

# Similarities and Differences in Four Views of David

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*In this article, each author gives a brief comment on similarities he or she sees throughout the case formulations captured in the articles by Watson (2010a), Silberschatz (2010), Goldfried (2010), and Caspar (2010). A systematic comparison is added. Overall, the impression is confirmed and maintained that if authors are ready to renounce the use of the jargon of their specific approach, many similarities can be found. There are nevertheless differences that would lead us to expect a different course of therapy and different effects beyond the main effect of recovery in the case of David, pursuing the conceptualization and interventions proposed by Watson (2010b).*

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What are the differences and similarities in the four case formulations from the perspective of the authors? The challenge for them was not to comment on all aspects formulated by the colleagues, but to limit themselves in the interest of brevity to what they found most relevant.

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## JEANNE WATSON

### Similarities

It is clear that all of the authors regard early childhood experiences as important in the development of the person. As I read the other articles, it was clear that we all saw David's problems as originating in his childhood. This perspective draws on Rogers' (1965) view that conditions of worth emanate from early attachment relationships and includes an interpersonal perspective that emphasizes clients' treatment of self and others; all four authors highlight the importance of David's early attachment history. Silberschatz suggests that David's early history is seminal to the development of pathogenic beliefs; Goldfried sees it as the source of his self-criticism and anxiety in the face of conflict in the present, and Caspar as the source of Plans that structure his behavior. While Goldfried and I both come from traditions that posit that knowledge of clients' early childhood experiences is not necessary, we both recognize that this information can be very useful in guiding therapists' interventions.

All four see David's depression as a function of his self-denial and avoidance, that prevents him from achieving specific goals and objectives, together with his intense self-criticism and very high standards. However each author describes slightly different ways of working with these problems within the therapeutic relationship. While there is some overlap between my formulation and that of Silberschatz and Caspar, I would like to stress that, like Goldfried, I do not subscribe to a motivational drive model notwithstanding the recognition that emotions motivate us to action.

### Differences

There are different foci of treatment in each of the articles. Silberschatz is focused on the beliefs that David has formulated from his past that need to be worked through in the therapeutic relationship and the acquisition of greater self-understanding. While Goldfried and Caspar recognize the role of the past, they focus on the clients present problems with work and relationships. Goldfried and Caspar focus on helping the client change his behavior, as they both suggest having the client look at different career options as well as consider the possibility of divorce if his relationship with his wife does not improve. These authors emphasize the need to change behavior in order to change emotion. In contrast, experiential and emotion-focused practitioners believe that changing emotion will change behavior.

Emotion-focused therapy (EFT) therapists trust in clients' own ability to problem solve once they have developed alternative ways of treating themselves, and have full access to their emotional experience and the meanings implicit in their emotion schemes (Greenberg & Watson, 2005). The primary focus in EFT is on processing clients' emotions to help them learn more effective ways of regulating and processing their emotions to develop ways of being that are more satisfying. Thus, change results from restructuring emotion schemes in terms of seeing a situation differently, accessing different feelings in response to a situation, identifying new needs and goals, or symbolizing experience in new ways. Life skills are not taught explicitly; rather the process is one in which skills such as learning to explore and to listen to one's experience, as well as good communication, are modeled and experienced.

## MARVIN GOLDFRIED

### Similarities

Perhaps the most striking similarity between the other authors and me is that we all view David's problems as being associated with implicit cognitive premises, which may not be readily available to conscious awareness. Although the labels for this phenomenon may differ, they all seem related to what Teasdale (1993) has referred to as "implicational meaning." As opposed to propositional meaning, which provides more of a dictionary definition of something, implicational meaning—based on past learning experiences—refers to the difficult-to-articulate emotional meaning associated with one's view of self or others. In a sense, these are the areas of vulnerability in David's life that account for his problematic emotions and behaviors. Relatedly, another point where the four of us agree is that it is essential to obtain a history of early experiences, as this will provide clues to current vulnerabilities and problematic functioning.

Another point of agreement among the four of us is that David's self-criticism plays a key role in his problematic intrapersonal and interpersonal functioning. Similar to Watson and Caspar, my own view is that the intervention process needs to take place during a state of emotional arousal. Like Watson, I place particular importance on a good therapy relationship, which will allow for the implementation of various techniques. Like Caspar, I believe that the specific techniques that are used may be associated with varying orientations, and that what dictates the use of the procedure is less one's primary theoretical orientation and more an attempt to intervene in light of one's case formulation. In the case of David,

who has difficulties in satisfying his personal needs, I concur with both Silberschatz and Caspar, who note that the therapy should help him to become more self-assertive.

### Differences

There are two particular points that Watson emphasizes that are less likely to occur within a cognitive-behavioral (CBT) intervention. One is that she places far more emphasis on attending to any observable lack of emotional arousal. I believe that this is a limitation of CBT, which at times can be faulted for being too intellectual in nature. Indeed, if we see as a goal the need to modify implicational meaning, then more emotional arousal should be in order during our interventions. A second point of difference is that the experiential approach she describes places more emphasis on the use of the therapist's personal emotional reactions, which are used to provide clues to what the client might be experiencing. Although I would personally advocate the importance of therapists using their own reaction to clients, I suspect that my cognitive-behavioral colleagues might disagree with me.

Silberschatz's theoretical model is based on the notion that clients make tests to confirm or disconfirm their beliefs/schemas. I very much agree that it is clinically significant to focus on the discrepancy between schemas and current reality, but I would not ascribe to the drive-like assumption that is implicit in the model. Similarly, Caspar's discussion of the function of criticism as protecting David from being criticized by others makes an assumption that goes beyond what we know about schema functioning, which I believe to be a cognitive-emotional process based on past learning and not necessarily reflective of underlying motives. I would also question whether the specific insights that Silberschatz says are important are needed for therapy to be successful. Finally, a point of difference where I believe Caspar makes an important contribution is that his case formulation and Plan analysis is highly detailed, providing the therapist with very specific areas and issues for the therapeutic focus.

## GEORGE SILBERSCHATZ

### Similarities

There are many interesting similarities among the authors both in our models and theoretical assumptions and in our formulations of the David

case. Watson points out that EFT therapists should focus on those tasks that are most likely to help clients achieve their therapeutic goals. She also points out that the therapist should develop a good understanding of the client's early attachment history because clients learn to relate to themselves and others based on these early experiences. Goldfried also addresses the role of early relational experiences with attachment figures and how these contribute to the development of psychopathology. Caspar's Plan Analysis pays attention to how early childhood traumas (e.g., the mother's uncontrolled rage) play an important role in current symptoms and problematic behaviors. In short, there appears to be considerable convergence among the four models regarding the role of early experiences in the development of interpersonal and intrapsychic schemas. Another point of convergence among the four models is that these schemas often operate outside of a person's awareness; in other words, they are typically unconscious.

The four case formulations of David all emphasize his self-critical tendencies, difficulties expressing anger, and his willingness to subjugate or defer his needs to those of others. In various ways all four authors note that in order to maintain attachment ties (initially to his mother and later to his wife), David has internalized others' criticism so that his attachment will not be jeopardized. Each of the formulations point out that the therapist should seek ways to provide a sense of safety or security so that David could feel more comfortable exploring and expressing problematic feelings. There also appears to be considerable convergence among the authors in emphasizing the importance of a supportive, nurturing therapeutic relationship in this case given David's early traumatic experiences (critical mother who died early in his life; unsupportive, alcoholic father). In his remarks, Goldfried explicitly mentions the importance of the therapist providing a corrective experience—a point on which I wholeheartedly agree and believe is an essential component of any effective therapy.

### Differences

Perhaps because all four of us are experienced clinicians who have an interest in psychotherapy integration, the similarities in perspectives are easier to see than the areas of divergence. Nonetheless, we do come from different theoretical perspectives and there are differences in how we think about cases and treatment. The EFT approach, for instance, pays very close attention to the client's level of emotional arousal, suggesting that optimal therapeutic work occurs in states of emotional activation. Watson also notes the importance of therapists monitoring their own emotional states

and affective reactions to the patient as these can help therapists develop greater empathy for their clients. Although I completely agree with Watson about the value of attending to both the client's and therapist's emotions, I disagree with all three of my colleagues' emphasis on particular therapeutic techniques (e.g., the empty chair) to address and resolve problematic emotions. As noted in my article, I believe that patients are highly motivated to master their traumas and work on therapeutic goals and that patients and therapists cocreate optimal strategies for doing so. Consequently, I do not privilege one particular technique over another. Instead I emphasize the importance of a therapist developing a clear and accurate understanding of the patient's traumas, goals, pathogenic beliefs, and tests. With such an understanding in hand, there are a broad variety of ways that the therapist can be helpful to the patient and no one of these ways is likely to be superior to another.

## FRANZ CASPAR

### Similarities

Some kind of schema model is shared by all authors: Silberschatz's psychodynamic model is relatively cognitive, so it should not come as a surprise that he designates the pathogenic beliefs also as schemas.

History is important to all four, but in different although overlapping ways: Goldfried emphasizes the aspect that history is responsible for vulnerability; for Silberschatz it is a source of pathogenic beliefs. Watson emphasizes the attachment history and that it is needed as a background for understanding all reactions and planning interventions; for Caspar, Plans and the cognitive premises on which Plans are built develop in the past.

The belief in the importance of patient resources, which we hold strongly, is also apparent in several approaches, in various ways: Silberschatz emphasizes most the strengths David has shown in his youth, which are in a way also the background of his view of omnipotent responsibility. Watson and Silberschatz seem to believe most strongly in the force of an innate self-actualizing tendency.

The necessity of including the unconscious for a case conceptualization is particularly emphasized in the Silberschatz and Caspar approaches.

An aspect that I find important is the importance of states during which patients may be more or less accessible for new information and are malleable. Watson and her approach are very much tuned to considering the current patient state; Goldfried emphasizes the role of emotion in

states that are related to the patient problems and therefore relevant; Caspar has elaborated on this on the basis of connectionist models (Caspar, Rothenfluh, & Segal, 1992) but did not go in to this issue with the David case to avoid overload.

All authors refer to research and its impact on how they conceptualize and act.

### Differences

As far as differences are concerned, one might ask what is most unique in each of the approaches. Watson is certainly more in the moment during therapy, using information coming up in the process, although she emphasizes that a productive process could not be accomplished without a good, explicit model. Interventions are strongly based on the perception of the patient's current situation by the therapist, who strongly uses his own reactions, including bodily reactions, to evaluate the current situation of the patient. The notion of a partly under and partly overaroused patient is nowhere else stated so clearly.

Silberschatz applies the heuristic of seeking restrictive guilt feelings and "tests" very stringently. I learned that concept 20 years ago and have believed in taking advantage of it ever since, embedding it in our Plan analytic case conceptualizations, but I would not have been able to come up with a similarly convincing application of these principles to David. The identification with the mother is nowhere else formulated so clearly, nor is David's pride.

Goldfried gives a perfect model for a modern, integrationist behavior therapy approach that preserves the quality of diligent, heavily data-driven case formulation with an emphasis on behavior, abilities, cognitions (including probability estimates), and temporal chains, and is at the same time open to concepts as well as interventions from other models when the case suggests or requires this. In good behavioral tradition, he emphasizes the transfer of learning from therapy into real life and the notion that most important things may happen between sessions.

Caspar (myself) believes to have offered what is the explicit aim and strength of Plan Analysis: A good overview of how motives are interrelated in a hierarchical structure, and how behaviors can be seen as strategies serving these motives. To see the high, perfectionistic standards as means serving particular purposes is just one example of a stringently instrumental view of human functioning.

## SUMMARY

It is important to see that all authors have been selective in what they emphasize. While the importance of something may be the main reason for an author mentioning it, some important things may have remained unmentioned if they were considered to be a matter of course. An example is the continuous revision of one's view of the case as it proceeds. While for Watson, who mentions this, the need for openness to new information may be even more in her constant awareness that for the others, it would probably be correct to say that all authors claim to be open to new information and to revise their formulations on a continuous basis. Another example would be that probably that all of us "use our guts" and not only rational reasoning, whether or not this has been explicitly mentioned.

Table 1 shows a number of aspects of the case and by whom they were mentioned. Some aspects may not speak for themselves. "History" is mainly related to attachment history; "behavior toward the wife" refers to the goal of more assertive behavior toward her; "reliance on the patient" means a particularly strong belief that the patient has an inherent power to develop; "intervention arousal" refers to the notion that for some interventions to work a certain level of arousal is needed; "intervention integrative" means that it is emphasized that the interventions being used may have various origins; "graph" means that some form of graphical representation is used in the case formulation.

Table 1 gives an overview of similarities as well as differences and shows that in our view, as far as differences are concerned, there are no obvious camps or coalitions. If space would allow adding more aspects to

**Table 1.** Overview of Various Aspects and Who Has Mentioned/Given Particular Weight to Them

Aspects	Goldfried	Watson	Silberschatz	Caspar
History (attachment)	x	x	x	x
High standards/self-critical	x	x	x	x
Self-denial	x	x	x	x
Lack skills	x			
Environmental circumstances	x			x
Emphasis on motives			x	x
Emphasis on emotions		x		x
Focus on present	x			
Behavior toward wife	x			x
Reliance pattern		x	x	
Implicit cognition	x	x	x	x
Intervention arousal	x	x		x
Intervention integrative	x			x
Need for inferences			x	x
Graph	x			x



the Table, one might mention the convergence of authors on the importance of a safe, supportive therapeutic relationship and on corrective experiences with the therapist (although the latter was mentioned explicitly only by Goldfried).

An interesting question with reference to the bio-psycho-social claim of modern psychopathological models, and with reference to the rise of neurobiological models, is to what extent biological aspects have been included. Watson refers to Damasio's idea that intense emotional reactions are transformed and soothed when they are represented in words. Goldfried refers to LeDoux regarding the possibility of immediate, noncognitively mediated triggering of emotion. Silberschatz states that the "sense of safety" is based in biology. Caspar states that, because of its neurobiological state, a depressed brain is not open to awareness of needs and to the monitoring of their satisfaction, and claims that such aspects are more thoroughly considered in therapy planning than expressed here. None of the authors comes up with a more systematic analysis of neurobiological factors. Whether this represents neglect of these factors or is justifiably because of the authors giving relatively higher weight to psychological factors in the case of David remains an open question at this point.

Not surprisingly, given their integrative stance, none of the authors has claimed that his or her view is the only possible or true view, not even in some aspects. Unless the aim is to discuss an issue scientifically in a narrow sense, the usefulness of the formulations for the therapists and ultimately for the outcome is what matters. There are many streets leading to Rome! To the extent that what constitutes a good outcome is agreed to, it can be assumed that all approaches proposed here would lead to a good outcome. The differences in these proposed views as well as the procedures used may lead us to expect different side effects. Preferences for such side effects may be based upon the expected chances of a sustained main effect, upon additional patient goals, and of course upon patient preferences. Another issue is that the usefulness of an approach may depend on the selected case. The case of David has allowed all of us to demonstrate specific advantages of our approaches for him, but the next case may make this more or less difficult. A comparative case discussion therefore always calls for discussion of another case and so on.

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