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A Therapist's Review of Process: Rupture and repair cycles in relational transactional analysis psychotherapy for a client with a dismissive attachment style: 'Martha'

Abstract

This article is a therapist review of the process that occurred during a systematic case study of psychotherapy with 'Martha', a female client who presented with depression, anxiety, alexithymia and dismissive/avoidant attachment style. Assessment, diagnosis of the client and treatment direction is described, followed by a detailed account of the therapeutic process through 12 sessions and 2 post-therapy interviews. Analysis team results are summarised, indicating support for the therapist's identification of issues during the process of the therapy. Particular attention is paid by the analysis team two points of rupture and repair, with pragmatic evaluation confirming that the relational struggles between therapist and client seemed pivotal in generating positive change.

Key words

Avoidant Attachment Style, Dismissive Attachment Style, Relational Transactional Analysis Psychotherapy, Systematic Case Study, Hermeneutic Single Case Efficacy Design, Systematic Case Study, Alexithymia

Introduction

The following is based on a case study of 'Martha' (not her real name), a self-referred client in her late sixties, who was seen in private practice for short-term weekly psychotherapy (twelve sessions).

This is a process-orientated report of therapy, by the therapist, in which the focus is to make sense of the dynamics of the therapeutic relationship by tracking the points of rupture and repair (Safran, Muran & Eubanks-Carter, 2011) with Martha, a client whose life position is I'm not OK- You're not OK (Ernst, 1971) and who appeared to have a dismissive/avoidant attachment pattern (Wallin, 2007).

For a therapist working from a two-person, relational perspective, with its emphasis on mutuality and bi-directionality, clients such as Martha represent a challenge. Typically clients with a dismissive/avoidant attachment style are:

- cut-off from their own feelings, thoughts or desires and from others (rigid internal and external boundaries)
- have a limited capacity to symbolise and typically manifest their distress as physical symptoms (Leader & Corfield, 2008)
- dismiss the importance of their own history and the influence of parental figures in their emotional development
- avoid psychological closeness - Don't be close injunction (Goulding & Goulding, 1976)
- constrict feeling - Don't feel injunction (Goulding & Goulding, 1976)
- diminish the importance of others and are reluctant to let the therapist matter to them
- believe that 'all is well' but their physiological response indicates otherwise

Wallin suggests that working with such clients requires that the therapist "... balance empathic attunement with confrontation. Usually patients need the former to feel that we understand them. Often the dismissing patient, in particular, needs the latter in order to feel that we exist- that we can have an impact on him and they can have an impact on us" (Wallin, 2007, p. 212)

This case study shows the therapist's struggle to perform this delicate balancing act, in her attempt to reach Martha in a meaningful way and to acknowledge the impact that they had on each other, so that Martha could begin to formulate her experience.

Methodology

The case used a mixed methodology (qualitative and quantitative) in line with current guidelines for systematic

case studies (McLeod, 2011). Outcome measures were used on a weekly basis including Patient Health Questionnaire (PHQ9) (which measures depressive symptoms) (Kroenke, Spitzer & Williams, 2001), CORE-10 (measuring overall levels of distress) (Barkham, Mellor-Clark & Cahill, 2006) and GAD-7 (measuring anxiety symptoms) (Spitzer, Kroenke & Williams, 2006). The client also completed pre- and post-therapy measures: CORE-OM (giving a more detailed picture of overall distress and functional impairment) (Barkham et al, 2006) and Inventory of Interpersonal Problems (IIP) (measuring interpersonal problems) (Horowitz, Alden, Wiggins & Pincus, 2000), as well as the weekly Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989). The therapist conducted two post-therapy interviews.

This report is based on analysis of detailed sessional notes, twelve hours of session recordings and transcripts, weekly feedback forms completed by the client, and the two semi-structured exit interviews. A summary of the outcomes of the case evaluation by the analysis team is given at the end of the paper, and provides confirmation that positive change occurred, that change was due to therapy, and that the relational struggles between therapist and client seemed pivotal in generating positive change.

Ethical Considerations

I consider consent as an ongoing process. I am mindful that clients cannot fully know what they are entering into at the outset of the therapy (Gabriel, 2009).

At the outset of therapy I provided a detailed information pack and a research contract and I made myself available to answer any queries regarding the purpose of the research and the methodology used. Throughout the therapy I continued to enquire about Martha's experience of the research process. I made it clear that she had a right to withdraw from the research at any point. Martha also read a draft of my rich case study and was invited to make comments.

There is always a risk that the research will intrude on the therapy process. Once the research became part of the therapeutic frame (Langs, 1978), I continued to monitor how my client experienced tasks such as filling out questionnaires, giving process feedback and being recorded. Research can have a beneficial effect on the working alliance in that clients feel reassured when the therapy outcomes are being evaluated and also feel empowered by the fact that they can give the therapist feedback and suggestions.

The issue of breaching confidentiality (Bond & Mitchels, 2008) is a major concern in any case study research, as a considerable amount of detail about the client's profile is needed in order to make the case study meaningful. This risks seriously compromising client anonymity. I invited Martha to collaborate with me on this issue by letting me know which aspects of their current and background information I could use in the published version whilst preserving anonymity.

Assessment

Symptoms and problems:

Martha came to therapy because she recognised she had symptoms of depression and anxiety: she was not sleeping well, everything felt like "*too much to bother*". She was feeling constantly anxious, especially when driving, up and complained of forgetfulness such as misplacing keys and credit cards. Her GP had suggested that her memory problems were linked to high levels of anxiety rather than a degenerative brain disorder.

Current life

At the time of assessment Martha was in a long-term marriage, with grown-up children, who had moved away from home. Although the marriage was stable, Martha described an atmosphere of pervasive hostility, with first degree interpersonal games (Berne, 1964) around Martha's need to do things her way ("*I am stubborn*") and her husband's need to direct her *("I'm only trying to help you*"). Martha perceived her husband's attempts to help as intrusive criticism.

Martha had an active social life and many interests – but I had a sense that Martha did not feel particularly close to anyone. She preferred not to confide in friends about personal problems and said that people found it hard to "*read*" her. "*I don't let on if I'm annoyed or angry or happy, but I don't know why*". Martha would not allow herself to express anger openly, but had an awareness that holding on to her anger affected her negatively. "*So I really hurt myself. I feel tense inside because I am angry and I have no way to let it out.*"

Background

To begin with, Martha had little to say about her family and her experience of growing up. She described her childhood history using a vague term - "*normal*". I felt reluctant to pursue this line of enquiry, as Martha did not seem to think that her background was relevant in any way to her symptoms. The eventual emergence of Martha's story was an important aspect of therapy, which allowed us eventually to a link disparate islands of narrative.

Treatment history

In her early twenties Martha had a major depressive episode and attempted suicide. Following hospitalisation Martha was given electro-convulsive treatment, a treatment frequently used in the 1970's to treat severe cases of depression. At the time she was seen by a psychiatrist/psychotherapist and was later referred for behavioural therapy. The context of Martha's referral was revealed later during treatment and illuminated an important aspect of our relationship dynamic.

Medication

Two weeks prior to seeing me, the client was prescribed Sertraline. The daily dose was raised to 100mg two weeks into therapy. Sertraline hydrochloride is used to treat a variety of mental health problems. It is thought that Sertraline hydrochloride makes biogenic amines avail-

able for longer periods of times in the synapses. There is evidence that the combined use of antidepressants and psychotherapy is more effective than either intervention alone (Holtzheimer & Nemenoff, 2006, cited in Panksepp & Biven, 2012).

My initial response

I noted that throughout the session Martha appeared to be in a state of hyper-arousal. Her whole body seemed to be buzzing. What struck me in particular was Martha's laughter, which had a tense rather than joyful quality. I found myself struggling during the assessment interview to keep the conversation going. Martha's replies were brief and I noticed that I compensated by bombarding her with more questions. My enquiries into Martha's state of being in the session resulted in a polite "*I'm fine*", followed by nervous laughter.

Diagnostic considerations

Martha's self-diagnosis was supported by clinical questionnaires which all indicated moderately severe symptoms of depression and moderate-severe symptoms of anxiety [GAD- 7 score of 15, PHQ-9 score of 15 and CORE-OM clinical score of 17].

The preliminary picture (including interpretation of IIP-2 scores) indicated interpersonal problems stemming from issues of trusts and suspicion and difficulty in expressing anger openly which led to being overly accommodating towards others, but holding grudges. The IIP-2 alerted me that Martha felt distrusting of people's motives generally, and felt easily exploited.

Risk issues

Although Martha appeared to have a Don't exist injunction and had attempted suicide up fifty years before, there was no indication of current risk issues (no suicidal ideation or impulse to self-harm).

Diagnosis using transactional analysis concepts

Following an extended period of assessment – I had the following diagnostic picture.

Injunctions (Goulding & Goulding, 1976): Don't exist, Don't be close, Don't feel (anger)

Early protocol: Avoidant (dismissive) attachment.

Drivers (Kahler & Capers 1974): Please Others and Try Hard

Life Position (Ernst, 1971): I am not OK, You're not OK

Impasse (Mellor, 1980): Type I, II and III

Interpersonal games (Berne, 1964): Do me something, Being dragged over hot coals

Drama triangle (Karpman, 1968): Victim to Persecutor. Others are ineffective Rescuers

Passive behaviours (Schiff & Schiff, 1971): over-adaptation and agitation

Discounting (Mellor & Sigmund, 1975): at the level of significance of stimuli

Early defences (Valliant, 1977): denial, projection, and suppression.

Using concepts from interpersonal neurobiology, I also conceptualised Martha's problems as a compromised capacity for affective regulation. Research into the effects of chronic stress on the body shows that cortisol has a neurotoxic effect on the hippocampus leading to inhibited neurogenesis and cell death, which may explain memory problems.

"In extreme cases prolonged high levels of cortisol released into the circulation cause the hippocampus to become overstressed to the point of being impaired. Excess cortisol can eventually injure and even kill neurons in the hippocampus, resulting in memory loss." (Panksepp & Biven, 2012, p.334)

Depression can also follow on the heels of sustained activity in the stress response system (Sapolsky, 2004; Panksepp & Biven, 2012).

Treatment direction

In planning a treatment direction, I used a relational framework (Widdowson, 2010; Hargaden & Sills, 2002). Research into psychotherapy outcome (Norcross, 2011; Wampold, 2001) supports me in developing a style in which the emphasis is on contact-in-relationship through attunement, involvement and sensitive inquiry (Erskine, Morsund & Trautmann, 1999), and exploration of right-hemisphere-to-right-hemisphere unconscious communication (Hargaden & Sills, 2002; McGilchrist, 2009; Porges, 2011; Schore, 2003, 2011; Siegel, 1999).

1. Framing the therapeutic space, making contact and arriving at an agreement about how to proceed.

I had a sense that Martha wanted relief. She wanted to feel less anxious, more confident and to engage with the world rather than withdraw from it. There was no story to go with the symptoms. I considered that an exploratory contract (Sills, 2006) would be suitable, as Martha did not have an understanding of the nature of her distress.

I was soon to discover that Martha's unspoken expectation was that I would wave a magic wand and make her symptoms go away. This became evident early on, leading to a therapeutic impasse and a temporary collapse in the working alliance, but also provided us with an excellent opportunity to openly discuss the psychological-level contract.

We spent a good part of the assessment interview talking about the practical aspects of our work, including the purpose of the research. Martha agreed to take some documents home to study before giving her consent. Martha stated that therapy would be a challenge to her as she did not like 'opening up' and did not like talking about her problems.

2. Working with transference dynamics

My expectation was that Martha's engagement with me in the here-and-now, and the transactional patterns that

would be established between us, would offer me a direct insight into how Martha structured her relationships in general and her implicit assumptions about others and the world.

3. Ending, evaluating outcome

I planned to pay attention to our ending and to facilitate a discussion about the outcome of therapy and the meaning of the therapeutic journey for the client.

The psychotherapy process

Phase 1 (Sessions 2-4) 'Tug-of-war'

The first phase of therapy was a prolonged assessment and contracting period. A pattern quickly emerged between us. We seemed to engage in a game of 'tug-of-war' about many aspects of our contract: payment, number of sessions and the logistics of research. It felt to me as if Martha was approaching me from a defensive position, and a basic assumption that I was out to take advantage of her.

Session 2

I stated a preference for being paid cash. At the beginning of our second session Martha said emphatically "I do not deal in cash". As Martha rummaged through her bag, resolutely not looking at me, I could feel that we were already in the middle of something. I felt my heart beating faster. I had started my 'cash only' policy after working with a client who would routinely test the therapeutic boundaries around fees. That experience had led me to distrust that all clients would honour their financial commitments to me. I wondered about the nature of Martha's own distrust that was prompting her to refuse to deal in cash.

For the time being I agreed that she could pay me with a cheque, not sure whether it was a good idea not to stand my ground, but with a gut feeling that there was no room for negotiation. Later on in the session, once we had both calmed down, I enquired into Martha's experience of what was going on between us around payment. I picked up on the fact that Martha denied feeling angry and appeared to discount the existence of tension between us, reframing it as a negotiation. To me it had felt more like I had been given an ultimatum. She was also talking about a compromise, but I felt I had given in.

Martha eventually explained that it had been drummed into her that people who deal with cash do so in order to avoid paying their taxes. I remarked that she had not been reassured by my offering to give her receipts for payments and that she had concluded that I might 'fiddle' with my accounts. Martha reassured me profusely that this had not been the case.

It seemed to me that during the session we had both switched between the roles of Persecutor and Victim. I also noticed that guilt was a payoff for both of us. I felt guilty for allowing my distrust to shape how I deal with clients, and also for not holding steadfast against Martha's challenge of the therapeutic frame. I also wondered whether Martha's statement "I am the bully" was a reiteration of a core belief at the heart of her script system (Erskine & O'Reilly-Knapp, 2010).

Session 3

After a week's break (due to a pre-booked a holiday) Martha arrived to our session visibly agitated, saying she had a few apologies to make: she had forgotten to bring the research and therapy contract and she had forgotten the Helpful Aspects of Therapy questionnaire. I felt sorry that Martha was in such a state but also noticed a rumbling of irritation. Martha told me that since she had last seen me she had "gone to pieces". She had forgotten her credit card PIN and could not use the card, and was concerned that she was showing signs of Alzheimer's disease.

I asked Martha whether she was aware that her voice was trembling as she spoke and that she appeared to be agitated and restless. Momentarily she seemed genuinely puzzled by my observation, but then reflected: "*I don't think I've ever felt relaxed in my life. I know I have tension throughout my body. If I go anywhere for a massage the first thing they mention is the tension in my neck and back.*" Martha described the trouble she had parking the car, getting cash for the session and looking for her questionnaires. As she explained how she had worked herself up into an anxious state and demonstrated breathing anxiously, I mimicked and exaggerated her breathing. She made a realisation: "*It's ridiculous, really*".

T: When you get into that state it's so hard to calm yourself down, to self-soothe. (...)

C: I am a bit like a dog with a bone. I tell myself: I'm not going to give up.

T: "I will not let it go. I will pursue this until the end of the world..." Last week we were talking about stubbornness (I notice that Martha at this stage is no longer agitated.) I have an image of someone digging their heels in and their body becoming very rigid (I turn my body into a plank and dig my heels into the carpet to show her. Martha laughs in recognition.) This is what babies look like when you try to strap them into the pushchair and they don't want to go in. By contrast being flexible is more like being a river that changes its shape following the landscape.

C: No, I can't do that. Hmmm...

T: How are we doing? Are these images helping?

C: Yes, they are helping. The trouble is – how do you change after all these years?

T: Does change feel impossible?

C: It does at the moment. I don't know how I am going to do it.

I noticed that I never attended to the feeling of irritation that I had felt at the beginning of the session. I wondered whether seeing Martha in such an anxious state had

prompted me to Rescue her rather than confront her about her failure to bring in the questionnaires and ponder what it might say about her commitment to honour her side of the therapeutic and research contract. I felt hemmed in as either the Persecutor or Rescuer, not quite sure how this pattern might relate to Martha's script. On the other hand, I was pleased that by using my body and imagery this was allowing Martha to reconnect with her body.

Session 4

Martha pointed out that we had not decided for how long she would need to attend therapy. There was something about the manner in which Martha raised this – averting eyes, overly cautious formulation, that prompted me to feel irritated. I seemed to detect an underlying assumption that I was going to trick Martha into making a commitment she did not want to make.

T: There is a theme that has come up a couple of times – and I was wondering whether we could talk about it -

C: Yes

T: ... as it might be relevant for our understanding of your anxiety. It's related to trust.

C: [Laughs]

T: It seems that the place you go to in your head is one in which I would mess around with money...

C: [Laughs agitatedly]

T:... or enforce something, pin you down in some way – you signed a paper and now there is no way out!"-

C: [Interrupting] I just think it is a throwback to working in [her previous profession] because you have so many dealings with illegal things [gives examples].

T: Yes... yes...

C: And people turned around and said – "You've signed it, it's your fault"-

T: "You've made your bed and now you must lie in it".

C: And I think that with everything that happens – that you read about in the media these days... Ummm.... I think that's made me even worse.

Again I noticed Martha's discount at the level of significance. She dismissed the idea that she did not trust me. At this point Martha stopped looking at me and rummaged through her bag for a bottle of water. I wondered whether this now familiar sequence - breaking eye contact and distracting herself by looking for something, was Martha's way of avoiding seeing the expression on my face and facing up to a potential conflict.

Martha went out to get some water to soothe her throat leaving me to notice my own erratically beating heart. When she returned we found ourselves locked in an uncomfortable silence. Briefly her face seemed to have lost all muscle tone. I enquired into her experience. *"*You seem to have stopped breathing and look like you've frozen up*"* This was met with surprise *"Did I?!"* Martha seemed again to discount – this time at the level of existence of stimuli (Mellor & Sigmund, 1975).

Although she had attended for four sessions, I still did not have a sense of Martha's story – all I had by way of identifying the Type III impasse were these moments of impasse between us. I decided to ask about her upbringing, although we had established that Martha did not believe that one's own early experiences had anything to do with their predicament in adult life (a typical belief of clients with avoidant attachment).

I learned that Martha had been born after World War II. Hers had been a typical post-war family, with a stay-at-home mum and a father who worked hard – days and nights. She remembered her father as a gentle man, but Martha did not see much of him. He lived in his head, inventing things and pottering about in his garage. Mother was less gentle. If Martha had an accident her mother would say: "*It's your fault but don't cry or else I'll hit you." Her mother's motto used to be*: *"You've got to live with the consequences."* The client remembered that once she fell in a stream and wandered about soaking wet, avoiding home, because she knew she would be in trouble with her mother.

This information was immensely useful for me as it helped me make sense of Martha's current issues around trust and helped me firm my understanding that there was a protocol for avoidant (insecure) attachment. I remember however ending the session with a sense of hopelessness, unsure that Martha herself had grasped the point of my enquiry and also not sure how to communicate my understanding to her.

Phase II Sessions 5-8 *Joining the islands/Forgetting the map*

Session 5

I was genuinely surprised to hear a week later that Martha had found it extremely useful talking about her childhood. She reported that telling her story had brought back a host of memories, including one from around the age of seven. A schoolteacher had mentioned to her mother that Martha was very thin. Her mother started pressuring her to eat more. Mealtimes became a "*battle of wills*", with mother insisting she had to eat and Martha saying she could not. For many years there was an argument at nearly every meal. "*Just the look of the food made my stomach turn over*."

I started to wonder if we were dealing with a projective transference (Hargaden & Sills, 2002), with Martha projecting her mother onto me, and responding to me as if I were the bullying parent.

At this point I asked Martha whether it would be helpful for me to summarise what had emerged over our first four sessions. Martha had come to see me because of symptoms of anxiety. The first theme that emerged had

been "*being bullied*" versus "*being stubborn*". In our sessions this theme has manifested around our struggles in arriving at a mutual agreement about how to proceed. Martha evocatively described "*being dragged over hot coals"* as the core relational scheme with her mother, one that she had internalised.

T: I hear that in some ways in your life right now you are also dragging yourself over hot coals, by pushing yourself and getting annoyed with yourself.

C: [The client looks pensive] I get angry with myself and I blame myself.

T: I can see that a part of you is trying really hard, is very frightened that things might go wrong, and there is another part that gets really frustrated and angry and has not time for weakness. [Dramatising] "Oh, for God's sake!"-

C: "Pull yourself together!"

T: [Dramatising] "Pull yourself together! Messing up! Losing the keys!" A part of you is driving you and a part of you is-

C: Pulling back. Yes, that's it! It is – it's a conflict!

I dramatised the internal dialogue at the heart of the impasse to illustrate the struggle between the scared Child (C_1) and the attacking Parent (P_1), which had once been a real-life parent –child struggle, fossilised as an internal conflict, which kicked in automatically in stressful situations. As Martha readily recognised the quarrelling voices in her head, this seemed like the right opportunity to show how the same conflict was being played out in our own relationship.

T: There's something about having to rush yourself in here too, having to see results now, not having the patience – I was wondering whether there was something of that going on when we were negotiating the number of our sessions. You were anxious to get things done in ten sessions. I can really understand how it is about money. But I am also wondering whether this process is being triggered that does not allow you to give yourself time, because what I noticed in me after our session was that I went home and felt frantic: "I've got to get some results with Martha - Fast!" [I dramatise this a bit by clapping my hands and breathing like I'm harried. We both laugh]

C: So it had an effect on you as well!

T: I realised that we both risk playing "dragging Martha over hot coals" in here too.

For the first time since our work began I felt like Martha and I had made contact. I could also see that what had been a survival strategy in Martha's original environment, a brave attempt to stick to her guns and not give in to her mother, had become a defence that was sabotaging, both internally and in relationships. Martha had recognised before that there were both advantages and disadvantages to maintaining this defence. On the one hand, nobody could "*walk all over me*". On the other, it was emotionally draining, kept her stuck and feeling anxious, and prevented Martha from experiencing intimacy in relationships.

Session 6

Martha began the session by saying she had lost the Helpful Aspects of Therapy (HAT) questionnaire. I asked whether instead she could reflect on last weeks' session and give me a verbal feedback. "*I can't remember what I wrote down!"* All Martha could remember was that I had said she was stubborn and did not like being told what to do. Martha was adamant that she could not recall anything else.

Then Martha told me that she got a self-help book from the library on social anxiety. "*I brought it home. There were people as bad as myself but I didn't get to the part where it told you what to do."* I thought that maybe this was Martha's way of saying: "*I need a quick fix*".

I wondered whether forgetting the previous session was a way of protecting herself against something that she would rather not think about. I noticed that the old feeling of discouragement returned. I had a hunch that Martha was finding it difficult too**.**

As I pondered all this Martha talked about going into her "*worry mode*". I seized again the opportunity to bring the focus back to our sessions – anything she was worried about in here? This approach yielded no results. Martha was discounting both at the level of existence and significance of the problem. The claim 'no problem' acted as a blocker, as a shutter that prevented me from contacting her. I noticed how uncomfortable it was for Martha to stay in contact with me around this issue and that it was only after quite a bit of over-detailing that she admitted that she was "*annoyed*", but then she quickly redefined, claiming that she was talking about "forms in general" not our questionnaires. After taking a long time to consider what next, I decided to take a risk and be open with Martha about how I felt as if she was behind a screen and I could not reach through.

My disclosure did not facilitate contact; on the contrary, Martha appeared to retreat further. I felt defeated and wondered whether my feelings mirrored Martha's own Despairer (Get Nowhere With) position, based on the core assumption I'm not OK- You're not OK.

Martha reiterated that she wanted "*a tool*" to help her stop anxious thoughts coming in. I told her that I could not help her erase unwanted thoughts and that there was no 'quick fix' for her anxiety and then went into a long monologue about how I thought therapy worked. I wondered out loud whether she believed that therapy was like a magic pill, which Martha was at pains to deny.

T: If feels as if each session you scoop up a handful of sand and then you go away and it slips through your fingers. And then you come back and say: "My hands are

empty. Can you fill up my hands?" And we go through the same process again and - it slips through your fingers. Here we are at session six and it seems like we have to start from the very beginning, as if we've built nothing so far

I experienced myself as quite challenging in the session, feeling I had to confront the expectation of Do me something. I feared that having spoken from my frustration, Martha would not come back. At the end of the session Martha said: "*It must be hard working with someone like me*".

Session 7

Martha did return the next week but her feedback (Working Alliance Inventory) confirmed my fears about the fragility of our alliance. She was open with me about having been really stirred up after the previous session and that she had considered not coming back at all. After last week she remembered why her psychiatrist had transferred her to another therapist all those years back. She concluded that all the therapists that work with her end up feeling fed up.

C: I think he must have got fed up with me. I was transferred to another hospital. Nobody said anything to me at the time and it wasn't until after I came out of my depression that my mother said to me that the doctor had said I wouldn't tell him anything. It wasn't deliberate – I thought I had, but clearly I wasn't telling him enough. Last week I thought I was doing the same with you. I know my husband says I don't open up enough.

T: Perhaps you don't know how to.

C: I don't know what it is. Perhaps there is a barrier that stops me doing that but I am not aware of it at the time. When you read these [the HAT questionnaire] you will find a lot of negativity. I got to the stage where I wasn't going to come anymore.

T: You were angry.

C: Well, I thought: "I'm not helping myself by not doing it, I'm not helping you because it must be frustrating for you to think you're not getting anywhere with me." I've been worrying about it every night this week.

T: I wonder if at some level you also feel let down – that we, the experts, are not fixing the problem.

C: Perhaps that is there but I can't blame other people becaus it's me, my fault. I am the one causing all the difficulty because I am not open.

T: I hear that you take responsibility for it all, but I'm wondering whether there is contribution from both sides.

C: It could be.

T: Last week I worried I was pushing you beyond your comfort zone. I had this image of pushing someone in a swimming pool when they don't want to swim – and they don't want to swim because they don't know how to!

C: That could be, yeah

T: And yet you've joined a swimming course!

C: Yes, that's it! That's another thing that I was thinking. I wanted to come and do this and I'm not doing it. That's where the anomalies come in, really.

T: And I'm this swimming instructor thinking: "How do I get this kid in the water?"

C: (Laughs in recognition) Yeah... [The client goes on to talk about one of her children and how hard it is to get them to tell her what is going on for him] – He's like me. To find anything out you have to pump him.

We were also able to talk about our diverging expectations. Martha explained that her difficulty was in seeing that present and past were connected. She could not recognise patterns. The events in her life seemed "*like little islands with nothing joining them*".

Session 8

Martha remarked on how helpful it had been for her discussing her feelings of anger towards me. We noticed that her anxiety and depression scores were much lower than when we had started.

Martha told me that her husband had asked her to mention the fact that she was speaking to him in her sleep. As she spoke I felt that Martha's voice conveyed irritation, which I reflected back. She was angry at her husband's intrusive request and managed this situation in quite a unique fashion: she raised the issue with me whilst also closing it down immediately by dismissing it as irrelevant. So then I was left with the dilemma of how to respond to this double message. At the social level she was bringing the issue up, at the psychological level she was closing it down. Exploring this sequence of transactions, we began to understand that she did not feel she had the option to say "*no*", which left her feeling anxious (and perhaps angry). In this light, I began to wonder whether Martha's forgetfulness was really a way of saying "*no*".

Phase III Sessions 9-12 and Outcome review - Enough for now

This phase of therapy was marked by frequent breaks. Martha had to cancel one session because she had to visit an elderly relative, and another two sessions because she was having a surgical intervention. We also had two weeks off for Christmas. This intermittent contact had the effect of preventing us from keeping the momentum going. I experienced our last four sessions as 'catching up', yet the outcome scores and Martha's own self-reports indicated that she was no longer anxious or depressed. At session nine Martha announced that she had resigned from two of her charity roles. She felt pleased with herself for being able to say 'no', and found that she could cope with the feelings of guilt.

At times I felt like I was no longer needed. It seemed to me that she had done what she had needed to do in

therapy and she was now just passing time. We spoke about her desire to limit therapy to twelve sessions. I knew that money had been an important factor but I was wondering whether keeping our contact short was a way of maintaining the Don't be close injunction. Martha admitted that: "If therapy drags on too long, I'd be getting too reliant on you – pushing all my problems to somebody else, hoping they can find it for me." When Martha asked whether she could come back for a "booster", this made me laugh because the choice metaphor indicated to me that Martha still saw therapy as a vaccine that could inoculate her against harm.

Post therapy interview no. 1 (one week after ending therapy)

During our post-therapy review Martha described the therapy as "productive" in that she had noticed positive changes such as the fact that she was now sleeping reasonably well. Martha found that she was no longer stressed during the day, and that she experienced her state of mind as OK, that she achieved the things she set out to do and was enjoying life more. She also reported that she had started to confide in people more and was relieved to hear that friends who seemed to be above worry were also struggling with similar fears.

Martha emphatically told me that she had not found therapy enjoyable. It had felt "*a bit like taking an exam*", which suggested that she had found my style too confrontational. She remembered feeling very anxious to begin with and progressively more comfortable towards the end of therapy.

All of Martha's outcome questionnaires indicated non-clinical levels of anxiety, and the exit IIP-2 scores showed an overall improvement in interpersonal problems and skills.

Post therapy interview no. 2 (three months later)

I interviewed Martha after she had read the case record. In spite of current stressors Martha's scores at three months post therapy remained at a low, non-clinical level. Martha reported that reading the case study had quite an impact: she had not realised that she had come across so "*awkward and evasive*" however she added that "*in some cases you were as bad as me"* i.e. regarding payment. The most important aspect of therapy for Martha was realising that she pretended to negotiate when in fact she wished to say "*no*". She would rather engage in a drawn-out, frustrating process, rather than face outright confrontation.

Martha felt that I had completely misunderstood the significance of borrowing a self-help book from the library: I had seen an ulterior motive when there had been none.

Reading the case record had helped her "*make sense of the process of therapy but made me realise that with my failures of making good relationships with my counsellors that [talking] therapy is not right for me*". Interviewing Martha I realised that her core belief "*I am a failure at helping people help me*" had remained intact.

My Learning

The issue of how to work relationally with clients with avoidant attachment is something that I am very interested in and continue to be challenged by. It is hard for me to 'sell' the idea that relationships matter and that relationships shape us. Clients with avoidant attachment style have a sort of 'relational aphasia'. They do not speak the language of relationship.

At the heart of the 'avoidant' style is a dread of becoming too dependent or allowing anyone to become significant enough. Clients typically limit therapy to a short-term intervention. With less time I notice that I feel pressured to establish a connection even quicker, which can then scare the avoidant client as they might experience me as too intrusive. It is hard to negotiate across a rigid interpersonal boundary and often I fail by being either too 'eager' and active or remaining too uninvolved. With Martha I noticed that working in a time-limited context stimulated my own Hurry Up and Try Hard prompting stubbornness and rigidity on my part, which contributed to a re-enactment of the original mother-daughter drama. Therefore, an inter-subjective/relational approach may have been too challenging and too alien for Martha. Perhaps I could have employed a more behavioural-based approach, but then I would have maintained Martha's expectation that there was a magic pill she could take.

I discussed Martha's case with a CTA colleague, who also works within a relational frame. He commented on the fact that my idea of 'relational' may be too narrow as in " … working in a reflective, mutual, intimate way of relating'. In this sense we as practitioners can be 'aphasic'; we exclude a whole range of relationships which do not fit this paradigm and 'offer' them as 'non-relational'" (Hill, 2017). In my colleague's opinion Martha's avoidant attachment style may have been too challenging to my own narrow frame of what constitutes a relationship. Often clients like Martha give up on us because they struggle with our relational rigidity and our dislike of their failing to securely attach to us." (Hill, 2017).

I am becoming more accepting of the limitations of a two-person approach (Stark, 1999) and more willing to function in a one-person psychology mode (expert/didactic role), as a transition position to a more mutual therapeutic relationship. Clients like Martha typically function from a left-brain field and are willing to

entertain the idea that stress has very real physiological effects. Because these clients somatise and lack 'mindsight' (Siegel, 2010), I explain that interpersonal and intrapsychic events generate specific changes in the

body (Porges, 2011, Sapolsky, 2004). I typically draw the hypothalamus-pituitary-adrenal axis (HPA), show pictures of the brain and speak about the brain-body connection.

What I have found most helpful so far is to create a separate space - I call it a 'virtual space'. In this alternate space I introduce any image that occurs to me in relation to the client and invite them to play with it. As Martha and I talked of waving magic wands and jumping in, I found two pictures to represent our transferential roles – one represented the client as a boy plunging into a swimming pool. The other, representing me, the therapist as I thought I was being experienced by my client, was a picture of Professor Minerva McGonagall the teacher/witch from Harry Potter (Rowling, 1997). In these images the roles and ages are reversed. In real life Martha is a woman in her sixties and I am roughly half her age. Having this picture of the transference relationship (Child-Parent transactions) I was able to become aware of power dynamics, which potentially foreclose Adult-to-Adult communication. This virtual play-space was somewhere safe from where we could look at, reflect and even laugh at what we had created together.

Having Martha read my narrative of therapy her has been an unexpected but positive aspect of research. She began to recognise how she affects others. She did not find the reading easy but was able to grasp the idea that others are affected by relationships and they create narratives to make sense of what is happening.

Case evaluation process

The rich case record was examined and evaluated by an analysis team, facilitated by Dr Mark Widdowson, TSTA (Psychotherapy)of the University of Salford, and included Giselle Hayers, Jayne Hayers, Amanda Rushton-Carroll and Rebecca Valentine, all of whom are graduates of the University of Salford's counselling and psychotherapy training programmes. The analysis team members were invited by the facilitator to participate in the case analysis on the basis that they were all non-TA therapists (although some had completed a TA101) and therefore had no prior allegiance to TA, and were all therapists who had expressed an interest in participating in case study research during their training. The analysis team read the rich case record and prepared their responses based on the pragmatic case evaluation criteria developed by Bohart, Tallman, Byock & Mackrill (2011)). This method uses 56 criteria to evaluate whether the client changed, and whether these changes can be attributed to therapy. The analysis team also considered the non-therapy explanations for change (i.e. factors other than therapy which might be responsible for any change identified in the client) as developed by Elliott (2002).

Conclusions of the Analysis Team

Overall, the analysis team were unanimous that the client did indeed change and that these changes could be attributed to therapy. Specifically, the analysis team were in unanimous agreement that there was sufficient evidence for each of the following criteria:

Evidence that the client changed

[numbering as in pragmatic case evaluation criteria (Bohart, Tallman, Byock & Mackrill,2011]

1.The client themself noted that they had changed.

2.The client mentioned things that they were doing differently in their everyday lives.

3.The client was relatively specific about how they had changed.

4.The client provided supporting detail.

9. The client mentioned problems that did change.

10. The changes mentioned seemed plausible given the degree of difficulty of the problem and the time spent in therapy.

13. The client reported either managing anxiety better or reductions in anxiety in key situations which showed a positive trend over therapy.

19. There was evidence of greater proactive determination and persistence in relation to a reasonable goal.

24. The development of a new perspective where they seemed to be criticising themselves, seeing their own limitations but not in a defensive or overly critical way.

30. Positive interpersonal changes.

31. Specific changes (e.g. finished a project, made a new friend, got and kept a job).

32. Greater realisation that there may be some issues, which will take ongoing work.

33. Positive changes in self-relationship.

38. Physiological changes (e.g. less sweating, calmer and relaxed in therapy.)

Evidence that is was therapy that helped

40. The client clearly reported that therapy helped.

43. In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials.

45. To a rater, a plausible narrative case can be made linking therapy work to positive changes.

48. Therapist's encouragement, support, positive attitude seem to be related to client's overcoming demoralisation and willingness to confront challenges and not be discouraged by failure.

50. Therapist's in-tune questions, reflections, interpretations, or comments, seem to facilitate client's exploration, gaining new perspectives, developing action plans.

53. Client reports changes in trajectory from their past life with regard to the problem. Clients report something new

in regard to coping with the problem and relate it to therapy.

The analysis team were unanimous that these criteria were sufficient to consider that Martha had made positive changes during therapy and that these changes could be attributed to therapy. The analysis team examined the case using all of Elliott's non-therapy explanations for change and rejected all of them, thus reinforcing their conclusions that the therapy had been responsible for change.

In discussions following the pragmatic case evaluation procedure, the analysis team came to the conclusion that it was the relational struggles which took place between Martha and her therapist which seemed to be pivotal in generating positive change, and specifically enhanced the interpersonal changes that Martha made during therapy. The analysis team also noted that Martha seemed rather sceptical about therapy and would be very unlikely to offer unrealistically positive reports about her changes. The analysis team identified that there seemed to be issues for the client connected to the identification, acceptance of and expression of emotions, and that the therapist's focus on drawing out and clarifying unexpressed emotion appeared to have been helpful.

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