CASE # 1

A CASE FROM A PERSON-CENTERED PERSPECTIVE

Judith: "I Have a Sexual Problem"

By **David N. Elkins,** PhD, Professor Emeritus, Graduate School of Education and Psychology, Pepperdine University

Background Information

Judith is a 25-year-old White female who works as a receptionist at a law firm. Six months ago she began dating Shawn, a 27-year-old man who lives in her apartment complex. Their relationship has deepened and they now see each other two or three times a week, despite their heavy work schedules. Recently, they began to talk about getting married.

Judith came to therapy because she is concerned about what she describes as her "sexual problem." Judith told her therapist, "When Shawn and I make love, I get turned on at first but then I just shut down. It's like my sexual feelings evaporate into thin air. Shawn is very understanding but I know it's difficult for him." Judith went on to say that she thought her strict religious upbringing was part of the problem. She said, "I grew up in a small Southern town and my family was almost fanatically religious. My parents thought sex was shameful and dirty and that premarital sex was a horrible sin. If they knew that Shawn and I were having sex, they would be appalled. I left the church when I was in college and I no longer believe many of the things my parents and church taught, but I think my upbringing has caused me to block out my sexual feelings."

Dr. Dave Elkins's Way of Working With Judith From a Person-Centered Perspective

Person-centered theory posits that children, because they need the love of their parents, tend to "deny to awareness" experiences, including their own feelings, that do not fit their parents' value system. Judith's parents considered sex "shameful and dirty" and believed that premarital sex was a "horrible sin." Thus, it is understandable that Judith, as a child growing up in such an environment, might learn to block out or "deny to awareness" feelings related to sexuality. Although person-centered therapists do not focus on the past in therapy, they do understand that childhood experiences often explain why adults "block out" certain feelings or other aspects of themselves. Person-centered theory says that in order to reclaim previously denied aspects of their experiences, clients must be provided with a therapeutic environment characterized by empathy, congruence, and unconditional positive regard. To the degree the therapist is able to provide this environment and to the degree clients perceive it, they will begin to grow. Their growth will include a natural tendency to explore and gradually allow into awareness feelings that were previously denied.

Using this theoretical structure, it becomes obvious what I need to do in working with Judith from a person-centered perspective: I must provide her with a therapeutic relationship in which she feels deeply understood and accepted. As she begins to realize that I understand how she feels, that I accept and do not judge her, and that I, too, am trying to be open and honest in my relationship with her, Judith will increasingly feel free to be her real self in therapy and to explore and access parts of herself that she had previously blocked out or denied to awareness. As a person-centered therapist, I would not use techniques in my work with Judith nor would I push, cajole, or try to persuade her to do what I thought was best. Person-centered therapists believe that human beings grow naturally when they are provided with empathy, honesty, and acceptance—just as a flower grows naturally when it is provided with sunshine, water, and soil. Thus, based on my own clinical experience and a great deal of research that supports the effectiveness of a deeply human therapeutic relationship, I would predict that Judith, if she stays with the therapeutic process, will not only recover her sexual feelings but will also grow as a person, perhaps in ways that she has not even imagined.

CASE #2

A CASE FROM A BEHAVIOR THERAPY PERSPECTIVE

"Nasty Nails No More: Helen's Triumph over Nail Biting"

By **Caroline Bailey, PhD.,** Assistant Professor of Social Work, California State University, Fullerton

Background Information

Helen, a nine-year-old Chinese American child lives with her mother Eleanor and her two younger brothers. She is a well-behaved and likeable fourth grader who is doing well academically. Helen has friends at school and also has several friends in her neighborhood. Most adults describe Helen as a "good kid." Her mother feels that Helen has always been a well-behaved child until recently.

Dr. Carolyn Bailey's Way of Working With Helen and Eleanor From a Behavior Therapy Perspective:

Input and support of loved ones is often useful in behavior therapy because they can provide excellent sources of reinforcement and motivation for behavior change. Also, loved ones can provide important information about the way the client's behaviors affect the client's life. When working with school-aged children, primary care givers play an integral role in supporting their children's therapy outside of the therapy session by prompting their children to use a specific behavioral strategy when needed and helping their children to complete their therapy homework assignments.

My first session is spent working collaboratively with Helen and her mother to develop clear treatment goals. Both Eleanor and Helen were initially apprehensive about meeting with a counselor. This is understandable not only because counseling is a new experience for the family, but also because young children often associate going to the "doctor's office" with having medical procedures done. In light of this, I began my session by giving an age appropriate description of what the counseling process entails and made sure to tell Helen that unlike other times she had been to see a doctor, that today she would *not* be getting a shot. I also allowed Helen ample opportunities to ask questions about the counseling process and about me as her therapist until she felt comfortable starting our work together.

Helen and Eleanor both clearly stated their shared goal of helping reduce Helen's nail biting. Eleanor was concerned for Helen's health and while Helen mentioned that biting her nails "hurts a lot," she was most concerned about the teasing she receives from the children at school who call her names like "nasty nails." Helen said the teasing makes her feel sad and bad about herself and that she wishes all the kids at school would just "knock it off." With both Eleanor and Helen on board with shared treatment goals, psychotherapy could begin.

Behavior therapists work collaboratively with clients and empower them to change maladaptive behaviors into more helpful actions through teaching behavior modification strategies. The first step of this process is providing clients with *psychoeducation* about how behavior therapy works and how clients can learn to make choices about how they behave. When working with children, use of age appropriate examples and developmentally appropriate terminology is very helpful in explaining how behavioral principles work.

In our first session I explained to Helen that while some behaviors are reflexes (like coughing when you eat too much pepper), most of our behaviors are learned and that this means that we can learn to change them. I also explained to her that most people's behaviors, even the behaviors that we wish we didn't have, are often executed because of the consequences the behaviors yield. One example I used to illustrate this concept is that although most children do not like being upset and throwing tantrums, if they have learned these

Dr. Bailey & Helen & Eleanor

CASE #2 (cont'd.)

tantrums will get them out of doing chores, they are much more likely to throw them. Next, I had Helen generate some examples from her life of how her behaviors are maintained by contingencies and highly praised her for her participation in this exercise. By teaching Helen that behaviors are governed by reinforcement contingencies that can be modified and that most behaviors are triggered by their antecedents and consequences, she is learning the basic principles necessary to use a behavior therapy technique called *self-monitoring*.

Self-monitoring requires clients to be mindful of the "what," "where," "when," and "why" of the behavior they have targeted for change and to keep a careful and detailed record of their thoughts, feelings, actions and their environment at the moment that behavior occurred. Clients are also asked to keep track of the antecedents and consequences of their behaviors. In order to help Helen learn this technique, I asked Helen if she could think of the last time she noticed herself biting her nails. When she was able to picture that moment in her mind, I asked her to tell me what she was doing, feeling and thinking at the moment she noticed the nail biting. She stated that she was in class and being asked to read out loud by her teacher and felt nervous. Helen was hoping she would not make a mistake when reading because she didn't want kids to start teasing her. Next, I provided Helen with a small, blank journal and worked with her and her mother to develop a recording system that Helen could use during the day to monitor this behavior. For homework, I asked Helen to self-monitor her nail biting over the next week. Her mother agreed to help Helen keep her journal and agreed to ask Helen's teacher to allow Helen to keep her journal during class.

In our next session, reviewing Helen's homework revealed Helen tends to bite her nails at times when she feels self conscious or nervous about her performance and when she fears that others will evaluate her negatively. She also bites her nails when she is worried that adults in her life might abandon her or leave her behind. Helen bites her nails about twenty-five times during a school day but very infrequently at home. Helen mentioned that she thinks the nail biting "takes her mind off of" the anxious feelings she is having.

While Helen's underlying anxiety is important, Helen's nail biting is causing her injury and must be worked on immediately. Knowing some of the contingencies that reinforced her nail biting enabled Helen and I to create a *behavioral substitution plan*, where she executes a more adaptive behavior in place of the nail biting. Together, Helen and I agreed that when she begins to feel her anxious feelings she will make careful efforts to replace her nail biting with a new, less harmful behavior of rubbing her thumb across her fingertips. Eleanor agreed to help Helen monitor her progress on the behavioral substitution program, and will provide Helen with a double scoop, chocolate ice-cream cone if Helen can go an entire school day without biting her nails.

Three weeks later, Helen proudly stated that she was able to reduce her nail biting from an average of 25 times a day to only 2 times a day. She felt that for the most part the behavior substitution program is working. Her nails were healing nicely and children at school were teasing her less.