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Guiding a person with a diminished sense of the meaning of life, applying Cognitive Behavior Therapy with special emphasis on the Therapuetic Alliance

Randi Brevik

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Summary

Therapeutic alliance is a key element in Cognitive Behavior Therapy. As a social educator I see the value in the empathetic and compassionate approach. I will share a story of my encounters with Anna when I guided her using the principles of Cognitive Behavior Therapy.

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1.0 Preface

The journey fueled by my need to understand human behavior and get a sense of balanced mental health, started many years ago as a young child growing up in Chicago. Born the youngest of six, I knew the hurtful feeling of not being seen, heard, or understood all too well. An alcoholic father, a distant mother and much older siblings finding themselves in dysfunctional relationships gave me plenty of time to practice the art of observation since no one seemed to notice me as I twirled around in the background. Still to this day, I feel that little girls hectic need to be "understood" has forged how I think and feel of myself and others over the years. When I am not conscious of these behaviors, I too can get stuck.

You might ask yourself what does this have to do with guiding a person in therapy with the emphasis on therapeutic alliance? The only logical connection for me is the importance that I put into how we as humans relate to one another and to the thoughts and feelings we have of ourselves and our world. The importance in understanding the world of that other person, have empathy for what that person is going through to obtain simple human connection, and to practice therapy in the best way possible. How wonderful it must feel for a struggling client to be have established an alliance with a therapist whose only objective is to help them get unstuck. To be heard. To be seen. To be understood.

My interest in human behavior since childhood has led me on a path of both practicing yoga and meditation. I led a small enterprise as an Aromatherapist, where I offered mindfulness and several motivational techniques based on cognitive and behavioral principles. I apply an eclectic blend of value-based humanistic approaches such as the teachings or writings of Kierkegaard, Immanuel Kant, Carl Rogers, Abraham Maslow, Eckhart Tolle and Jon Kabat Zinn. As a professional therapist I carry a bachelor's degree as a Social Educator, also employing the principles of Acceptance Commitment Therapy (ACT) a values-based cognitive therapy. As part of my continuing education in Mental Health, I have chosen the topic of this paper to convey the significance of obtaining and sustaining a healthy therapeutic alliance, something that has guided me in encounters with clients over the years. I doubt I would have enjoyed the positive feedback or sense of compassion had I not taken the time to establish empathy, genuineness, and emotional ties with my clients. A therapeutic alliance.

2.0 Introduction

Therapeutic Alliance – a therapeutic relationship- compassion

The practice of therapeutic alliance is a term primarily used in my psychotherapy of choice, Cognitive Behavior Therapy (CBT). Several other psychiatric approaches use similar concepts of therapeutic alliance. In Carl Rogers' world of person-centered therapy, the art of therapeutic alliance communicates itself as the therapeutic relationship: working with *empathy, congruence, authenticity, and unconditional positive regard.* In self-psychology (Kohut), therapeutic alliance expresses itself as *empathy*, an ongoing process of engagement. This means understanding the other persons views as you contemplate your own reactions to the thoughts and emotions the client is sharing. In Acceptance Commitment Therapy, a method that promotes psychological flexibility, we often use the term compassion.

I only mention these qualities above in order to highlight the fact that I have noticed that there are more comparations within the various psychotherapy approaches than there are differences. The therapeutic relationship is regarded as an important factor in psychotherapy now more than ever. The archaic concept of a man with a pipe and a beard taking notes and donning the expert robe, while his client lies on a couch with his back towards him has thankfully been replaced with a more humanistic flavor. Thank you, Carl Rogers. Thank you, Beck.

Seeking help for mental health issues can be problematic for many. They might doubt the process or have little knowledge of psychotherapy. Perhaps they feel coerced into treatment, or even feel shame. If I can provide the client with a sense of self-determination and respect, where they feel safe and are allowed to be the expert of their lives, perhaps it makes it easier for that client to start the journey towards therapy. There are studies (Norcross 2002) that indicate that when a client perceives the therapist as empathetic, genuine, respectful, and understanding, it increases the likelihood of the therapy going favorably. I have experienced this firsthand, not only as a therapist but also as client. Being met with positive regard and a wish to understand "me" made all the difference. In this study I aim to put emphasis on the therapeutic alliance as applied in Cognitive Behavior Therapy, which holds the most essential principles that I use in my field of work.

I am familiar with the principles of Cognitive Behavior Therapy, and they make sense to me. As I was reading Anna Kåvers` book Alliance- *The therapeutic Relationship in CBT* (2012) I realized that she essentially was illustrating my personal working methods, achieve an awareness to one's thoughts, emotions, and behavior.

2.1.1 Aims of Study

I have continually strived to be conscious of the manner in which I approached my clients, striving to establishing trust and comfort. I have experienced not just the positive, but also negative outcomes when I was not present or available in the moment. This was mostly due to the lack of establishing or maintaining a therapeutic relationship, although sometimes the client was not motivated or had far too many complex issues. During my current studies, the curriculum has been focused on four separate psychotherapeutic approaches. I was familiar with most of them, but it soon became obvious to me that the most central common denominator was not in the method, but in the manner the various approaches were applied by the therapist: with a therapeutic attitude. Qualities like establishing a relationship, applying sound communication skills, the ability to put oneself in the other persons shoes, showing empathy and genuine interest and conducting oneself in a non-directive fashion. A therapeutic relationship. An alliance.

I am previously familiar with the psychotherapeutic method Cognitive Behavior Therapy. I wished to explore and outline the principles I used in guiding Anna. In addition, I was also curious as to what sort of research existed on the significance of the therapeutic alliance in Cognitive Behavioral Therapy, and what sort of impact it could have on the outcome of therapy. If I had experienced the value, then surely others had studied the matter? I will not be conveying a manual on how to apply Cognitive Behavior Therapy or therapeutic alliance. I simply intend to portray the main principles, theories and guidelines used in my line of work.

Guiding a person with a diminished sense of the meaning of life, applying Cognitive Behavior Therapy with special emphasis on the therapeutic alliance

There are three questions I would like to address in this study:

1. How to establish, nurture and maintain a therapeutic alliance working with CBT?
2. How significant is therapeutic alliance in working with CBT?
3. What are the natural strategies in guiding a person experiencing an altered sense of the meaning of life?

2.2 Literature search

The process of collecting information to validate my study had me turn to many of the books I already own, accompanied by literature used in my current studies and books I have borrowed from the library at Molde University College. In addition, I utilized reference lists from some books that had relevance to the topic, i.e. *Berge & Repål, Kåver, Beck, Hayes, Eide & Eide etc.* I searched for these online to examine them closer for information that might be helpful. I made online searches for empirical studies, reviews, and meta-analysis through portals such as BIBSYS, ORIA and Google Scholar using the following key words:

Benefits of therapeutic alliance* - *therapeutic alliance in CBT* - *alliance* - *CBT* - *mindfulness* - *reflection* - *trust* - *empathy*- *communication* - *therapeutic relationship* - *psychotherapy outcome* Relationship in psychotherapy* *working alliance

I considered the narrative with Anna as an additional empirical reference point. I was aware that my investigations into therapeutic alliance might be biased since it already had a place in my toolbox as a Social Educator and ACT therapist. I intended to stay curious and open minded to what the literature, references, studies, and analysis might reveal. I simply intended to understand how things work or at least how they come about.

There were literally hundreds of studies, reviews, books, papers and meta-analysis on the effect, the application or outcome of therapeutic alliance in therapy, yet not specifically bordered as therapeutic alliance in Cognitive Behavior Therapy in general. I found articles and research where Cognitive Behavior Therapy connected to specific disorders or diagnosis. I found articles and studies on "working alliance in psychotherapy" connected to anxiety, trauma, depression, bipolar disorder, trauma, cancer, etc. I simply wanted to explore the significance of the alliance in therapy, and how to guide a person who has lost her way. Therefore, there is no specific disorder or mental illness tied to the Cognitive Behavior Therapy guidance I refer to in this study. To me, Annas issues seemed more existential in nature rather than pathological. There were several reviews, articles, and meta-reviews from the early 90`s, for example Bordin (1994). I did manage to find a recent meta-analytical review by A. Soto (2017) that investigates the association between therapeutic alliance and the outcome of psychotherapy

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2.2.1 Overview

Title

Guiding a person with a diminished sense of the meaning of life, applying Cognitive Behavior Therapy with special emphasis on the therapeutic alliance

Theory - Therapeutic Alliance and Cognitive Behavior Therapy

In the first part of this study, I will submit the principles and implementations of the therapeutic alliance, followed by central theoretical and practical components of traditional Cognitive Behavior Therapy. I refer to the reviews and articles that I found, which may shed some light on the therapeutic alliance in Cognitive Behavior Therapy.

Narrative

In the narrative, I share the story of my encounter with Anna, a divorced mother of two experiencing life changes that would eventually lead her to my doorstep for therapy and guidance. The information outlined in the narrative gives only a snapshot of her life.

Discussion

In this section, I theoretically examine how to apply central components of Cognitive Behavior Therapy while establishing and nurturing a therapeutic alliance. Anna is woven in throughout the theoretical and practical parts, to demonstrate my understanding of employing Cognitive Behavior Therapy with an emphasis on the therapeutic alliance.

Conclusion

I will share my reflections on guiding Anna, and some thoughts on therapy.

3.0 Therapeutic Alliance and Cognitive Behavior Therapy

3.1 Therapeutic Alliance

There have been countless definitions of the term "psychotherapeutic alliance" over the years. I look to Bordin (1994) and Kåver (2012) who offer a simple definition of the term therapeutic alliance as applied in Cognitive Behavior Therapy. There are three simple and mutually dependent factors to look for.

- An agreement on which goals to strive for
- An agreement on which methods to use towards those goals,
- An ongoing emotional bond characterized by warmth, mutual trust, and collaboration.

Developing and using the therapeutic alliance, according to Beck (2005), requires that the therapist follows certain cognitive therapy principles, all the while assessing the degree of workability. Here is a summary:

- Actively collaborating with the client – the therapist works as a guide and jointly work as a team with the client. Their engagement and motivation are essential.
- Demonstrate genuine empathy, caring and understanding: Being mindful that caring or being too positive can also be uncomfortable or feel condescending to some.
- Adapt the therapeutic style- if the client seems uncomfortable with the therapist's style, then one needs to modify the approach.
- Alleviate distress- can strengthen the alliance when the client feels improvement due to the therapist's guidance.
- Elicit feedback at the end of sessions- The client's reactions to therapy provides information for effective therapy. "*What did you think about today's therapy", "Anything you would like to do differently?"*

(Beck 2005: 63-68)

3.1.1 Therapeutic alliance in Cognitive Behavior Therapy

I have assembled extracts of abstracts from three empirical reviews and one meta-analytical review, research that I collected as part of my literature study. I would have liked to find more relevant research on the significance of therapeutic alliance in Cognitive Therapy. The research indicates that statistically, the therapeutic alliance seems to be a predictor of improved outcomes (Soto 2017). It also would appear that Cognitive Behavior therapists obtain high scores in the therapeutic alliance, transparency, and empathy (Langhoff et al 2008). Relationship factors have a consistent but moderate impact on CBT outcome (Keijsers et al 2000).

"*The quality of the therapeutic alliance was compared in sessions of psychodynamic- interpersonal and cognitive- behavioral therapy….. Results indicated significantly greater alliance scores for cognitive-behavioral sessions on the whole"*

*Raue et al (1997)

"The therapeutic alliance has consistently been associated with improved client outcomes across numerous psychotherapy outcome studies….. After accounting for therapeutic alliance, therapist empathy was a small but statistically significant predictor of improved outcomes"

*Soto (2017)

"Empirical studies are reviewed, the aim being to investigate characteristics of the therapeutic relationship in cognitive-behavior therapy (CBT) and to identify therapist or patient interpersonal behavior that affects treatment outcome…..it is further concluded that relationship factors in general have a consistent but moderate impact on CBT outcome.

*Keijsers et al (2000)

"The therapeutic alliance is seen as an important dimension in any type of psychotherapy…. Cognitive behavior therapists attained high positive scores in all perspectives for all dimensions of the therapeutic alliance, such as empathy, cooperation, transparency, focusing, and assurance of progress.

*Langhoff et al (2008)

In my opinion, there seemed to be an apparent consensus in the world of research, that the therapeutic alliance or therapeutic relationship, is essential in the application and outcome of therapy not only in Cognitive Behavior Therapy, but in psychotherapy in general. I would like to see more research on the value of the therapeutic alliance in psychotherapy.

3.2 Cognitive Behavior Therapy

"Man is disturbed not by things, but by the views he takes on them" Epictetus (AD 55-138)

Cognitive Behavior Therapy is a structured manual-based therapy method that aims to create change in one's own thoughts and feelings. A cognitive model mainly developed by psychologist Aaron T. Beck in the 60s` based on his research on depression. Basically, there are three key goals in treatment:

- gain control over the problem
- understand what has sustained them
- find ways to prevent new problems

Aaron Beck was influenced by clinical psychologist Albert Ellis's research and method known as Rational Emotive Behavioral Therapy (REBT), a theory that shows how people can behave both rationally and irrationally. On one hand, people possess the potential to be positive about new things, to be tolerant and learn from our mistakes. On the other hand, they tend to procrastinate, show intolerance, or avoid thinking things through. Basically, people rarely act without thinking or think without feeling (Nielsen & Lippe 1993).

Bach & Moran (2012) conveys how REBT suggests that when a client holds an irrational belief about life events, she is more likely to have negative feelings and act dysfunctional. If she can replace those with rational and functional beliefs, she might behave with less negatively when presented with hardship. Beck presented Cognitive Behavior Therapy, a comparable type of clinical intervention that proposed how individuals are emotionally affected by the manner they cognitively distort interpretations on their world, their future, and their self. (Bach &Moran 2012:26). Cognitive Behavior Therapy has some of its roots in *behaviorism*, operant psychology to be more specific. (Haugsgjerd et al. 2009). We have only to look to the central principles of the ABC model used in Cognitive Behavior Therapy to see the connection. *(fig.1).* Present-day methods, however, seem to be influenced by *humanistic values*, recognized in what we know as the therapeutic alliance. Haugsgjerd (2009) mentions how relationships between individuals, a client and therapist for example, can be existential and social in nature. When two individuals meet as their true selves, as equals, and with mutual respect, that can create possibilities of increasing one's ability of understanding, acceptance, and obtain nuanced perspective.

Cognitive Behavior Therapy was back in the day considered a short-termed, structured, and directive type of psychotherapy, which limited itself to treatment of symptoms such as anxiety or depression. Although the client- therapist relationship was certainly a factor, it was not until a few decades ago that the focus on therapy became far more experience-oriented, and the therapeutic relationship was considered an essential factor in therapy (Nielsen et al. 1993).

It has become a popular method worldwide, used in many settings and for several types of disorders or phobias. Somatic and psychological disorders such as panic disorder, fibromyalgia, tinnitus, have successfully been clinically treated by Cognitive Behavior Therapy (Eide & Eide 2011) and Beck (2012). There are various therapeutic techniques in therapy such as role play, exposure training, social skills training, relaxation exercises, or homework such as mapping and journaling one's thoughts and feelings related to certain situations.

In the characterization of Cognitive Behavior Therapy as a manual-based method, it simply means that there is a certain order and structure in the strategies and concepts that help to pinpoint effective therapeutic strategies. The manner in *how* to implement the therapy is an ongoing process, keeping eye on the therapeutic attitude.

Bach & Moran (2009) explain how gathering information includes finding environmental influences, integrating assessment data, developing treatment goals and treatment plans are primary goals in the early stages of intervention.

- The first would be to establish an alliance- trust, empathy, candor- with the client
- Assessment data- gathering information- with the client
- Creating a conceptualization of the client - with the client
- Determine what schema (negative automatic thoughts or beliefs) and strategies that are influencing the client's behavior - with the client.
- According to beliefs and strategies, determine possible therapeutic strategies-with the client.
- Agreements on the what, the how and the when of therapy- with the client
- Consecutively evaluate the progress and experiences of therapy- with the client

3.3 Cognition and the Cognitive Mental Processes

The philosopher Immanuel Kant encouraged the idea that we give shape to our own experiences and perceptions, which are characterized by our minds. The mind works as pair of colored glasses easily influenced, rather than that of a mirror that passively reflects reality. We create cognitive, cultural, and social forms in our minds, which appear in our thoughts, feelings, and behaviors. This describes the use of schema in the cognitive model. Our prior experiences and thoughts all play a part in how we view the world.

Cognition is the term for how the brain constantly processes information and connects to the way in which we think. The term refers to our inner language that involves activities such as planning, worrying, fantasizing, analyzing and even judging. There is an ongoing internal discussion as to how things will unfold, a *scenario*, which often happens unconsciously. Cognitive behavior is connected to prior experiences, conclusions, and memories (Corsini, et al. 2010). Berge & Repål (2008) explain, that if you initially have *a negative* outlook on life due to poor self-esteem, anxiety or illness, the attention will then be directed to interpret the information negatively. This negative attention can generate emotions such as fear, disappointment, sadness, withdrawal, or irritation. These are known as emotional strategies.

These might cause bodily sensations such as abdominal pains, heart flutters or shortness of breath. If the mind decides that the information is *positive*, it can awaken feelings such as joy, contentment or curiosity which also may well lead to similar sensations I mentioned above, such as heart flutters or tingly feelings in the gut. These are known as physiological reactions. (Berge & Repål 2008).

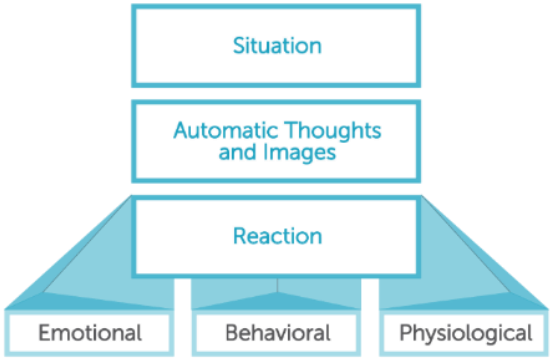

Fig 2 *The cognitive model illustrates the theory of Cognitive Mental Process. (Beck 2005)*

3.3.1 The Cognitive Model- ABC

The cognitive model, better known as the A-B-C model, is used in Cognitive Behavior Therapy to uncover how individuals react to activating events or situations.

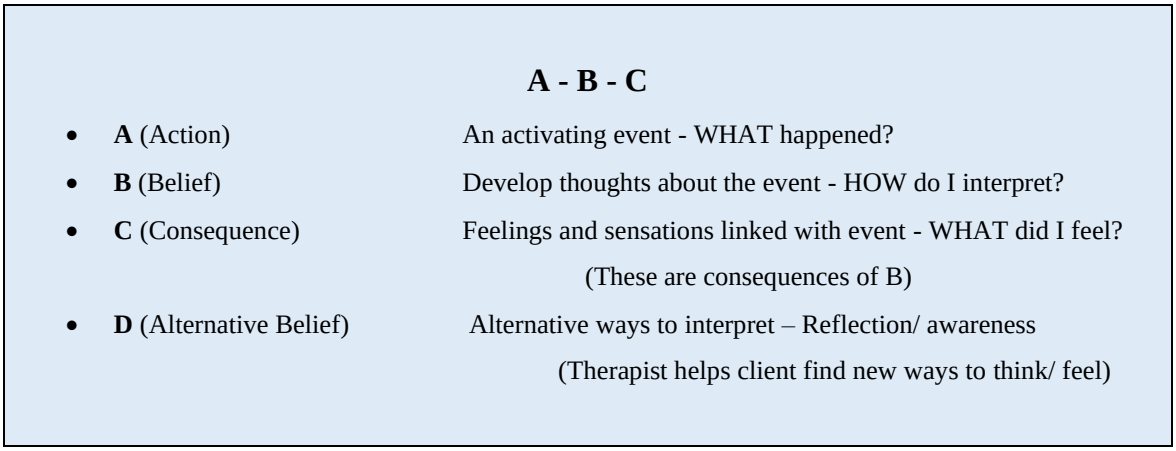

Fig 1

The CBT model shows an activating event occurs **(A)** (*stimulus)* and the client has an inner reaction, a belief about the event **(B***) (organismic response)* that leads to responses **(C)** (*functional or emotional*). These responses can lead to emotional, behavioral, or physiological strategies. Bach & Moran (2005) explain that case conceptualization in CBT typically focus on assessing, then changing what the client believes (the **B)** by showing that their core beliefs, schema or thinking patterns might be irrational.

3.4 Socratic conversation

There are many ways to correct misconceptions, whether it be physically through exposure, or verbally disputed by way of Socratic conversation (Bach & Moran 2005:80-86). Socratic conversation between the client and therapist is an effective tool where the therapist engages in counter questioning the client's negative automatic thoughts, core or global beliefs, and strategies. For instance, thoughts like *"If I go on stage I will die"*. The therapist can, in a compassionate manner, challenge that statement by posing different questions that allow her to either investigate worst case scenario or highlight situations where she has NOT died. The goal is to help the client think rationally and normalize, all in the here and now (Eikeseth & Svartdal 2011). Our cognitive mental process may lead to a rigid and possibly avoid our own potential for change or growth (Berge & Repål 2008).

4.0 Narrative

4.1 Anna

Establishing and sustaining a relationship and good communication is key when connecting with another human being. The relationship between therapist and client, no matter which approach one choses to work from, is of no less importance.

I would like to tell you about my experiences with a female client I encountered several years ago. Anna, a 45-year-old divorced woman and mother of two teenage boys, worked as a Hotel Manager at a large hotel in the city. The job led to many moments of gratification, but also huge amounts of stress. She had recently divorced her husband when she found out he was having an affair. The divorce had not been an amicable one. Verbal outbursts from Anna occurred more often. Her immediate family soon found her to be inflexible, and that she did not take feedback all too well. Her efforts to keep her head above water over a long period of time landed her in my ward for outpatient therapy.

Anna was referred to my ward by her doctor. The doctors report told me that in the last two years Anna had complained about symptoms of depressive thoughts or sadness, persistent fatigue, concentration issues and periods of sleeplessness. She reported aches in her abdomen and lower back that overwhelmed her daily. Physical checkups ruled out any somatic issues. Therefore, her doctor recommended there might be some psychological reason to Annas situation. The periods of anxious and depressive behavior was most likely linked to the all the life changing events in her life. Anna had experienced a miscarriage in her early twenties and lost her father shortly thereafter. Anna would often call off appointments or coffee dates with friends. She struggled with unfinished projects which drove her to be depressed. This led her at times to self-medicate with a bottle of wine, which in turn led to a more depressive and anxious state of mind.

All these factors led her doctor to prescribe a mild anti- depressant for a period to help Anna sleep better. Anna had not benefited from the medication so far. The next step was to attend some type of therapy with the possibility of trying out a different medication. Cognitive Behavior Therapy is compatible with medication therapy

My first meeting with Anna was two weeks after our initial appointment. She had failed to show, so I called her and together we agreed upon a new date. When she sat down, I noticed her arms crossed in front of her chest and legs crossed. She made it clear that she was uncomfortable. I offered her a cup of coffee and sat down across from her. My first intuition was to earn her trust, help her relax and feel safe in my therapy room. At this point I could only imagine the deep sorrow she must have endured. She had never seen a psychiatrist or therapist. Instead of dealing with her grief, it seems she bottled it all up inside.

This woman sitting across from me was not far from my age. Was I not also a single mother? Had I not also experienced hardships as a woman that possibly could give me insight? I reflected on the fact that I might be able to empathize with Annas situation on many levels. I recognized the hopelessness she was trying to disguise. I reassured her that if she were willing to "talk out loud" and put her thoughts and feelings in words, that I simply was interested in understanding her thoughts and feelings so that I in return could help her understand them .

Anna was silent for a while. She then asked, "How does this work?"

Her question expressed openness and curiosity. To me it was a sign of trust. The rest of our first session I explained the principles of how her thoughts and feelings were connected, and how the mind creates automatic responses and various behavioral strategies.

It seemed clear by the end of the session, that Anna was motivated to be guided within the principles of Cognitive Behavior Therapy.

5.0 Discussion

5.1 The Power of a Therapeutic Relationship- compassion and empathy

In the book Acceptance and Commitment Therapy, Hayes (2012) talks about how the therapist, by assuming a "we are in this together" attitude, can have a dramatic effect on the therapeutic relationship. When the therapist is willing to connect with the others emotional pain without rescuing, despairing, or running away, the client is more likely to obtain a sense of reassurance, reducing feelings of being abnormal or different. Hayes (2012) explains how both client and therapist are probably confronted by many of the same dilemmas just by living their lives. This leveled the playing field somewhat. As a therapist, I could capitalize on the common concerns that Anna and I shared, helping us both move forwards. I was not an expert, but a fellow human being that could relate to certain challenges in life.

"Relationships that are powerful, uplifting, moving, supportive or transformational are those relationships that are accepting, attentive to the present…. characteristic of psychological flexibility" (Hayes 2012).

In the beginning Anna would not show up regularly to our scheduled appointments. At first, I was annoyed, but reminded myself that therapy was new to her and I needed to give her time to adjust. This was at a time in my life when there was an ongoing conflict in the family, and I experienced some health issues that were dragging me down. Needless to say, I also was feeling depleted and not especially energetic. My mother had just passed away the year before, so I was still emotionally affected.

It took a while to establish a therapeutic relationship with Anna since she either did not attend at the last minute, or she rescheduled the day before claiming she was not feeling well, or something had come up. Despite this, we were able to work on a tentative conceptualization together and slowly she let her guard down the times she actually attended our sessions. We had by now revealed that her belief- of -self was that of being unlovable and worthless. Her inner dialog was telling her that she was broken, useless and ugly. She suffered from automatic negative thoughts that convinced her that that she was worthless. Her global beliefs were suspicious: she was convinced everyone was out to sabotage her because they were jealous. She was especially wary of female colleagues.

I recall an afternoon when Anna was particularly defensive and restless. We had already worked together for a month or so. She seemed preoccupied and unfocused. I remember asking her if whether she had any thoughts of how things were going so far. She started yelling at me only to start crying. “You will never understand me, you have a perfect life” It seems my manner and compassion triggered a response in her. Suddenly I felt sad and I teared up. At that moment I let her see that I too was vulnerable and obviously had dilemmas of my own. I told her that “No, I can never put myself in your shoes, but I genuinely can feel and understand your pain as a woman.”

Something new happened that day. I saw in her eyes compassion for me, that look a person gets when they actually “see” you. Also, I noticed how she relaxed and sighed. Perhaps I had given the impression of an expert, the fixer without noticing? We talked for a while and exchanged thoughts on the hardships of life.

Since that afternoon I believe she saw me with different eyes. She was rigid in her belief that everyone was judging her and were far better than her. When she finally could see me as an “equal” and genuinely supportive and in tune with her world, I felt we finally had established a solid therapeutic relationship.

5.1.1 Empathy and self-empathy

At the end of the day, if Anna was unable to perceive my empathy, even though I thought I come across as empathetic i.e. genuine, understanding, non-judgmental, we might not have obtained a functional therapeutic relationship. I agree with Berge & Repål (2008) who conveys the importance of empathy in therapy as it stimulates the client’s ability for self-empathy, self-affirmation and self-compassion. Self-compassion and self-empathy helped lead Anna to a more openness to herself, more constructive inner dialogue and reflection over inner thoughts and feelings. Perhaps even revealed a hope that change was possible.

5.1.2 Reflections as a therapist- relating with empathy and equality

Kåver (2012) reminds us that it makes sense that if you like the person you must cooperate with, things go a bit easier. As a therapist, I might not always have a natural liking for the person sitting across from me, or vice versa. That means I must strive to find a positive

feeling and empathy for the client. How I accomplish that, can be a combination of the following: Being present, looking past the symptoms or behavior, an awareness of my own way of being, evoke a sympathetic view for their world and show respect. Is there a culture gap? I believe in checking in one's own attitudes and core beliefs from time to time This allows an awareness on my part on how my conduct influences the environment. I remember thinking "How is my behavior conducive to or obstructive to the therapeutic alliance?". "Am I meeting Anna with "expert glasses?". "Am I giving solutions and advice as to how she should do things?"

There have been times in the past where I have had to check the urge to offer my advice or solutions. An inherent quality very common for many of us in the mental health profession- we would like to fix others. This attitude can surely backfire. Some clients crave you give them the solution. Other take offence if given advice. Once given, it may amplify the feeling of failure. (Kåver 2012).

5.1.3 Conceptualization

Separate problems require separate measures. Therefore, it was important that I developed a cognitive conceptualization at the beginning of therapy sessions with Anna.

Conceptualization is in a way similar to making a map of the client's belief system and behavioral strategies. What are their core assumptions, rules, and attitudes? According to Beck (2005), as we struggle to make sense of ourselves, others and the world growing up, we develop and organize concepts in our minds. Continuously filling new data into existing schemas (templates). If there are enough positive and meaningful experiences, we can grow up with reasonable ideas of ourselves. When negative concepts are allowed to process that information in a distorted and dysfunctional manner, we focus on the negative and develop an inability to process the positive (Beck 2005). When talking to Anna I tried to make a distinction which core beliefs of self she was experiencing. There are three categories to choose from:

Helpless: Was she feeling ineffective, powerless, or inadequate? "I am a victim; I am a failure".

Unlovable: Was she feeling rejected, neglected, or undesirable? "I am defective; I am ugly".

Worthless: Is she feeling bad, crazy, worthless? "I am unacceptable: I am broken".

Mapping and identifying Anna`s core self-beliefs was essential in conducting the correct conceptualization which in turn guided me towards an effective treatment strategy. An example is how she saw herself helpless and ineffective and felt unlikeable. Anna needed to work on her socializing skills and of course engaging in mastery exercises.

Furthermore, we needed to figure out what were Annas core beliefs about others or even the world? Which assumptions, rules and attitudes did she possess? Did she categorize others in black and white, not as complex human beings? Did she see others as manipulating or uncaring? Or did she see others as superior or in an unrealistically positive manner? Often the world outside gets the blame for the obstacles in one's personal world, don`t they? She might even experience generalized global beliefs that the world is unfair, dangerous, and out to get her.

Determining the goals comes about through the conceptualization process in Cognitive Behavior Therapy, where the client and therapist work together to map out the areas the client wishes to improve. In the spirit of therapeutic alliance, the therapist has a responsibility to help the client seek realistic and workable goals (Kåver 2012). Sometimes the goals are too abstract or unrealistic, like "get a better life" or "feel less pain".

Repål (2008:28) suggests the therapist can then get creative by using solution-oriented questioning that could reveal the heart of what needs to be changed. I often ask my clients to imagine if they had a magic wand and could create their life without "x", what would it look like? Working within the Cognitive Therapy structure, I could then use that to define what is keeping Anna from achieving her goal. According to Kåver (2012), essentially if a client can pinpoint goals that are in harmony with their inner values, their motivation and taking ownership increases the likelihood of a positive outcome. Once a client's goals are established, the strategies and techniques used to realize these should be clear, specific and have meaning for them. They might not understand the practical side of therapy or may be experiencing an inner resistance to getting better (Kåver 2012).

In Cognitive Behavior Therapy, there are a multitude of techniques. Exposure (the clients expose herself to a phobia or anxiety in phases), homework (journaling feelings and thoughts that arise in situations), mindfulness exercises or just talking.

A clear awareness of an empathetic therapeutic relationship can be shown simply by being present or holding the client responsible for her part in the journey (Beck 2005). In Annas case, we agreed at the start that homework would fit her well. This consisted of journaling her thoughts and emotions to certain events or situations. This helped her be more conscious of when and how her thoughts might get the better of her. An awareness that led her to become self-reflective and motivated. In addition to this, she responded well to psychoeducation. The knowledge of what was going on in her thoughts and emotions, gave her a sense of empowerment and mastery over her own life.

5.1.4 Behavior Strategies

We all develop patterns for certain behavior to protect ourselves or compensate (coping mechanisms and strategies). As an example, I can tell you about an earlier client who had a strong core belief of helplessness and vulnerability with a general world belief that all others were potentially up to no good. Her strategy included being overly kind and pleasing to others, always on guard for others` negative moods and avoided conflict whatsoever.

My hope in Annas case was that through a sturdy therapeutic alliance, I could guide her to be aware of how her automatic negative thoughts and core beliefs lead to feelings that lead to and automatic behavioral strategies. (Beck 2005) I conducted the conceptualization in collaboration with Anna to help highlight how she reacts to situations and to identify central cognitions and behaviors that should be targeted in her therapy plan.

According to Kåver (2012), there may be several issues or problematic behavior, dozens of automatic thoughts or dysfunctional beliefs. Identifying which is the most likely to work on enables us to work towards clear and functional goals. Let us imagine that I ask Anna what goals she would like to reach in therapy, she might answer she would like to feel *"happier*".

This long-term goal is broad and diffuse, and perhaps harder to achieve. I would then ask her what she would be doing *differently* if she were happier. The behavior she envisions then become short-term goals we can work on at each session. This type of questioning is helpful for me to gain a broader understanding of Annas world and help her mentalize alternative outcomes (Kåver 2012).

The client's engagement in basic strategies such as identifying and responding to their automatic thoughts or core beliefs, completing work assignments or activities throughout our sessions is essential. If they were to become resistant to the strategies that were agreed upon to work with, they might lose focus and become unwilling to cooperate in therapy (Beck 2005).

Kåver (2012) reinforces my thoughts that to assess the progress and plan treatment, I would conduct a mood check at the start and at the end of our sessions. This allowed Anna to check on the degree of her experiences, how she was reacting emotionally and of course to establish how the session was going. All the while I was thinking: "Is there a connection?" "Am I understanding Anna correctly?" "Does she feel that I empathize?" "How is Anna feeling, what are her thoughts?" When I voiced these thoughts openly to Anna throughout therapy, she would aid me by confirming or correcting me. This helped me gain valuable information and nurture the therapeutic alliance.

5.1.5 Socratic method

Socratic questioning used in Cognitive Behavior Therapy is a method that encourages the process that helps the therapist in challenging or changing irrational thoughts that the client reveals. As the therapist probes and challenges these irrational thoughts, the client can improve their awareness and hopefully begin to question their own thoughts or feelings. Berge and Repål (2011) reminds us that Socratic questioning is not a matter of convincing the client that they are wrong or abnormal. The line of questioning needs to be relevant and open up for self-reflection. Kåver (2012) suggests that pointing out the negative thought patterns does not lead to change on its own.

There were times when Anna got stuck in her cycle of "I am a failure, I have no energy, no one loves me and there is no meaning to my life" despite the fact that she had made progress over the course of three months. I would sometimes contest her negative beliefs by engaging in a Socratic conversation. The questions would vary, but I noticed she soon learned to self -reflect and eventually question what her thoughts were telling her.

5.2 How to nurture and maintain the therapeutic alliance

Kåver (2012) reminds us that it would be a mistake to assume that the therapist and client merely need to establish a therapeutic alliance right at the beginning of therapy. The alliance must be attended to like a flower garden. Nurtured and fertilized, tended to on a regular basis. The therapist can look at it as in three stages. Kåver (2012) explains that the opening stage mainly consists of getting to know each other, negotiations, agreements on goals and strategies, and creating trust. The focus being on the client experiencing a sense of hope and motivation. This could mean not interrupting the client or asking too many questions at first. The middle stage can be used to openly explore and reflect the alliance and therapy itself along with the client.

The third stage is most likely to be the most sensitive stage. The working phase is well on its way, the client might be experiencing reduced symptoms or changes in self-awareness. The client can very well show signs of experiential avoidance, or old patterns emerge form the murky waters below. She might feel stuck and the motivation level drops. What if the client becomes aggressive out of frustration? The therapist will then need to muster up all their "coolness" and continue to relate to her with empathy and understanding (Kåver 2012).

At this point the therapist could motivate the client to self-reflection, remind them of their progress or that being stuck is also a normal part of the process. It could be that they are stuck in the past or the future at this point. I would then draw them back to the here and now with breathing exercises or other meditative methods.

Anna experienced a period during the third stage, just as anticipated. She was starting to feel better after a about two months only to start sobbing at the most inconvenient places, for no apparent reason. (yes, I know). This behavior scared her because she was used to asserting herself by yelling at people or acting rudely towards others over the years. My strategy was that I initially re-educated her in the principles of cognitive method, and then we revisited her core beliefs and negative automatic thoughts that had revealed themselves at the beginning of therapy. She was able to reflect on her own knowledge and accept that what she was experiencing was temporary. Anna also benefited from breathing exercises that she still uses to this day.

6.0 Conclusion

I feel I was able to guide Anna using the principles and techniques of Cognitive Behavior Therapy so many years ago. I established and sustained a nurturing therapeutic alliance with her and helped her understand her thoughts, feelings, and behavior. The therapy was semi-structured, customized to her needs and ability. I am aware I have used elements and principles from other types of psychotherapy, assuming a more synergetic approach. Using several methods and approaches is becoming more relevant these days. Hopefully with empathy, understanding and compassion.

I often think people like Anna might not fit into the types of treatment that the mainstream mental health clinics have to offer. To me her ailments seemed more existential in nature than pathological. The waiting lists are long and perhaps that would prevent people from wanting to go to see a therapist.

It makes me wonder if there would be a way to customize this type of therapy for clients like Anna. I am curious if there possibly could be more courses and seminars for people in our community who need guidance when life gets the better of them, but do not have a complex psychological disorder to lean on. I mention this only because after a societal and global isolation caused by Covid 19, there has been a noticeable rise in advertisements on social media for cognitive self-help, self-actualizing and personal growth techniques using online sources. No longer sitting across from your therapist in person to capture that human connection.

Will that become the normal path to therapy?

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