A Behavioral Approach to the Case of Ms. S

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This article provides a behavioral formulation and treatment plan for the case of Ms. S. Given the complexity of Ms. S and the status of current research, interventions proposed emphasize empirically supported principles of change over any specific protocol. This particular behavioral approach incorporates aspects of dialectical behavior therapy and functional analytic psychotherapy in addition to more traditional behavior therapy. The utility of the therapeutic relationship in this approach is described.

My approach to psychotherapy is behavioral, such that I conceptualize the development and maintenance of behaviors according to learning theory (operant conditioning, classical conditioning, etc.). I view the context in which behavior occurs as critical to accurate conceptualizations and change. I focus on the *function* of behavior over the *form* of behavior (i.e., what the behavior does for the person as opposed to what it looks like), and I place high value on accurate assessments of (the function of) behavior, adhering to the adage, "Assess; do not assume." I have a broad perspective on behavior and view most things that humans do as behavior (including feeling, thinking, behaving, and even some glandular squirting), all influenced by the same principles of learning, and all worthy of consideration in the development, maintenance, and change of problems. My interventions pull from empirically supported treatments and principles that are targeted to my behavioral formulations. I have been influenced by functional analytic psychotherapy (Kohlenberg & Tsai, 1991), a radical behavioral approach to psychotherapy that places high importance on attending to and addressing clinically relevant in-session behavior and views the therapeutic relationship as critical to change.

I also have a strong background in dialectical behavior therapy (DBT;

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Linehan, 1993a), and this informs my case formulations and interventions in significant ways. DBT is, in part, based on a theory of borderline personality disorder (BPD) that emphasizes the role of chronic invalidation in the development of severe emotion dysregulation that is characteristic of this disorder. Therefore, when I see evidence of emotion dysregulation in my clients (whether or not they meet criteria for BPD), I assess for a history of invalidation. DBT is designed to directly treat the emotion dysregulation (and associated problems) of individuals with BPD, and it does so in part by adding validation strategies to traditional behavior therapy (change) strategies. Likewise, if I conceptualize the development and maintenance of emotion dysregulation in my clients (BPD or otherwise) as related to invalidation of emotional experiences (e.g., they evidence current self-invalidation or uncertainty about how to feel or react), I use validation strategies in my work.[1]

DBT is also a stage-oriented treatment that bases the focus and content of treatment on clients' stage of disorder. In essence, DBT prioritizes interventions to treat first those behaviors that are most likely to threaten the client or the therapy process (e.g., suicidal behavior), then moves to treating emotional disruptions and other life problems. The dialectical philosophy in DBT implies that (apparently) opposing viewpoints can simultaneously be true and that change occurs through the synthesis of oppositions. In therapy, this translates to a holistic (or systemic, contextual, or transactional) perspective of behaviors and change (the therapist is always looking for "what is left out") and to the artful balancing of acceptance-based strategies and skills with the change strategies of behavior therapy. In addition to validation strategies, DBT incorporates additional acceptance-based strategies and teaches clients acceptance-based skills (e.g., mindfulness). As a world view, a dialectical perspective has applicability in therapy across diagnostic groups. Similarly, I incorporate acceptance-based interventions with traditional behavior therapy in my work across clients.[2]

Okay, so how does this apply to the case of Ms. S?

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[1]For a review of research that supports the application of DBT to a range of disorders that are characterized by emotion dysregulation, see Koerner and Dimeff (2000).

[2]The synthesis of acceptance-based interventions with traditional cognitive–behavioral therapy is becoming increasingly common and gaining empirical support across disorders. The reader is referred to Hayes, Strosahl, and Wilson (2002); Jacobson, Christensen, Prince, Cordova, and Eldridge (2000); Marlatt (2002); Roemer and Orsillo (2002); and Segal, Williams, and Teasdale (2002).

DIAGNOSIS AND CHARACTERIZATION

The case of Ms. S is interesting to discuss conceptually, as she does not appear to fit neatly into a diagnostic category of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). She has some symptoms of depression but does not meet the frequency or intensity criteria for major depressive disorder. She has several symptoms of posttraumatic stress disorder (PTSD), but, again, it is unclear from the description whether she meets the intensity and frequency criteria that warrant the diagnosis (avoidance symptoms were not mentioned, and I would assess this further). In addition, it is unclear whether the abuse can be considered a Criterion A event, because her reactions to the abuse are not fully described. Some of her problems overlap with the criteria for BPD, such as chaotic interpersonal relationships and identity confusion, but, once again, Ms. S does not meet the full criteria for this disorder. Further, many of the problems she presents with do not appear in any diagnostic category (e.g., difficulty trusting others, self-hatred), though it is hard to deny the importance of addressing these problems in therapy. Despite this less-than-clear-cut diagnostic picture, Ms. S's presentation is actually typical of the modal outpatient and brings to light some of the limitations of the current diagnostic system.

Ms. S's presentation also raises interesting questions about intervention. I value psychiatric diagnoses in part because of their utility in determining which therapy is warranted on the basis of the treatment outcome literature (i.e., if a psychotherapy has data to support its efficacy for a certain diagnostic group, it is the treatment of choice for a client with the same diagnosis). Yet, because the majority of treatment protocols have by and large been evaluated on discrete diagnostic groups, their applicability to clients with more complicated presentations (e.g., multiple diagnoses or multiple problems that fail to meet the full criteria for any diagnosis, as in the present case) is unknown. For this reason, in my clinical practice I rely heavily on the use of ideographic case formulations based on thorough functional analyses of the presenting problems (Davison, 2000; Goldfried & Davison, 1994) and determine treatment interventions on the basis of these case formulations. My case formulations are guided by behavioral theory, and my interventions pull from empirically supported *principles* of change (Rosen & Davison, 2003). In this way, my general approach again overlaps with DBT, which has been characterized by Linehan (1993a) as a principle-driven psychotherapy that includes protocols. The approach has utility with individuals with BPD, who frequently present with a variety of coexisting difficulties and diagnoses, and likewise has applicability to the typical clinical outpatient.

For Ms. S, I would conduct functional analyses on her presenting problems, with the goal of identifying the factors related to the development and maintenance of her problems. For example, when assessing her feelings of sadness and anhedonia, I would focus on discrete periods of increased sadness and anhedonia (perhaps identified through daily self-monitoring) and inquire about the context in which these feelings occurred; her actions, thoughts, and additional emotional reactions; and the consequences (of her actions, thoughts, and emotional reactions). Through several functional analyses, I would look for patterns that suggest points for intervention. Because the theoretical and empirical literatures highlight the role of decreases in reinforcement and avoidance in the development and maintenance of depression, I would stay alert to the ways this was manifesting for Ms. S and the ways her additional problems might be contributing. I would similarly assess her intrusive memories of childhood sexual abuse (looking for environmental and emotional cues that set these off and consequences that might contribute to the maintenance—e.g., avoidance behavior) and hyperarousal. I would assess the factors related to the maintenance of her relationship difficulties, particularly her tendency to become involved quickly with men she does not feel strongly about and to stay in relationships that are abusive, and her difficulty assessing the trustworthiness of others. I would examine her interpersonal skills, the beliefs she has about herself and others, her emotional reactions, and contextual factors. Likewise, I would assess her feelings of self-hatred and her uncertainty about her views, beliefs, goals, and sexual identity. A contextual approach includes attention to the role of the broader context in which behavior occurs as well as the immediate context. I would therefore assess the influence of cultural and racial factors in Ms. S's difficulties (e.g., self-hatred, identity confusion). I would look for ways these diverse factors and problems interrelate and attempt to develop an integrated formulation to point to specific targets and interventions for therapy.

On the basis of the information provided in the case description, I attempt a very tentative behavioral case formulation of Ms. S, though, in actual practice, I would assess in the manner I have described prior to developing a formulation for treatment-planning purposes. I view case formulations as working hypotheses and would therefore stay open to changing the formulation as new information became available. From this perspective, it seems reasonable to begin a case formulation with the information presented.

Ms. S is experiencing intrusive memories of childhood sexual abuse and accompanying arousal and hypervigilance. She reports a history of childhood sexual abuse, and a recent visit to a gynecologist appears to have cued memories of these experiences. There are likely ongoing cues in her environment that elicit these memories, and, in addition, she may be

engaging in some avoidance behaviors (i.e., behaviors that function as avoidance) that are maintaining the memories (e.g., trying not to think about the experiences when the memory arises, judging herself for the experiences).

Ms. S's feelings of sadness and anhedonia appear related to several factors. It seems likely that her negative feelings and beliefs about herself (regarding the sexual abuse as well as her current life struggles) are contributing to her negative mood. In addition, Ms. S is likely experiencing feelings of grief related to the ending of her recent relationship and perhaps related to her new realizations about the way she was treated by her father. Further, she appears to have had few experiences in her life that give her reinforcement (roughly translated as pleasure and meaning). She has virtually no social support or meaningful relationships, and she appears to get little pleasure from her school and work activities (which take up most of her time). This may, in part, relate to a general pattern of avoidance of cues to her childhood abuse and, more generally, negative affect. In addition, given her difficulty identifying her preferences and desires, she may have trouble creating a life that is inherently reinforcing.

Ms. S's difficulties in relationships appear related to several additional factors. On the basis of her relationship with both of her parents, it can be hypothesized that she has not learned how to determine whether someone is trustworthy, how to develop intimacy, or how to balance dependence and independence in relation to others. For example, her father (someone she was presumably emotionally close to and dependent on in some respects) caused her physical harm, sexually abused her (which she appears to have experienced as both positive and negative at the time), and was very unpredictable. This makes it difficult for Ms. S, as an adult, to know whether certain behaviors in others are dangerous, acceptable, loving, and so forth. In addition, her mother treated her as incapable and conveyed disapproval and rejection when Ms. S demonstrated more independent, self-generated behavior, yet Ms. S perceived her mother as very capable. From this, Ms. S could have learned to discount her own needs, beliefs, and desires in relation to others and to downplay her accomplishments and strengths, simultaneously believing that she should be doing better than she is. This might additionally have led Ms. S to feel she is not worthy of friendships or positive relationships in general.

The anxiety that Ms. S experiences may, in part, relate to her childhood sexual abuse (reminders of her abuse can elicit fear and anxiety). In addition, on the basis of her learning history, she may currently experience anxiety in reaction to the high expectations she has for herself as well as the belief that she may lose people close to her if her behavior does not live up to their expectations. Some of her current difficulties may be maintained by

their function in temporarily reducing anxiety, such as worrying, working excessively, and avoiding friendships.

Further, it seems likely that Ms. S's history contributes to her overall feelings of self-hatred, uncertainty about herself (sexual orientation, goals, etc.), and depression, specifically because of the *invalidating* characteristics of her experiences. Linehan (1993a) defined an invalidating environment as one that pervasively and chronically conveys to a child that his or her emotional reactions and self-generated behavior are faulty, inappropriate, pathological, or unimportant. Over time, this interferes with the child's ability to recognize, label, communicate, and change or regulate internal experiences; leads to an excessive reliance on others to determine how to feel, think, and act; and leads to the development of self-invalidation. The behavior of both of Ms. S's parents has prototypic elements of invalidation and likely contributed to her difficulty trusting her own perceptions and reactions, knowing what she wants in relationships and life in general, and valuing herself. Finally, because Ms. S is biracial, it could be hypothesized that Ms. S has experienced episodes of invalidation throughout her life in the form of racism. Her confusion about her identity might similarly relate to uncertainty about (or lack of acceptance of) her racial affiliation.

TREATMENT METHODS

I use case formulations to guide my therapy. To these I add knowledge about the factors required for effective intervention (from the empirical and theoretical literature) and clients' priorities for treatment. In terms of stages of disorder and therapy, Ms. S is fairly highly functioning and does not have any behaviors that directly threaten her well-being or therapy. She has maintained a heavy school and work load, she is not suicidal, she does not appear to engage in additional dysfunctional behaviors that can function as emotional avoidance (though I would assess thoroughly for the following behaviors, which can function as emotional avoidance: alcohol and drug use, eating-disordered behavior, dissociative behavior, and self-injurious behavior), and she seems committed to and motivated for therapy. According to Linehan's (1993a) terminology, Ms. S is more of a Stage II client (with primary problems related to emotional suffering and identity confusion), as opposed to a Stage I client (for whom behavioral dyscontrol is primary), and therefore I would not impose specific targets for therapy. However, as is the case with Stage I DBT, if Ms. S began to engage in life-threatening or therapy-interfering behavior, those behaviors would become the primary focus of therapy, given the risk they pose to her well-being and the therapy process. I would orient Ms. S to this expectation and its rationale at the onset of therapy.

I would initially propose that the therapy focus on depression, given the salience of Ms. S's recent relationship break-up, the difficulties she is beginning to experience in school and work, and the potential impact of continuing school and work problems on increasing her depression. I would suggest a focus on depression prior to her PTSD-related problems, because talking about childhood sexual abuse would likely lead to an increase in her emotional experiencing, which could further affect her school and work performance and increase her depression. In addition, there is some empirical evidence that depression can interfere with the effectiveness of exposure-based interventions for PTSD (e.g., Ehlers et al., 1998), which are the treatment of choice, given the case formulation (discussed further below). I would begin by having Ms. S track her daily activities and the mood associated with these activities. I would pay particular attention to disruptions in her routine and biological functioning that might be contributing to her depression, such as inactivity, excessive or insufficient sleep, and excessive or insufficient eating, and I would do problem solving (e.g., sleep hygiene) and activity scheduling to work on this. To help Ms. S reach these goals, I would thoroughly orient her to the role of these disruptions in depression and help her break the goals down into reasonable steps (i.e., shaping). Consistent with the components of behavioral activation (Martell, Addis, & Jacobson, 2001), I would work with Ms. S to identify the activities in her life that are reinforcing, the behaviors she engages in that function as avoidance, the ways she might not be fully engaging with the reinforcing properties of activities in her life (e.g., through worry and rumination), and new activities she could add to her life that would be reinforcing (and, as such, consistent with her values and goals).

This process would necessarily begin to address problems in addition to depression. For example, as Ms. S worked to add to activities to her life, she would likely struggle with identifying what she likes, wants, values, strives for, and so forth. Therefore, to build a life that is inherently reinforcing, she needs to work on increasing her awareness of her experiences and beliefs and further developing her values, goals, and preferences. Toward this, she may benefit from skills training aimed at increasing her ability to identify and label emotions and other internal experiences (e.g., training in Linehan's, 1993b, emotion regulation skills, mindfulness skills). I might suggest assignments in which she engages in new activities and pays attention to her experiences while participating in these activities as a means of gaining additional awareness about her own reactions and preferences. Similarly, because Ms. S has identified a desire to have more meaningful relationships, increasing reinforcement would also include attention to the factors that interfere with her development of meaningful relationships. The specific interventions would be dependent on a thorough assessment of these factors but, on the basis of the information provided

about Ms. S, would likely include skills to increase her awareness of her reactions in relation to others (e.g., mindfulness training); identification of her beliefs about herself and others that may influence her choices in friends and partners (and challenging of these beliefs when warranted); skills to increase her tolerance of the emotions she experiences when she is not in a relationship (therefore decreasing the likelihood that she will move quickly into a relationship prior to getting to know the person well); and further identification of her desires, values, and goals in relationships (again, through mindfulness and experimentation).

Although it is difficult to convey, the point I'm trying to make is that I do not view therapy as completely linear, as multiple problems are often being addressed simultaneously. Nonetheless, having a clear target (in this case, depression) helps to ensure that progress is made on this target, which is often not the case when therapy jumps from problem to problem independently of case formulation. For example, during work on depression with Ms. S, if our therapy moved to increasing her awareness of her values, goals, and preferences, I would be sure to link this back to the way her increased awareness could be useful in identifying the kind of life she wants (i.e., experiences as reinforcing), which is essential for reducing depression. Additional work on her identity and relationship problems might not happen at this point in therapy but might recur when we focused on PTSD-related problems or might have a discrete focus at another point in therapy, independently of the treatment of other problems.

I would recommend that therapy focus directly on the treatment of Ms. S's PTSD-related problems when her depression was reduced (to at least the mild range) and when she had learned and incorporated skills for reducing depression. Prior to this direct focus, I would help Ms. S manage her intrusive symptoms (particularly if they were highly distressing) by identifying cues that elicit the intrusive symptoms and developing methods to eliminate, avoid, or cope with the cues. For example, if Ms. S experienced an increase in nightmares following contact with her father, early in therapy I likely would suggest that she (temporarily) avoid contact with her father. I might also teach her skills, such as mindfulness, for focusing her attention when she is experiencing unwanted memories.

When treating Ms. S's PTSD-related problems directly, I would again base specific interventions on my case formulation. I have hypothesized that her intrusive and arousal symptoms were developed through classical conditioning and are maintained by current cues and avoidance behavior. Empirically supported *principles* of change for this formulation are exposure and response prevention. I would first thoroughly orient Ms. S to the rationale, goals, and expectations for exposure. I would then work with Ms. S to develop a hierarchy of her intrusive memories (according to the degree of distress they evoke, the frequency with which she experiences the

memories, and the degree to which they interfere with desired activities) and begin exposure with the more distressing and frequently experienced memories (on the basis of the possibility that habituation to more distressing memories may generalize to less distressing memories; Batten, 2002). Typical exposure to memories involves describing the memories out loud while imagining the scene, with as much detail as possible, over and over, until the memory loses its conditioned association with the initial event. Research suggests that effective exposure requires contact with the cue and habituation to the cue (e.g., Jaycox, Foa, & Morral, 1998), and, therefore, the specific methods used might vary for Ms. S to achieve these goals. For example, if Ms. S was initially unwilling (i.e., felt too overwhelmed) to talk about her memories, I might propose that she initially write out her memories, read them to herself, and then read them in session (shaping). Likewise, if Ms. S did not experience much emotion during her description of her memories, I would create a context that elicited more emotion, such as having her add more sensory details, speak in the first person, and so forth. Other methods that have been shown to facilitate habituation include intersession exposure practice (e.g., by listening to audiotapes of the previous session's exposure) and lengthening the session. I would consider these methods for Ms. S as needed to achieve habituation.

Simultaneously, treatment would address avoidance. During the imaginal exposure, I would stay awake to possible (and subtle) ways that Ms. S might be avoiding contact with the cues. These could be volitional or not (and, likewise, in conscious awareness or not) and could include dissociation, changing the topic, distracting, judging herself, omitting certain parts of the memory, and secondary emotions (e.g., anger in response to fear). I would work to block avoidance by pointing out these behaviors when they occurred and directing Ms. S back to the memory. In addition, Ms. S might be engaging in behaviors outside of therapy that function as avoidance of cues to her childhood abuse, and I would address this type of avoidance as well. In part, I would identify these behaviors by assessing the situations and experiences Ms. S is aware of avoiding because they remind her of her abuse and that are getting in the way of her goals (no obvious examples were provided in the case summary, but these might include sexual intimacy or contact with certain family members). In this case, treatment would involve gradual exposure to these situations and experiences (in vivo exposure), blocking avoidance, and allowing for habituation.

An additional, necessary component of exposure-based therapies is that corrective information is obtained from the process (e.g., Foa & Rothbaum, 1998). This can occur in many forms, including realizing that the emotion can be tolerated for longer than expected and without disastrous consequences, experiencing a decrease in emotions in the presence of cues (habituation), remembering or attending to additional details of the

trauma that change one's beliefs and feelings about the event, and obtaining information from the therapist that changes one's beliefs and feelings about the event (e.g., that the dependence and immaturity of children greatly inhibit their ability to say "no" to an adult abuser, that it is normal to have liked some aspects of the abuse). Therefore, I would structure the exposure to maximize the chances that corrective information would be obtained (e.g., altering the length or frequency of sessions to ensure habituation, choosing situations for exposure that are not overly or insufficiently emotionally evocative) and highlight the new information that is obtained from the process. Instruction and practice in dialectical thinking could similarly help Ms. S process her experiences in new ways. In DBT, this translates, in part, to adopting a belief system that allows for multiple truths and recognizing the transactional nature of reality. For Ms. S, the notion of multiple truths might be helpful for understanding how her father's actions could be both loving and hurtful and how she could feel different and even contradictory feelings for him at the same time. The transactional perspective can further remove conflicts around blame and fault and lead to greater self-acceptance and self-validation.

Ms. S presents with additional problems that likely originated, in part, with her childhood sexual abuse but that may not change through the process of exposure (e.g., her difficulty recognizing, trusting, and communicating her emotional experiences, her difficulty trusting others, her self-hatred, and her uncertainty about her preferences and goals). This is because, as discussed in the case formulation, other factors relate to the maintenance of these problems beyond classically conditioned associations and avoidance. Nonetheless, many of the interventions I have mentioned above have applicability to these additional problems, and, therefore, I would address them indirectly throughout therapy (e.g., mindfulness would aid Ms. S's ability to identify her internal experiences; dialectical thinking might reduce her self-blame and increase her self-acceptance). In addition, the therapeutic relationship is a powerful and important context in which these views can be influenced, and it is particularly important for Ms. S, as I discuss next.

THERAPEUTIC RELATIONSHIP

As mentioned, I view the therapy relationship as critically important for change. In part, this is because many of the problems for which clients seek therapy are interpersonal in nature. Likewise, when problem behaviors occur in the context of therapy, the therapist has much greater access to information about the factors that elicit and maintain these problems

and, therefore, has much greater ability to intervene effectively. Further, the therapy relationship is often a very powerful source of reinforcement for new behavior and can be used strategically (and naturally) to influence and maintain change. Toward creating an effective therapeutic relationship, I strive to be genuine (in voice tone and manner), I am explicit in my behavior and expectations, and I express my feelings and views when this is in the client's best interest.

Ms. S reports difficulty trusting others and a pattern of becoming involved quickly with men who are harmful to her. She also seems to have difficulty trusting and forming her own views and opinions, and this, too, appears related to her relationship difficulties. I would stay aware of similar patterns that might emerge in our relationship and address these when relevant. For example, I would expect that Ms. S would initially be wary of me and the therapy process and might present as very "together" and invulnerable. I would look for discrete examples of this (e.g., direct statements that she does not trust me or reticence to express herself) and then assess her thoughts and feelings, the context, and my behavior to understand the factors related to her distrust. Interventions at this point could take many forms, depending on this assessment, but might include encouraging her to take risks with me by expressing herself despite her fear (exposure), cognitive restructuring (evaluating what she knows about me, my reactions), or, perhaps, encouraging her to seek more information to determine whether I am trustworthy. I would then work with her on generalizing these interactions and interventions to other areas of her life.

In addition to helping Ms. S build trust with others, the therapy relationship could be used to help her develop and trust her own experiences. I expect that, as therapy progressed, Ms. S would become highly concerned about my opinions and views and have difficulty expressing her own opinions and views in my presence. Initially, some degree of feedback and input from me would be important because, on the basis of the case formulation, she has not learned how to identify emotions and beliefs and likely invalidates those experiences she can identify. This might occur in the context of any topic in which she is expressing or attempting to express an emotion or belief. I could give Ms. S feedback by providing information on "normative" experiences, agreeing with or supporting her expressed experiences when they seem accurate or understandable, attending to her with interest, and so forth (i.e., Linehan's, 1993a, definition of validation). Given the goal of increasing her self-validation, self-awareness, and self-generated behavior, it would be important to reduce the degree to which I provided this over time (i.e., shaping) and instead encourage Ms. S to rely on her own reactions and experiences.

I would also use this process of providing validation and increasing her reliance on self-validation to help Ms. S clarify her career goals and

questions of sexual identity. Though these topics would likely take a lower priority in treatment (with depression and her PTSD-related problems being the initial focus), ongoing attention to increasing self-awareness and self-validation in the context of a genuine and validating therapeutic relationship would likely contribute to increased clarity about these issues as therapy progressed. Throughout therapy, I would work to stay aware of when Ms. S was engaging in new and relevant behavior and respond in ways that reinforced these changes when they occurred (e.g., through praise, warmth, and responsiveness). Changing long-standing and intense views of oneself (e.g., self-hatred and self-invalidation) is a slow process, however, and will likely be an ongoing process for Ms. S, influenced in part by changes in her life experiences over time.

THERAPY PROCESS

I've described much of the process my therapy would take with Ms. S, including the use of assessment, the order of targets, and the form and use of the therapy relationship over time. To be a bit more explicit about the structure, I would recommend weekly individual therapy and suggest an initial contract period of 20 sessions, with a plan to assess progress and goals at that point. I view individual therapy as useful for achieving a thorough case formulation and for providing interventions specific to the factors maintaining the patient's difficulties (this degree of precision can be difficult to achieve in a group setting). In addition, the individual therapy relationship would allow Ms. S to work on her difficulties with relationships, as discussed above. However, I could also argue that Ms. S would benefit from a group therapy context, in which she could have opportunities for building trusting relationships with a variety of others as well as learn that others have had similar experiences (e.g., in an abuse-focused group), which would thereby reduce her beliefs about stigmatization and self-blame. Skills for regulating emotions and increasing self-awareness could also be taught in a group context (see Cloitre, Koenen, Cohen, & Han, 2002).

In my first session with Ms. S, I would review my consent form and limits to confidentiality, emphasizing the reporting laws in my state (given her history). I would provide information about my general approach to therapy as well as options for alternative therapy, particularly given her lack of previous therapy experience. I would assess her reasons for seeking therapy, collaboratively develop a problem list, and begin the process of obtaining functional analyses of these problems. I might provide some psychoeducational information about depression and/or childhood sexual

abuse, and I likely would give her an assignment to begin self-monitoring her depression and PTSD-related problems. I would make a point to ask her at the end of the session what the session was like for her and to answer any questions she might have.

In general, I would be more structured early in therapy, given her lack of experience with therapy and her difficulties with self-awareness as well as to obtain needed information. I would gradually and explicitly decrease my imposition of structure as a means of strengthening her identification and communication of feelings, beliefs, and needs. I would assess her functioning throughout the course of therapy, both subjectively and objectively with self-monitoring and self-report measures when possible.

It is important to keep in mind, given Ms. S's relationship difficulties and history of rejection and abuse by people she has been close to, that termination from therapy could be difficult for her (e.g., eliciting feelings of rejection or fear about her ability to cope). I would stay aware of this and assess and intervene as I had with other relationship issues that emerged during therapy. I would bring up termination well before the end of therapy and determine the timing of termination as collaboratively as possible. I view the ending of therapy as similar to the ending of other important relationships and as an opportunity to say goodbye in a way that is meaningful and perhaps new to the client. As Ms. S likely has not had many experiences ending relationships in positive ways, I would discuss options for doing this and determine the actual format collaboratively as well. Finally, I would end with a focus on relapse prevention, including reviewing the course of our work together, highlighting the factors most relevant to the changes she had made, and likely scheduling a follow-up "booster" session a few months out.

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