# Overcoming Obstacles: Therapeutic Success Despite External Barriers

Lisa Sebotnick McLean, M.D.



What predicts therapeutic success? One might answer the question with a question: "How many psychiatrists does it take to change a light bulb?" The answer: "Only one, but the light bulb has to really want to change." It is true that motivation, desire to change maladaptive ways, is often a key ingredient for therapeutic success. How can the power of motivation be harnessed when the external barriers (social, situational, financial) impede significant change? That question is answered, in part, by a strong body of research pointing to the power of the therapeutic relationship.

The power of the provider-patient relationship is significant in all areas of medicine. Ciechanowski et al.[1] demonstrated that the type of interaction between patient and provider was associated with patients' degree of diabetic control. Specifically, the researchers examined patients' attachment styles (types of relatedness) and their perceived communication with their provider (i.e., whether they perceived good or poor communication with their provider). In those patients who had "dismissing" attachment styles, the ones who perceived poor communication with their providers had higher glycosylated hemoglobin levels than those who perceived good communication with their providers. The quality of the provider-patient bond translated into better self-care for the patient.[1]

The following case illustrates these principles. The patient, Ms. N, presented with an initial goal of getting out of her bad environment, which she perceived to be causing much psychological distress. Her financial and situational circumstances initially rendered her goal impossible. Our relationship fostered an environment in which she developed a stronger sense of self, which eventually gave her the strength to make the ultimate leap forward to achieve her goal.

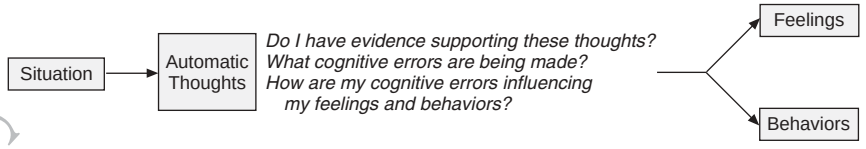
## CASE PRESENTATION

Ms. N is a 27-year-old single mother of 3 young boys who presented to our clinic stating, "My DSS [Department of Social Services] caseworker thought I needed some help." She was very nervous during our first encounter and had difficulty initiating dialogue. This was the first time she had seen a psychiatrist. She began by describing symptoms that had been bothersome, including "crying about 30% of the time," having no motivation, feeling tired all the time, having problems with concentration, and frequently worrying about her children, her children's father, and their financial situation. She denied a history of panic attacks, obsessive-compulsive symptoms, psychosis, mania, suicidal or homicidal thoughts, or suicide attempts. She also denied use of drugs or alcohol and endorsed smoking 1 to 2 packs of cigarettes per day.

Ms. N described the current stressor as having mixed feelings about leaving her boyfriend John, stating, "I'm not very strong and I can't say no." She provided a detailed account of their relationship. They met in their senior year of high school and began dating. From their first date, he would show up drunk and without money, and she financially supported the relationship. She became pregnant in her senior year of high school, had her first son, and graduated. She and John have been together on and off for several years. She reported that when he is not at home, it is usually because he is in jail for offenses such as driving under the influence, other driving offenses, and criminal domestic violence. He has an alcohol abuse disorder and, while intoxicated a few years ago, physically attacked Ms. N and her son. Because of this incident, DSS is involved. He has also been unfaithful several times. Ms. N was very conflicted with regard to the relationship, stating that "he has taken everything away from me," yet she did not want to be alone and did not want her children to be raised without a father.

Ms. N has no significant past medical or psychiatric history. Her family history is positive for alcohol abuse and bipolar disorder in distant relatives. She and her 2 brothers were raised in a middle-class family. She describes her father as very critical and her mother as passive. It was not a very emotionally expressive household.

Figure 1. The Cognitive-Behavioral Model






Her parents, though, are currently very involved in helping out with Ms. N's sons.

My diagnosis was major depressive disorder. Ms. N's goal for therapy was "to have happy kids that don't grow up to be white trash." She wanted to learn to stop crying, to learn to feel okay with being alone, to stop constantly feeling punished, and to get a decent job. She was not interested in medications to help with her mood, but was interested in psychotherapy. We decided on a cognitive-behavioral approach to address cognitive distortions regarding her relationship with John and her constant feelings of punishment.

## PSYCHOTHERAPY

The significance of the provider-patient relationship in our work together became apparent during our first therapy session. She began by telling me that she had "left some things out" for fear of being judged. She reported having approximately 2 mixed drinks 3 times a week, but denied symptoms consistent with alcohol dependence. She reported occasionally getting physically aggressive with her children (grabbing their arms, holding them still, but not hitting them), and she described living in a small camper on a yearly income of less than $6000. We discussed her reluctance to report these details, the associated anxiety, and how the actual outcome vastly differed from her fears. This provided a good transition to introducing the cognitive-behavioral model. She was provided with a diagram (Figure 1), which we applied to the above situation. She demonstrated good understanding of the theory and noted that she could apply this at home. She was encouraged to identify automatic thoughts (those initial thoughts to which she reacted during stressful times). At our next visit, we applied the model to her relationship with John. I presented the idea of examining the evidence for and against her automatic thoughts. During the session, we were able to identify her use of catastrophizing (a cognitive error) and its impact on her subsequent feelings and actions. She feared that if she were not with John, he would find another woman, fall in love with that other woman, and become the perfect father and partner that Ms. N had always wanted.

Over the next 3 sessions, we continued to examine the reasons she was staying with John. It was evident that the relationship was causing significant emotional distress. I pointed out the cognitive error of polarization, or "black-and-white thinking." Between visits, John had broken into their camper while drunk and become verbally abusive. She was conflicted about the thought that "either my kids will have a father and develop into normal, healthy kids, or they won't have a father and will miss out forever." To provide evidence to the contrary, we looked at the value of an environment with a physically abusive, alcoholic father versus an environment with a single, very supportive, nonabusive mother.

Over the next few visits, Ms. N began to spontaneously challenge her own beliefs with regard to John. Her focus then shifted to questioning her ability to be independent and to be a good mother. She related that due to her age and living conditions, people did not respect her. When asked what she could do to achieve greater respect, she stated that if she got a better job, she would make more money and be in a more respected position (i.e., a manager). She believed that this would help both her self-esteem and financial situation. However, she would be away from the boys more, and "they would lose another parent." This dilemma was the theme for the subsequent sessions. She was able to identify the cognitive distortions (indeed, if she had a job, her children would have more respect for her and she would be a better provider), yet could see no alternative option. I labeled her stance as an active decision not to change.

This discussion continued over a few visits. During this time, she was presented with the option of moving in with her parents and assuming a managerial position in the town where they lived. She was afraid that the independence she was gaining from John and her progress thus far in therapy would be jeopardized by returning to the scene of her father's overbearing critical nature. This

laid the groundwork for the focus of the next phase of therapy, Ms. N's self-esteem.

In discussing her automatic thoughts with regard to moving in with her parents, it became evident that Ms. N feared resuming the child role, despite being an adult and the mother of her own sons. She could not foresee being able to set boundaries with her parents, even though she had started doing so with John. I shifted gears at this point and engaged in supportive work, emphasizing her strengths in parenting and interpersonal relationships and her ability to begin to separate from John. I also gave her a chapter to read from Dr. Edmund J. Bourne's *The Anxiety and Phobia Workbook*,[2] which takes a cognitive approach to self-esteem. At our next visit, she talked about how beneficial she had found filling out the worksheets in the book. Using this information as a springboard, we noted how her inability to set boundaries for herself vis-a-vis her sons, her parents, and John was a major source of her feelings of being "not worth it." Noting the automatic thoughts associated with these beliefs, we again found the same pattern of cognitive errors: catastrophizing and polarizing. For example, she felt that if she established clear boundaries with her children regarding her possessions, they would perceive her as a bad parent. The fear of setting limits with her children, coupled with the fear that without a father figure, her children were being deprived, were strong reinforcers, making behavioral change difficult. Over the span of several sessions, using both cognitive-behavioral and supportive therapy techniques, she began to practice limit-setting. We discussed her fears of change and how the actual results were not the anticipated negative outcomes. As she continued to practice limit-setting, her affect in our sessions brightened, the language she used to describe herself and to describe John was much stronger, she was able to mention her needs, and she was surprisingly able to tolerate referring to John in a very negative way. Consequently, her crying frequency decreased, as did her irritability.

The remainder of our sessions were spent discussing Ms. N's frustration at feeling stuck. I shared her sentiment regarding her situation. She was able to look at the progress she had made in therapy, but recognized the very real financial constraints that kept her from moving forward. She had been offered a job at about $20,000 a year, but by taking the higher-paying job she would lose her government assistance (child care, Medicaid) and could paradoxically end up with even less money. She had seen that the solution would involve working more hours for more money and spending less time with her boys, with a better overall outcome. She had calculated her break-even point, but was unable to find a suitable job locally. Through a friend, she had a lead on a managerial job out of town and was considering it. We spent our second-to-last visit discussing what it would be like to start over in another town. She was able to address the anxiety-provoking situations and the associated automatic thoughts and found that challenging her automatic thoughts could result in a lessening of symptoms. She took a week off of therapy for a job interview out of town, and we set a routine follow-up appointment for the next week.

She began the session by stating that she was moving that weekend and that this would be our last visit. She had gotten the managerial job and successfully negotiated a salary based on her break-even point. We used a cognitive approach to discuss her fear of "not making it" and addressed the normal feeling that "big changes can be scary." We recapped the enormous progress she had made in therapy and terminated our relationship.

The work with Ms. N demonstrates how, within the context of the relationship, someone who appeared to be in a no-win situation was able to gain the self-confidence necessary to break into new, unknown territories. Although psychotherapy ended rather abruptly, it has been shown that the improvement gained through psychotherapy can be stable over time.[3] Over the course of 16 weekly sessions, Ms. N achieved significant life change. In the end, she was able to reach her seemingly impossible therapeutic goals.



## REFERENCES

1. Ciechanowski PS, Katon WJ, Russo JE, et al. The patient-provider relationship: attachment theory and adherence to treatment in diabetes. Am J Psychiatry 2001;158:29–35
2. Bourne EJ. The Anxiety and Phobia Workbook. 3rd ed. Oakland, Calif: New Harbinger Publications; 2000
3. Andrews G, Harvey R. Does psychotherapy benefit neurotic patients? Arch Gen Psychiatry 1981;38:1203–1208

***Editor's note:*** Dr. McLean is entering her fourth year of general psychiatry training and her first year of child and adolescent fellowship training at the Medical University of South Carolina.