

CASE TEACHING NOTES

for
"Case of Maria: A Cross-Cultural Study of the Therapeutic Relationship"
by

Stephanie L. Brooke, Psychology Department, University of Phoenix
Janet Morahan-Martin, Department of Applied Psychology, Bryant University

INTRODUCTION / BACKGROUND

This case study illustrates concepts of assessment, diagnosis, and treatment within the context of a counseling relationship. The purpose of the case is to teach the dynamics of the therapeutic relationship, specifically that it is a relationship based on power. In an Introduction to Psychology or General Psychology course, this case would work well if presented at the end of the semester and can be covered under psychological disorders and/or therapy. The students in these courses typically represent a variety of majors since these courses usually satisfy an elective requirement for non-psychology majors. The case could also be used in an Abnormal Psychology course, an upper-level course, where the students tend to be psychology majors. Specifically, the case would work well when covering depression, diagnosing psychological disorders, cross cultural issues, or treatment planning. The case would also be appropriate in upper-level courses in counseling to illustrate issues in cross-cultural counseling, problems in communication, and abuse of power in therapeutic relationships.

Objectives

- To understand the process of diagnosis.
- To conceptualize the process of setting treatment goals.
- To appreciate that various etiological approaches can be taken to explain depression.
- To discuss how the specific etiological approach of a therapist affects treatment goals and methods.
- To emphasize the importance of a client's culture and the impact of cultural communication styles and beliefs.
- To conceptualize the impact of the power dynamics between the therapist and client.

CLASSROOM MANAGEMENT

This case was developed as an interrupted case in which students are given information in a piecemeal fashion. It generally takes 50 minutes to administer. The table below lists the allotted time for each task. These suggested times will work well with a group of 20 to 25 students.

Task	Time
Introduce case and hand out Part I	5 minutes
Think-pair-share activity (see description below)	5 minutes
List critical problems on the board; hand out Part II; break into groups	10 minutes
Groups discuss case, evaluate treatment plan, make recommendations	15 minutes
Class discussion; review whether critical problems were addressed	10 minutes
Write a summary of what was learned	5 minutes
Show objectives that were covered	5 minutes

Part I—The Patient

One strategy for teaching the case is to use a think-pair-share activity when presenting the first part of the case. According to Gunter, Estes, & Schwabb (1999), the think-pair-share activity results in increased student participation and improved retention of information. Using the procedure, students learn from one another and get to try out their ideas in a non-threatening context before venturing to make their ideas more public. Learner confidence improves and all students are given a way to participate in class, rather than the few who usually volunteer. The first part of the activity is to have the student think individually about the following question: “What are Maria’s critical problems?” Have them summarize their thoughts in a paragraph. The next step is to have them share their thoughts with someone in the class. Each student now has a chance to try out possibilities. Together, each pair of students can reformulate a common answer based on their collective insights to possible solutions to the problem (Gunter, Estes, & Schwabb, 1999). The final step of think-pair-share has several benefits to all students. They see the same concepts expressed in several different ways as different individuals find unique expressions for answers to the question. Moreover, the concepts embedded in the answers are in the language of the learners rather than the language of the textbook or the instructor. Here, students can draw or otherwise picture their thoughts and different learning styles, and individual preferences can come into play when attempting to understand the concepts behind the answers (Gunter, Estes & Schwabb, 1999).

Part II—The Therapist

Part II of the case can be done in small groups. Unless you have several blackboards in the room, you will need post-it, poster size paper for the students to record and display their answers to the questions. Part II utilizes a cooperative learning approach. This approach fosters learning based on a high level of interaction. Cooperative learning is a successful teaching strategy in which small teams, each with students of different levels of ability, use a variety of learning activities to improve their understanding of a subject (Johnson & Johnson, 1991). Each member of a team is responsible not only for learning what is taught but also for helping teammates learn, thus creating an atmosphere of achievement. Students work through the assignment until all group members successfully understand and complete it. Research has shown that cooperative learning techniques (Johnson & Johnson, 1991) promote student learning and academic achievement, increase student retention, enhance student satisfaction with their learning experience, help students develop skills in oral communication, develop students’ social skills, promote student self-esteem, and help to promote positive race relations.

According to Johnson & Johnson (1991), cooperative learning has five elements: (1) positive interdependence, (2) face to face interaction, (3) individual and group accountability, (4) interpersonal and small group skills, and (5) group processing. With positive interdependence, each member’s efforts are required for the group to be successful. In addition, each team member has a unique contribution to make to the joint effort because of his or her resources and/or role and task responsibilities. The face to face interaction is a good way for students to check their understanding of the problems and concepts. Team learning allows for problem solving, discussing concepts being learned, and connecting present with past learning. Brainstorming is a valuable part of this process. With this approach, there is individual as well as group accountability. Having students teach what they learned to someone else is a great way to promote learning. Interpersonal skills can promote opportunities for leadership, decision-making, building trust, fostering effective communication, and practicing conflict-management skills. Team learning provides an opportunity for group processing. Members discuss how well they are achieving their goals and maintaining effective working relationships. Further, they make decisions about what behaviors to continue or change.

First, have the groups share their answers to the questions. After the groups have had the opportunity to share their responses, the instructor can lead a discussion about the implications of their findings. Some questions that might be raised include:

- How does the gender of the counselor come into play when working with clients from different cultural backgrounds?
- What does the concept *machismo* mean?
- Is it possible that Latino communication styles are leading to inaccurate assumptions made by the counselor? Alternative wording: Is it possible that Dr. C is not sensitive to cross cultural differences in communication styles?
- What cultural forces may be impacting Maria's manner of expressing psychological conflict?
- What are some stereotypes associated with Latino Americans? How might these stereotypes affect Maria? How do they affect Dr. C's perception of Maria?
- What Latino values might make it difficult for Esteban to see a Caucasian, female psychologist?
- Does Dr. C appear to be sensitive to Maria's cultural values?
- How is the counseling relationship based on power? What are the sources of the counselor's power?
- What are the social costs of divorce for Maria?
- What are the culturally relevant options that would allow Maria to relieve her symptoms and yet remain a part of her cultural group?
- How do other women in Maria's culture cope with these issues and gain power and influence in their lives? What are Maria's options if she leaves her cultural group?

Finally, the instructor should summarize what has been learned based on the discussion. It is important to revisit the initial list of critical problems that the students generated in Part I of the case. The instructor can ask the students if Dr. C's plan addresses Maria's critical issues. The instructor should highlight that most therapists typically combine different approaches, depending on their preferred therapeutic orientation, their therapeutic flexibility, and the specific problem that they are dealing with.

An alternative approach to teaching Part II of the case would focus on interpreting Maria from three perspectives: cognitive, biological, and cultural. Divide the class into three different sub-groups, labeling one a cognitive group, one a cultural group, and one a biology group. Each group would answer the following questions:

- From your group's perspective, what do you see as the source of Maria's emotional difficulty, and how would you diagnose her?
- What would you suggest that Maria do differently?
- What would you suggest that Dr. C do differently?

The instructor should give each group enough time to discuss the three questions and then ask each group to present their findings to the other two groups. The instructor can begin the summary by asking the class what they learned from this activity and try to relate their answers to the teaching objectives. It is important to drive home the point that a counselor's role is to help a client by showing concern for the client, emphasizing the client's inherent worth and dignity irrespective of race, creed, color, or sex, and valuing freedom and opportunity for the client to explore their own characteristics and potentials (Sue & Sue, 1990).

BLOCKS OF ANALYSIS

When a client first comes for treatment, the therapist has several goals: to understand the cause(s) of the client's problems, to establish a therapeutic relationship, to diagnose the client, to understand the client's

world view, and to set treatment goals. Part I of the case can be used to introduce students to the process of diagnosis, case formulation, and setting treatment goals.

The Diagnostic Process

The diagnostic process involves using all relevant information about the client to arrive at a diagnosis that appropriately characterizes that person. This information can come from varied sources: observations, interviews, the client's history, and testing. The *Diagnostic and Statistical Manual of Mental Disorders* provides the basis for diagnosis. Referred to as DSM, the manual is published by the American Psychiatric Association (APA, 2000). DSM is regularly revised based on current research. The current edition is a text revision of the fourth edition and referred to as *DSM-IV-TR* (APA, 2000). DSM requires a multiaxial diagnosis that is an assessment of the client's functioning in five different areas, or axes.

Axis I	Clinical disorders and other disorders that may be a focus of clinical attention
Axis II	Personality disorders and mental retardation
Axis III	General medical conditions
Axis IV	Psychosocial and environmental problems
Axis V	Global assessment of functioning (GAF)

Axis I:

Axes I and II are used to report the mental disorder(s) that the client exhibits. Axis I includes all the psychiatric disorders except personality disorders and mental retardation, which are listed on Axis II. A diagnosis requires that the client's symptoms coincide with the criteria for a specific disorder. In Maria's case, the Axis I diagnosis would be that she is suffering from a mood disorder, specifically a major depressive episode. Maria's case can be used to illustrate that specific diagnostic criteria must be met for a specific diagnosis. For the past two months, Maria's depressed mood is evidenced by her hopelessness. Her varied somatic complaints also may be indicative of depression (Criterion A1). Her appetite is diminished (Criterion A3), she suffers from insomnia (Criterion A4), is fatigued (Criterion A6), and has made a suicide attempt (Criterion A9). Maria's symptoms are inconsistent with a mixed episode (Criterion B) and cause clinically significant distress (Criterion C). Further, the clinician must exclude that Maria's symptoms are not caused by the effects of a medical condition (e.g., hypothyroidism) or substance abuse, either recreational or prescribed (Criterion D), and are not better accounted for by bereavement (Criterion E). The decision tree for differential diagnosis of mood disorders in *DSM-IV* (APA, 2000) could be used to introduce the importance of differential diagnosis. It would be particularly important for the clinician to determine if Maria has ever had any hypomanic or manic episodes to determine whether she may be suffering from a bipolar disorder. Also important is to determine whether Maria has been chronically dysphoric and also is suffering from dysthymia.

Axis II:

No Axis II diagnosis is evident given the limited information on long-term functioning provided in the case. This could be listed as diagnosis deferred, insufficient evidence of long term functioning.

Axis III:

Any current general medical condition(s) that may be relevant to understanding or treating the client's mental disorder are listed on Axis III. None are described in Maria's case.

Axis IV:

Axis IV includes stressors and events in a person's life that may affect the diagnosis, treatment, or outcome of a client's disorder. These may include disturbances in a variety of areas. DSM lists problems related to: the primary support group (child abuse or neglect, marital problems, spousal abuse), the social environment (death of a friend, social isolation, acculturation difficulties), education, occupation (job change, unemployment, difficulties at work), housing (homelessness, unsafe neighborhood), economic situation (poverty, credit problems), access to health care services, interaction with the legal system or crime (crime victim or suspect), or other psychosocial issues (natural disasters). On Axis IV, Maria's marital problems would be listed as a problem in her primary support group.

Axis V:

Axis V is a rating of the client's overall level of psychological, social, and occupational functioning. The Global Assessment of Functioning (GAF) scale in *DSM-IV-TR* provides the basis for Axis V. The clinician rates an individual's level of functioning on a scale of 1–100, with higher numbers reflecting greater mental health. Maria's GAF when she tried to commit suicide would be rated in the 1–10 level if it was considered "a serious suicidal act with clear expectation of death" or in the 11–20 range if it was considered an "attempt without clear expectation of death" (APA, 2000, p.34). If further data were provided, Maria's highest level of functioning in the past year would be useful in assessing Maria's prognosis.

To illustrate the process of multi-axial diagnosis, abnormal psychology students could be asked to provide a multi-axial diagnosis for Maria. It should be emphasized that the case provides limited information, but enough for a tentative diagnosis. The diagnosis is:

Axis I	Major depressive episode
Axis II	Diagnosis deferred, insufficient evidence of long term functioning
Axis III	None
Axis IV	Problems with primary support group: marital problems
Axis V	GAF = 10 (on admission)

A discussion of issues related to the diagnostic process can follow. For example, disagreements in diagnoses could be used to emphasize the importance of diagnostic reliability and consistency between clinicians in the application of a diagnosis to an individual. Students also may question the purpose of diagnosis; this can lead to a discussion of the strengths of a unified and valid diagnostic system. Problems associated with labeling, including the self-fulfilling prophecy, and the stigma of mental illness also can be discussed. Rosenhan's (1973) classic experiment, "On being sane in insane places," though dated, is a good article which provokes much student interest.

It is important to emphasize the importance of DSM for mental health practitioners. The DSM provides a common classification system that makes it easier for clinicians to communicate and conduct research. A clinician who is told that Maria has been diagnosed as suffering from a major depressive episode would know the types of symptoms she has displayed, and, based on research, be better equipped to understand etiology, treatment, and prognosis for Maria. Further, because DSM provides the basis for third party payment, it is an essential tool for clinicians.

At the same time, there is much criticism of DSM. Feminists have argued that DSM reflects gender bias (Kupers, 1997). Kutchins' and Kirk's two books, *The Selling of DSM* (1992) and *Making us Crazy: DSM, the Psychiatric Bible and the Creation of Mental Disorders* (1997) are highly critical of DSM. These provocative and controversial books challenge the reliability of DSM, criticize the proliferation of mental illnesses in DSM, and place the DSM in an historical and social context. A copy of one of their articles critiquing DSM can be found online (Kutchins & Kirk, 1994). Feminist therapy is discussed in a later section.

Treatment Planning

Treatment planning is illustrated in Part II of the case. It involves setting the goals of treatment as well as determining the optimal treatment setting, who will administer treatment, the specific modality of treatment, and theoretical approach. Ideally, this is done jointly with the client. Availability and financial feasibility must be considered. Overall, the goal is to design a treatment plan that can best serve the client's needs. The initial phase of treatment planning is setting goals; that is, establishing the objectives that the clinician and client want to accomplish. This involves immediate management of any pressing needs that require urgent attention and the setting of both short-term and long-term goals.

Treatment sites vary in the types of services and environment that they can provide. Choosing a treatment site takes into account the type and severity of the client's problem(s) as well as personal and financial resources available for the client. Sites include psychiatric hospitals, outpatient treatment, halfway houses, day treatment programs, and non-traditional sources such as schools and Employee Assistance Programs (EAPs).

The choice of the modality or form of treatment is another important part of planning treatment. Options include individual one-to-one therapy, family therapy, or group therapy. Another modality, milieu therapy, involves placing the client in a therapeutic environment or milieu. Alternative modalities include occupational therapy, peer counseling, creative arts therapy, and recreational therapy. Not infrequently, multiple modalities are chosen.

Finally, treatment planning involves the choice of the specific theoretical perspective(s) that will be utilized in providing treatment for the client. Regardless of what treatment site or modality is recommended, the clinician is aware of differences in the approaches to understanding and treating an individual, and chooses the approach(es) that best match the client and specific problem.

Maria's treatment goals:

The goals for Maria's treatment are not specified, but are apparent by deduction. The immediate management goals upon her suicide attempt would have been to stabilize her physically and psychologically. Her therapist's long-term goals for her include being less dependent, more assertive, taking an active part in decision making, and changing the balance of power in her marriage. This stems from a feminist perspective, which is described in a later section.

Maria's treatment plan:

Maria's treatment plan involves hospitalization following her suicide attempt followed by outpatient treatment with individual psychotherapy with a feminist therapist. Family therapy had been suggested, but her husband refused to participate. Students can be asked to explore the implicit goals of therapy that were utilized in the case and then compare them to their own goals. They also should be encouraged to explore the alternative treatment options.

Paradigms for the Etiology and Treatment of Depression

There are multiple explanations for the causes, or etiology, of depression. Treatment in turn is determined by the assumed etiology of depression. The major approaches or paradigms that have dominated psychology differ. Each rests on assumptions about the causes of normal and abnormal behavior, how behavior should be studied, and how abnormalities should be treated. Each serves as a lens through which we understand behaviors and affects how we interpret and organize our observations. As such, they can both illuminate and limit our understanding of behaviors. Clinicians must be aware of their culture-bound values, class-bound values, and language-bound values (Sue & Sue, 1990).

Most clinicians are trans-theoretical and integrate various paradigms in their approach to understanding and therapy. However, it is important for students to understand the major contemporary approaches used to explain and treat abnormal behavior, and how adherence to a given paradigm affects etiology and treatment. Three major approaches used to understand and treat depression are discussed below: the biological, behavioral, and cognitive perspectives. The brief discussion of each and how they relate to Maria's case that follows highlights key areas but is not comprehensive. Any text in abnormal psychology can be used for a more comprehensive overview.

Biological approach:

The biological approach assumes that behavior is genetically based. Research supports the importance of biological factors in the development of depression, especially genetic influences and biochemical imbalances. There is substantial evidence suggesting that genetics play a significant role in mood disorders (Dunman, 2002). The concordance rate for mood disorders is high; i.e., the agreement rate or likelihood that relatives of a person diagnosed with a mood disorder will also have a mood disorder. About 30% of children with one parent with a mood disorder develop a mood disorder; the rate increases to between 50–75% if both parents have a mood disorder (Gershon, 1983). Studies of twins have found a lower concordance rate among dizygotic, non-identical twins (15–20%) than monozygotic, identical twins (up to 67%) (Torgerson, 1986). Further support comes from studies of adopted children that have found a higher concordance between adoptive children and their biological parents than the concordance rate with their adoptive parents (Wender et al., 1986). Support for a genetic explanation is stronger for bipolar than unipolar disorders, and researchers assert that multiple genes are involved. Despite the importance of heredity as a risk factor for the development of a mood disorder, it should be emphasized that genetics do not fully explain the development of mood disorders. If so, one would expect a 100% concordance for identical twins. No current treatment is based on genetic explanations of mood disorders.

Medications are widely used in treating depression (Helpguide.org, 2004). The widespread use and effectiveness of antidepressants attest to a biochemical basis for depression. Two neurotransmitters—serotonin and norepinephrine—have been associated with depression. The major categories of antidepressants include the tricyclics such as Elavil (amitriptyline), monoamine oxidase (MAO) inhibitors such as Nardil (phenelzine), and selective serotonin-reuptake inhibitors (SSRI's) such as Prozac (fluoxetine) and Zoloft (sertraline). Antidepressants take from two to six weeks to work, and treatments based on biochemical explanations of depression—medications—are widely used.

Behavioral approach:

The behavioral approach assumes that all behavior, normal and abnormal, is learned. The learned helplessness model of depression argues that depression is a result of early conditioning (Peterson, Maier, & Seligman, 1993). Researchers have found that animals that are put into a situation where they could not escape from electric shocks do not escape shocks in later situations when they could prevent it. Instead, the

animals become passive and helpless; they have learned to be helpless. Seligman (1991) found similar results in studies of humans who have been conditioned to be helpless in situations where they were initially exposed to aversive stimuli, such as uncontrollable noise and cognitive tasks that are impossible to solve. Noting the similarity in symptoms of depression to those displayed when individuals were conditioned to be helpless, Seligman (1991) argues that depression is a result of early conditioning—i.e., the passivity, helplessness, and apathy that characterize depression result from early experiences in which an individual was made to feel powerless (Maier & Seligman, 1976).

The learned helplessness model has been revised to take into account cognitive factors. This model emphasizes the role of attributions or explanations that people make to explain events. That is, as a result of early conditioning, when depression-prone individuals are exposed to situations, such as trauma and loss, which evoke helplessness, they make self-explanations to attribute their powerlessness to a lack of personal resources. They view this situation as permanent, and see their powerlessness as extending to all situations in their lives. This leads to a sense of hopelessness and depression (Peterson & Seligman, 1984).

Cognitive approach:

The cognitive approach assumes that depression is caused by maladaptive beliefs and faulty cognitive styles (Beck, 1967). In this model, what happens to an individual is not as important as how the individual interprets it. Mood is controlled by cognition. The revised learned helplessness model brings into account the role of both cognitions and behavior. Beck's (1967) model of depression is more cognitive. He argues that many psychological disturbances are activated by automatic thoughts. These thoughts are so deeply entrenched that the person is not aware of them, but can be activated by specific types of events. Automatic thoughts arise from dysfunctional attitudes, which are personal values or rules that individuals hold that interfere with their adequate adjustment. These attitudes underlie why some may be prone to depression and other disorders because, when activated, they lead to negative affect. An example of this process that may apply for Maria is illustrated below:

Table 4. Sample Application of the Cognitive Approach	
Dysfunctional Attitude:	I am nothing if my husband does not love me
Activating Event:	Esteban's rage
Automatic Thought:	I am useless
Emotion:	Sadness, desperation

The cognitive behavioral therapist would help Maria become aware of how her dysfunctional attitudes and automatic thoughts are causing unhappiness and would use cognitive restructuring to help her alter the way she views herself, the world, and the future. These would be combined with behavioral activities to foster greater coping abilities.

The Feminist Approach to Treatment

Dr. C's approach in treating Maria was feminist. The feminist perspective stems from an in-depth study of women's issues. According to Guindon (2004), feminist therapy has the following goals:

- External forces in the “real world” rather than your internal “shortcomings” may be the source of many disorders and psychological distress.
- The feminine attributes of connection and caring are seen as strengths to draw on rather than

inherent weaknesses.

- Reproductive and biological issues are realities that play a role in women's lives throughout all life stages.
- Violence—physical, emotional, psychological—is an all too common consequence of being a woman in our culture and often goes unrecognized.
- Women need information and education about these and other issues and the therapist's role is to provide it.

Feminism “is the advocacy to social equality for men and women, in opposition to patriarchy and sexism” (Macionis, 2005, p. 344). It is important to note that there are several different types of feminist approaches. Liberal feminism asserts that people should be free to develop their own talents and pursue their own goals. Further, they are open to both men and women improving their lives (Macionis, 2005). The socialist feminist seeks to replace the traditional family and feels that capitalism increases patriarchy. Finally, radical feminists seek to eliminate gender. They advocate for social revolution to promote egalitarianism (Macionis, 2005). Dr. C may fall more in the radical feminist category.

Although feminist therapy is a viable treatment option for many clients, students may want to explore the appropriateness of this approach given Maria's presenting problems. Here, the importance of the match between the therapy and client concerns can be addressed.

Cultural Sensitivity

Culture is the lens through which a person views the world. Therefore, culture plays a critical role in mental health because people have different world views (Sue & Sue, 1990). It defines what is normal and abnormal, the causes of problems, and the appropriate ways to help a person who is disturbed. In an increasingly diverse population, it is critical that clinicians be culturally sensitive to their clients. This requires awareness of cultural differences in the expression, perception of etiology, and treatment of mental illness.

There are cross-cultural differences in how abnormality is expressed. Some disorders such as depression are universal across cultures while others are unique to a specific culture. In *DSM-IV-TR*, the latter are called culture-bound syndromes and are defined as “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a specific DSM-IV diagnosis” (APA, p. 898). A number are described in *DSM-IV-TR*. Culture also can influence how individuals experience and express the same disorder. For example, depression is experienced somatically rather than with sadness or guilt in some cultures. In Latino and Mediterranean cultures, depression may be expressed as complaints of nerves and headaches (APA, 2000).

Different cultures explain the causes and treat disorders differently as well, which are known as culture-bound disorders. Many cultures have spiritual explanations. Susto, a culture-bound syndrome that is prevalent among some Latinos in the United States, Mexico, Central and South America, “is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness” (APA, 2000, p. 903). Some symptoms overlap with those of depression: sleep and appetite disturbances, sadness, lack of motivation, and low self-worth. Treatment of Susto is consistent with its perceived causes. It consists of “ritual healings (which are) focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance” (APA, 2000, p.903).

When working with clients from culturally diverse populations, clinicians must be aware of the role of culture. The authors of *DSM-IV-TR* suggest that clinicians dealing with a multicultural population supplement a multiaxial diagnosis with a cultural formation. This consists of “a systematic review of the

individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician" (APA, 2000, p. 897).

In therapy, clinicians must be aware of cultural differences. Research indicates that many minority clients terminate therapy early. Sue & Sue (1990) argue that culturally sensitive approaches to therapy are needed. Cultural sensitivity requires that the therapists be aware of cross-cultural differences in how disorders are expressed and in the meaning of a client's verbal and nonverbal behavior. It is arguably easier for therapists to impose their own values on clients from different cultural backgrounds and this can be harmful. Therapists must be aware of their own cultural biases and not impose them on clients in defining and treating what is abnormal.

Maria's case raises issues relevant to cultural sensitivity. Dr. C is a white female, radical feminist psychologist. Her recommendations reflect feminist values, but it is not clear how Maria views Dr. C's recommendations. Dr. C clearly views Maria's dependency as a problem. She is trying to enable Maria to be more autonomous and assertive, to share responsibility within the marriage, and to divorce her husband. Whereas Dr. C does not believe in patriarchy, Maria was raised in a patriarchal culture. The assumption is that dependency reflects North American values which emphasize autonomy. Yet, in other cultures, including the Latino culture, dependence on others is valued. Dependency in this context is reinterpreted as a positive experience of caring and "counting on other people to provide help in coping physically and emotionally with the experiences and tasks encountered in the world when one has not sufficient skill, confidence, energy and/or time" (Stiver, 1991, p. 160). In this context, one's self-worth and self-esteem is dependent on the quality of one's relationships.

A feminist perspective can never be monolithic or homogeneous as it will reflect the diversity of the complex social relations it addresses. A feminist perspective in family therapy is not limited to any particular methodology or technique, but rather is committed to exploring and elaborating the context and the process in the formation and transformation of any human experience. (Mirkin, 1990, p. 51).

Author's Note: This case was developed to the extreme to demonstrate the mismatch between therapist and client and in no way is meant to criticize feminist therapy.

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