The Therapeutic Relationship and Cognitive Behavioural Therapy: A Case Study of an Adolescent Girl With Depression

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Abstract

The therapeutic relationship in Cognitive Behavioural Therapy (CBT) has been argued to play an essential role in positive outcomes in therapy. However, it is described as necessary and yet, secondary to technique, often receiving little attention in the training of CBT therapists. This case study explores a trainee psychologist’s experience of finding difficulty in feeling authentic and the application of CBT techniques with her client. This difficulty informed the research question; what is the value of the therapeutic relationship in CBT? A hermeneutic approach with a strong emphasis on phenomenology, is used to explore the therapeutic process and the therapeutic relationship that developed between therapist and client. Qualitative descriptions of 11 sessions are divided into themes, these are discussed in relation to what happened in therapy, and are then discussed further regarding discovery and process into the therapeutic relationship. Conclusions from this case study could possibly reveal the value of the therapeutic relationship when working from a CBT approach, and how it seemed to enable the client to achieve her goal in therapy.

Keywords: depression (Major Depressive Disorder), Cognitive Behavioural Therapy (CBT), therapeutic relationship

The therapeutic relationship has been argued to be one of the most important factors in psychotherapy. Currently, Cognitive Behavioural Therapy (CBT) and the value of the therapeutic relationship have been receiving more attention in the literature and research. In this paper, I discuss a case study that supports the value of the therapeutic relationship when working from a CBT approach.

The Rationale for This Case Study

There are a number of factors that I found interesting when I worked with Noluthando’s case that made me decide to use this as a case study. When I first started working with Noluthando’s case, what I found initially interesting was working with an adolescent. Entering into the psychology profession, I believed that working with adolescents was an area of specialisation that I may enjoy working within. This belief was confirmed by this case. CBT was the therapeutic approach I adopted. I found, as a therapist in training, that I was battling to apply therapy, namely CBT and its techniques, to the case and I felt that it was creating distance between me and the client, and the therapeutic relationship. This difficulty enabled me to realise the importance of the therapeutic relationship and how without it, I found therapy to be impossible. There were many dimensions of interest to this case, but what I was interested in particularly within the therapeutic process with Noluthando, was the value of the relationship between therapist and client when working from a Cognitive Behavioural Therapy approach.
Therapy and the Relationship

Different theorists use the terms “therapeutic relationship” and “alliance” interchangeably. Bordin (1994) differentiates between the therapeutic relationship from the therapeutic alliance by describing the alliance as being a relationship in which both the therapist and the client work together in therapy. Both therapist and client have valuable contributions to bring to therapy, and the relationship is a partnership in which both therapist and client work together to reach the client’s goals. Bordin (1994) dispels the view of the therapist being viewed as a “magician” and advocates for the use of the therapeutic alliance.

Many authors agree with Hobson (1985) who states that the therapeutic relationship is what is crucial in any therapy. Yalom and Leszcz (2005) uphold that the relationship is integral for any therapy to be effective and meaningful for clients. When discussing the therapeutic relationship, Kahn (1997) reflects on the value of one of his teacher’s words of more than 30 years ago, “The relationship is the therapy” (p. 1).

Many more authors place value on the therapeutic relationship. Reisner (2005) points to the therapist as being the important factor in determining the outcome of therapy and that the strong alliance formed between therapist and client is a powerful indicator of positives gained in therapy. Teyber (2006) says that forming a strong therapeutic relationship early is the best predictor of positive treatment outcomes, and that the relationship is the foundation of change for the client.

Garfield (1997) highlights common factors that are important in most therapies, and that one of the common factors is the therapeutic relationship. This is considered as one of the most basic factors but is crucial for continuation in therapy and change. Some psychotherapy approaches follow a view that the therapeutic relationship is sufficient in itself and all that is necessary for therapy. However, Garfield (1997) relates that the relationship between therapist and client is necessary but other variables need to be applied too.

The therapeutic relationship is a factor that accounts for 30% of positive outcomes in therapy, as revealed by Lambert (1992). Duncan (2002) tells how therapists place so much emphasis on tools and technique, whilst the perception of how the client views the therapeutic relationship is what is crucial to positive outcomes in therapy.

CBT and the Therapeutic Relationship

Many authors have argued about the importance of the therapeutic relationship and how it is one of the most valuable factors in therapy. One of the major criticisms of Cognitive Behavioural Therapy (CBT) as recounted by Sanders and Wills (1999), is that CBT pays little attention to one of the most valuable cornerstones of therapy, and that is of the therapeutic relationship. The therapeutic relationship in CBT seems to be used as a “container” in which one can address therapist and client issues, and only then can the real work start through the use of techniques. Many therapists that are attracted to CBT often lose interest because of the lack of attention to the therapeutic relationship (Sanders & Wills, 1999).

In CBT’s past, the value of the therapeutic relationship between therapist and client was not viewed as important to affect change, as recounted by Giovazolias (2004). Value was placed on technique. The therapeutic relationship was considered a by-product that just happened as part of the process, but technique was the most important part of therapy with its focus on restructuring automatic thoughts and dysfunctional beliefs, and for clients to do this themselves. Beck, Rush, Shaw, and Emery (1979) call attention to the therapeutic characteristics of warmth, genuineness and accurate empathy, and how these characteristics are necessary but not sufficient in themselves.
for positive change in therapy. The therapeutic qualities are viewed as a means to provide the space for CBT techniques to be applied. This therefore, revealed the view of not regarding the therapeutic relationship as being of primary significance.

Presently, there has been more focus given to the therapeutic relationship in CBT. The relationship in CBT is not viewed as a precondition to technique, but rather the use of both technical and interpersonal factors can result in a favourable outcome (Giovazolias, 2004). According to Leahy (2008), CBT values therapeutic tasks such as working in the here-and-now, rationalisation, behavioural activation, and solving problems; which is different to therapies such as Psychodynamic Therapy. CBT is viewed as being structured and sessions often start with direction and following up on the previous session’s homework task/s (Beck, 2011). This structure and direction may conflict with the client’s use of strategies that prevent them from taking action; such as being avoidant, procrastinating, blaming, assurance seeking, and the acting out of their safety behaviours (Leahy, 2008). Previously, such behaviours as being avoidant, blaming and assurance seeking are often mentioned in psychodynamic terms and other therapies, and it is suggested that CBT ignores these factors by providing no space for them in the therapy. However, Leahy (2008) relates how the relationship between therapist and client may provide insight into how the client operates in other relationships.

Whisman (1993) discusses five studies that looked at the therapeutic relationship as a moderator of change in depression from a CBT approach. Three of the studies found the therapeutic relationship partially significant for a positive outcome with CBT, whereas two of the studies revealed the therapeutic relationship as unimportant for a positive outcome with CBT. Whisman (1993), thereby, argues for further research into the importance of the therapeutic relationship when working from a CBT approach, as there is little evidence supporting its role in a positive outcome in treatment, other than it being a contributory factor.

There are specific factors and techniques that CBT uses when working with depression that have been argued to be as important as the therapeutic relationship, yet technique is often misconstrued as the only focus of therapy (Westbrook, Kennerley, & Kirk, 2008). Leahy (2008) explains how people often have the mistaken belief that the relationship is not a focus in therapy because, in the training of CBT, emphasis is placed on technique, which is falsely believed to be enough for change. According to Belsher and Wilkes (1994), novice CBT therapists are too often focused on technique and forget to consider the therapeutic principles. The therapeutic relationship is considered to be an essential part of therapy, however, CBT has few guidelines on this important component of therapy (Wright & Davis, 1994). Wright and Davis (1994) advocate for CBT training programs to include intensive supervision on the therapeutic relationship and relational issues. According to Addis, Wade, and Hatgis (1999), training programs and psychotherapy researchers of manualised therapeutic approaches (such as CBT) need to focus more on the value of the therapeutic relationship to address the perception that these approaches turn therapists into technicians, rather than authentic human beings. Beck (2011) stresses the importance of a warm therapeutic relationship, rather than the misconceived idea of CBT therapists as being cold and mechanical.

**Case Illustration**

The case study of Noluthando is based on one of the cases that I saw as part of my training during my Masters in Counselling Psychology Degree in 2010. Noluthando was referred to me as a 17 year old girl, who had attempted suicide earlier in the year and was displaying the criteria, according to the DSM IV-TR (2000), for Major Depressive Disorder. I had been exposed to Psychodynamic Therapy, Cognitive Behavioural Therapy and Narrative Therapy as part of my Master’s Degree year, and I decided to use CBT with this case. My training in CBT included a series
of seminars and workshops at my training institution, as well as being supervised by my clinical supervisor, who was trained and used CBT as her primary modality. I decided to use a CBT approach with this case was because of its argued applicability to the South African context (Young, 2009), and of research demonstrating CBT’s efficacy with depression. Butler, Chapman, Forman, and Beck (2006) researched the positive treatment outcomes with CBT, which revealed that, as a therapy, it is highly effective for a number of psychological disorders, including that of children with depression and adolescents with unipolar depression. A number of authors (Brent et al., 1997, 1998; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Klein, Jacobs, & Reinecke, 2007) acknowledge the use of CBT for the treatment of depression in adolescents as valid and as having clinical utility value.

I found a number of interesting factors when I worked with Noluthando’s case; this included working with an adolescent, applying CBT and its techniques, and the therapeutic relationship. As a psychologist in training, I struggled with what I perceived as CBT’s prescriptive treatment plans and techniques rather than following and trusting my own authenticity in the therapeutic relationship with my client. Rogers (1961) ascribes being genuine and real in the therapeutic relationship as very important, as it surmounts to the likelihood of change in the client. Addis and Krasnow (2000) found, in a survey of 891 American psychotherapists, that 33% perceived manualised treatments to detract from the authenticity of the therapist. I found that in using CBT, it was nearly impossible to use techniques to my client without feeling inauthentic and feeling as if I was further isolating and closing communication down. This difficulty enabled me to realise the importance of the therapeutic relationship and how without it, I found therapy to be impossible.

CBT is often misconstrued as being purely technique orientated, and that the relationship and collaboration between therapist and client is neglected and viewed as secondary in therapy (Westbrook et al., 2008). With Noluthando specifically, the forming of the collaborative relationship after a number of sessions enabled her to become more involved in therapy, providing her a space to open up more, which was her initial goal when she started therapy.

Material and Methods

Research Methodology

Kazdin (2003) describes case studies as research focusing on a single case (group or individual). A case study examines the experience of either the clinician or client of the case in a narrative that may explain the problem experienced, investigate why a person is the way that they are, the treatment and why or how it worked, and other such issues. Fishman (2005) emphasises the usefulness of case studies in research, because multiple case studies can enable inductive reasoning and generalisation for future utilisation. Quality case studies have enabled critique and reflection on existing theories and the beginnings of new theories in the social sciences (Lindegger, 2002). For this case study, I decided to use a hermeneutic approach with a strong emphasis on Phenomenology to explore the psychotherapy process. Phenomenology, according to Terre Blanche and Kelly (2002), is an approach that aims to gain understanding of people and their experiences in context.

In this case study, a narrative of the sessions will be presented, which embody my experience of working with Noluthando. The narrative of the sessions is discussed under themes that were derived from an exploration of what happened in sessions. In this case, I have predominantly used qualitative descriptions, but also quantitative data through Noluthando’s self-reports on the Beck depression Inventory (BDI). The BDI was used to monitor Noluthando’s symptoms, and to create further self-awareness and management of her depression symptoms.
Data Collection

Data for this case study was obtained through tape recordings of all sessions, session notes made immediately after sessions with the client, supervision notes, and the client’s BDI scores. Noluthando signed an informed consent form for her therapy to be recorded and used for research purposes. Informed consent was discussed with her in the first session of therapy.

Client’s Background and History

Noluthando is a black isiXhosa speaking South African adolescent girl. She is fluent in English, which is her second language. At the time of psychotherapy, Noluthando was 17 years of age and in Grade 11 at a high school. She was boarding away from her family at her school. She has four siblings, of which she has a younger brother living with her parents, two older sisters and an older brother, who have moved out of her parents’ home. Noluthando reported experiencing living away from home as difficult, but was receiving a scholarship that was providing for her financially to finish her schooling (which denoted the attendance of this particular school). She would visit her home, a township in the Eastern Cape, South Africa, during the school holidays and on long weekends. The home setting that she found herself living in was problematic and she was exposed to difficult life experiences on a daily basis. Noluthando’s mother was reported, by Noluthando, to be an “alcoholic” and she could not remember a time from her childhood when her mother was not drinking, except when there was no money in the household to afford alcoholic beverages. Noluthando described her father as being abusive towards her mother, and she had witnessed this throughout her life. Noluthando’s father was diagnosed as HIV positive in 2009, however, her family does not talk about this. It seemed, as reported by Noluthando, that communication within the family is closed and they often do not speak about their feelings or even directly to each other.

Presenting Problem and Reason for Referral

Noluthando was referred to the psychology clinic by the school counsellor after she had attempted suicide earlier in the year. Noluthando reported that during the year of 2009, she was performing well at school and although she was experiencing problems at home, she felt that she was coping. However, towards the end of 2009, Noluthando recounted how she learnt of her father’s HIV positive status and how this had an impact on her, as well as the relationships she had with her family members. Noluthando told me that she attempted suicide after an incident in which she could not obtain help from her parents, with regard to finding a home for her recently homeless cousin. She attempted suicide by drinking a poisonous liquid and was admitted to hospital.

In the intake sessions, Noluthando met the criteria of Major Depressive Disorder, as defined by the DSM IV-TR (2000). She had difficulty conveying her feelings and displayed a depressed mood state. Noluthando reported not being interested in activities she used to enjoy such as reading fictional books and attending church. She found it difficult to eat, had lost weight and said that she had no interest in the taste of food; whilst, with sleeping, she would battle to fall asleep, and then would wake in the early hours of the morning, unable to fall asleep again. Noluthando experienced feelings of blame and guilt because she felt that she was not doing anything to stop the difficult circumstances at home, such as the abuse her mother experienced from her father. She also reported having a lack of energy, having difficulty concentrating on her studies, and feeling irritated. All of these symptoms,
although varying in manifestation, had been present for more than two weeks. Of significance, was Noluthando’s attempted suicide made earlier that year, and this was the primary focus of the initial intake and therapy sessions.

## Case Formulation and the Treatment Plan

### Case Formulation

Dudley and Kuyken (2006) suggest using the five P’s when formulating a case with Cognitive Behavioural Therapy. These five P’s are: the presenting issues, predisposing factors, precipitating factors, perpetuating factors / maintaining factors and the protective factors. The presenting issues are the presenting problems in relation to the client’s emotions, behaviours and thoughts. Predisposing factors are described as the longitudinal factors that increase the client’s risk to the problem. The precipitating factors are factors related to the proximal events that have triggered the problem. Perpetuating factors are also known as the maintaining factors, and these factors maintain the problem. Finally, the protective factors pertain to a client’s resilience and/or strengths that enable the person to have emotional health and may serve to enable recovery in therapy.

Case formulations in CBT change, depending on the client and what is brought out in a session and therefore, is a work in progress, which enables planning and is used collaboratively with the client, allowing them to agree or disagree with the formulation. This collaboration of the case formulation empowers the client to be aware and have insight into themselves, but also to understand their problem. The below section formulates Noluthando’s case, in relation to the presenting issues, predisposing factors, precipitating factors, perpetuating factors and protective factors from a Cognitive Behavioural Therapy approach.

### Presenting Issues

Noluthando’s presenting problem is described above, under the headings “presenting problem and reason for referral”. When looking at Noluthando’s emotions, she displayed a depressed mood and suppressed most of the feelings that she was experiencing. Noluthando had become withdrawn in her behaviour and was not engaging in activities that she previously enjoyed. According to Noluthando, she was not eating and had lost her appetite, as well as having difficulty in sleeping. She was also closing herself down from communicating with others by being quiet and not opening up to others. She had thoughts of not feeling good enough and thoughts of being a failure. Her emotions, behaviours and thoughts revealed Noluthando’s depression.

### Predisposing Factors

Noluthando reported that she could not remember a time when her mother was not drinking alcohol and witnessing her father abusing her mother. Her mother’s abuse of drinking alcohol might have prevented Noluthando and her mother from forming a secure attachment in her early childhood. Noluthando had never had an open and communicative relationship with her parents, which suggests that the model she received from her parents, on communicating and openness, was absent in her early years as a child. According to Seroczynski, Jacquez, and Cole (2006), depressed adolescents generally have experienced distressing home lifestyles and come from troubled homes.

Noluthando lost her maternal grandparents at a young age and reported being particularly close to her grandmother. She still thinks about her often and may have still been dealing with her loss. Lloyd (1980) describes research that shows that the experiencing of early loss/bereavement in childhood has a high correlation with subsequent
severity of suicide attempts and depression later in life. According to Kaplan, Sadock, and Grebb (1994), life events that may be experienced as stressful, may result in a person’s first episode of a mood disorder.

**Precipitating Factors**

Noluthando reported finding it difficult to attend a school that is so far from home. Being far away from home may be difficult because of the thoughts she may have about what is happening at home in her absence. She said that she feels responsible for the events and problems at home and has a sense of failure, as she does not take any action to help her mother when she witnesses her father abusing her. The silence that surrounded Noluthando’s father’s HIV positive status further isolated her from her family, and placed another emotional burden for her to carry, which is not acknowledged within the family system. Negative core beliefs of parents and parenting styles which are poor in nature, may cause insecure attachments in childhood and are associated with an increase in depressive features later in life as described by Shah (2000). Rothschild (1999) says that disturbances and problems in early childhood relationships have shown to increase vulnerability to depression.

**Perpetuating Factors/Maintaining Factors**

Noluthando was uncommunicative and this means, for her, that she does not speak about her feelings or difficulties that she is experiencing. The silence makes it difficult for her to reach out to someone when problems become too much for her and when she needs help. This made her vulnerable to the suicide attempt she made earlier in 2010. Kaplan, Sadock, and Grebb (1994) attribute suicide attempt rates as being higher in persons who are socially isolated.

Noluthando had lost her appetite, had little interest in food and had lost weight. Her difficulties in eating, affect her mood and can affect her energy levels, adding to her depressed mood state. Noluthando has difficulty sleeping and wakes early in the morning, which may leave her with little energy during the day, consequently affecting her mood. The loss of appetite and difficulty with sleeping reveal problems in basic health maintenance that need attention when working with depression (Leahy & Holland, 2000).

The more Noluthando suppresses her feelings and thoughts, the more she ruminates and forms negative automatic thoughts. When she closes herself off from feeling, she prevents herself from opening up and developing new relationships and working on her present relationships. The suppression of feelings is a defence mechanism that Noluthando uses that is causing harm to her relationships and possible forming of new relationships. Vaillant (1999) describes defensive mechanisms as being the unconscious trying to cope with psychological stress. Properties of defences are unconscious, managing affect, being discrete from one another, are reversible, and may be adaptive or pathological. The DSM IV-TR (2000) places defences in different levels, and suppression is placed under level seven, which is a high adaptive level and allows for optimal adaptation and handling of difficulties.

Noluthando had disengaged herself from activities that she used to enjoy, i.e. attending church activities, reading, etc. Her lack of activity may aid/feed the depression. The lack of activity provides her with more time to think about the negative aspects of her life and maintains her ruminating state. This also isolates her further from the emotional support of her friends and peers, confirming her belief that she is alone and cannot share her difficulties with others. Westbrook et al. (2008) describe how a reduction in activity results in a low mood as there is no engagement in activities that the person used to find enjoyable, and a sense of pleasure and achievement is lost.
Protective Factors
Noluthando reported being passionate about drama and although she had lost interest in much of her activities, drama is still something she enjoys. Her involvement in drama may give her a sense of belonging, a feeling of being pro-social with her peer group, forming part of a community group, and may provide an opportunity for feelings of responsibility and success, which are protective factors against depression, as described by Barrett and Turner (2004). Noluthando has a close relationship with two adults, namely her cousin, and, after the suicide attempt, she developed a deeper relationship with one of her older sisters. These relationships are social protective factors, according to Barrett and Turner (2004). Noluthando immediately set goals in the initial stages of therapy (to open up more with others), making known her motivation to feeling better and improving her level of functioning.

Noluthando and the Six Cycles Maintenance Model of Depression
There are different models and ways of conceptualising when working with depression from a CBT approach. I found the Six Cycles Maintenance Model of depression useful when working with Noluthando’s case. The model was adapted from a Cognitive Behavioural Therapy model of anxiety disorders. According to Moorey (2010), the model for depression was developed based on a CBT understanding of maintenance factors in depression. The model is considered useful in conceptualising cases and when used in treatment planning, when working with depression.

Moorey’s (2010) Six Cycles of depression include: automatic negative thinking, rumination and self-attacking, mood and emotion, withdrawal and avoidance, unhelpful behaviours, physical symptoms and motivation. Automatic negative thinking is the negative thoughts one experiences in any given event or situation that are biased from a negative perspective. Cognitive distortions and their misinterpretations also fall within this cycle. The cycle of rumination involves thinking about a negative event, in which thoughts are about what one could have done differently, how it happened and what went wrong. Ruminations may form part of the past or present, as part of this cycle. Self-attacking describes how one persistently attacks and provides criticism to the self. Mood and emotion as a cycle involves feeling in a low mood, feelings of sadness and emptiness, anxiety and irritability. The depressed person’s mood may serve as a feedback loop as they may feel that their mood makes them feel as though they are no fun to be around. This leads to further self-attacking. The withdrawal and avoidance cycle is a significant maintenance factor in depression. When a person is in a depressed mode, they may feel worthless and may have thoughts of failure, which results in less engagement in activities than what they used to take part in and enjoy. The disengagement of activities prevents the negative thoughts from being tested and reduces the possibility of finding pleasure in activities that one enjoys. The unhelpful behaviour cycle describes behaviours that try to compensate for unpleasant feelings and negative beliefs. The cycle of motivation and physical symptoms describes the biological symptoms of depression and may lock the person into the depressive mode. Feelings of inadequacy may result in the person with depression, leaving them with feeling worthless and with nothing to offer. The environment also forms part of the six cycles and may trigger and maintain depression. The environment may include a person’s home, school, work, friends, family, etc. The six cycles do not naturally occur in a step-by-step fashion and clients will not necessarily fall into all six cycles (Moorey, 2010).

Moorey’s (2010) Six Cycles Maintenance Model of depression helps to provide an understanding of Noluthando’s depression from a CBT approach. Noluthando’s automatic negative thinking includes thoughts such as thinking she is a failure, thoughts that she is to blame for what happens at home and her family life, and thoughts that something is inherently wrong with her. Her ruminations include thoughts of feeling as though she is to blame and feelings of guilt, as she feels that perhaps she could do something different to change the circumstances within
her family. She then places much pressure and responsibility on herself for aspects of her life that are beyond her control. Her mood and emotions include feelings of being depressed, guilt, irritability, inadequacy, and suppression from having any feeling. Noluthando’s withdrawal and avoidance cycle include her disengagement from activities that she used to enjoy, such as: taking part in church activities, socialising with friends, and reading. The unhelpful behaviours that she engages in are her inactivity, the suicide attempt she made earlier in the year, not eating, and avoiding her feelings. Noluthando’s loss of appetite, the difficulties she experiences in sleeping, and loss of energy pertain to the physical symptoms and motivation cycle.

**The Treatment Plan**

In working with Noluthando, I experienced difficulty in following a treatment model strictly, and this will further be elaborated on through the discussion on what happened in therapy, below. The reasons that I found implementing the therapy model difficult at times, was that often Noluthando was in an uncommunicative state and I feared developing a further barrier between us, and at times, it felt inappropriate and damaging to the relationship. However, the treatment plan was followed and was often naturally integrated into therapy. I battled at times (this was part of my process of integration of using CBT and focusing on the therapeutic relationship, and seeing them as separate constructs) to find the balance of the implementation of the therapeutic relationship and using technique.

Moorey (2010) reveals ways to break the cycle of depression / or the six cycles maintenance model. When applying this treatment model to Noluthando, I tried to work with the automatic negative thinking cycle, by testing negative thoughts and beliefs. This involved confronting her negative beliefs, the way she thinks about things, and testing them against reality and other viewpoints. When working with her ruminations and the self-attacking cycle, I used problem-solving and the development of compassion. Part of Noluthando’s therapy involved self-awareness of her thought processes and ruminations, psycho-education on problem-solving and practicing of this in and outside of therapy. Developing compassion would be important for Noluthando, as she frequently believed that she was a failure and needed to learn to be gentler with herself. To help with Noluthando’s mood, we collaborated in recognising mood shifts, as she needed to become more aware of what she was feeling as she often used suppression as a defence mechanism against feeling. In approaching the withdrawal and avoidance cycle, I suggested that Noluthando start to slowly engage herself in activities again and to start opening up, rather than isolating herself. Noluthando could deal with her unhelpful behaviour cycle by not avoiding her feelings, eating when it is difficult, and to rather engage in problem-solving and reaching out to someone for help when things do become too difficult. Psycho-education aided in this. In terms of the motivation and the physical symptoms cycle, it benefited her to become aware of her symptoms, to keep healthy through exercise, and sleeping and eating in a healthier way.

Implementing the above does not mean that the environment/context will change in which Noluthando finds herself in. It is of value to create awareness of this for Noluthando and for her to come to an understanding of how to live in her environment and possible alternatives to this.
The Therapeutic Relationship and Cognitive Behavioural Therapy

Therapy Narratives

The description of the sessions below provides the details and reflections of 11 therapy sessions, to outline what happened in therapy and to provide a narrative of the therapeutic relationship that developed between Noluthando and myself. The sessions are divided into four themes regarding the development and changes in therapy and the therapeutic relationship. These themes are: a quiet beginning (Sessions 1 and 2), the development of the therapeutic relationship (Sessions 3 and 4), a change and progress (Sessions 5 to 9), and reaching out (Sessions 10 and 11 and a phone call). After a description of what happened in therapy sessions, under each theme, the therapeutic relationship, its value in therapy, and my experience of the therapeutic relationship are discussed.

A Quiet Beginning: Sessions 1 and 2

Session 1

Noluthando and I met for the first time in May 2010. In the first session, Noluthando was extremely quiet, her voice was strained and she spoke very little, and she seemed to find the experience difficult. She had a depressed mood and displayed low energy throughout the session. She spoke of the problems that she experiences when she lives at home with her family and how she has been experiencing this for a number of years. I spoke about the suicide attempt with her and she provided little detail other than the method that she used (drinking a poisonous substance), and that she left no suicide note. I asked Noluthando to make a commitment to therapy and we signed a contract that detailed our working together in therapy. Both Noluthando and I kept a copy of this contract. During the session, I asked her about what she would like to gain from therapy and what her goals were. She said, “I would like to be able to open up to people”. Noluthando reported having difficulty trusting people as they have broken her trust in the past. I introduced the BDI to Noluthando, as I had become aware of her depression symptoms in the session. In my training and clinical supervision, I was taught that this inventory is a useful tool in identifying depression symptoms and as a means to explore the client’s experience of their symptoms. We worked through the questions together, which aided me in understanding some of her symptoms. She obtained a score of 16 points. This score is indicative that the client is on the borderline between a mild mood disturbance to clinical depression.

Session 2

In the first session, I experienced difficulty in obtaining information on Noluthando’s personal and family history, and experienced what I did obtain as providing little detail and context. Therefore, I made plans to be more practical in Session 2 and introduced the idea of a timeline. Noluthando seemed willing to give the exercise a try, which involved placing a horizontal line across a page and placing dates as we worked collaboratively in collecting her history. She wanted me to write, and looked at the page whilst dates and events were added. When she spoke of her mother and father, she recalled how she has never experienced her mother not drinking alcohol. Noluthando opened up some more in this session with regard to her suicide attempt and reported that the thoughts that she had before her attempt were about her mother and father fighting, her father’s diagnosis of being HIV positive, the alcohol problem her mother experiences, and her cousin who was helpless and had nowhere to stay. However, through the timeline, she was able to speak about hopes for her future and a possible career in drama. I noted how her posture and voice changed to being upright and more assertive, revealing an uplifted mood when speaking about drama.
Further Discovery and Process
The theme of a Quiet Beginning describes how I experienced Noluthando in the first two sessions. In the first session, I was concerned about Noluthando’s quietness and was unsure of the impact that this may have on the therapeutic relationship and therapy itself. In fact, I felt that I did most of the talking in the session, as Noluthando would not answer questions in more than a few words. Noluthando’s goal in therapy was revealed when I asked her to describe herself, as illustrated in the below transcript.

**Trainee Psychologist:** How would you describe yourself? Who is Noluthando?

**Noluthando:** (pause) I am Noluthando. (silence) I’m not a very talkative person. I don’t like to talk to people.

**Trainee Psychologist:** Is there anyone that you like to talk to?

**Noluthando:** No (silence), I don’t have people like to talk to.

**Trainee Psychologist:** It may be quite difficult for you to be here, because in therapy you will do a lot of the talking.

**Noluthando:** This is the reason I want to come here. I want to overcome that.

**Trainee Psychologist:** Maybe that can be a goal in therapy, something we can work and challenge together?

**Noluthando:** Yes (quiet short laugh).

I reflected on Noluthando’s goal of wanting to open up more and I thought about how I had experienced her as being so quiet and uncommunicative and I wondered how we could approach and work on this together. I felt that it would possibly take time for her to develop trust with me as she has difficulty with trust in her other relationships. I felt that the “Commitment to Therapy” document aided therapy and the therapeutic relationship between us; as it provided a space for her to share her goals of therapy and an understanding of how we would work together.

In the second session, I noted that by me being more practical in the session by working on a timeline together, allowed more information to be shared between Noluthando and myself. This could be because the focus appeared to not be on her but rather on the task. I reflected on how difficult it was for Noluthando to openly communicate and how I could try to create a space in therapy where she could begin to open up more. This would entail moving at a pace, which would be comfortable for her. The recording of the session revealed Noluthando’s silence and how she often used one or two words to answer questions that I asked. I felt that she might have difficulty speaking in the session because of the emotional content, as shown in the transcript below.

**Trainee Psychologist:** It sounds like quite a few people in your family do not get along. What is that like for you?

**Noluthando:** It is hard, (silence) because now you have to choose between family members.

**Trainee Psychologist:** What do you think of your family not getting along?

**Noluthando:** (silence and long pause) I have tried to talk to my father (voice very silent), (inaudible) he doesn’t really talk about it.

**Trainee Psychologist:** He is not open to talking about it. And your mom?
Noluthando: When she is drunk I can’t talk with her (very quiet / inaudible).

Trainee Psychologist: How often is your mother drunk?

Noluthando: (pause) Everyday (long silence).

In the first session, I had not decided which therapeutic approach to use, as I wanted to gain a deeper insight and understanding into Noluthando’s case. It was only after the second session that I felt that Noluthando may benefit from CBT. I felt that the collaborative relationship in CBT may help her to feel responsible for therapy and may assist in her working together with me. Belsher and Wilkes (1994) believe collaboration in CBT to be one of the key therapeutic principles when working with adolescents. However, I had some feelings of apprehension with Noluthando’s passivity in therapy and I wondered how I could use the techniques of CBT without closing the communication down between Noluthando and myself. I was concerned that the techniques of CBT may break down communication in therapy and that the therapeutic relationship may not develop. Strunk and DeRubeis (2005) describe how the techniques of CBT may be experienced as boring and not age appropriate, by younger people, and I did not want her to have this experience.

The Development of the Therapeutic Relationship: Sessions 3 and 4

Session 3

I asked Noluthando, in this session, to draw her family members doing something. I initiated this activity to try and obtain further insight into Noluthando’s family and to see if by working with some activity it would allow her to feel the focus was not so much on her. It was hoped that by doing this it may relieve some of the anxiety she may have been experiencing in sessions so that she may open up (similar to the previous session with the timeline). Whilst drawing, she spoke about her father and how she learnt of his HIV positive status by reading about it in some notes he had made, which she had come across by accident. She related how difficult it was for her as she did not know who to speak to about the information that she had learnt about her father. She described her father as not wanting to talk about his feelings. She described a family that does not communicate with one another. Although I experienced Noluthando finding the session difficult, I found her to open up more than the initial two sessions.

Noluthando completed the BDI in this session and her score increased from 16 points to 19 points. I was concerned about this and reflected about it after the session and discussed it with my supervisor. I thought that perhaps she under reports her experiences and feelings as, in this particular session, she shared how she often smiles even though she is not okay on the inside. Before the session ended, I provided her with an automatic thought record to start recording her thoughts. Beck et al. (1979) describe automatic thought records as an essential part of therapy. Thought records provide the client with the task of responding and challenging negative automatic thoughts in writing and the therapist can then help the client to find a more balanced or alternative thought. I felt that perhaps she would not be accepting of completing the thought record on her own, and was interested to see if she would bring it with her to the following session.

Session 4

Noluthando started the session by saying she was very stressed about the examinations that she was presently busy with at school. That day, she had written her theoretical drama exam and was anxious about her performance, as she felt she had not done well. This allowed us to explore what she often reported, on her BDI, as feeling like a failure. Noluthando reported how she feels like a failure not only in her studies, but also when her father beats
her mother and she does not stand up for her. She said that being a failure is what she really believes about herself and may represent her core belief. A core belief is described by Westbrook et al. (2008) as a person’s bottom line and their basic belief that they have about themselves. We challenged this belief about being a failure by referring to how she has performed at school despite difficult circumstances. I also provided a space for her to reflect on what may happen if she did stand up for her mother when her father became violent. This was not easy for her and she became somewhat disassociated in the session when talking about the feeling and thoughts of being a failure.

In the session, I provided psycho-education about CBT and the hot cross bun that looks at five aspects of life that are interconnected, namely: thoughts, moods, behaviours, physical reactions, and the environment, as described by Greenberger and Padesky (1995). Noluthando and I applied this to her belief of failure at school, and she then later said that she would like to try this in future sessions. The session closed with her speaking about a play that she was involved with as part of a school project, in which she was acting the part of a man who is a husband who fights with his wife. I reflected on how this role may be difficult for her to act and how it is similar to her own life story with her father who abuses her mother. Both Noluthando and I felt it was sad. Noluthando forgot her thought record form as she was busy with studying and said that she would bring it with her the following week. In lieu of her being busy with examinations, I did not challenge her on not completing the thought record as I felt it to be inappropriate at the time and may close communication down between us. On reflection of her not completing her thought record, a possible explanation could be that due to the thought record only being introduced at the end of the session, it may have provided too little time to demonstrate its use effectively. However, she seemed to understand the thought record homework without any further explanation in the session, and therefore, her not completing her homework may have been a preoccupation with her examinations, which seemed appropriate due to her grade level and number of subjects she was writing at the time. Noluthando’s BDI score was 19 points, which had no quantitative difference to the previous session.

**Further Discovery and Process**

The significance of Sessions 3 and 4 was the beginning of the development of the therapeutic relationship. In Session 3, I found that our relationship was developing and Noluthando was beginning to open up. I felt that perhaps as she was beginning to develop a relationship with me, she may have felt more able and willing to disclose how she was feeling and, therefore, was able to report how she often smiles even when she is not feeling okay. This was aided by the drawing that she completed, as it provided a space for her to communicate in an indirect way, as revealed in the below transcript.

**Noluthando:** Like when I went home on the weekend, (long pause), was it Monday, no Tuesday (pause, silence and mumbled voice) I got home and my mother and father were arguing about the chicken. They were both so angry (strained voice) and he just slapped her. I had to help carry her by her feet to the room. I thought she had taken the chicken. When my mother does something wrong she will cry and then stop. Otherwise she cries and will talk about it. This time (silent), she cried and went to the neighbours afterwards. I couldn’t take it. (pause) I called a friend and we went to walk.

In Session 4, I felt that the therapeutic relationship was growing and that Noluthando was becoming more communicative in the therapy setting. This was revealed by her being able to talk about her feelings and thoughts of failure. She opened up about feeling like a failure when she experiences her father abusing her mother and she takes no action, as revealed in the below transcript.
Trainee Psychologist: One of the things I have noticed is how you mark past failures on the questionnaire (BDI) in every session.

Noluthando: (silence)

Trainee Psychologist: Can you tell me a bit about this?

Noluthando: (silence, a minute passes) Before coming to therapy (pause), I couldn't talk to anyone. I couldn't stop what was happening (mumbled and very quiet voice). I didn't do anything to help my Mom.

Trainee Psychologist: You feel as though you could have done something?

Noluthando: I could cover her and then my father would stop (very quiet and mumbled voice).

Although I experienced Noluthando as being more communicative, I was aware that she was battling with this but was trying. I felt this because I could hear in her voice how emotional she was and yet how she did not avoid talking about the issue. In regard to her not completing the thought record, I felt uncertain of being more assertive with her not completing the homework exercise and battled with this. Intuitively, I decided not to follow up on the homework in a confrontational manner, as I felt that doing so may break down any relationship that had developed. I felt a pull between following CBT techniques strictly and focusing on the relationship. I wondered whether CBT was necessarily the best choice for my client, as, although Noluthando understood CBT and how it was applicable to how her thoughts were impacting on her depression, I was unsure of the fit between myself, the techniques and the client. Leahy (2008) describes how through the experience of the training of CBT, often emphasis is placed on technique and little attention is given to the therapeutic relationship, resulting in a misconception of the therapeutic relationship not needing much attention in CBT. I felt the need for emphasis to be on the therapeutic relationship so that communication could be opened between us.

A Change and Progress: Sessions 5 to 9

Session 5

Noluthando arrived 20 minutes late for her session as she reported that she was trying to help someone find a museum in the area. She was quite out of breath when she arrived for the session and was very apologetic. Noluthando was starting holidays and this was to be the last session for a number of weeks because of the long break due to the 2010 Soccer World Cup. She wanted to (during the time away from therapy) work on her own and to do her own therapy. She wanted to work on her thought records (she had completed the thought record homework from the previous session) and reflecting. She reported that she was trying to pick up weight, was sleeping a bit better, and was feeling excited about the Soccer World Cup. Her BDI score reduced markedly to a score of 10 points. The score could be attributed to positive changes she was trying to make in her own life by trying to eat more and being more active in her daily life (helping a stranger, etc.).

Session 6

Six weeks later (extended school holidays due to Soccer World Cup), Noluthando displayed herself in a very introverted manner, she appeared down and her speech was soft, and almost inaudible. She said that there was no fighting between her mother and father during the holiday and that everything was “fine” and “normal”. Everything I asked was answered by Noluthando as being “fine” or “normal”. Her mother moved out of the house and moved to a different town during the holiday and Noluthando reported not knowing why this had happened. I experienced her as being very closed off. I explored the “fine” feeling and Noluthando said that she had decided she was going to be fine regardless of what happened. She named this feeling, “Heaven” and saw it as a way to control how she...
feels about things. She said, “Heaven is a safe, quiet space where I do not hear the bad”. I wondered if not hearing the bad referred to the fighting that she witnesses between her mother and her father. However, I battled to question this as Noluthando was very uncommunicative. When asking her how she felt about being at school, she said that she felt neither good nor bad about it. This further revealed to me how she was attempting to prevent herself from feeling anything and provided understanding regarding why she was quiet, as she was blocking herself from feeling anything. She did reveal feeling positive about a play she would be auditioning for in the following week. I felt that although there was a closing down in communication, there was new insight gained into how she was trying to cope with difficult life issues and her use of suppression as a defence against hurtful feelings. She received a score of 10 points on the BDI in this session.

Session 7

In Session 7, Noluthando said that in the last week she had not been using the “Heaven” space as much as she had, as now she has to attend play practice (Noluthando was successful in her play audition and had been assigned a role) almost every afternoon. She related how being busy keeps her more positive as she feels that she can keep a more positive frame of mind and does not think about the negative things. I then provided psycho-education on activity and depression and also, with regard to sleep so that Noluthando could practically apply and be active in being her own therapist with these factors that can influence one’s mood. Noluthando related her experience of anxiety about being in the play and acting with learners she does not know, however, she felt that she may learn from them and develop new friendships. She brought up an issue that she was experiencing with her roommates, in the place in which she boards. She was able to speak openly about the problem. I experienced her as more open and more talkative than in past sessions. I felt that this change may be because she was taking steps to eat better, engage herself in more activities and to be more aware of her thought processes around issues that she finds difficult. Noluthando’s BDI score decreased by 1 point from the previous session, to a score of 9 points.

Session 8

Noluthando appeared different to how she had presented herself in the first session. She had put on weight and although, as always, was dressed in her school uniform, she appeared very well groomed. She reported finding the activity of being involved in the play helpful with her depression and was worried about going home that weekend because there wouldn’t be much to do. She felt that the inactivity at home may result in her having negative thoughts. We looked at activities that she could do at home, and if she does have the negative thoughts, to use the thought records. This helped Noluthando before as she was able to see where the thoughts originated from and why she was feeling and behaving in a certain way.

Noluthando spoke about an early life experience, in which her father told her about how her mother left her on the street without any food or anyone to care for her. She expressed insight into why her father does not want her to stay with her mother because he is fearful that this may happen again. Noluthando and her boyfriend had broken up that week but she was hopeful that they would get back together. She was uncertain about information that she had received about him in regard to his possible cheating on her. She said that she had thoughts of “maybe the other girl was prettier”, “I wasn’t good enough”, and “something is wrong with me”. Noluthando and I challenged these thoughts together. In this session she scored a BDI score of 7 points.
Session 9
During Session 9, Noluthando appeared to have a low mood, and seemed frustrated and irritated. When I asked her about her feelings, she expressed that she was “okay”, however, she was very quiet. Ten minutes into the session, she reported that she had lost her paternal grandmother that week. I felt that this must be very sad for her as she wanted to learn more about her and develop a relationship with her, but she felt that her father had never given her the opportunity to get to know her. This was yet another topic that she felt that she could not speak to her father about. In fact, Noluthando learnt of her grandmother’s death from her boyfriend (Noluthando and her boyfriend are in a relationship again, however, she reports feeling little about this and says that she has to learn to trust him again) and had not directly communicated with her father that week. She was to see her father on the weekend because of the funeral. She received a BDI score of 10 points, which was an increase from the previous session but I considered it appropriate given the bereavement.

Further Discovery and Process
Sessions 5 to 9 presented with changes and a number of challenges, which enabled growth and progress in the therapeutic goal of Noluthando wanting to open up. In Session 5, Noluthando seemed quite different and positive, not only in how she was viewing the world, but also how she was approaching therapy. She seemed as though she wanted to be active and was no longer taking a passive approach to therapy, although I initially felt that she may have been avoiding therapy when she was late for the session. However, I decided that since this was the first time that this had happened, that I would rather reflect on this with her and see it as a positive outcome of her observing what is happening in the outside world and taking action to help someone else. This was a possible sign of Noluthando opening up as she became involved in helping someone else. When I asked her about what had happened, she said, “I wanted to come” and then explained the incident. Noluthando had also completed her thought record from the previous week revealing her engagement in therapy. This was also confirmed with her wanting to do her own therapy during her holiday. When I asked Noluthando about how she could do therapy on her own she said, “I would use questions. I would ask myself where this feeling or thought was coming from.” This is similar to what one would question when completing a thought record. Noluthando’s wanting to engage in her own therapy revealed to me the value that she found in this process.

When Session 6 started, I felt that we were at the start of the therapeutic relationship again. The session was very quiet and I battled to understand what was happening as Noluthando was very uncommunicative. The following dialogue took place in the session.

**Trainee Psychologist:** And besides feeling cold, how are you?

**Noluthando:** Okay (long pause), fine.

**Trainee Psychologist:** What was it like to come back here?

**Noluthando:** Here? (long pause) Normal.

**Trainee Psychologist:** What was it like to see your brother during the holiday?

**Noluthando:** Fine.

**Trainee Psychologist:** Fine?

**Noluthando:** Yes.
Trainee Psychologist: And your Mom and Dad?

Noluthando: Normal.

I wondered whether Noluthando was upset by the long break in therapy and I was concerned about what was happening in regard to the relationship that we had built. When I decided to explore the “normal” and “fine” feelings, it provided the space where “Heaven” was revealed, which opened up our communication. I felt that although the session had been very quiet, she had opened herself up by speaking of “Heaven” and what it meant for her, revealing how she suppresses herself from feeling. This is shown in the below transcript.

Trainee Psychologist: What does the normal and fine feeling feel like?

Noluthando: In Heaven.

Trainee Psychologist: What does Heaven feel like?

Noluthando: It’s a quiet sort of place. (long pause) Where I can’t hear them, and (long pause), I am just happy.

I became aware that Noluthando’s holiday may have been difficult and this is why she may have been so uncommunicative. Although she was uncommunicative, she was able to speak (with difficulty) about problems that had happened during the holiday. In the previous session, she had seemed so active in therapy and having a desire to work in therapy, that these contrasts of disengagement made me think about the “collaboration” of therapy and how, in any meaningful relationship, there is give and take. I felt that the working together in therapy had started with the essentials of willingness to work together and having trust and openness about the experience. According to Westbrook et al. (2008), in order for a working alliance to begin, empathy and trust in the therapeutic relationship must develop first.

In Session 7, I felt that the therapeutic relationship had formed and collaboration was an integral part of the therapy and working together. It seemed that Noluthando had developed trust, as she was able to speak about and initiate talking about a problem (the problem with the roommates) for the first time without me actively asking her about it. This was interesting to me, as it formed part of the psycho-education, from using CBT, that initiated her thoughts about having difficulty going to sleep and this opened communication about the problem with her roommates. The discussion also involved what she can do when she cannot sleep because of her ruminating thoughts. Technique seemed to, therefore, assist in opening up communication. This is supported by Giovazolias (2004), who explains that with CBT today, technique and interpersonal factors are viewed as complementary and are not used separately.

When I listened to the tape recording of Session 7, I was aware of a difference from the initial sessions. The difference was in the audibility of Noluthando’s voice, her expressiveness and the increase in the amount of words that she had spoken in the session. An example of this, was when I asked her what thoughts she was having when she could not sleep the previous evening. Noluthando said, “I was just lying there... Oh, I was thinking about my phone, because I borrowed my phone to my friend and she borrowed it to call someone. Now, she didn’t bring it back, and I can’t sleep without my phone. I can’t sleep without my phone. It made me feel so angry.” In the initial sessions, Noluthando was giving one word answers to questions, such as, “fine”, “okay”, “nothing”. The contrast of the initial sessions to Session 7 reveals Noluthando being more communicative in sessions.
It was my observation, in Session 8, that Noluthando was becoming more aware of herself, her problems, and how she thinks about things. Although she was still somewhat quiet, she had opened up and had spoken more expressively in the session. In this session, she had shared a significant past experience with regard to her mother abandoning her as a child and negative thoughts that she had about herself when she thought about the possibility of her boyfriend cheating on her. The dialogue below shows Noluthando’s suppression of feelings and thoughts, and how we explored these together in therapy.

**Trainee Psychologist:** Do you find that you are still using Heaven, like in the boyfriend situation?

**Noluthando:** Well, when I don’t, I find I start questioning myself. I try to keep myself busy and then try to think of the exciting things. I would rather think of the exciting things and keep busy.

**Trainee Psychologist:** What kind of thoughts would you have when you are not busy?

**Noluthando:** I would start questioning myself, like why did he do it, is she more beautiful than me?

I found Session 9 rather difficult as Noluthando was very quiet and she seemed to be suppressing her feelings. She had closed down. This was understandable due to the loss of her grandmother. CBT techniques were not used in this session but rather a focus on the client, her needs, the use of empathy and a focus on the therapeutic relationship. The focus on the relationship and what she was feeling seemed appropriate considering the loss that she had experienced. This was congruent with the CBT principle of working in the here-and-now (present), as described by Westbrook, Kennerley, and Kirk (2008), and in maintaining the therapeutic relationship.

**Reaching Out: Session 10, a Phone Call and Session 11**

**Session 10**

It was 1 month before we had our next session because of a nationwide teachers’ strike which made it impossible for Noluthando to come to therapy because of safety and transport issues. Noluthando was in a positive mood and seemed happy to see me. I made her aware that we would have to terminate therapy for the year in a few sessions as I would be finishing my training of my Masters Counselling Psychology degree. I however, recommended that she should stay in therapy, as I felt that she needed support, given her life context and being in Grade 12 the following year.

Noluthando was more active in the session and initiated speaking about a problem she had with her roommates and studying. She was able to express and identify the feeling of irritation she had towards her roommate and was able to reflect on the possible feeling her roommate had. We explored this feeling of irritation in acknowledgement to how, in the past, she would hide away from bad feelings. Noluthando received a BDI score of 8 points.

**A Phone Call**

Shortly after Session 10, Noluthando phoned me on a Friday evening during her school holidays, in crisis. Her mother was drunk and was fighting aggressively with Noluthando’s uncle. I could hear the shouting and fighting over the phone and the despair in Noluthando’s voice. I helped her to call the police and to find a safe space from the fighting as she was very scared and in possible danger. I followed up with Noluthando the next day and she expressed her disappointment in her mother.
Session 11

In Session 11, Noluthando reflected on the incident where she needed to phone me for help and was able to communicate her feelings about what she felt after the incident. She spoke about being more future orientated and was interested to look at her career. She reported feeling that she may like to work within the helping professions and said that she started to feel this way after the incident on that Friday night. Noluthando said that she would be interested in working with issues such as poverty. However, she said that she is still very interested in the drama field. We discussed how, in the future, we could focus on careers as part of therapy in the following year. Noluthando had a BDI score of 4 points in Session 11.

Further Discovery and Process

Sessions 10, 11 and the phone call showed Noluthando opening up and communicating more, thereby, achieving her goal in therapy. When I reflected on what happened in Session 10, I was aware of how different Noluthando presented herself in the first session to how she was now. Her ability to reflect her feeling of irritation and her ability to think about how other people in the scenario discussed were feeling, showed significant growth. The therapeutic relationship had created a space in which she could openly communicate her feelings without feeling that this would impact negatively on our relationship. Sharing of the feeling seemed to be experienced as more of an exploration. It seemed that Noluthando was opening up more and was able to communicate more clearly than how she presented in the initial therapy sessions. Noluthando expressed how she felt about therapy, as revealed in the below transcript.

**Trainee Psychologist:** You and I have met for a number of sessions and I was wondering how you have found coming to therapy?

**Noluthando:** (long pause) I like coming. When I come here I talk about things that are bad, but it’s strange when I leave I don’t feel bad from talking about it. Like when I feel bad when I think about it on my own.

The phone call that Noluthando made in crisis, made me think about how she had reached out and how in the past she was unable to do this. She was also able to become aware of her feelings of disappointment, and this was different to the suppression defence that she had used in the past. Reflecting on the experience, I felt honoured that she had trusted me and had reached out. It conveyed to me that she valued our relationship.

I felt that Session 11 revealed a different goal that Noluthando and I may begin working on in the future. Therapy and the therapeutic relationship had helped Noluthando to open up and she was now trying to make sense of her life and the way forward. She was beginning to do this by focusing on careers and her future. For me, this placed value on the therapeutic relationship as it signified her trust in us working together with a new goal.

Summary and Conclusion

The above discussion of what happened in therapy by means of themes, provides an outline of what happened in therapy and the important role that the therapeutic relationship between Noluthando and myself had in the positive outcome of therapy. The initial presentation of Noluthando was very closed and uncommunicative, as revealed under the theme of a Quiet Beginning. Noluthando expressed opening up as her primary goal. When looking at Noluthando’s history, one can see that she had experienced problematic communication from her early childhood. Once she started to open up in therapy, as described under the theme of the Development of the
Therapeutic Relationship, I became concerned that using a CBT therapeutic approach may close communication, as I perceived it as being very technique orientated. A major criticism of CBT and working with young people, as offered by Gosch and Pollock (2005) is that it is an over structured therapeutic approach and young people may find it off-putting and find the approach dull. However, after applying CBT in therapy, whilst I worked at the client’s and my pace, and what I felt was in the client’s best interest, the therapeutic relationship developed and became collaborative. This collaboration empowered Noluthando to take responsibility in her own therapy. The responsibility and the work Noluthando did in therapy was aided by the therapeutic relationship and is described under the theme of Change and Progress. In sessions under the theme of Reaching Out, Noluthando was more communicative and open in therapy. Noluthando’s BDI score indicated mild depression when she started therapy and her scores ranged between 16 to 19 points. Towards the end of therapy, her BDI scores were indicative of minimal depression symptoms. Her scores ranged from 10 points and below, and in the final session of this case study, she received a low score of 4 points. Much of Noluthando’s symptoms of depression had dissipated in the later sessions, therefore, suggesting how CBT and the relationship in therapy are useful, and how technique and relationship should not be viewed as separate. The very collaborative nature of CBT enabled Noluthando to become active and to start the process of opening up in therapy.

This case study supports the value of the therapeutic relationship when working from a CBT approach. It may be argued that by merely providing technique and by simply changing and activating behaviour and activity, as in Noluthando’s case, may have attributed to her improvement of symptoms. Borkovec, Newman, Pincus, and Lytle (2002) critique CBT by arguing that a change in one of either: cognitive, behavioural, affective or physiological psychological states may lead to a change in all of them. Therefore, using CBT, which focuses on cognitive and behavioural psychological states, is not worthwhile because therapies such as Behavioural Therapy can effectively change the behavioural psychological state and thereby, implement change in all psychological states. However, this activation of activity (and therefore, a change in the behavioural psychological state) in Noluthando could not have taken place if the therapeutic relationship had not developed, as Noluthando was disengaged and not communicating in therapy and in life in general. Had the therapy been purely technique orientated, she may not have committed to the therapeutic process, and therefore, collaboration and working together between therapist and client would not have occurred. Although Noluthando’s depression symptoms may have been alleviated due to the increase in activity, had there been no therapeutic relationship, her goal of opening up may not have been achieved.

The value of the therapeutic relationship, when working from a CBT approach, has been receiving more attention (Gilbert & Leahy, 2007; Leahy, 2008). I support the continued research into the value of the therapeutic relationship when working from a CBT approach. Possible further research could look at quantifiable studies that have coded markers for a strong therapeutic relationship and outcome measures working with adolescents. In the case of Noluthando, the therapeutic relationship provided the space for her to achieve her goal in therapy. From the evidence provided in this case study; the therapeutic relationship appears to play an important role in working from a CBT approach.

Notes

i) Noluthando is a name created to protect the identity of the client. All names of places and people are removed or changed to safeguard confidentiality.
ii) The therapeutic relationship and the therapeutic alliance are terms that are used throughout this case study that have the same meaning for the purpose of this case study.

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**References**


