

Using Client-Centered Psychotherapy Embedded Within A Pluralistic Integrative Approach to Help a Client With Executive Dysfunction: The Case of "Judith"

TONY WARD^{a,c} & KEVIN HOGAN^b

^a University of the West of England, Bristol, England

^b Newman University, Birmingham, England

^c Correspondence regarding this article should be addressed to Tony Ward, Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Bristol, BS16 1QY.

Email: tony.ward@uwe.ac.uk

Acknowledgement. An earlier version of this case study was presented at the annual conference of the British Psychological Society's Division of Counselling Psychology, held at the University of Warwick, July, 2009.

ABSTRACT

Executive dysfunction refers to a breakdown within a cluster of cognitive and behavioral processes that regulate, control, and manage the achievement of particular goals. Executive dysfunction can thus encompass problems like disinhibition, poor planning, impulsiveness and unproductive repetition. Previous reports in the literature have suggested that psychotherapy with clients affected by the condition can be complicated. This report consists of a case study on the successful use of psychotherapy for "Judith," a 48-year-old client experiencing emotional disruption and affected by long standing executive difficulties due to a head injury sustained at work 10 years earlier who was seen in therapy by the first author (TW). Emotional well-being was assessed before and after a period of psychotherapy, using an ABA design, and appropriate single-case statistical techniques. The primary approach to the client's issues was client-centered, but other problem-solving techniques were incorporated within a pluralistic framework and are described. The client's reported well-being improved, and this improvement was statistically reliable and clinically significant. A previous report of therapy with a client with executive dysfunction suggested that the tendency to perseverate on particular negative thoughts can induce considerable distress in such clients. Judith's case study shows that while this might be a risk, it is possible to work successfully with at least some such clients, and to do so using a client-centered approach.

Key words: Executive dysfunction; client-centered therapy; pluralistic therapy; rehabilitation; clinical case study; case study

1. CASE CONTEXT AND METHOD

Rationale for Selecting This Client

The case study reported here concerns "Judith," a client who was experiencing severe trauma due to personal upheaval. Judith was 10 years post head injury, and her cognitive

difficulties continued to be characterized by extreme executive dysfunction, including disinhibition, poor planning, impulsiveness, and repetition. Judith's case is therefore interesting in several respects.

First, Judith is similar to the case of FS, described by King (2002). Both FS and Judith had experienced trauma with accompanying intense psychological distress and executive dysfunction from a head injury. In FS's case, therapy proved problematic because outside of sessions the client experienced repetitive evoking of his trauma and difficulties. Having encouraged the client to access his traumatic memories, perseverative difficulties meant that FS was unable to disengage from these thoughts outside of the session. King therefore suggests that caution should be observed when conducting therapy with such clients. We thus decided to follow Judith to see if similar issues to those observed by King occurred, and if so, how these could be ameliorated.

Secondly, Judith presents the opportunity to observe whether a client-centered approach (Rogers, 1951) to dealing with her traumatic stress could be effective for someone like her with a history of head injury. The question in this instance is whether extreme executive difficulties are likely to impair access to the innate growth processes posited by client-centered therapy. Our prediction at the outset of the study was that this approach could be effective with this type of client, since we had previously experienced success with clients with another type of neurological impairment (chronic fatigue syndrome/myalgic encephalopathy [ME]) that interfered with their cognitive processing (Ward & Hogan, 2009).

Methodological Strategies for Enhancing the Rigor of the Study

Given that the question in Judith's case was whether she came to repetitively dwell on negative aspects of her predicament and ability to cope, we decided to record and transcribe five early sessions, and to rate the number of positive and negative coping statements that occurred, along with instances of suicidal ideation. This would give us an early indication as to whether Judith's in-session behavior was increasing in these dimensions. Also, this would then be repeated later in the course of therapy, to see if the proportion of negative and positive coping statements had changed. These first five transcripts also allowed us to discuss the therapy process, and to ensure that the sessions were faithful to a Rogerian, client-centered way of working. Note also that while client-centered therapy was the approach chosen to deal with Judith's emotional difficulties, we also intended to address her other concerns, involving practical issues of daily living, using rehabilitation principles in an integrative way.

Clinical Setting

Judith's case study was based in a community outreach counseling center situated in a university setting. Sessions were held weekly, and later in the course of therapy some home-based interventions were included. Judith's case study was part of a larger study on the efficacy of counseling interventions for clients with head injury. The case study received ethical approval from Newman University, and Judith gave informed consent to take part in the research and for the work to be reported as a case study.

The therapist (the first author, TW) and the supervisor (Peter Hudson, based in Bridgnorth, UK) in this case were both counseling psychologists with training in the client-centered model of psychotherapy, together with a background working with neurologically impaired populations. The second author (KH) was involved in data collection and analysis.

Sources of Data

Sources of data in Judith's case include client questionnaires and other outcome measures, session recordings and transcripts, and reports from rehabilitation workers in a community rehabilitation center.

Confidentiality

All significant client details have been altered to preserve client confidentiality. Judith gave permission for this case to be reported.

2. THE CLIENT

Judith, a 48-year-old woman, was referred by a local charitable association, which deals with head injury, to a community outreach counseling service operated by a university. At intake Judith initially presented in a highly emotionally distraught state. Three months prior to the assessment her husband had walked out of the marital home, having given her notice that he was leaving the previous night. The husband had subsequently set up home elsewhere with another woman, and divorce proceedings were in progress. This event had a very adverse impact on Judith. She felt utterly abandoned and alone and unable to cope, with a sense of hopelessness about the future. She recounted how she had entertained suicidal thoughts and how she had come close to initiating self-harm on several occasions.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Psychotherapy with Clients with Executive Dysfunction

This work was part of a project evaluating the efficacy of client-centered, integrative therapy for clients with head injury. This approach involves maintaining a respect for the client in trying to implement the therapeutic conditions envisaged by Carl Rogers (1951), while being open to the client's needs and goals and being willing to use techniques and approaches from other therapeutic modalities such as cognitive behavioral therapy (Laatsch, 1999; Cooper & McLeod, 2010, 2011).

Before thinking about possible therapeutic approaches in more detail, it is worth initially considering the implications of attempting therapy with a client who has a neurological condition such as executive difficulties.

Descriptions of patients with the symptoms of executive dysfunction have existed for over a century. For example, the case of Phineas Gage was documented by John Harlow in 1848. Gage sustained extensive damage to his left frontal lobe following an industrial accident. Subsequently he drifted from one low level occupation to another, and was noted to be disinhibited and at times profane. His friends noted that "Gage was no longer Gage" (Martin, 1998). A concerted effort amongst researchers to explain and understand these difficulties has only been evident in the last 20 years. The more common symptoms of executive dysfunction include poor planning, lack of insight, poor decision-making, lack of concern for social rules, impulsivity and perseveration (Burgess, 2003). These consequences typically result from damage to the frontal lobes caused by head injury, stroke, dementia, or encephalopathy (Martin, 1998).

Clients with executive dysfunction face many obstacles in their day-to-day lives. They may find it difficult to work in even relatively straightforward employment without close supervision. There may be difficulties in planning everyday activities, and following through on a sequence of tasks in order to achieve routine objectives. Behavior may become quite impulsive and disinhibited, often resulting in inappropriate sexual or aggressive responses towards other people. The tendency to perseverate may lead to a continual repetition of simple behavior and speech (Worthington, 2003).

Not surprisingly, these difficulties may have a considerable personal impact. Clients may experience intense frustration and feelings of loss. Their behavior may place an intolerable stress on their personal relationships. As with clients with other types of head injury, there is a very high risk of marital breakdown (Wood, Lioffi & Wood, 2005; Kreutzer et al., 2007).

Given the psychological distress that clients may experience, it is highly likely that they may be considered at some point for psychotherapeutic intervention. However, it may well be that therapists consider them unsuitable for this kind of approach, due to the cognitive difficulties such clients experience.

On the other hand, there are a number of suggestions in the literature that clients with cognitive difficulties can be amenable to psychotherapeutic interventions. Lewis (1991) suggests that the reaction of clients to psychotherapy will depend upon a number of factors, including the nature of their injury and their reactions to this, plus their personal psychological makeup from before the injury. Lewington (1993) contends that the success of psychotherapeutic interventions will depend on the therapist's knowledge coupled with flexibility and creativity, as all clients will be unique in terms of the issues and difficulties presented. Langer, Laatsch and Lewis (1999) also discuss the history of psychotherapy with neurological client groups, the typical issues encountered, and strategies for dealing with particular problems. Thus it seems that for therapy to be effective with clients such as Judith, the therapist will need to evaluate the presenting cognitive profile and the reaction and difficulties it produces, and couple this with creativity and flexibility.

For therapy to be effective, the cognitive limitations of clients must be appreciated and taken into account by the therapist. It may be necessary to make considerable adaptations to the normal therapeutic process. For example, Laatsch (1999) talks about allowing for clients having

limited concentration abilities, and needing to make allowance for this in terms of session length, or reminding clients about upcoming sessions to compensate for memory problems. And Iverson (2000) details how a cognitive profile can be used in thinking about client needs in therapy. Similarly, we (Ward & Hogan, 2009) describe how therapy sessions can be productively varied in length as a consequence of the client's changing energy levels.

In terms of therapy with Judith, these studies imply being willing to vary the length and nature of sessions, being willing to include therapeutically nontraditional types of activity, e.g., to address cognitive deficits, and being willing to assess cognitive functioning in order to guide choices about how to proceed with therapy.

While there clearly are many therapists working with head-injured clients, there is a dearth of published literature supporting its efficacy other than the few studies mentioned above. A reason for this may be the highly individualized nature of psychotherapy interventions, especially with this type of client. As in traditional neuropsychology one solution to this issue is the dissemination of successful case studies (McLeod [2010]).

In terms of psychological interventions there are a number of models that can be used. For example, it is clear from a number of articles that practitioners have applied psychodynamic concepts in working with clients with head injury (Lewis, 1999). However, it is far from clear how psychodynamic concepts and processes relate to cognitive dysfunction, and this issue is not discussed by Lewis. It remains unclear whether such processes are likely to operate in a normal way in clients with neurological issues.

Rogers' Client-Centered Therapy

A model that is widely used by counseling and psychotherapeutic practitioners, either in its own right or as a basis for integration (e.g. Kirschenbaum & Jourdan, 2005), is the client-centered approach (Rogers, 1951). This model allows clients to explore their difficulties in their own terms and at their own pace. Such an approach has been shown to work with other neurological populations in helping them to come to terms with their difficulties and psychological distress. For example Ward & Hogan, (2009) found this approach to be effective in a small trial involving fourteen participants with myalgic encephalitis. These participants were often coming to terms with severe personal loss, similar to that of Judith, in the face of neurological symptoms such as lack of concentration, fatigue, and mental slowing, also similar to those faced by Judith. .

Client-centered therapy (Rogers, 1951) involves offering the client an empathic and non-threatening relationship, characterized by the core conditions of empathy, congruence and unconditional positive regard. Empathic understanding involves communicating to the client that the therapist is able to grasp and understand their predicament from the client's own perspective or "frame of reference." The relationship should be genuine, so that the therapist does not hold attitudes or opinions about the client that the client is unaware of and that would be detrimental to the relationship. Finally, the therapist should come from a stance of "unconditional positive regard," so that he or she does not have or communicate negative attitudes towards the client.

Regarding this latter point, note that this does not mean that the therapist has to approve of all of the client's behavior, as long as the therapist responds to the client in a way that is congruent with and respectful of the therapeutic relationship.

In accounting for how the process of client-centered therapy works, Rogers (1959) describes the self-structure as:

the organized, consistent conceptual gestalt composed of perceptions of the characteristics of the "I" or "me" and the perceptions of the relationships of the "I" or "me" to others and to various aspects of life, together with the values attached to these perceptions. (p. 200).

When an individual perceives an incongruence between this self-structure and their experience, having not defended against this perception, they will experience anxiety. At this point the self-structure is disrupted and becomes disorganized.

According to Joseph (2005), although this conceptualization might usually be applied to everyday events, it could also be applied to traumatic stress (and as Joseph points out, Rogers had experience with treating war veterans).

Thus, trauma may shake many of the assumptions people hold about themselves and their lives. According to Rogers, on the one hand people will try to accurately represent the new experience in their self-structure, but on the other, will try to hold onto and retain the previous self-structure. According to Joseph (2005), in these circumstances people need to accurately symbolize their experience, leading to a reintegration of self and experience.

In thinking about a client with neurological executive dysfunction, there are a number of challenges that might arise from using a client-centered stance. In client-centered therapy, it is assumed that the client's actualizing potential will cause him or her to move in the direction of positive growth during therapy. This is an under-researched concept with mainstream clients, and also we do not know if neurological populations have the same access to such a process. Certainly the originator of the approach, Carl Rogers, suggested that there might be difficulties in applying the approach to clients with some categories of psychiatric disorder (Rogers & Stevens, 1967). Nor do we know if executive difficulties might interfere with the client's ability to use the client-centered process to develop insight and move towards a more integrated position as they come to more objectively symbolize their experience.

The Pluralistic Approach and Non-Client-Centered Components in the Therapy

The pluralistic therapy approach (Cooper & McLeod, 2010, 2011) is a framework that allows for the integration of different theoretical approaches through a process of collaboration with the client. Cooper and McLeod describe a process of assessing clients and deriving an agreed upon set of goals. Ways of working towards these goals, which may be selected from multiple theoretical orientations, are then discussed and agreed upon with the client. These goals and the ways of achieving them are then reviewed with the client throughout the process of therapy. They can be adjusted if necessary. It is reminiscent of the approach advocated by Duncan and Miller (2000).

It's important to note that the pluralistic model is an alternative to the established method of the U.K.'s National Health Service for defining an efficacious therapy. In this established definition, an efficacious therapy is one that (a) is based on a single theoretical approach, (b) requires the practitioner to follow a generically written manual focused on the client's primary presenting diagnosis, and (c) has been shown to be significantly better than a control in a number of randomized clinical trials. The British Psychological Society recently funded a pilot efficacy trial to test the pluralistic model in the treatment of depressed individuals so as to compare its results with those from studies using the established model with depressed individuals (Cooper & McLeod, 2014). Of particular interest in this study is the demonstration that adherence measures can be developed to assess whether a therapist has conformed to the stated principles of pluralistic therapy (McLeod, 2014).

The pluralistic framework allowed us to integrate a client-centered stance with more action-focused, rehabilitation-oriented, and psychoeducational interventions. The latter components consisted of a problem-solving intervention to help Judith recognize and deal with items of postal mail, use of automatic date prompts to overcome difficulties with remembering when sessions were scheduled, and training to use a prompt board at home to schedule important day-to-day activities, all as mentioned by Laatsch (1999).

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

As mentioned above, Judith, a 48-year-old woman, was referred to our university-based, community outreach counseling service. At intake Judith was very emotionally upset. Three months before her husband had walked out of their home, giving her almost no notice, and went to live with another woman. Judith and her husband were in the process of getting a divorce. In response to her husband's leaving, Judith had felt utterly abandoned, alone, helpless, and hopeless. She had had thoughts of harming herself, and had come close to taking action on these on a number of occasions.

Background

When Judith started therapy, she had been married for 25 years. There were three children from the marriage. The eldest was 24 and was living and working in France. The two youngest were non-identical twins, a boy and girl, both aged 21 and in the later stages of higher education, living away from home, but returning for vacations. Both of Judith's parents were deceased. There was a brother of about Judith's age, who was married. The brother provided a lot of support, for example, with the court proceedings around the divorce, and eventually Judith moved to live closer to him. Judith had also been receiving a lot of help and support from a local charity that aids people with head injury and which referred Judith to our clinic.

Judith had been employed in a highly responsible job within education. This had been until 10 years previously, when she experienced a moderate head injury while at work. A part of

the fabric of the building had come free, resulting in a glancing blow to the head. Reports at the time suggest there was a period of unconsciousness, although she had regained consciousness by the time an ambulance arrived. Judith recalls a period of post-traumatic amnesia lasting approximately 12 weeks in which she struggled to recognize her neighbors. Psychological assessment at the time indicated that there were some executive difficulties. She attempted to return to work but this turned out to be impractical. She found that she had difficulties carrying out some of the tasks required of her and being able to organize her work. She received a six-figure sum in compensation and was retired from work on health grounds with a disability pension.

In subsequent years Judith performed the role of homemaker. It is clear from her account that she needed considerable help and support from her husband to achieve some of the day-to-day tasks. Some routine tasks such as preparing packed lunches for the family required a great deal of effort and concentration and could take many hours.

Diagnosis

As mentioned above, King (2002) presents the psychological treatment of FS, a 47-yr-old male with co-existing post-traumatic stress disorder (PTSD), head injury, and mild executive dysfunction. King describes the detrimental consequences when the re-experiencing of a traumatic event appears to have become a perseverated response. In the King case, the perseveration meant that the most distressing part of the traumatic event became unavoidable and led to it being continuously re-experienced without remittance over a very prolonged period (7-10 days).

Within the context of the King case, it is important to consider whether Judith could be considered as suffering from PTSD. In terms of DSM-IV criteria part A (American Psychiatric Association, 1994), Judith felt a threat to her future physical integrity in that she did not feel she would be able to survive without her husband's support. There was no objective immediate physical threat or risk to life. Therefore, it could be argued that Judith should not be said to meet the criteria for PTSD. However, during therapy it became obvious that she was in considerable fear of her husband, and feared physical consequences from him, although there was no history of physical abuse. Judith did, moreover, meet all of the other criteria in DSM-IV of PTSD. She experienced recurrent and distressing recollections of the night when her husband announced that he was leaving her. This had led her to a sense of a foreshortened future. She had difficulty concentrating, which had lasted for more than one month, and the distress was impairing her ability to function on a social level.

In terms of her emotional reaction to her husband's leaving, as described above, Judith frequently recalled the moment when he announced he was leaving. On this recollection, Judith was overcome with intense feelings of despair, moving her to tears. She articulated her concern that without her husband, she would not be able to survive, and that she had depended on him for the last ten years. She described how when left to her own devices, it would take her many hours to complete a task. For example, she might be up well into the night making sandwiches for the family for the following day.

Judith experienced her husband as intimidating. For example, on occasions like the above when she was up late at night, she might well sleep downstairs for fear of disturbing him by going to bed. As mentioned, Judith voiced on a number of occasions that she could not see any future, and she had thought about killing herself. On one occasion she had started to take Paracetamol medication with the apparent intent of overdosing, but was disturbed by the neighbors.

Assessment of Current Executive Functioning

To assess the client's current executive functioning, two standard tasks were administered from the Wechsler Adult Intelligence Scale version 3 (Wechsler, 2000). These were the block design task and digit span. The respective scaled scores were four and seven, which suggest full-scale IQ scores of 63 and 70, respectively. In contrast she had a scaled score of 16 on the vocabulary subtest, suggesting an overall full-scale IQ of 134. This suggests that Judith's current level of executive functioning was very low compared to a high pre-morbid ability level.

Strengths

Judith's strengths lay in her good sense of humor, good intellect, and prior learning, and strong and abiding love for and support from her children.

5. FORMULATION AND TREATMENT PLAN

Formulation

Judith suffered a head injury some ten years previously, which left her unable to pursue her normal occupation, and experiencing some difficulties in the day-to-day tasks of running a home. She perceived herself to be very dependent upon her husband, who took responsibility for all the complex household affairs. There appears to have been very limited attempts to offer her rehabilitation immediately after the head injury, although there was a neuropsychological report that documented some memory and executive difficulties.

A pattern seems to have developed over the years whereby Judith perceived herself as dependent on her husband. She came to see herself as incapable of any independent existence without his support, and this led to her behaving as if she were "helpless" on her own, thus self-perpetuating her view of being dependent on her husband. While the relationship was not ideal in many respects, she was very emotionally dependent on her husband. Thus, her self-structure had become dominated by thoughts of dependence on her husband, partner, and of her inability to cope or carry out complex tasks without his help.

Treatment Plan

The treatment plan was therefore in two parts. First, a client-centered relationship would be offered to her so that she could process her emotional reaction to her husband leaving. This would allow her to fully experience her feelings, within the safety of the relationship.

Second, it was expected that over time the intensity of her feelings would subside, and she would be able to explore other aspects of her feelings besides the overwhelming sense of loss and despair. It was anticipated that as sessions unfolded, it would then be possible to move on to consider in more practical ways how Judith might be able to cope with the challenges of her everyday life, and how she might be able to make use of both other community resources and her children in being able to move forward towards a new, and as independent as possible, existence.

These two aims were expressed as two overriding goals, as per the pluralistic framework. Goal 1 was to not feel overwhelmed emotionally by her husband's departure, and this goal was treated with client-centered therapy. Goal 2 was to work on specific home management tasks to enable Judith to be as independent as possible in carrying out these tasks. This goal was addressed using the more action-focused, rehabilitation-oriented, and psychoeducational interventions described above.

6. COURSE OF THERAPY

Judith's therapy included a total of 65 sessions, with 43 in the first year at a once-a-week frequency, and 22 in the second year, at a once-every-other-week frequency. These 65 sessions fell into two phases, as described below.

The First Year, Sessions 1-43: Working With Emotional Trauma and Phasing into Practical Difficulties

Initial Working With Emotional Trauma

Following the initial assessment, the therapist and Judith agreed that her initial main goal was to process and come to terms with the trauma represented by her divorce. A traditional client-centered approach was used to help Judith deal with this trauma. The therapist carefully reflected Judith's narrative while facilitating her experiencing of the associated emotional states. This approach dominated the first eight weeks of therapy.

Judith's statements in this early phase tended to revolve around the initial trauma of the separation, her huge sense of loss, and her fear for the future. For example, in relation to the initial shock of her husband revealing that he was leaving her, she said:

I never used to have panic attacks before, the first one was the first night after he told me, I went to bed and I was really upset, and [my husband] came home from seeing his lady and it was sometime like half one in the morning and he got into bed with me and I was crying but when [he] got into bed I tried to even cry quietly because I was so scared 'caus he controlled me about noise.

And also:

I was really scared and then I uhh (tears) I went downstairs and I just decided I couldn't cope anymore—I tried the best I ever could, a super human effort all my life and it wasn't good

enough—I decided I was going to take all the tablets to commit suicide and I was going to but (hmm) [he] came downstairs.

Judith's utter despair at this development was reflected in her recollections of thinking about committing suicide:

One of the neighbors stopped me from committing suicide. It was the twins' godmother, she came over to see how I was and I didn't know she was coming over and it was the first day [the twins] weren't at home and just after [my husband] had told them so it was quite close to the event, and, err, I just couldn't cope anymore 'caus actually I had done my absolute absolute best.

In relation to her fear for the future and not being able to cope, she on one occasion used the metaphor of trying to swim in a lake:

I feel like it's like being in a big lake and only just being able to breathe (hmm), and I can't get out of the lake, 'caus I need somebody to throw me a rubber ring, something to show me how to get out of what I am in, and I just want somebody to, to (tearful) tell me, tell me how to learn what I've (hmm) lost so I can run my own house.

Some of her negative views of the future seemed to stem from beliefs she had acquired from her ex-husband, e.g., in relation to whether she would have any friends:

Because [my husband] said to me you've got no friends, nobody would want to know you or speak to you, you haven't got any friends apart from my friends.

By the fifth session, the client's narrative was beginning to change. To the therapist it seemed as though the emotional trauma was losing its raw edge, as though the client had come to accept and acknowledge these feelings. She was hearing other aspects of her story being reflected back, and this was bringing other feelings to the fore. Judith was re-evaluating the relationship she had endured over the previous years with her husband, and beginning to feel anger at some of the ways she had been treated. These signs of movement were reassuring to the therapist, since on the one hand it suggested that Judith was not going to experience the preservative negative trauma outside sessions that King's (2002) client FS had, and secondly, that Judith was able to access growth processes and go beyond blaming herself. For example she said:

I just had to stay at home and do all the work—bit like Cinderella, I've just thought of that—while he [my husband] went out and bought anything he wanted, best he wanted, the children said if he ever wanted anything he always had the biggest and best.

In reviewing her past relationship, and through acknowledging the anger she now felt, Judith was able to question many of the assumptions she had accepted over the years. She realized that many of these notions had been planted by her husband, who had not given her opportunities to relearn some of her previous skills. For example she said:

[My husband] said I would never have any friends, but look I've got loads of people looking out for me and trying to help—I've been amazed.

Inability to Deal With Housework

After eight weeks of therapy other issues began to emerge in the narrative that were taken up and worked with using other strategies by the therapist in collaboration with the client. In particular, a key issue that came up many times was Judith's inability to deal with household paperwork. For example, she said:

It was half past seven and there were two papers still and I picked them up and I thought right two more papers, that's all I've got to do and I've done it, I feel awful but I've done it, and it was a real sense of maybe I can do this and I turned around, ... and everything that I had sorted through that whole day..., was behind me... and I just burst into tears.

Here she is referring to how she spent an entire day trying to sort through paperwork, only to realize at the end that all she had done was lay them out in a big trail behind her.

Memory Prompts

Given that Judith was frequently late for sessions due to her memory difficulties, an SMS cell phone text system was implemented in the 17th session that reminded her each week just ahead of each session. This reduced the number of sessions missed quite considerably, although a chi-square analysis did not show that the change was significant.

Executive Difficulties and Therapy

It was evident during therapy sessions that Judith's executive difficulties had an impact on the therapeutic dialogue. Judith's statements were considerably longer than typically experienced. There was also a great deal of repetition within a particular utterance, and across utterances within a session. To determine the extent to which this was objectively true, a comparison was made between the average length of Judith's utterances across the first five sessions compared with a head injury client without executive difficulties. For Judith, the average number words per intervention was 244.3, with a standard deviation of 242.4, while the comparison client had an average of 115.1 words per intervention and a standard deviation of 100.4. (These high standard deviations reflect the very wide variations in actual utterance lengths.) The difference was statistically significant ($t = 4.4, p < 0.05$).

This issue was discussed at some length in clinical supervision, and it was decided by the therapist that it would be more facilitative for the client if some of the repetition was circumvented, thus helping the client to process a greater amount of material during the session. The therapist attempted to avoid this repetition by acknowledging points that the client had already made, thereby allowing the conversation to move forward. For example, if Judith began to reiterate a previously made point previously about how long it took her to make the family's meals, the therapist might prompt with "uh-huh, as you've said, it took ages to get the family meal prepared." A previous case report had also illustrated how repetitive speech can be

problematic in therapy for clients with executive dysfunction and required specific interventions to reduce such speech (Alderman & Ward, 1991). (Of note, in this previous case positive reinforcement and extinction were not sufficient in reducing the frequency of intrusive speech, while response cost and cognitive overlearning were. These latter procedures were not required in Judith's case.)

End of First Year, Assessing Progress Within the Therapy Process

At the end of the first year of therapy we wanted to make an objective assessment of whether Judith had been making progress, because we were concerned that additional therapy would be undermined by Judith's potential to perseverate on her difficulties and to express negative perceptions about her coping ability. Specifically, as a baseline, we had taped and transcribed sessions 1-5 by counting different verbal behaviors, specifically, positive and negative coping statements and suicidal ideation. Positive coping statements were any expression by Judith that indicated she was able to do something or expressed a positive outlook on her current situation. For example, Judith might say, "I have lots of friends now," or "I managed to get my car tax sorted out." In contrast, negative coping statements were expressions of not being able to do things or having a negative outlook. For example, "I'll never be able to sort out my house move," or "I'm never going to be up to cope with my financial affairs." Suicidal ideation was any expression linked to possible current or future intentions to harm oneself, for example "Sometimes I just think I'd be better off out of it all."

As a comparison to the baseline verbal behavior rates, we audiotaped and transcribed sessions 39-43 and analyzed them for the same verbal behaviors.

To determine the reliability of our counts of verbal behaviors, the sessions were broken down into 10-minute segments, and a correlation carried out between the two subsets of ratings across all 10 sessions. The reliability correlations were very high: for positive and negative coping statements, .97 and .95, respectively, and for suicidal ideation, .95.

An independent measures t-test was used to compare the total session ratings across the first five sessions compared with the last five sessions at the end of year one. These results can be seen in Table 1. There were statistically significant differences in the expected direction for all three sets of ratings. Thus, compared to the rate in the initial sessions 1-5, in the last sessions 39-43 Judith was making more positive coping statements (12.4 to 1.6 per session, respectively); fewer negative coping statements (62.4 to 33.0 per session, respectively); and fewer statements reflecting suicidal ideation (6.2 to .8 per session, respectively).

These positive results were taken as evidence that Judith had made important progress in not perseverating on her difficulties, nor expressing negative perceptions about her coping ability, nor making statements reflective of suicidal ideation. Based on this evidence, the therapy continued into a second year.

***Second Year, Sessions 44-65: Working With External Agencies and Supporting
Judith to Move On with the Practical Aspects of Her Life***

After one year Judith began rehabilitation work with a local head injury charity, and therapy sessions were reduced to once every two weeks. These final 22 sessions continued to address Judith's emotional trauma and reintegration using a client-centered method, but additional problem-solving interventions were also introduced, as described below.

During this time, the rehabilitation agency worked with Judith and her therapist to consolidate the approaches and gains she had made previously. Judith was also supported in going through the process of divorce, and selling and moving from her house. In relation to the latter she said:

I just don't know how to go about it, I can't make any decisions. How do you know how much you should ask for? Do you just take what the estate agents tell you? I can't decide what I want, or where I should go.

This illustrates the real difficulties Judith had in making rational decisions and sticking to them. She tended to become stuck at such points, leading to an inertia and lack of progress. However, at this point it was also becoming evident that the client's family and adult children were becoming more active in stepping in and helping Judith to move on, for example by exploring housing options with her and taking her to view available properties.

Given that Judith's husband had previously managed the complex affairs of the family, Judith was, for the first time, having to try and cope with running the household, dealing with financial matters, etc. It began to become apparent that this was causing her a great deal of distress and so gradually these issues became part of the focus of the sessions. An indication of her difficulties is apparent from this quote, in relation to a bank letter, which gave details of how a sizable investment had been moved into a new, more advantageous account:

My next door neighbor was helping me sort through my mail, and he passed me that and said it was important, and to put it somewhere safe—I didn't have a clue what it was...

[And further on she said:]

So this is quite a lot of money? Can I get it? Is that a good thing to have done with it?

This illustrates that Judith was not able to identify what different pieces of mail and paperwork related to, nor was she able to deduce what if any action she might need to take, e.g., in response to a gas bill. Her concerns about her paperwork were addressed through the following intervention.

Initially a volunteer from the agency visited Judith at home to assess how she was coping in her daily environment. Following this a number of strategies were put in place. This included a whiteboard prompting system together with a notice board and calendar for managing appointments. Working closely with Judith, a filing system was developed into which mail could

be placed for future reference. A mail identification system was devised so that Judith would be able to determine what different items of mail were and how they should be dealt with. To evaluate this intervention a baseline was recorded of how many items of mail Judith was able to successfully identify before and after development of the system. Before she was able to identify 5 of 36 items of mail. Afterwards, some six months later, this improved to 17 of 45 items of mail. A chi-square analysis showed that this improvement was significant (Yate's Chi Square = 4.6, $p < 0.05$).

The therapy relationship ended after two years, at which point Judith had moved into a new house and was being well supported by her family. In the initial session, Judith seemed very uncertain about the setting and the likelihood that the therapist could help her. However, this quickly changed, so that the therapist and supervisor perceived a very positive relationship between the therapist and Judith. What seemed particularly important in establishing such a relationship was Judith having another person who patiently listened to her and showed empathy and respect for her personhood and her plight. At first, consistent with her clinical picture, Judith was very unsure of herself and dependent on the therapist. As she gained more confidence, she showed more assertiveness and the therapeutic relationship became more collaborative. At termination, Judith was sad about ending therapy but accepting that she was ready to cope on her own, with the support of her children and friends.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

As mentioned above, this case was conducted by the first author (TW) and supervised by Peter Hudson. Supervision sessions were scheduled on a monthly basis. Supervision sessions were structured to consider progress on the work with the client, and exploration of any difficulties or concerns. Therapist notes were brief summaries of the issues discussed and pointers for future sessions, recorded immediately at the end of every session.

Also described above, sessions 1-5 and 39-43 were audio-taped and analyzed for positive and negative coping statements and suicidal ideation, to assess after one year whether progress was being made and that therefore whether therapy should continue.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Quantitative Measures of Outcome

As mentioned above and shown in Table 1, during the first year Judith showed statistically significant gains in positive coping statements within each session and reductions in negative coping statements and statements reflecting suicidal ideation within each session.

The outcome of the therapeutic intervention at the end of therapy after two years was assessed using the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2000). The results are shown in Table 2. Each scale was evaluated on Jacobson,

Follette, and Revenstorf 's (1984) Reliable Change Index at one year versus before therapy, and at two years versus before therapy. That is, the change on each scale was assessed in terms of whether it met the following criteria: (a) the change in the scale scores over time was statistically significant; and (b) over time Judith moved from being above the clinical threshold on the scale to being below that threshold. Results meeting the first criteria alone are considered as showing "reliable change," and results meeting both criteria, as showing "clinically significant change."

As seen, after one year Judith's scores on all the major dimensions of the CORE-OM moved in a positive direction towards the subclinical threshold, with two (the Function and Risk scales) showing reliable change, but none showing clinically significant change. These observed changes did reflect the fact that Judith was experiencing a greater degree of well-being, was less overwhelmed by her problems, was feeling more able to function, and expressed less of a tendency towards self-harming impulses.

At the two year point, the CORE-OM scores had continued to move, such that reliable change was now evident on all scales, and this change could be classified as clinically significant change for all dimensions except Well-Being, which was still slightly above the clinical threshold.

Qualitative Indicators of Outcome

As discussed above, in qualitative terms, at the end of therapy Judith subjectively appeared to be more confident and less emotionally distressed. Behaviorally, she was attending community-based rehabilitation, had completed her divorce, had successfully moved into a new house, and was able to cope on a day-to-day basis with support from her children.

Discussion

It is clear that Judith's executive difficulties had a significant impact on the process of the therapy. Her utterances tended to be lengthy with considerable repetition. In response, the therapist was successful in helping Judith to short-circuit this repetition by actively and explicitly acknowledging points that had already been made. Overall, Judith's case study illustrates how a client with significant executive difficulties can be helped in psychotherapy, as indicated by her impressive quantitative and qualitative outcomes, outlined above.

Judith's case illustrates how a client with executive difficulties can make use of a fairly nondirective therapeutic strategy to process and come to terms with emotional trauma. This is therefore counter to King's (2002) case of FS that illustrates how some such clients can experience difficulties in processing trauma due to their inability to inhibit perseverative thinking around the trauma outside of therapy sessions. It should be noted that, in contrast to King's case, Judith did not achieve a clearcut diagnosis of PTSD, although she met most of the criteria. The question is around the degree of Judith's perceived threat to her physical integrity on the night when she found out about her husband's intention to leave. It will be interesting in the future to build up further cases of similar clients, in order to determine whether there are particular

distinguishing features of those clients who have the kind of difficulties observed in King's (2002) case. For example, there might be a particular neuropsychological profile that will predict such issues.

In Judith's case, it can be seen how the client was able to successfully process the impact of the trauma. In terms of client-centered theory, it would seem that Judith was able to perceive the core conditions of empathy, congruence, and unconditional positive regard, and to access her own innate self-actualizing growth processes (Rogers, 1951). By session eight it was apparent that her initial highly charged emotions were lessening and becoming redefined. This is consistent with Joseph's (2005) suggestion that trauma produces a disruption of the self-structure, which clients can restore through a process of reintegration.

Thus, in Judith's case, her sense of self included notions of not being able to cope, and of her life collapsing around her without the support of her husband. On re-examination, she comes to see that in fact her life with her husband was far from pleasant, and anger comes to the fore as the dominant emotion. (It is relevant at this point to compare the notion of self-structure with the notion of schema and Young, Klosko and Weishaar's [2003] related view that anger is often involved in moving on from maladaptive schemas.)

Judith is then able to re-evaluate her self-structure and assumptions, and to come to a reconciliation of self and experience. From this perspective, the therapist felt able to work with Judith to move on to and to examine other issues as they became apparent. These revolved around Judith's anxieties about her future ability to manage her finances and household affairs. As described above, various practical, supportive strategies were put in place to help Judith deal with some of these concerns. By the end of therapy, Judith had successfully made a number of important life changes and was still receiving rehabilitative support from another agency.

This study therefore also illustrates how a formulation, based on knowledge of the effects of brain damage, can be used flexibly and creatively to guide the incorporation of techniques from cognitive rehabilitation into psychotherapy (Lewis, 1991; Langer, Laatsch and Lewis, 1999; Laatsch, 1999).

In terms of the limitations of this case study, clearly this was a complex intervention involving multiple strategies, including external rehabilitation in year two. Therefore, we cannot be certain which specific aspects of the therapy are responsible for Judith's change. However, it is important to highlight that the focus of the early sessions was on a pure client-centered way of being with Judith. This was intended to enable her to process her initial very high levels of distress. In our view, if this had not proven effective, then Judith would not have been able to move forward and benefit from the additional approaches introduced later. On the other hand, although the therapist had practiced from the client-centered approach for a number of years and while the therapist was clinically supervised by a psychologist highly experienced in the client-centered approach, we did not use formal fidelity checks to ensure that these early sessions were faithful to the client-centered method.

In sum, this case study illustrates the importance of careful reflection upon and evaluation of strategies and outcomes when working with clients suffering from head injuries. There is considerable need for additional research—both at the group level and the case-study level—looking into the factors that determine effective therapeutic outcomes with neurological client groups. In relation to client-centered theory and practice specifically, it is important for future research to investigate in what ways particular conditions impede or facilitate first, a client's perception of the core conditions of the therapist's empathy, congruence, and unconditional positive regard; and second, a client's access to the processes of self-actualization.

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Table 1. Mean (and SD) for Process Scores for Sessions 1-5 Versus 39-43

<u>Process Rating</u>	<u>Sessions 1-5</u>	<u>Sessions 39-43</u>	<u>Significance</u>
Positive coping statements	1.6 (2.3)	12.4 (3.9)	p <0.05
Negative coping statements	62.4 (8.9)	33.0 (9.1)	p <0.05
Suicidal ideation statements	6.2 (3.8)	0.8 (1.1)	p <0.05

Table 2. Before and After Average Item Scores on the CORE# Dimensions

Dimension	Before	At 1 Year	Change from Before	At 2 Years	Change from Before	Clinical Threshold	Reliable Change Level
Well-Being	3.5	2.5	1.0	1.8	1.7*	1.72	1.34
Problems	2.8	2.0	0.8	1.4	1.4**	1.59	0.84
Function	2.4	1.4	1.0*	1.0	1.4**	1.29	0.85
Risk	1.5	0.5	1.0*	0.3	1.2**	0.31	0.97
All items	2.5	1.6	0.9*	1.1	1.4**	1.48	0.52

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2000). Higher scores indicate greater pathology.

* The degree of change on these items can be judged as "reliable change," according to Jacobson et al. (1984), with subsequent correction by Christensen and Mendoza (1986).

** In addition to reliable change, these items show a change from above to below the clinical threshold, meaning these changes meet the criteria for "clinically significant change," according to Jacobson et al. (1984).