Ann

A Case Study

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Aaron Beck's cognitive therapy model has been used repeatedly to treat depression and anxiety. The case presented here is a 34-year-old female law student with an adjustment disorder with mixed anxiety and depressed mood. It is presented to illustrate a successful treatment outcome using cognitive interventions. Sessions by session summaries are offered to further demonstrate the specific treatment plan implemented and to serve as a learning tool for clinicians and students.

Keywords: anxiety; depression; adjustment disorder with mixed anxiety and depression; cognitive therapy model

1 THEORETICAL AND RESEARCH BASIS

A review of the literature shows strong support for cognitive interventions in the treatment of depression and anxiety (Barlow, 1988; Beck, Rush, Shaw, & Emery, 1979). Both depression and anxiety are problem areas identified in this case of a woman with an adjustment disorder, which also has been effectively treated with cognitive strategies (Freeman & Dattilio, 1992). Cognitive therapy focuses on the content of the client's cognitions and seeks to change negative or biased and unsupported thinking related to ongoing events (Corey, 1996). The client's description of events in her childhood and adulthood and the quality of her thinking style, in general, were replete with cognitive distortions. Her thinking style indicated that cognitive therapy was a reasonable treatment for this client's presenting problems.

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2 CASE PRESENTATION

The client was a 34-year-old law student who was seen at a university student counseling center. The therapist was a 3rd-year clinical psychology doctoral student completing her practicum rotation (Ericka Stricklin-Parker) and was supervised by a faculty member, director of the clinic who is also a licensed clinical psychologist (Barry A. Schneider). To protect confidentiality, the client described is referred to as "Ann," and all identifying information have been changed.

3 PRESENTING COMPLAINTS

Ann presented for treatment in August of 1998, reporting that she sought therapy because of feelings of anxiety and depression associated with "financial and school pressures." She described symptoms of agitation, irritability, frequent tearfulness, and concentration difficulties. She said the symptoms had become progressively worse since May 1998 when she began her 1st year of law school and was denied a student loan because of her poor credit history.

At intake, Ann described her current stressors as including a pending bankruptcy claim, a recent automobile accident, final exams, and her roommate pressuring her to move out.

4 HISTORY

Ann reported that in addition to attending law school full-time, she was working as a massage therapist 1 day a week. She stated that working as a masseuse did not provide adequate income to meet her financial needs so she had recently began working as a stripper ("Starla"). Ann reported that for the past 6 weeks, she had been working at a downtown nightclub approximately one night per week. She related that she enjoyed working as a stripper, stating, "I get to be an actress, it's great." She did admit, however, that she was somewhat concerned about how working as a stripper could affect her reputation, because a few of her classmates had attended the club and reportedly "told the whole school" where she worked.

Ann has two brothers, ages 40 and 31, and a sister, age 25. Ann is the second eldest child. She was raised by her parents who remain married. Ann grew up in Charlotte, North Carolina, and described her up bringing as being raised in a "very strict, Christian home." She reported that at times her father was physically abusive to her mother and her brothers. When asked about her current relationship with her father, Ann stated that there has been "some improvement and resolution." In the past, she would have described her mother as "weak" for taking the abuse from her father, but now she sees her mother as a "strong person." Ann attributed her change in attitude regarding her

mother to her own personal experiences of being abused. She does not feel comfortable confiding in her parents, stating that she feels "misunderstood" by them. Ann reported good relations with her siblings and noted frequent contacts with them.

Married to her high school sweetheart at the age of 20, Ann subsequently divorced 7 years later. She described her exhusband as both emotionally and physically abusive and, not surprisingly, described their marriage as "very unhappy." She reported that her exhusband was unfaithful to her 4 months into their marriage. As a result of his infidelity, she contracted herpes and genital warts. She reported remaining in the marriage because she was committed to her marriage vows. However, after 7 years of unhappiness and her husband's unwillingness to change, Ann filed for divorce. She related that the herpes leads her to feel "tainted and dirty," and she is concerned that she will never find another partner who will accept her.

Following her divorce, Ann stated that she became involved in another physically abusive relationship that lasted approximately 1 year. She reported that the boyfriend broke her arm and threatened her life. She filed battery charges against him on three separate occasions. At the time of intake, she had a restraining order issued to protect her from him. Initially, Ann believed she could change her boyfriend, but after he broke her arm, she decided to end the relationship.

Ann stated that it has been 2 years since her last serious relationship. At this time, she described a pattern of sexual escapades marked by "quickie, love'em and leave'em" relationships. She related feeling "detached" from men, an inability to "open up," and a sense that she was maintaining a wall around herself because of fear of rejection and being hurt again. Ann attributed this fear to her belief that she never lived up to her father's expectations. She admitted that she is angry with herself for making poor relationship choices stating, "I always go after the wrong man."

During her divorce, Ann sought psychiatric services for the first time. She saw a psychiatrist for approximately 6 months in 1995 and was prescribed Xanax for anxiety. Following her second abusive relationship, she sought counseling for about 9 months. She described both of these experiences as "positive and helpful." She reported that she has also attended numerous group-counseling sessions aimed at abused women's issues. She stated that she has been invited to speak on numerous occasions as a survivor of domestic violence and is a volunteer at a local abused women's shelter.

Academically, Ann reported that she had always been an above average student and denied any disciplinary problems. She described herself as a Type A personality and that she likes to be the center of attention. She related that she has always enjoyed the company of others and reported that she was always popular growing up. Currently, she described having two very close friends whom she can lean on for support.

After graduating from high school, Ann attended college and received an Associate of Arts degree in sociology. She later received a certification as a massage therapist. She worked in this field until the end of her second significant relationship. At that time, she was in sales but stated that she did not enjoy that line of work. She then attended a south-

ern college and received her bachelor's degree in legal studies. At the time of the interview, Ann was about to complete her first semester of law school. Her goal is to work with battered women.

Ann reported that she consumes approximately two to three alcoholic beverages per week. During her last abusive relationship, she stated that on occasion, she would drink up to a six pack of beer a night. She denied any current or past use of illicit drugs. She stated that she occasionally smokes cigarettes when she drinks.

At the time of intake, Ann was living with a roommate in a condominium located near school. Her roommate owns the property and recently had asked Ann to move out, reportedly because of conflicts over the roommate's boyfriend. Ann was unsure of her future living plans.

5 ASSESSMENT

Ann is a 34-year-old, single, Caucasian female who was self-referred to the student counseling service at the university. Pretreatment evaluation consisted of an intake interview and an in-session behavioral observation. Additional information was provided through use of the Multimodal Life History Questionnaire (Lazarus, 1981), Sentence Completion (Loevinger, Wessler, & Redmore, 1970), and Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kraemer, 1989). The interview, behavioral observations, and test measures were administered to assist in diagnostic formulation and development of an effective treatment plan appropriate to Ann's presenting symptoms.

Ann is an attractive, slender, Caucasian female who appeared to be younger than her stated age. She was casually dressed and appropriately groomed for the interview. She displayed no observable physical abnormalities. She was alert and oriented in all spheres. Her reality testing appeared to be intact. Her speech was normal with respect to tone and pressure. Her mood was mildly depressed with affect congruent with thought content. Thinking was clear and logical. Her intelligence was estimated to be above average based on her academic background and her use of vocabulary during the interview. She was openly tearful when describing her past abusive relationships and her contraction of sexually transmitted diseases. She displayed no overt signs of hallucinations, delusions, or other psychotic behavior. She denied past and current suicidal or homicidal plans or intent. There was no obvious impairment in memory function.

Ann was given the Multimodal Life History Questionnaire (Lazarus, 1981) and Sentence Completion (Loevinger et al., 1970) on the day of the intake evaluation to complete and return to the therapist at the first session. The Multimodal Life History Questionnaire assisted the therapist in gathering a more comprehensive background history about the client and helped gain a better sense of her problems to implement an effective treatment plan. This questionnaire targets the basic ingredients of an individ-

ual's BASIC I.D.—her behavior, affect, sensory experiences, images, cognitions, interpersonal dealings, and biological factors (Lazarus, 1981). Generally, the information derived from this assessment tool identified Ann's strengths to be ambition, motivation, intelligence, and openness. Weaknesses were painful affect and impulsive behavior. Also, this questionnaire asks questions related to the client's expectations regarding therapy. Ann's response to therapy goals were "helping me solve the problems that exist in my life," and she expected her therapist to be "compassionate and concerned."

Sentence Completion is an assessment tool that measures current personality function as it relates to the everyday global needs and wishes of the client. Education and career are very important to Ann. She sees herself as strong and committed to achieving her goals even if she has to do it "on her own." She is able to openly acknowledge her weaknesses.

Ann was also administered the MMPI-2 following the second meeting with the therapist. The MMPI-2 was used as a measure of formal personality testing. Her scores on the validity scales revealed a valid profile. She had only one significant elevation on the clinical scales (Scale 9). Her profile suggests that she tends to be impulsive and has a history of interpersonal problems. She most likely would appear outgoing, social, and extroverted. Although she has many social relationships, they are likely to lack genuine intimacy. She is inclined to be rebellious and demonstrate poor impulse control. Ann endorsed items that suggest that she is particularly prone to feelings of self-alienation. Ann's MMPI-2 profile is quite consistent with reported patterns in her current level of functioning. Indeed, she reports many interpersonal relationships in and outside of school and a strong involvement in work and academic activities. These actions would demonstrate her outgoing nature. Despite many social relationships, Ann admits that they generally lack depth and genuine intimacy. Her social history reflects a pattern of poor choices of partners along with an impulsive style. Although Ann has been successful in some of her personal achievements, she maintains a profound sense of failure and inadequacy.

On the basis of *Diagnostic and Statistical Manual for Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994), Ann met criteria for the following diagnoses based on the information gathered during intake evaluation:

Axis 1: 309.38 Adjustment Disorder with Mixed Anxiety and Depressed Mood
Axis II: V71.09 No Diagnosis
Axis III: Sexually Transmitted Disease
Axis IV: Financial difficulties, Housing problems
Axis V: GAF = 65 (at intake)

A diagnosis of adjustment disorder with mixed anxiety and depressed mood seemed most appropriate based on the information Ann reported during the intake. The *DSM-IV* states that the hallmark feature of an adjustment disorder is an identifiable psychosocial stressor, which triggers significant emotional and behavioral symptoms.

Ann reported exacerbation of symptoms, which included irritability, agitation, concentration difficulties, and frequent tearfulness following a denial of a student loan, pending bankruptcy claim, a recent automobile accident, and pressure from her roommate to move out. Her symptoms began within 3 months of these stressors. Her depressive symptoms were too few in number to meet criteria for a diagnosis of major depression. Ann's presenting symptoms did not meet criteria for any other Axis I, anxiety or mood disorder.

In addressing differential diagnosis, *anxiety disorder not otherwise specified* was considered. However, because Ann did report several identifiable stressors leading to the development of her symptoms and her symptoms were insufficient to meet criteria for an anxiety disorder, this diagnosis was ruled out. Both posttraumatic stress disorder and acute stress disorder require the presence of a psychosocial stressor, but in these cases, the stressor must be extreme. Furthermore, a specific range of symptoms must be present. Ann did not report such symptoms, so these diagnoses were also ruled out.

As for Axis II disorders, Ann did not meet criteria for any specific diagnosis nor was *personality disorder not otherwise specified* appropriate. However, she did report a history of rather unstable interpersonal relationships with men and did acknowledge some impulsive behaviors. She had two long-term abusive relationships followed by a series of sexual adventures, which she described as "quickie love 'em and leave 'em." Based on this information, Ann demonstrated some features of borderline personality disorder, but she did not demonstrate a pervasive pattern since young adulthood. Therefore, she did not meet the full criteria required for a formal Axis II diagnosis.

6 CASE CONCEPTUALIZATION

Discussions with Ann during her intake in conjunction with her assessment information suggested a pattern of dysfunctional thinking dating back to her childhood. Additionally, she experienced depression and anxiety resulting from demands of adjusting to everyday life changes. The cognitive model provides an appropriate vehicle for understanding negative thinking, changing thought patterns, and developing coping strategies to improve daily functioning (Beck et al., 1979). There is support for cognitive interventions in the treatment of adjustment disorders (Gilson cited in Freeman & Dattilio, 1992). It appeared that major life changes including financial difficulties, law school, and unstable living arrangements triggered thinking that led to exacerbation of anxiety and depressive symptoms.

As a result of these distressing circumstances, Ann's available resources to address personal, external, and future problems began to diminish (Meichenbaum, 1977). Furthermore, Beck believes that the way individuals perceive their experiences helps determine how they feel and behave (Corey, 1996).

Ann's depressive symptomatology can be understood by reviewing Beck et al.'s (1979) cognitive theory of depression, which utilizes the concepts of the cognitive triad,

schemas, and cognitive distortions. The first component of Beck's theory to explain the psychological etiology of depression is the cognitive triad in which individuals maintain a negative perception of themselves, their world, and their future. This negative thinking predisposes an individual to depression. Ann's poor adjustment to her current life stressors and subsequent depressive symptoms arose from her view of herself as inadequate and unsuccessful, seeing others as rejecting and critical and predicting a hopeless future. Her personal feelings of inadequacy maintained her low self-esteem.

Automatic thoughts are immediate, involuntary cognitive responses to a situation, which reflect the cognitive triad (Freeman, Pretzer, Fleming, & Simon, 1990). Ann often made statements that demonstrated automatic thoughts, such as "I'm not worthy" or "I'm not good enough." These firmly held beliefs supported her depressive symptoms and her pervasive feelings of frustration and hopelessness.

The cognitive model's second concept, schema, is a pattern of information processing based on early life events and learning. Schemas are stable hypotheses that initiate the process by which an individual perceives and organizes information about the world. They guide the way a person selects information (Beck et al., 1979; Freeman & Oster cited in Caballo, 1998). This selection process may very well become maladaptive as the individual is narrowly attuned to his or her own cognitions based on past experiences (Craighead, Craighead, Kazdin, & Mahoney, 1994). Ann's schemas developed from her early life experiences, and they have continued to maintain her negative self-defeating cognitions. Despite external evidence that supports her many accomplishments, she maintains the belief that she is a failure and unsuccessful. These inaccurate interpretations arise when she is confronted with stressful events.

The third concept according to Beck's model of depression is cognitive distortions. An individual may choose to interpret experiences in a biased fashion. Ann demonstrated several cognitive errors, which included selective abstraction, personalization, dichotomous thinking, and the control fallacy. An example of her selective abstraction was her inclination to ignore her many academic and personal accomplishments and, instead, to focus on her weaknesses. She also personalized her contracting of a sexually transmitted disease from her husband by stating, "I should have known he was cheating. Maybe I could have been a better wife." Ann often described herself as either "all good" or "all bad," which demonstrates her tendency toward dichotomous thinking. Her fear of rejection and being hurt led her to adopt the control fallacy, "I'll leave them before they can leave me."

Anxiety is often the main result of an overactive survival strategy (Freeman & Dattilio, 1992). Based on her painful emotional and physical abuse history, Ann was keenly aware of potential threats in her surrounding environment. Although she was not currently involved in an abusive relationship, she developed anxiety symptoms as a result of current stressors, which decreased her ability to cope with daily events. Worry and irritability led her to fear the outcome of her problems. These fears negatively

impacted her school functioning and led her to question her capacity to manage the stressors (Barlow, 1988).

As for her family, Ann described her father as "controlling and critical" and her mother as "passive." She was reared in a very strict, Christian household where her every move was carefully scrutinized. On several occasions, she witnessed her father physically assault her mother. She quickly escaped from her childhood home into a marriage that turned out to be emotionally abusive. After her divorce, she entered into a physically abusive relationship. All of these experiences made her fearful of others, and she viewed her future as bleak. In her words, "I've been hurt and rejected by others. I have to protect myself. I'll never get married again. I'll always be on my own." According to cognitive theory, relevant events, distorted thinking, and strong emotions such as depression and anxiety activate early maladaptive schemas (Beck & Freeman, 1990). In Ann's case, she developed compensatory behaviors, which allowed her a sense of control—detachment from men and her emotions. Her current presentation demonstrates dichotomous thinking, as she describes herself as "I'm the all-good little girl, Ann" (the product of her childhood) or "I'm the all-bad, Starla" (impulsive, reactive response in adulthood).

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

In general, treatment initially begins with establishing a strong, collaborative therapeutic alliance. A collaborative approach fosters a greater sense of self-efficacy in the client and challenges negative perceptions regarding the self, world, and future (Beck et al., 1979; Freeman et al., 1990; Freeman & Oster cited in Caballo, 1998). An initial challenge would be building rapport quickly to achieve a solid therapeutic relationship. For Ann, there was an initial emphasis on issues of trust. Because she reported beneficial gains from prior treatment, there was a good indication of a favorable outcome. One of the main vehicles of cognitive intervention is collaboration, whereby the client is an active participant. This intervention was thought to be quite useful as it would immediately give Ann a sense of empowerment and perhaps boost her self-esteem.

Ann's feelings of anxiety and depression were targeted by helping her become more aware of and reevaluating the ways in which she attributed meaning to her experiences and by helping her develop healthier ways to think and behave. According to Beck's model, cognitive restructuring critically examines the thoughts and feelings triggered in various situations, thus reducing tendencies to automatically jump to conclusions and misinterpret the relationship between cause and effect. Reality testing is the process by which these faulty cognitions can be explored. Educating, in regards to symptoms; learning to identify automatic thoughts; and understanding the relationship between thoughts, affect, and behavior are other cognitive strategies in treating depression and anxiety.

Ann reported financial difficulties, law school, and an unstable living environment as identifiable stressors that triggered her depressed and anxious symptoms. Because there was a clear relationship between her psychosocial stressors and problems in adjustment, the therapist's role was to restore some stability and provide objective feedback on her current situation.

Collaboratively, Ann and her therapist explored the factors that initiated Ann's distressing emotions and sought realistic ways to solve Ann's problems. Having the knowledge of research support for alleviation of adjustment disorder symptoms in a short time, the therapist shared this information with her as an indicator of good prognosis (Freeman & Dattilio, 1992; Kaplan, Saddock, & Grebb, 1994). Also, it was determined that based on her early maladaptive schemas, therapy would most likely be somewhat longer than typical for an adjustment problem, because her underlying, internal dialogue exacerbated her presenting stressors (Sawrey & Telford, 1975). Ann's hesitancy to move past her current situation was demonstrated during her initial evaluation when she remarked, "I feel as though I'm in a tunnel and the tunnel is getting longer and longer."

Because Ann reported mild anxiety and depressive symptoms, her negative cognitions were targeted first. Discussions were focused on examination of her thought patterns, which revealed distorted thinking and unrealistic expectations of herself and others. Focusing on the cognitions was made in an effort to help her change her unhealthy behaviors. The rationale for cognitive therapy was explained to facilitate her understanding of the structure of the sessions and to gain her commitment to real-life homework assignments. Goals for therapy included diminishing anxiety and depressive symptoms, communicating feelings more assertively, reducing impulsive behaviors, and establishing a more positive self-concept.

Because Ann was studying law, it proved extremely beneficial to use the following analogy. Therapy sessions explored her thoughts and the information that either confirmed or denied her way of thinking. She, the attorney, would have to plead her case in front of a judge and jury examining all of the available evidence in support of her case. On a regular basis, Ann and the therapist collaboratively investigated the "hard evidence." As a result of what Beck calls collaborative empiricism (Beck et al., 1979), Ann made a concerted effort from week to week to apply her skills in real-life situations. By making contact with friends and family, she often found that these experiences contradicted the meanings she had associated with her beliefs.

Treatment consisted of 24 individual sessions from August 1998 to April 1999. Each weekly session was approximately 50 min. The initial phase of treatment laid the groundwork for establishing a strong, collaborative, therapeutic alliance. As noted above, a critical component for the treatment was developing solid rapport; this was achieved as the therapist demonstrated empathy, genuineness, and a nonjudgmental attitude toward Ann. The latter of which was particularly important as she disclosed her sexual habits and discussed her work as "Starla" the stripper. As the client and therapist proceeded with these early sessions, concurrent treatment goals included gathering

more background information and attempting to understand better Ann's persistent interpersonal difficulties.

Treatment goals, which were outlined previously, were formulated in a collaborative process during these initial sessions. The rationale for cognitive therapy was presented, and cognitive techniques that included Socratic questioning, self-monitoring, and positive self-statements were implemented.

Based on the sensitive nature of her sexual activities and work as a stripper, it was important to provide a safe, nurturing environment for Ann to feel comfortable discussing these issues openly. The first several sessions revealed that by allowing her to freely talk about these experiences, she gained a sense of mastery and control without having to fear a negative reaction by the therapist (Noshpitz & Coddington, 1990).

By the fifth session, it was established that Ann's current stressors included law classes, finances, and her living situation. She reported a pattern of brief sexual encounters with men where she admitted to enjoying the thrill of the chase, yet rejecting the men once she had "won" them. The working hypothesis at this point was that Ann was clearly seeking something more, yet she was struggling with giving up her sense of "control." Similarly, she viewed her work as "Starla" as another means of controlling men. She remarked, "As Starla, I'm powerful. I can exploit them and at the end of the night, I go home with all the money." As much as she wished this to be true, she soon admitted that this sense of power and control came with a high price. Ann recognized these behaviors as dysfunctional, but was ambivalent in regard to change. She had a tendency to generalize, make absolute statements, and add the word *but* to the statement "I deserve better." Ann was encouraged to develop a list of positive self-statements to refute negative thinking. She and her roommate were able to work out their differences, which resolved her living situation dilemma.

By Session 6, Ann decided she wanted to quit working as a stripper and set a deadline for doing so. To make this a realistic goal, the therapist encouraged her to develop a plan for ways to research and execute other alternative employment opportunities. During this session, Ann was able to be more accepting of positive qualities about herself. She was now beginning to take the next step by making the link between her thinking and other behaviors (e.g., examining her manipulative behaviors with men).

Sessions 7 and 8 revealed Ann's difficulty with giving up the manipulative role and allowing her true self to emerge. She had begun dating who she called her "perfect man," yet she was fearful of the challenge this represented. It was interesting to note that when asked to identify positive characteristics about herself, Ann would speak in the third person (e.g., "Ann is attractive" or "Ann is intelligent"). These self-statements were challenged, and she was asked to stop herself when referring to these attributes in the third person.

Sessions 9 through 13 focused on Ann's dichotomous thinking of being either the "bad girl, Starla" or the "good little girl, Ann." Her desire to work toward a more integrated self was evident, yet she still oscillated back and forth between these roles. Her

current relationship with her boyfriend Tom was triggering affect that proved very uncomfortable for her. Worry and fear about rejection was a key issue. Sexual intercourse was no longer viewed as "just sex," but rather as "making love." She was encouraged to take a hiatus from sexual relations, which would afford her the opportunity to sort out her thoughts and feelings. In the past, she demonstrated an inability to communicate her feelings that resulted in anxiety and frustration. Role play was utilized in an effort to facilitate assertiveness skills. Although she was able to assert herself in this way, she remained anxious and fearful that her boyfriend would not be faithful to her as the weeks progressed. The therapist challenged her to examine his commitment to date as a means of exploring the evidence. She reported being able to make love with her boyfriend and stated that she was willing to accept more realistic outcomes rather than catastrophizing worst case scenarios. Ann achieved her goal of quitting work as a stripper. She worked more hours as a massage therapist because her summer class schedule was more flexible.

Session 14 focused on her struggle with her decision to reveal that she has herpes to Tom. Ann was a virgin prior to her marriage and contracted the disease 4 months into the marriage when her husband had an affair. Ann maintained some responsibility for this and was very ashamed. The therapist attempted to help her combat the negative perceptions of these events. Her distorted thinking supported her depression and anxiety over this "secret" and was negatively affecting her ability to become more emotionally involved with her boyfriend. Ann was asked to accept the reality of her past and to appreciate that she was not responsible for her husband's actions.

By Session 15, she had disclosed her secret to Tom. To her surprise and ultimate relief, Tom revealed that he too had herpes. He shared similar reasons for not telling her sooner. Ann was set on the idea of a guarantee that this relationship would work out, especially because she had invested so much of herself. The therapist confronted her on this line of thinking and directed her to reflect on all of the personal challenges she had overcome to this point. Session 16 focused on her tendency to judge her boyfriend based on her past relationships despite the evidence to the contrary. Ann was challenged to examine her thought processes and look at her current behaviors such as setting up "mini tests" for Tom to pass. This style appeared to reflect her own insecurities. This situation presented an avenue to explore the hypothesis that her anxiety symptoms were largely the result of her genuine fear of being hurt again. Also, this might have been the reason for her need of a "guarantee stamp" before fully committing herself to the relationship with Tom.

Sessions 17 and 18 focused on Ann's childhood and early significant relationships in an effort to help her understand her present style of relating to others. Examining her history of a critical and controlling father, an alcoholic and unfaithful husband, and a physically abusive past boyfriend helped her to understand why she had made certain choices, in particular her promiscuity, stripping, and sabotaging behaviors in her current love relationship. It was suggested that she had developed certain automatic thoughts such as "I'm not good enough" and "I'm not worthy." In Sessions 19 and 20, there was a

continued effort to challenge her self-defeating thoughts by use of reality testing. The fear of being hurt was cited as a deeply rooted concern. This fear became more salient as she felt more vulnerable as the relationship with Tom became more serious. Evidence of her progress was noted as she had moved in with her boyfriend, partly because her roommate had sold her condominium and also because she felt better able to tolerate her fears. At this time, the subject of termination was introduced. The therapist was completing her rotation the following month and therefore needed to address issues related to this change. By Session 21, Ann showed a good appreciation of the connection between feeling scared, insecure, and vulnerable as related to her self-defeating thoughts and her impulsive, compensatory actions. Such realization demonstrated her understanding of the relationship among affect, cognition, and behavior. She also adopted a more realistic thinking style, stating that "there are no guarantees" in any relationship. In Sessions 21 through 23, Ann reported that she recognized differences in goals and expectations between herself and Tom. Initially, she was quick to perceive this as a personal failure. However, after examining all of the positive changes she had made when fully committed to this relationship, she adopted a more reasonable response: "I've learned a lot and even if things don't work out, I've grown from this experience."

The last session focused on termination with this therapist and reviewed Ann's progress to date. Ann's strengths were highlighted and areas for improvement were pinpointed. The client reported many positive benefits from her therapy experience and stated that she wanted to continue for the short term with a new therapist as she recognized her tendency to adopt the worst case scenario and ignore the evidence before her. This therapist applauded her ability to recognize her own weaknesses and her acknowledgment that she could benefit from the treatment.

8 MANAGED CARE CONSIDERATIONS

There were no managed care considerations regarding this case. Ann received counseling services free of charge because of her full-time student status.

9 FOLLOW-UP

Contact with the subsequent therapist, who is also supervised by the clinic supervisor (Barry A. Schneider), revealed that Ann has continued to make progress. She entered into couples therapy with her boyfriend Tom. She learned that he could not meet her newly developed desire for respect, enhanced communication, and a mature level of intimacy—physical and emotional. Soon she will enter her law school internship and will graduate upon its completion. She impresses as more secure in her self-appraisal and self-esteem and seeks a relationship consistent with her achievements.

10 TREATMENT IMPLICATIONS OF THE CASE

Overall, Ann demonstrated significant progress throughout the course of treatment. Her intelligence and high motivation level were strong assets that facilitated a successful course of cognitive therapy. She initially presented with anxiety and mild depressive symptoms that were targeted early in the treatment process. By the last phase of treatment, Ann reported reduction in her anxiety and denied any symptoms of depression. She quickly adopted the skills she needed to begin monitoring her negative cognitions and replaced them with more realistic and reassuring self-talk. Initially, Ann had difficulty identifying any positive qualities about herself, but as treatment progressed, she was able to list many positive statements without the aid of the therapist. Her efforts to "get to the tape first" and "hurt them before they hurt me," as demonstrated by her brief sexual escapades and her working as "Starla," were abandoned by treatment's end. These examples would suggest a dramatic reduction in her borderline features. In addition to eliminating impulsive acts, Ann was able to recognize the cognitive errors that maintained these self-defeating behaviors. Furthermore, she began to recognize how negative emotions, such as insecurity and excessive anger, triggered self-deprecating thoughts and behaviors.

Ann entered into a genuine, caring relationship that was concurrent with her therapy attendance. This courageous decision demonstrated a significant risk for her based on her painful past history with men. Because her interpersonal relationships were a target of treatment, this relationship represented an in vivo experience where homework assignments could easily be carried out. Each week, she was able to provide real examples for her and the therapist to explore through the interventions of cognitive therapy. Ultimately, Ann began to envision even higher goals for herself and embraced hope for her future.

11 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

When working with clients who report highly sensitive issues, particularly of a sexual nature, it is vitally important to devote a significant amount of time to developing a safe, therapeutic environment. The treating clinician must maintain a nonjudgmental attitude to establish a solid working relationship. The client must feel supported. In addition, it is not at all uncommon to find low self-esteem as a presenting complaint. Often, clinicians devote their time focusing on a client's weaknesses rather than delineating the strengths that each client brings into the treatment. Building on a client's strengths is a positive way to address treatment goals. There is indeed something very therapeutic about a warm, empathic, nonjudgmental relationship. This particular case shows how such a therapeutic formulation can be enhanced with the intervention technology of the cognitive paradigm.

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