feeling better or changing a behavioral style to maintain a coherent sense of identity (Epstein & Morling, 1995, as cited by Wood, Marshall, & Brown, 2002). Because of the link between insecure attachment style, low self-esteem, and depression, research suggests that an important part of cognitive-behavioral therapy for this client is to provide individualized techniques for raising one's self-esteem (Wood, Marshall, & Brown, 2002; Deci & Ryab, 1995, p. 46, as cited by Schimel, Arndt, Pyszczynski, & Greenberg, 2001).

One beneficial technique is to allow the client to bring forth and discuss prior strengths and confidences not only achieved in relationship issues, but also in any areas that have proven to help one raise true, intrinsic self-esteem levels in the past. Public accomplishments are more associated with extrinsic self-esteem. Even though extrinsic self-esteem is beneficial, it is theorized to be not as powerful or long lasting as intrinsic self-esteem (Schimel, Arndt, Pyszczynski, & Greenberg, 2001). Confidences that have proven to help raise one's self-esteem level in the past are the most dependable and motivational for acquiring the same results in the present due to the fact that the client is already familiar with how this technique is mastered. Looking at one's strengths and confidences over time allows one to reflect and take into account a broader view of a situation; thus, one exhibits fewer cognitive distortions (Kuyhen, Kurzer, DeRubeis, Beck, & Brown, 2001). This procedure is also applicable for coping strategies. Coping techniques that have been successful for dealing with previous problems are familiar

motivational tools and can be discussed and tailored. Positive evaluations, confidences, and situational experiences, which are intrinsically self-enhancing can be discussed between client and therapist and can also assist in preventing behavioral disengagements for low self-esteem clients. Thus, expectations for success are already high, which assists in motivating one to take action to achieve their present goals. Prior self-esteem raising achievements and coping strategies can be analyzed and customized to specific, existing circumstances (Wood, Marshall, & Brown, 2002; Kuyhen, Kurzer, DeRubeis, Beck, & Brown, 2001; Bowlby, 1977).

#### Links to Low Academic Functioning and College Life Adjusting

It is also quite possible that individuals who reduce their anxiety by using avoidance do not persist sufficiently to make use of the learning resources supplied to them. In addition to other symptoms, this client also reports difficulty in adjusting to college life and college academics. Although she stated in the initial assessment that she has had some academic problems in high school, which she claimed were due to a lack of good teaching, Vivona (2000) suggests that sometimes low academic functioning in late adolescence is linked to avoidant attachment style. Individuals with insecure attachments are apt to develop neurotic symptoms such as depression or phobias and these impede to school and academic performance (Bowlby, 1977; Vivona, 2000). Research has affirmed the importance of secure parental attachment for late adolescent development and success in adjusting to the demands of academics and college life (Larose & Boivin, 1998; Rice, RitzGerald, Whaley, & Gibbs, 1995, as cited by Vivona, 2000). When a late adolescent enters college, she attempts to establish greater independence from parents as well as using parents as a secure base to meet the challenges of the new experience. In this

situation, the need for both attachment and autonomy become heightened. When no sense of a secure base exists for a client, the therapeutic relationship can help to serve as a sense of what security feels like. The client can then experience this for herself (Johnson & Whiffen, 1999).

Another adjustment to college life for avoidant women is the pressure of initiating and maintaining relationships with other women in dormitory settings. Vivona (2000) suggests that avoidant women may find themselves without sustaining interpersonal bonds that are a source of self-esteem, satisfaction, and protection from distress of other women. Therefore, all of these factors for successfully adjusting to college life can become stressors for the avoidant individual resulting in depression.

Results of recent studies suggest that helping students to discover ways to meet attachment needs for security and autonomy can be helpful in enhancing college life adjustment and satisfaction (Vivona, 2000). Therefore, addressing interpersonal deficits, increasing communications skills, and building self-esteem via addressing concrete academic needs are all factors for guiding treatment that may prove to be beneficial for helping this client adjust to college life and higher academic functioning (Vivona, 2000; Teyer, 1992; Gilles, 2001).

#### Implications for Best Practice

In review of this literature, the “best practice” for treating interpersonal and attachment related depression is a combination of psychotropic medication and an eclectic approach to psychotherapy. Since this client has refused drug treatment, this therapy will consist of psychotherapy alone. The psychotherapies chosen to be the most effective for treating this type of depression and related symptoms are Cognitive

Behavior Therapy and Interpersonal Therapy. The cognitive focus will address negative and distorted thoughts that lead to depressive mood. The behavioral focus will attempt to help the client distract from negative thoughts by increasing effective support seeking and social behaviors. The interpersonal aspect will help the client to identify negative patterns and deficits of interactions and help elicit better communication skills to improve interpersonal relationships. The therapeutic relationship will also be a primary focus in that it will serve as a positive experience (i.e. a secure base) with an empathically attuned individual. Therefore, the client will experience and learn that she can have a close relationship with another without the attached fear of being hurt.



## Chapter Four

### Normative Practice

In the context of this counseling center and its flexibility, this therapist was at liberty to investigate “best practice” treatments for addressing all issues of this client and implement them to the best of her abilities with the aid of her supervisor. No other constraints were placed on therapy outside of the normal restrictions that applied to the university setting. The university calendar did impose time constraints, as students normally break over the winter. It should be noted that counseling is still available during this time in emergency situations, but outside of these situations, students typically stop and/or start with the boundaries of the school year. Family counseling is also constrained in this setting according to the distance of the college to the home environment. Similarly, for practical reasons relating to distance from her parents’ homes, family members were not involved in this client’s treatment. The inaccessibility of family members is quite typical in the college-counseling environment outside of emergency situations.

Other activities that are standard practice at this counseling center include: case presentation at weekly staff meeting; supervised review of “best practice” literature for treatment; discussion of case interventions and progress with supervisor weekly; review of session audio tapes by supervisor; and efficient, confidential record keeping.

## TREATMENT PLAN

THERAPEUTIC GOALS	TECHNIQUES	POSSIBLE OBSTACLES	EVIDENCE OF TX EFFICACY
Relieve depressive symptoms.	Behavioral techniques for mood tracking & thought records. Support group seeking & distraction techniques (client's choice).	Client could become more depressed. Client stops therapy. Unpredictable circumstances.	Improvement on BDI score. Increased activity level. Self-reported symptom relief & success of distraction techniques.
Get client back to class & improve academic functioning.	Interpersonal techniques- Therapist as advocate w/ library/teachers. Client talks to teachers for make-up work. Therapist teaches "chunking & layering" technique for research writing.	Client may become more depressed, may have missed too much class to make-up, or lacks motivation/skills to continue college.	Client goes back to class, completes assignments, & demonstrates academic competence.
Bring interpersonal patterns into client's awareness.	Talk therapy pertaining to relationships w/parents & other interpersonal relationships. Identifying tracking similar patterns. Talk about similar feelings elicited among relationships.	Resistance due to fear and/or pain, or schema avoidance. Attempts to avoid/escape therapist if relationship becomes "too close."	Identification of avoidant pattern & fears associated with interactions w/others.

<b><u>THERAPEUTIC GOALS</u></b>	<b><u>TECHNIQUES</u></b>	<b><u>POSSIBLE OBSTACLES</u></b>	<b><u>EVIDENCE OF TX EFFICACY</u></b>
Client will take chances in disclosing intimate information in sessions & will spend more time with friends.	Modeling secure-base in therapeutic relationship. Use of standard CBT therapeutic relationship.	Avoidant behavior or great sense of mistrust & sense of abandonment due to limited number of sessions.	Reciprocal trust & continued attendance to sessions & ability to demonstrate trust & security without avoidance in client's personal relationships. Increased sense of activity exploration.
Client will learn about the connection between effects of negative thinking & mood congruency.	Negative thought records & related mood congruency levels.	Client may not complete homework assignments or have ability to process information, or may not recognize ability to choose her own moods.	Records reflect client's awareness between thoughts & moods. Client demonstrates a positive attitude & actively attempts to maintain positive status.
Correct schema distortions contributing to maladaptive patterns of behavior.	Cognitive therapy to identify distortions & resulting patterns in past interactions.	Client resists or is not able to uncover schemas due to fear and/or pain.	Improved patterns of interactions, self-esteem, confidence, motivation, & efficacy in interactions will be demonstrated.

<b><u>THERAPEUTIC GOALS</u></b>	<b><u>TECHNIQUES</u></b>	<b><u>POSSIBLE OBSTACLES</u></b>	<b><u>EVIDENCE OF TX EFFICACY</u></b>
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Improve client's communication skills.

Therapist models & educates on how to communicate effectively.

Client may be too depressed to be able to identify elements & may maintain "hopelessness" attitude. Client may demonstrate pessimism or lack of interest. Client may chose not to practice skills or revert to old style due to peer pressure or other unpredictable circumstances.

Client self reports & demonstrates effective communication skills in all interpersonal relationships.

Client will learn to identify cues, stressors, and triggers of depressive symptom onset.

Client will keep charts/ journals, that help identify cues, stressors, & triggers that lower mood.

Client will identify cues, etc. & use distraction techniques/coping skills to overcome negativity & stress.

Client will learn goal setting, problem solving, and coping strategies for dealing with stressful situations to prevent depression relapse.

Teach client problem solving models & identify strengths & effective methods that have worked in the past.

Client will demonstrate greater self-satisfaction & efficacy in dealing with problems & making better decisions. Client will demonstrate a positive attitude.



## Chapter Five

### Session Reviews

#### Session One

Upon entering the office, Dee appeared to be physically slumped, but smiling. She appeared pleasant and eager to enter the counselor's office. Her speech was slow and somewhat difficult to understand due to her tongue ring. Her manner seemed comfortable and open.

After the explanation and signing of all the aforementioned consent forms, Dee was given the Beck Depression Inventory. Despite her apparent physical depressive appearance, Dee scored an 18, which was interpreted as moderate clinical depression. Dee stated that she has had "ups and downs during the week" since the intake, but she "feels pretty good today."

This therapist attempted to clarify Dee's only goal for therapy of "I just want to feel better." She responded, "I want to understand the reason why I feel so upset and depressed." At this point, the therapist explained that this therapy would entail aspects of cognitive therapy to identify and correct any distortions that come up within sessions, some behavioral techniques for distraction and symptom relief, some interpersonal techniques for addressing her interpersonal interactions, and homework assignments in an attempt to help reflect on some important aspects covered within sessions. It was also discussed that this therapist is willing to work as an advocate in some specific concerning academic performance. In addition, the roles of client and therapist were briefly explained and that this time belongs to the client to discuss any and all matters that are

important to her. At this time, the client appeared comfortable in settling back in her chair, legs folded underneath her.

Dee began her session with her concerns for completing her class assignments. She reported that she had been attending her classes this week after her two-week absence, but had “not been able to get up enough courage to talk to her professors about missed or make-up work.” When questioned about what it would take to get the courage to talk to her teachers, Dee responded that she knew from the syllabus and friends what she had missed, but just didn’t have the energy to discuss with her teachers the reason why she had missed class. She knew she had some papers to write, but has not begun them due to her lack of energy, motivation, and skill deficit. Therapist explained that the energy and motivation would most likely return as she begins to feel better if they had existed before. The skill deficit issue was a factor to be addressed. Therapist, at this point, chose to initiate a confidence building technique to investigate some of this client’s strengths and past academic successes in an attempt to boost her confidence academically and building intrinsic self-esteem. Client talked about her first semester in which she reported being on the honor roll, but attributed some of her success to “easier courses” and “higher motivation” because school was new. Because Dee was quick to attribute her past success to outside circumstances, positive results of the intervention were most likely not achieved.

Together, therapist and Dee discussed some aspects of obtaining research from the library and some paper-writing techniques that may be helpful in getting the work done. Therapist suggested that Dee utilize the librarian as a resource. This was an attempt to address an academic deficit and also an attempt to instill hope and trust in the

therapeutic relationship. Dee was extremely agreeable and expressed a desire to try these techniques; however, due to her present lack of motivation, this therapist assumed that Dee would hesitate to take action on this matter.

Next, the therapist questioned Dee's early comment that she has had "ups and downs during the week." The client explained that she had visited a friend on campus and was "trying to have fun." She commented that she did not stay very long at her friend's dorm when she began to feel sad and depressed and wanted to go back to her own room to be alone. She remembers thinking about the boy from the near sexual encounter. She talked about how much she thought she had liked this boy, but how she always feels the need to push people away when they may be getting "too close." She expressed sorrow now in pushing him away even though she knows she was not ready "to do that" (participate in sex). *Dee appeared not to be comfortable talking about sex or even saying the word. She seemed more interested in discussing her patterns of pushing other's away and feeling "abandoned."*

Therapist questioned Dee about past friendships and/or romantic relationships. One female friend was discussed during grade school, but she had moved away. Dee recalled feeling abandoned by her friend and likens the experience to her father's abandoning the family. Dee talked about the relationship that her father now has with her new half-sister whom he calls Daddy's girl, and how she used to be Daddy's girl. She talked about how her father chose his new wife over her and her mother. She made the statement that she doesn't want to have anything to do with him. She talked about how she felt when she saw her father last. She stated that she had felt good when she went

over to show him her new car, but then remembered how she had felt when he abandoned her and became angry. She called her father “a jerk.”

*Dee’s statement that her “father chose her over me” may be reflective of a sense of abandonment, defectiveness, jealousy, and humiliation which are all factors discussed by Cortina, 2001, in an explanation of how one’s schemas serve to maintain an experience of self in response to unmet needs and a lack of communication with a significant caregiver. Teyber (1992) & Vivona (2000) both theorize that avoidant individuals learn that the best defense to parents for reducing stress and anxiety of unmet needs is through physical avoidance and withdrawal. Dee’s statements about avoiding her father and stepmother may be representative of this theory. She sees her avoidant behavior as her only alternative to dealing with her father.*

The conversation switched to Dee’s mother. She claimed that her mother had always tried to protect her. Dee explained how her mother had always warned her about men. She explained how her mother still always tells her “all men want is sex, and they will all hurt you in the long run.” “Be careful they don’t put anything in your drink.” “They’ll try to drug you and use you for sex.”

Dee continued by talking about her on-going fear of talking to “guys,” but lately has felt better about doing so. She questioned her mother’s disparaging comments about men due to the fact that her mother had been happily remarried since one year after her father’s leaving.

*Dee’s possible enmeshment with her mother might be interpreted. She sees her mother as her protector even though she feels at times her mother is overprotective; Although, Dee sees no wrong in her mother’s over-protectiveness. However, she does*



*note her mother's advice does not seem to match her own behavior. Dee's mother's example may be more on a "do as I say, not as I do" basis. Dee's mother, in an attempt to protect her daughter from the undue harm of becoming a victim to a man's sexual desires, has probabilistically caused Dee's fear and a sense of vulnerability to harm.*

*Possible distorted schemas identified in this session: Abandonment, Mistrust, Emotional Deprivation, Defectiveness, Vulnerability to Harm, and Enmeshment.*

*At this point in therapy, this therapist was still attempting to gain information and direction on this client and her core beliefs. Together, the client and therapist decided that in accordance with Dee's thwarted attempt to distract by visiting friends, keeping track of negative thoughts in a journal might help Dee to realize a connection between her thoughts and onset of depressive mood. Dee's homework assignment was to journal negative thoughts: recording date, time, activity she was performing when the thought erupted, a description of the negative thought, and a 1-5 ranking of the depressive mood that followed the thought. (In reviewing the homework assignment in the next session, therapist will guide Dee to include a more positive reinterpretation of the negative thought.) In addition, Dee would attempt to continue attending her classes, and make an effort to try some of the research and writing techniques that were discussed in session.*

### Session Two

Dee was prompt for her appointment. She was given the BDI and scored 19, which is moderately depressed and one point up from the previous session. Dee reported doing her homework, the negative thought journal assignment, but she claimed to have forgotten it. However, she discussed some of the things that she had remembered writing about.

This therapist explained the importance of bringing homework assignments to our meetings so that we could evaluate them together. This therapist imparted some psycho-educational information concerning how we can use the negative thought records in order to learn to make more positive reinterpretations of her thoughts, and how this is good practice for learning to monitor thoughts that produce negative mood. As Dee recalled some of her thoughts in her journal and the rating scores for how sad they made her, she began to process the connection between the effects of negative thoughts on her depressive symptoms. *(Having the journal as concrete evidence would have worked better.)* Dee seemed enlightened by the connection. She stated that this all made sense to her. She commented that she had enjoyed actually doing the assignment as well and asked if she could continue it as an ongoing homework assignment. The therapist agreed.

Dee reported on her week. She talked about watching a TV show about a young, happy couple with a baby. She talked about how sad this made her. She remembered writing about it in her journal and scoring it a degree of 5 in making her feel sad and depressed. She made the statement, "I know I will never have this type of situation." This therapist responded with a reality therapy technique and questioned Dee. I asked for proof about how she knew this to be true. She responded that she "just knows." She then shut down and refused to explore the question any further. *This may be representative of schema avoidance for Dee. Even though she had no proof that relationships are impossible for her, she held on to this belief. Distorted schemas representative of this might be defectiveness and/or unworthiness, which may both cause a sense being unlovable, or perhaps she fears the failure of relationships more than the inability to attain them. It would be interesting to know if her response would have been different if*

*she were not feeling depressed and hopeless at that moment. She may have never experienced a long-term relationship herself, but she has seen that they are possible even for her mother who was also abandoned by Dee's father. These distortions should therefore be considered, but it is difficult to determine if they would still exist outside of her depressive state.*

*Another possible explanation of Dee's unwillingness to examine her belief may be what Teyber (1992) refers to as an avoidant's test to see if the therapist will perform as ineffectively as the attachment figure, which is a form of transference. This client may have been testing the therapist to see if she will reinforce fear and defectiveness as Dee described that her mother has done. The consistency and unconditional acceptance of the therapeutic relationship is seen as a technique for providing Dee with a sense of a secure attachment figure in such circumstances. It would be interesting to know how Dee's mother would have responded to her relationship hopelessness.*

*Doing some family therapy or at least an interview with Dee's mother would have been beneficial in this case; however, due to the circumstances of the university (away from home) setting, and the fact that Dee has chosen not to tell her mother about the event leading to her depression or that she is in counseling, this was not possible.*

Dee continued by telling the therapist how she had "ruined" her last few relationships. She talked about liking these "boys" until they liked her back, then ignoring them until they go away. Therapist responded with process oriented questioning techniques pertaining to what she had been feeling in each case. Dee recalled feeling fear of abandonment in each of the situations. She explained that her fear was that these men would leave her for "somebody else." Several brief relationships were discussed.

Therapist intervened with the interpersonal technique of pattern clarification. Dee's relationships had all ended according to a similar pattern that she had manifested for herself. Dee agreed that her pattern was to push away when interactions seemed to be "going well." She has felt the need to end relationships before they had the "chance to cause her the pain of rejection and abandonment."

*At this point, it may have been a good idea to use the cognitive technique of drawing Dee's attention to the fact that her negative thoughts and feelings (fear and abandonment) resulted in negative behavior (rejecting the boyfriend before he could reject her), and how more positive reinterpretations of thoughts about these relationships may help her to sustain them. This may have also helped Dee to realize that she is not helpless in affecting the outcomes of her interactions.*

Dee continued to talk about rejection in her relationships, but her conversation kept reverting back to her mother. Therapist confronted Dee with this occurrence. She seemed to have accepted the connection. Dee noted that she had consciously realized her mother's disparaging comments, but not to the extent that they affected her behavior as it related to her escaping relationships.

*Dee discussed her mother further, and talked about how her mother quite frequently made disparaging comments about her father and controlled him through threatening and convincing arguments even after he had married another woman. She defended her mother, however, and turned against her father. Dee's mother's seems to be extremely influential and demanding in her familial interactions. Dee's attention turned to how she had mistrusted her father for abandoning her and also for being weak. She stated that he has always pushed her aside and made her feel unworthy. This therapist*

*attempted to intervene with a role-play for corrective recapitulation of the emotions Dee feels toward her father. Dee refused this attempt and stated that she was not comfortable doing this. The therapist concluded that Dee is not yet trustful enough of the therapist to engage in this type of intervention.*

For homework Dee was assigned to bring in the negative thought records, which she had forgotten this week, and to write down any secondary gains that may serve to help keep her in avoidance and depression. Further attempts to understand dysfunctional patterns, and identify schema distortions are the focus of future sessions.

### Session Three

Dee reported an uneventful week upon arriving. Her BDI score was 17. Most of her symptoms ratings were attributed to her not sleeping. She did bring in her negative thought records on which she had 17 pages of notes. Together Dee and therapist reviewed some of the thoughts especially those she had rated high for negative affect. We discussed the reality of some of these thoughts in an attempt to enlighten Dee to the fact that most negativity exists only in one's interpretation. Some possible more positive reinterpretations were agreed upon. Dee commented that she is beginning to practice doing this for herself and requested to continue this as her primary homework assignment in addition to continuing to try to socialize more with her new support group female friends as a distraction to her negativity and isolation. Dee appears to be making progress in attempting to control her negative thoughts.

As the session continued, Dee stated that she had been working on "not pushing friends away." She commented that the new group of girls with whom she had been socializing seemed to be different than the friends that she has had in the past. These girls

do not seem to be as much of a threat for rejecting or abandoning her as she had experienced in the past. Dee explained that these girls seem to be more sincere in listening to her and caring about her. She talked about how she had been telling them of the techniques she had learned in therapy pertaining to negative thinking, and how in her attempt to teach them what she had learned, she felt better and more accepted. Together, we discussed Dee's prior pattern of running from friendships to try to identify some of the initial cues that lead to her running. Dee was willing to engage in this intervention.

Her pattern and associated cues (mostly affect related) were written down for Dee to take home. However, Dee was hesitant to devise a plan of action to address the cues. She stated that she was not ready to make a plan because she still had some fear. (Possible schema maintenance may be working here.) *Therapist did not push for engagement. Instead, therapist guided Dee to talk about some of the confidences that she had felt in the past week with her new girlfriends, and the expectations she may have for where these relationships might lead.*

Therapist imparted some psycho-education material pertaining to some of the information learned in researching the literature on this subject. In addition, this therapist talked about Dee's possible sabotaging of her relationships with her negative thinking and possible schema distortions in an attempt to reframe all of the information into a coherent pattern. However, in listening to the audiotape of this session some time later, I realized that I had done more talking than I would have liked to and not enough listening or questioning.

#### Session Four

After Session 3, Dee had missed her appointment the following week. She called to cancel claiming to be sick. She did not reschedule with the secretary at the counseling center. This therapist returned her call and left a voice mail requesting Dee to call to schedule her next appointment. A few days went by and Dee still had not returned the call. Again, therapist called leaving another voice mail requesting Dee set up her next appointment. By this time, therapist anticipated that Dee was demonstrating her pattern of avoidance in the therapeutic relationship especially since during Session 3, Dee had explained that her first cue in preparation of escaping was to not return one's phone calls. *Keeping in mind the literature's support for new therapist's dealing with individuals who have avoidant tendencies, this therapist concluded that leaving phone messages would not prove to be effective in getting Dee to return. This may have been Dee's way of testing the therapeutic relationship as it compared with her previous pattern of relationships. Dee needed some concrete reassurance that someone cared enough to not willingly give up and allow her to drift away.* In accordance, I mailed Dee a letter explaining that, "often clients choose to discontinue therapy when their depressive symptoms begin to subside; but we had begun to make progress in therapy, and I was interested in continuing our relationship." Also in the letter, I had scheduled her an appointment date and time and expressed my hopes that she would show up. Two weeks had already passed. Although Dee never did call to confirm, she did arrive on time the date that I had scheduled her. *Note: I had known that our relationship would be ending in a few weeks anyway when my internship was concluded, and Dee's semester was over; however, I thought that a mutual ending of our relationship might prove to be more*

*beneficial in helping Dee to process the fact that relationships can end without causing the pain and fear associated with rejection and/or abandonment.*

Dee scored 14 on the BDI and engaged in the session without reference to her attempted “escape” from our relationship. She immediately began talking about how she had reconnected with two past male friends. When Dee didn’t bring up the avoidance matter, this therapist decided to question her about it. Therapist expressed concern that Dee would not return. Dee responded that she had been sick the first week and after that she had “felt better and just didn’t feel like talking about her problems.” Therapist inquired, “Do you think it brings you down to talk about your problems?” Dee responded, “Not necessarily, but I don’t want to risk my good week.” At this point, due to my inexperience and uncertainty of the effects that might be produced by further pursuit of the matter and feeling content with the fact that she had returned, I let it go.

Ironically, Dee talked about how she had recently reconnected with two old friends whom she had remembered “really liking” but had run from in the past. She talked about how she had remembered that she could depend on them and that they really had been good friends. She stated that she used to see them on and off, but she had recently realized that it hurts her when too much time goes by in between seeing them.

*At the time, this therapist didn’t see the connection between the events that occurred in the therapeutic relationship and the events that occurred in Dee’s relationship with these two friends. In looking back, there seems to be a definite connection between the two experiences.*

Upon further investigation of Dee’s reconnection with the two friends, this therapist asked if Dee still felt the need to push friends away. Dee explained that she still



might run eventually, but lately she had felt like pulling people in, especially those she felt she could count on. She stated that she only wanted to push people away who are bad for her. In response to this therapist's inquiry of what is bad for her, Dee explained that "bad" is when people try to "break her down," and "people who are self-destructive are bad" for her.

In ending the session, therapist talked to Dee about making empowering choices based on positive interpretations of events such as Dee's wanting to reconnect with these friends whom she had recalled being dependable. This discussion was an attempt to help Dee process the benefits of her empowering decision in hopes to increase her self-esteem. Therapist gave Dee a relaxation audiocassette (relaxing music and nature sounds) to help her fall asleep. Her homework was to test the tape.

*This therapist sees this session as a turning point in therapy. Not only did Dee return after avoiding the relationship, but she may also be testing her new sense of a secure based to two other relationships.*

#### Session Five

Dee scored 12 on the BDI. She entered the office bubbling with excitement. She reported having a great week. She explained that her relationships with her female friends had been going very well, but she was very excited to report that she had met a new "guy" whom she really liked.

Together, therapist and Dee decided that now might be a good time to set a plan of action for countering her cues that lead to her avoidant pattern. We made a chart. On one side, Dee described her old pattern of behavior with boyfriends; on the other side, we listed a variety of more positive and secure alternative behaviors that Dee might chose

from when the time arose. The positive/alternative behavioral side included much less negative self-disclosure than she had been used to divulging in the past. This therapist discovered that in creating this chart with Dee, she seemed to be more able to process the negative effects of her old pattern. As she would relay what she had normally done and therapist would question her as to the effects of that behavior, Dee recalled the negative affective state that the behavior produced within herself. Devising the positive alternative side of the chart was a much more difficult task for Dee. She seemed to be unsure of what a more positive behavior would be in many cases.

This very important piece of dialogue expresses Dee's desire to make healthy connections while at the same time schema maintenance is struggling to hold Dee to her old pattern of distorted schemas:

T: "You told me that disclosing does not work for you, right? How might you change this?"

D: "But when I start trusting them, we both start talking about things, and that's when I bring stuff out. I don't want to just be happy because that's not who I am. I don't want him to think I've been happy my whole life when I haven't."

T: "What can you do?"

D: "In the past, I made this happen, and I've forced it to because it's easier than trusting someone. I didn't want to risk them hurting me, so I pushed them away. I hurt them. I must have been doing it, and I finally realize that I was hurting other people by doing that."

T: "Can you put off negative self-disclosure, and stay in the positive until he gets to know you better?"

D: "I will try, but it's how I trust. I'll try."

In the remainder of the session, therapist suggested Dee applying her proven distraction techniques for countering negative thinking and practice her positive

reinterpretation skills for negative thoughts that do persist as they apply to her new relationship. In addition, we discussed Dee's desire to terminate therapy in the next session due to her leaving campus over winter break and this therapist's internship concluding.

*Despite Dee's progress and in accordance with this dialogue, it is clear that much work still is required in therapy to challenge Dee's avoidant pattern and her tendency to scare others away with her early, negative self-disclosure. If Dee can change her pattern and limit her negative self-disclosure until a more appropriate time in her relationships, she may have a better chance at not scaring away potential partners.*

#### Session Six

Dee's final score on the BDI (nine weeks from the intake) was 9. Her score still reflected some points for having trouble sleeping and some points for apprehension of the future and irritation with others. However, she seemed in a pleasant and happy mood, and reported feeling "good."

Dee talked about her week with her new boyfriend and said that things had been going well. She had been trying to limit her time with him and phone calls to a reasonable amount, so that she does not feel that she is getting too close too fast. (Although, a "reasonable amount" was not clarified.) As she had described in the previous week's session, this is usually the time when she releases the negative self-disclosure. She reported being happy with that situation so far, as the interaction had been going well.

On the other hand, she expressed hypersensitivity to some gossip and criticism that she had heard second hand regarding some girls who were talking about her. She stated that she had planned on confronting these girls on what she had heard they said.

This therapist questioned Dee as to what she had hoped to gain from this confrontation. We talked about the possible benefits and detriments of the confrontation in addition to some reinterpretation ideas for controlling this negativity. Dee responded positively to this therapist's quick demonstration of a problem-solving model intervention. She concluded that confrontation was probably not the best idea and thus decided that it probably was not worth her time, especially since she had been planning to go home for Christmas next week to have a nice time with her new friend.

Therapist did a quick review of the progress and changes that Dee had encountered during our time together. We discussed some of the techniques that Dee had learned in therapy and might choose to practice on her own, such as: distracting and coping with negativity, keeping negative thought records and reinterpreting events more positively, relaxation techniques, some problem solving techniques including the plan of action chart for her interactions, and making empowering choices. Dee commented that she had learned a lot using these techniques, but expressed her regret that she had not felt confident enough that she would use them in times of stress. She stated that she needed to learn to feel more sure of herself.

Therapist advised Dee that she was more than welcome to continue therapy at this center with another therapist if she so desired. Dee refused, stating that she had decided to terminate now because she had been feeling better and had planned to get a part-time job upon returning to college after the break. This therapist gave Dee the business card of a colleague at the counseling center and encouraged Dee to call for an appointment at anytime that she may decide to continue therapy. She commented that she found therapy

helpful and would not hesitate to return again if she felt the need. Dee completed a client satisfaction measure upon leaving the counseling center.

### Conclusion

In determining if this brief cognitive-behavioral/interpersonal therapy was successful for this client, individual sessions were reviewed as well as the goals stated in “Evidence of Treatment Efficacy” of the treatment plan. An important measure was the BDI. This client’s BDI score improved from 18 to 9. This client was adequately lending support to the hypothesis that she returned to her self-reported normal functioning. According to Gilles interpersonal therapy criterion, the goal of this therapy is to return the client to normal functioning prior to the onset of depression. The obvious improvement on the BDI supports the conclusion that this goal was attained for the most part even though no BDI score is available prior to the stressor. In addition, as evidenced by session reviews, it is likely that the client has made some improvements in knowledge base concerning self-understanding, development of socialization skills, and increased awareness to patterns in interpersonal relationships.

On the other hand, the results for cognitive-behavioral therapy are much more difficult to determine especially considering the brevity of this therapy. There may have been some shifts in cognitive distortions, but these were not clearly measured. Therefore, it is difficult to ascertain if they occurred. Session reviews do demonstrate, however, that the client was able to at least process the knowledge that some cognitive distortions did indeed exist for her. This was evidenced by the fact that the client stated that she now realizes that she “made this happen” and that she pushed people away because it was

“easier than trusting them.” She has begun to realize that her schema-driven behaviors may have been responsible for her avoiding close relationships.

Several other goals of the treatment plan have also been achieved in accordance with the specified efficacy. The client had reportedly gone back to class and had reported completing some assignments; however, academic competence was not measured given the circumstances of this therapy. The client had reported spending more time with friends and trusting them more. She also demonstrated competency in realizing the effects of her negative thoughts on her mood and learned techniques to combat them as she had reported in her journaling. In addition, this client demonstrated an increase in self-esteem and confidence by initiating a new interpersonal interaction with a potential romantic partner and has reportedly attempted to improve her interpersonal communication style with this male. This client has also demonstrated skills for identifying stressors and initiating distractions to combat the onset of depressive thoughts.

It is evident by the session reviews and the BDI scores that this client made a fairly rapid improvement in a brief period of time suggesting that perhaps this depression could be seen as an acute crisis that could have been easily resolved. Her depression may have remitted spontaneously without having attended therapy; however, the existence of her interpersonal attachment issues would have still continued unaddressed most likely causing her more depression in her future interactions. The interpersonal learning that this client experienced along with the techniques to relieve depressive thoughts and symptoms may prove to be a beneficial part of this client’s counseling experience as similar issues arise.

The therapeutic relationship factor, which signified a sense of an actual experience of a secure base (as discussed in the literature review), was most likely the most beneficial factor in this therapy in my opinion. Getting the client to return to therapy after she demonstrated her pattern of avoidance was considered to be a success in of itself. In addition, the client not only reconnected in the therapeutic relationship but also stated that she had reconnected in two other interpersonal relationships from which she had previously fled. Even though the client probably did not process the actual reason why she had made these reconnections, the reconnections still exist as an interpersonal achievement. This success experience exists for her cognitively as well as experientially and can be recalled later as a confidence-building strategy for increasing interpersonally related self-esteem. The client also gained the knowledge that close, interpersonal relationships can exist for her safely and securely without the pain or fear of abandonment or rejection, and they can be terminated by a mutually empowering decision without pain or fear.

In accordance with the treatment plan, a common goal of this and most other psychotherapies is to improve thoughts and functioning through self-awareness and interpersonal practice and to help the client move at least one stage forward along the path which leads to the cognitions and behaviors associated with the genuine self or the self that this client desired to become. Overall, despite the limited number of sessions, evidence exists that the client has actually experienced a valuable interpersonal interaction with a secure base and has learned information in self-knowledge that will help her to continue to move forward in attempting to achieve her interpersonal goals. Even though it is likely that this client will probably experience difficulties in

interpersonal interactions in the future as she drifts in learning from this therapeutic experience, she has learned that therapy can be beneficial, and she may return to therapy as these issues arise throughout her life.

The client was asked to complete an assessment for client satisfaction measure. In this assessment, she reported that she “strongly agreed” with aspects of therapy that included: being understood in therapy; encouraged to make her own decisions; being made to feel comfortable; given sufficient information, skills, and resources; and satisfaction with services. The client also reported “strong agreement” with therapy being positively effective. This client reported “agreement” with comfort in discussing her problems with this therapist. Further, she reported “feeling at ease” with the therapist and that the “therapist used visuals to help me understand. She went out of her way to help and to make sure we were on the right path.” No other comments were reported. These results support the conclusion that the client’s experience in therapy was a positive one.



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APPENDIX

## Appendix A

### Early Maladaptive Schemas with Associated Schema Domains

(Jeffrey E. Young, Revised November 1998)

#### Disconnected and Rejected Domain

The therapist should explore client's connections in an attempt to uncover information pertaining to how one connects to other people. The therapist investigates and evaluates the client's close emotional ties, sense of belonging in groups of friends, family, and community. Other areas of focus and investigation should include: social integration, social desirability, social skills, social acceptance, and issues concerning attention, love, respect, and trust. This domain involves expectations that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family of origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.

1. **Abandonment/Instability.** (The perceived instability or unreliability of those available for support and connection.) Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.
2. **Mistrust/Abuse.** (The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage.) Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "gets the short end of the stick."

3. Emotional Deprivation. (Expectations that one's desire for a normal degree of emotional support will not be adequately met by others.) The three major forms of deprivation are:
  - a. Deprivation of Nurturance – Absence of attention, affection, warmth, or companionship.
  - b. Deprivation of Empathy – Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.
  - c. Deprivation of Protection – Absence of strength, direction, or guidance from others.
4. Defectiveness/Shame. (The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed.) May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness).
5. Social Isolation/Alienation. The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

#### Impaired Autonomy and Performance Domain

The therapist should investigate and evaluate issues of independent functioning in the world and levels of one's presumed "safeness" (security), hyper vigilance to threat and criticism, and academic performance. Sufferers maintain expectations of about oneself and the environment that interfere with one's perceived ability to separate, survive,

function independently, or perform successfully. Typical family of origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.

6. Dependence/Incompetence. (Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others). (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, and make good decisions). Often presents as helplessness.

7. Vulnerability to Harm or Illness. (Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it). Fears focus on one or more of the following:

- a. Medical catastrophes – for example, heart attacks, AIDS;
- b. Emotional Catastrophes – for example, going crazy;
- c. External Catastrophes – for example, elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

8. Enmeshment/Undeveloped Self. (Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development.) Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or, in extreme cases questioning one's existence.

9. Failure. (The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement such as school, career, sports,



etc.) Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, and so on.

### Impaired Limits Domain

Exploration should focus on one's capacity to self-discipline, impulse control, sensitivity to the needs of others, and boundaries limits for self and others. These individuals show a deficiency in internal limits, responsibility to others, or long-term goal-orientation. Leads to difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family origin is characterized by permissiveness, overindulgence, lack of direction, or a sense of superiority – rather than appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, child may not have been pushed to tolerate normal levels of discomfort or may not have been given adequate supervision, direction, or guidance.)

10. Entitlement/Grandiosity. (The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction.) Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) – in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of, others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern of others' needs or feelings.

11. **Insufficient Self-Control/Self-Discipline.** (Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses.) In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion – at the expense of personal fulfillment, commitment, or integrity.

#### Others Directed Domain

Young suggests the therapist explore the client's ability to express his/her own needs and emotions without a sense of guilt or reprisal. This domain includes an excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs – in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires – or social acceptance and status – are valued more than the unique needs and feelings of each child.)

12. **Subjugation.** (Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation, or abandonment.) The two major forms of subjugation are:

- a. **Subjugation of Needs** – Suppression of one's preferences, decisions, and desires.
- b. **Subjugation of Emotions** – Suppression of emotional expression, especially anger.

Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents an excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out," substance abuse).

13. Self-Sacrifice. (Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification.) The most common reasons are to prevent causing pain to others, to avoid guilt from feeling selfish, or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of co-dependency.)

14. Approval-Seeking/Recognition-Seeking. (Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self.) One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as a means of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.

### Over Vigilance and Inhibition Domain

Therapist should explore and evaluate the client's expression of feelings, impulses, and choices with spontaneity, intense focus on mistakes, failures, and rigidity to rules or expectations. This domain an excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices or on meeting rigid, internalized rules and expectations about performance and ethical behavior – often at the expense of happiness, self expression, relaxation, close relationships, or health. Typical family origin is grim, demanding, and sometimes punitive: performance, duty, perfectionism, following rules, hiding emotions, and avoiding mistakes predominate over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry – that things could fall apart if one fails to be vigilant and careful at all times.)

15. Negativity/Pessimism. (A pervasive, lifelong focus on the negative aspects of life such as pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc. while minimizing or neglecting the positive or optimistic aspects.) Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, vigilance, complaining, or indecision.

16. Emotional Inhibition. (The excessive inhibition of spontaneous action, feeling, or communication – usually to avoid disapproval by others, feelings of shame, or losing control on one’s impulses.) The most common areas of inhibition involve:

- a. Inhibition of anger and aggression;
- b. Inhibition of positive impulses (e.g., joy, affection, sexual excitement, play);
- c. Difficulty expressing vulnerability or communicating freely about one’s feelings, needs, and so on; or
- d. Excessive emphasis on rationality while disregarding emotions.

17. Unrelenting Standards/Hyper criticalness. (The underlying belief that one must strive to meet very high-internalized standards of behavior and performance, usually to avoid criticism.) Typically results in feelings of pressure or difficulty slowing down, and in hyper criticalness toward oneself and others. Must involve significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relations.

Unrelenting standards typically present as:

- a. Perfectionism, inordinate attention to detail, or an underestimate of how good one’s one performance is relative to the norm;
- b. Rigid rules and “shoulds” in many areas of life, including unrealistically high moral, ethical cultural, or religious precepts; or
- c. Preoccupation with time and efficiency so that more can be accomplished.

18. Punitiveness. (The belief that people should be harshly punished for making mistakes.) Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one’s expectations or standards.

Usually includes difficulty-forgiving mistakes in oneself or others because of a reluctance

to consider extenuating circumstances allow for human imperfection, or empathize with feelings.